MASSACHUSETTS
HEALTH POLICY COMMISSION

Meeting of the Market Oversight and Transparency Committee

May 10, 2023

Agenda

CALL TO ORDER

Approval of Minutes **(VOTE)**

DataPoints Issue #24: Persistent Cost-Sharing for Contraception in Massachusetts, 2017 – 2020

Findings from the 2023 Health Care Cost Trends Report: Excessive Pricing in the Massachusetts Health Care System

Schedule of Upcoming Meetings

Reducing Unnecessary Administrative Complexity

Agenda

Call to Order

APPROVAL OF MINUTES (VOTE)

DataPoints Issue #24: Persistent Cost-Sharing for Contraception in Massachusetts, 2017 – 2020

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VOTE

Approval of Minutes

MOTION

That the Members hereby approve the minutes of the Committee meeting held on **October 12, 2022**, as presented.

VOTE

Approval of Minutes

MOTION

That the Members hereby approve the minutes of the Committee meeting held on **February 15, 2023**, as presented.

Agenda

Call to Order

Approval of Minutes **(VOTE)**

DATAPOINTS ISSUE #24: PERSISTENT COST-SHARING FOR CONTRACEPTION IN MASSACHUSETTS, 2017 – 2020

Findings from the 2023 Health Care Cost Trends Report: Excessive Pricing in the Massachusetts Health Care System

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The Affordable Care Act contraceptive mandate has been in effect since 2012, and has contributed to reduced spending and improved access and outcomes for patients.

- The ACA preventive care mandate requires commercial insurers to cover without costsharing at least one form of contraception in each FDA-approved category as well as related services. This mandate applies to all plans offered by employers or on state marketplaces.[1,2,6]
- The mandate has had many benefits for patients nationally, including markedly **reduced cost-sharing** payments, **increased adherence** to contraception, increased use of **highly cost-effective methods**, a decrease **in unintended pregnancies**, and **narrowing income disparities** in unintended pregnancy rates.[3-5]
- Prior HPC research has found similar benefits for residents of the Commonwealth: from 2011 to 2014, the share of oral contraceptive prescriptions with patient cost sharing dropped from **98.1% to 6.5%.**[7]

1 Kaiser Family Foundation. Preventive Services Covered by Private Health Plans under the Affordable Care Act. August 2015. Available at https://files.kff.org/attachment/preventive-services-covered-by-private-health-plans-under-the-affordable-care-act-fact-sheet# Excludes "grandfathered" plans that were in existence prior to March 23, 2010, and have not substantially changed in terms of benefits, cost-sharing, employer contributions, or other features of coverage since then
2 The Commonwealth Fund. The Latest Legal Challenge to the Affordable Care Act's Preventive Services Guarantee. July 25, 2022. Available at https://www.commonwealthfund.org/publications/explainer/2022/jul/latest-legal-challenge-affordable-care-act-preventive-services#
3 Becker NV, Polsky D. Women Saw Large Decrease In Out-Of-Pocket Spending For Contraceptives After ACA Mandate Removed Cost Sharing. Health Affairs. 2015;34(7):1204-1211. https://doi.org/10.1377/hlthaff.2015.0127
4 Snyder AH, Weisman CS, Liu G, Leslie D, Chuang CH. The Impact of the Affordable Care Act on Contraceptive Use and Costs among Privately Insured Women. Womens Health Issues. 2018;28(3):219-223. https://pubmed.ncbi.nlm.nih.gov/29544988/
5 Dalton VK, Moniz MH, Bailey MJ. Trends in Birth Rates After Elimination of Cost Sharing for Contraception by the Patient Protection and Affordable Care Act. JAMA Network Open. 2020;3(11):e2024398 https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2772565
6 Centers for Medicare & Medicaid Services. Affordable Care Act Implementation FAQs - Set 12. Available at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12
7 Massachusetts Health Policy Commission. HPC DataPoints Issue 3: Contraception Spending and Utilization. Available at https://www.mass.gov/info-details/hpc-datapoints-issue-3-contraception-spending-and-utilization

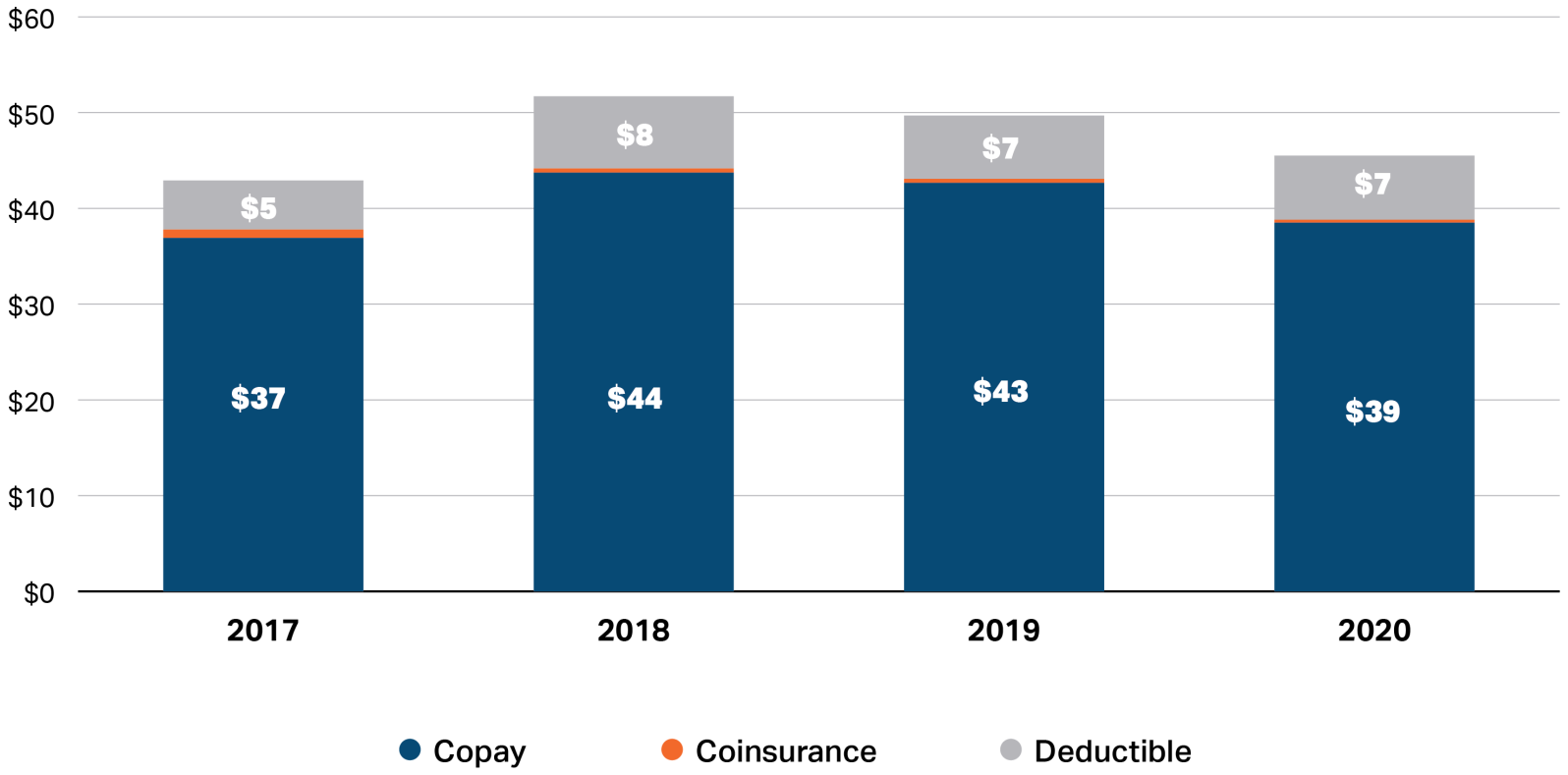
Confusion about the mandate persists, and implementation remains imperfect nationally.

- HRSA has issued updates on its guidance on the mandate, including clarifying in 2021 that it covers contraceptive counseling, initiation of contraceptive use, and follow-up care.[1,2] However, confusion has persisted about some aspects of how the mandate is applied, and there have been some gaps in its implementation.[3,4]
- During the current time of significant federal policy change on reproductive health,[5] it is important to understand the status of cost-sharing for contraception in the Commonwealth and any outstanding access barriers – especially because the Commonwealth has made reproductive health service affordability and access a priority.[6]
- In the 24th issue of the **DataPoints series**, the HPC investigated out-of-pocket costs for common contraceptive methods and services in the Commonwealth: prescription oral contraception and encounters for implant and IUD services, IUD follow-up care, and contraceptive options counseling.

1 Keith K. Federal Officials Clarify Contraceptive Coverage Requirements. Health Affairs Forefront. August 3, 2022. Available at https://www.healthaffairs.org/content/forefront/federal-officials-clarify-contraceptive-coverage-requirements
2 Centers for Medicare & Medicaid Services. FAQs about Affordable Care Act Implementation Part 54. July 28, 2022. Available at https://www.cms.gov/files/document/faqs-part-54.pdf
3 Hall KS, Kottke M, Dalton VK, Hogue CR. Ongoing Implementation Challenges to the Patient Protection and Affordable Care Act's Contraceptive Mandate. American Journal of Preventive Medicine. 2017;53(5):667-670. https://pubmed.ncbi.nlm.nih.gov/27939235/
4 Hughes R, Minnick DR, Peters A. HRSA's Confusing, Out-Of-Date Guidance Undermines Contraceptive Coverage And Access. Health Affairs Forefront. September 28, 2022. Available at https://www.healthaffairs.org/content/forefront/hrsa-s-confusing-out-of-date-guidance-undermines-contraceptive-coverage-and-access
5 Dobbs, State Health Office of the Mississippi Department of Health, et. al. v. Jackson Women's Health Organization et al. https://www.supremecourt.gov/opinions/21pdf/19-1392_6j37.pdf
6 e.g, with measures such as the 2017 ACCESS Law, the 2020 ROE Act, and Chapter 127 of the Acts of 2022. See https://www.mass.gov/info-details/information-for-providers-about-access-to-birth-control-and-emergency-contraception; https://www.npr.org/2020/12/29/951259506/massachusetts-senate-overrides-veto-passes-law-expanding-abortion-access; https://malegislature.gov/Laws/SessionLaws/Acts/2022/Chapter127

Under 2% of oral contraceptive prescriptions have had cost-sharing in recent years. For the minority of prescriptions that do have cost-sharing, patients paid about $40-$50 on average for a one-month supply.

Mean copay, coinsurance, and deductible spending per one-month supply of oral contraceptives with cost-sharing, 2017-2020



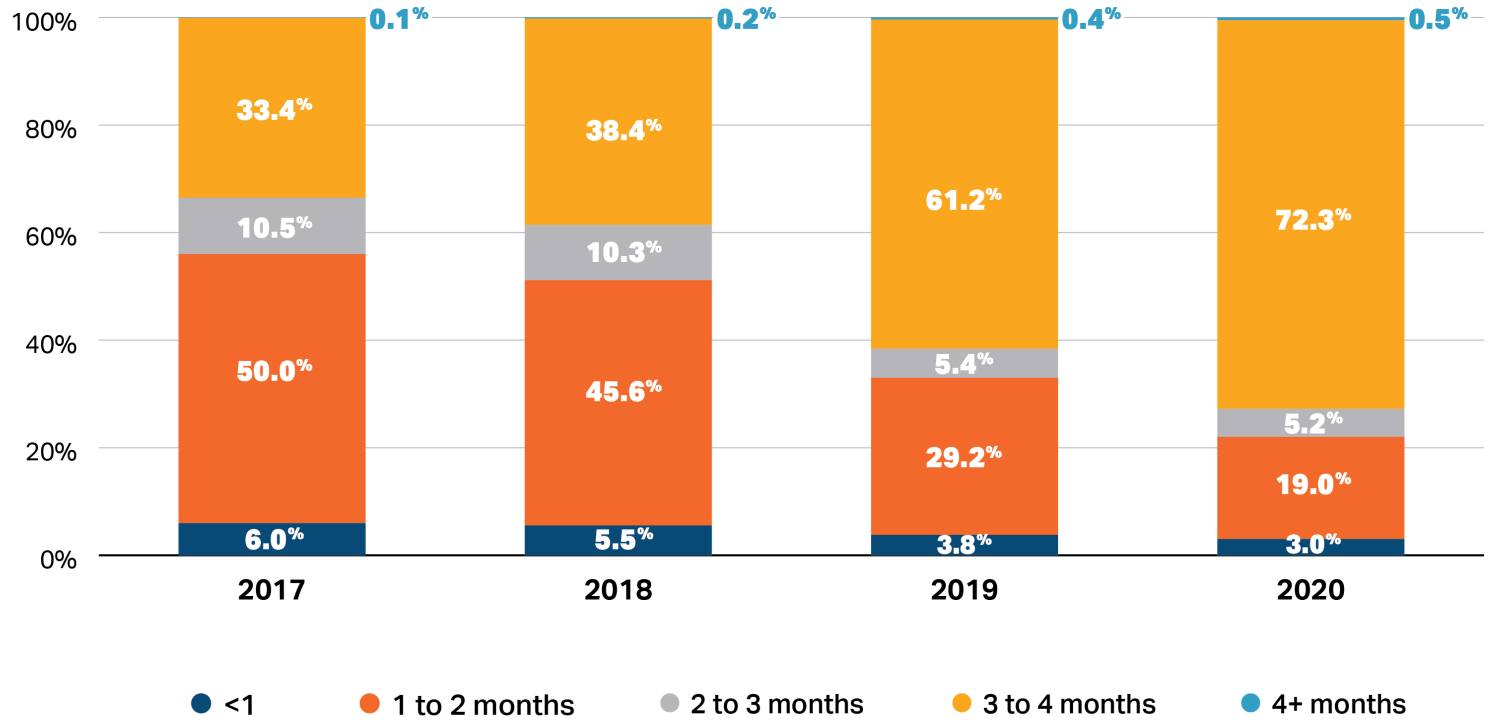
Each year from 2018-2020, 80% of the small subset of birth control prescriptions with cost-sharing were for branded drugs.

Source: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v10, 2017-2020

The share of oral contraceptive prescriptions filled for a 3-4 month supply has steadily increased.

However, there appears to be little uptake of 12-month supplies in the years immediately following the 2017 ACCESS law.[1]

Share of oral contraceptive prescriptions each year by number of months' supply, 2017-2020

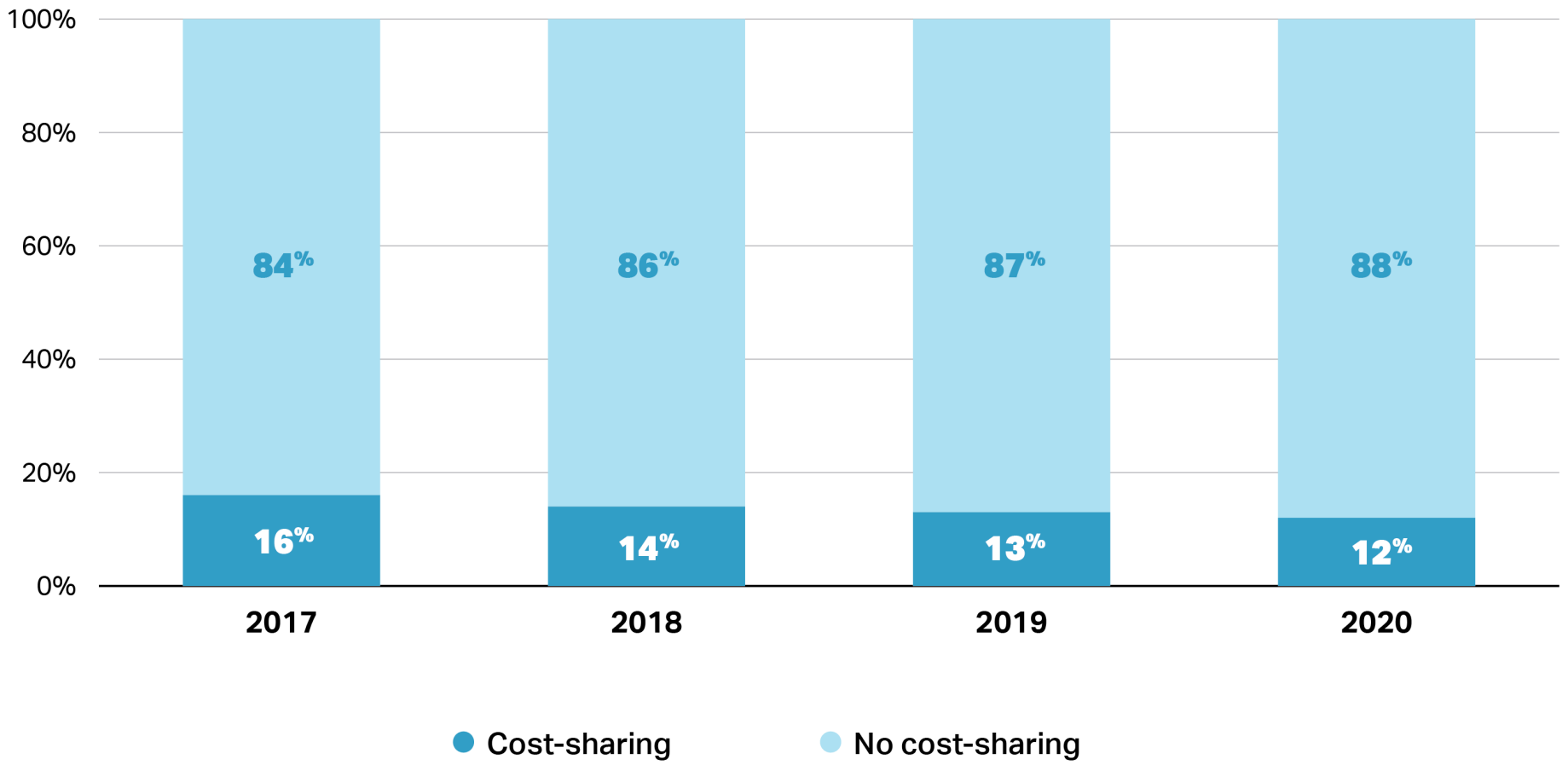


Notes: All categories mutually exclusive: 1 to 2 months includes ≥1 and <2 months, 2 to 3 months includes ≥2 and <3 months, 3 to 4 months includes ≥3 and <4 months.
Source: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v10, 2017-2020

1 Massachusetts Department of Public Health. Information for providers about ACCESS to birth control and emergency contraception. Available at: https://www.mass.gov/info-details/information-for-providers-about-access-to-birth-control-and-emergency-contraception

Over 10% of individuals continue to pay cost-sharing for encounters with health care providers for IUD, implant, contraceptive counseling, or follow-up care.

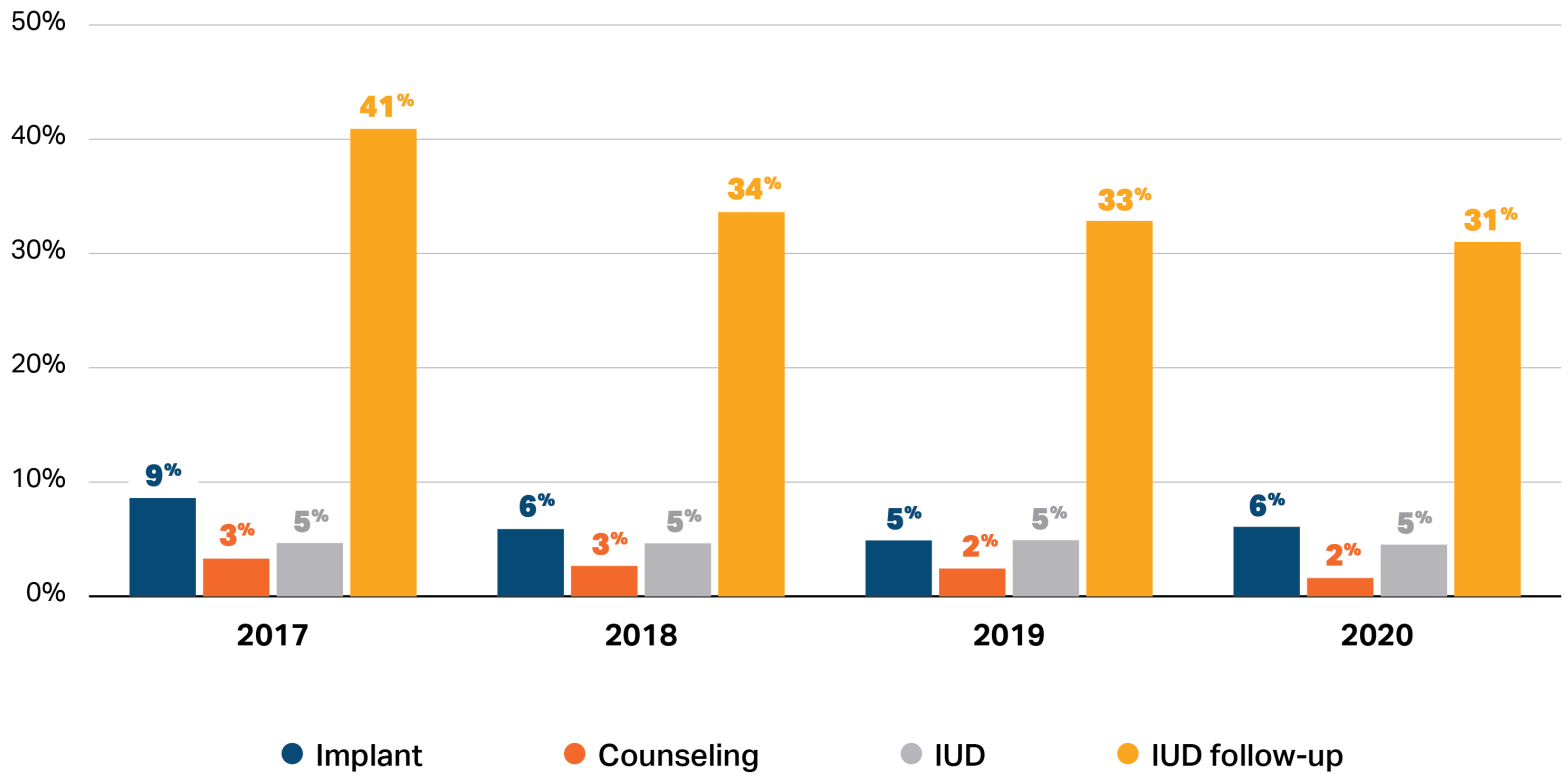
Share of commercially insured individuals with and without out-of-pocket costs for contraceptive encounters, 2017-2020



Source: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v10, 2017-2020

Most encounters that involve cost-sharing are for IUD follow-up care.

Share of encounters for IUD, implant, counseling, and follow-up services with out-of-pocket costs, 2017-2020

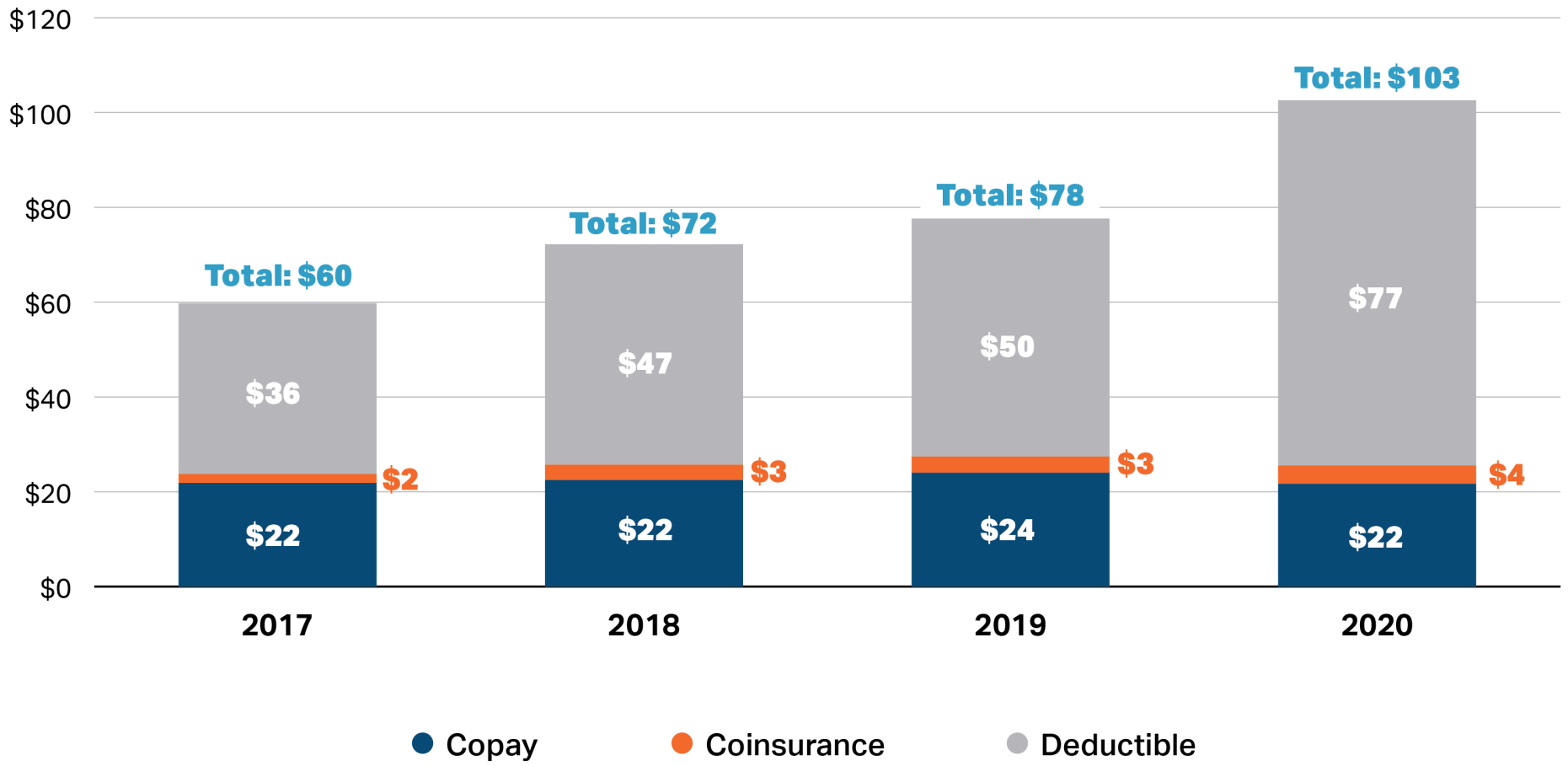


Over 60% of all encounters that have cost-sharing each year involve IUD follow-up care.

Notes: Encounters including multiple services are counted more than once (e.g., an encounter including both options counseling and IUD services will appear in both the Counseling and IUD bars in the exhibit)
Source: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v10, 2017-2020

Per-person out-of-pocket costs for contraceptive encounters with cost-sharing have risen over time due to rising deductible payment amounts.

Mean per-person contraceptive encounter copay, coinsurance, deductible, and total cost sharing amounts among those with any out-of-pocket costs for contraceptive encounters, and share of total out-of-pocket costs represented by deductibles, 2017-2020



Source: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v10, 2017-2020

Conclusion and Recommendations

- A decreasing share of Massachusetts residents pay out-of-pocket costs for contraception, but those who do face cost-sharing are **paying more over time**. Cost-sharing is most likely to occur for IUD follow-up services.
- Persistent cost-sharing may **represent an access barrier** even when appropriate under the ACA.
- Rising cost-sharing payments due to rising spending on deductibles may reflect **growing enrollment in high-deductible health plans**, driven by the **increasing unaffordability of health insurance premiums** in the Commonwealth.
- Providers and payers in the Commonwealth should ensure that they are following the latest guidance on services covered under the mandate, and should **ensure that their patients have up-to-date information about their rights and options**, so that contraception is covered as intended.

Agenda

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DataPoints Issue #24: Persistent Cost-Sharing for Contraception in Massachusetts, 2017 – 2020

FINDINGS FROM THE 2023 HEALTH CARE COST TRENDS REPORT: EXCESSIVE PRICING IN THE MASSACHUSETTS HEALTH CARE SYSTEM

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HPC 2023 Agenda for Action

In 2023, the HPC is pursuing an ambitious action plan to reduce health care cost growth, promote affordability, and advance equity, in addition to ongoing workstreams and responsibilities.

This comprehensive plan will prioritize disseminating data-driven insights and policy recommendations to address the critical challenges facing the health care system today: the workforce crisis, high costs, and persistent health inequities.

1. **Bolster the HPC's Cost Containment Activities**
2. **Address Health Care Workforce Challenges and Identify Solutions**
3. **Advance Health Equity**
4. **Enhance Pharmaceutical Pricing Transparency and Accountability**
5. **Reduce Unnecessary Administrative Complexity**

The HPC recommended action to address excessive prices as part a comprehensive approach to bolster the state's cost containment strategy.

- **Target Above Benchmark Spending Growth.** The Commonwealth should take action to strengthen the Performance Improvement Plan (PIP) process, the HPC's primary mechanism for holding providers, payers, and other health care actors responsible for health care spending growth. Specifically, the HPC recommends that the metrics used by CHIA to identify and refer organizations to the HPC should be expanded to include measures that account for the underlying variation in provider pricing and baseline spending, and by establishing escalating financial penalties to deter excessive spending.

- **Constrain Excessive Provider and Pharmaceutical Prices.** The Commonwealth should take action to constrain excessive price levels, variation, and growth for health care services and pharmaceuticals, by imposing hospital price growth caps, enhancing scrutiny of provider mergers and expansions, limiting hospital facility fees, and expanding state oversight and transparency of the entire pharmaceutical sector, including how prices are set in relation to value.

- **Limit Increases in Health Insurance Premiums and Cost-Sharing.** The Commonwealth should take action to hold health insurance plans accountable for affordability and ensure that any savings that accrue to health plans are passed along to businesses and consumers, including by setting affordability targets and standards as part of the annual premium rate review process.

The 2022 Policy Recommendations reflect a comprehensive approach to reduce health care cost growth, promote affordability, and advance equity.

Reducing excessive health care spending is essential to achieve an affordable, equitable, and accessible health care system for all residents of Massachusetts.

- **Commercial health care spending per person in Massachusetts grew 5% annually from 2019-2021.** Combined family health insurance premiums and out of pocket spending neared **$25,000 per year in 2021, on average in Massachusetts**.

- **These trends are unsustainable for government, employers (particularly small businesses), and all residents.** Premium growth that outpaces income growth will continue to **erode take-home pay, increase avoidance of care, worsen health outcomes**, and will require more and more residents to **choose between health care and other basic needs.**

- Limiting the future growth of health care spending will require identifying **areas where spending growth can be moderated**, particularly as policymakers and the HPC have identified the **need for investments** in **primary care, behavioral health care, health equity, the health care workforce,** and in **under-resourced providers**.

- In this **10th Annual Health Care Cost Trends Report**, the HPC returns to a chapter of the first Annual Report (2013), which discussed wasteful health care spending in Massachusetts.[1] This report will **highlight and quantify** areas of excessive spending throughout the health care system where **savings are *achievable* within the current system *without harming quality and access to care***.

Sources: Massachusetts Health Policy Commission. 2013 Cost Trends Report Chapter 3: Wasteful Spending. Available at: https://www.mass.gov/doc/chapter-3-wasteful-spending/download

2023 Annual Cost Trends Report: Outline and Public Presentation Dates

- **Chapter #1: Massachusetts Spending Performance** – *some initial findings presented at the HPC Benchmark Hearing March 2023; further findings to be presented at the HPC Board meeting on June 7, 2023*
- **Chapter #2: Excessive Spending in the Massachusetts Health Care System**
  - Excessive Prices (to be presented at the May 10, 2023 MOAT meeting)
  - Excessive Utilization
    - *Use of unnecessarily high-cost sites of care*
    - *Provision of care that adds little to no value*
  - Excessive Administrative Costs (Payer and Provider)
- **Five Chartpacks** – *key findings to be presented at the HPC Board meeting on June 7, 2023*
  - Primary Care and Behavioral Health *(new!)*
  - Price Trends and Variation
  - Hospital Utilization
  - Post-Acute Care
  - Provider Organization Performance Variation
- **Performance Dashboard** – *to be presented at the HPC Board meeting on July 12, 2023*
- **Policy Recommendations** – *to be presented at the HPC Board meeting on July 12, 2023*

In order to contribute additional data necessary to develop legislative policy options, the HPC is releasing three new publications in 2023 related to health care pricing.

2023 Health Care Cost Trends Report (September 2023)

- *What is the extent of excessive commercial prices in the Massachusetts health care system that could be reduced without harming quality?*

Options for Controlling Provider Prices (~Fall 2023)

- *What are some policy approaches for reducing excessive commercial provider prices and what are the implications of various approaches and implementation details?*

2023 Provider Price Variation Update (~Fall 2023)

- *How has the variation in provider prices changed since 2016 when the HPC released a report on Provider Price Variation and held a series of public meetings on options to reduce unwarranted provider price variation? To what extent are commercial prices related to quality, the amount of competition in the market, public payer mix, and other factors?*

Background on Prices Paid to Health Care Providers

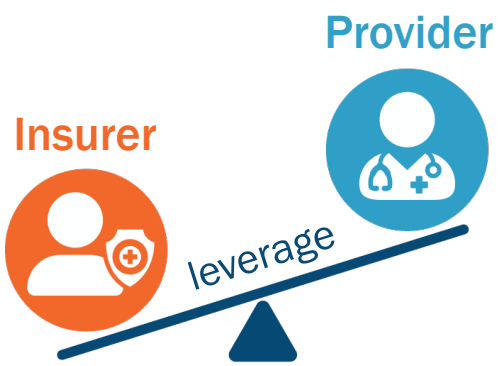
- In **competitive markets** for commodity goods and services, **prices are generally limited by what consumers are willing to pay**. (*"Is this faster laptop worth an additional $500?"*)
- But **this is not how pricing works for health care.** Individuals generally don't pay the full cost of care out of pocket at the time of use and often don't have the medical knowledge, time or resources to make cost/benefit tradeoffs. (*"If my physician says I need emergency heart surgery, do I know how to compare costs and benefits between different options? Do I even have time to shop for services?"*)

Accordingly, health care prices are generally set in other ways that do not rely on consumer willingness to pay.

- **In other countries, and for public payers in the U.S. (e.g. Medicare, Medicaid, Veteran's Administration, Tricare)**, governments or large third party entities establish or negotiate prices based on factors including **estimated costs of efficient provision of care, budget constraints and societal goals**.
- **However, in the U.S. private (commercial) coverage market**, prices are determined through **individual negotiations between insurers and health care providers**.

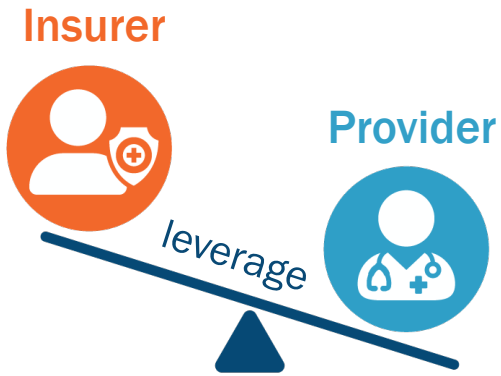
Implications of Individual Insurer-Provider Negotiations to Set Prices

As a result, commercial health care prices in the U.S. often reflect the **relative negotiating leverage** of a given insurer versus a given provider, **not necessarily costs of efficient provision of care, quality of care, or value of care to society.** This is consistent with HPC's past provider price variation findings: higher commercial prices for hospitals were not generally associated with higher value, but with market structure.



- Large provider systems
- Providers with few competitors
- Higher intensity services

Insurer has limited ability to exclude provider from coverage network.
Prices tend to be too high.



- Independent primary care providers
- Behavioral health care
- Higher public payer mix

Providers depend on insurers for patient volume; insurers can exclude providers.
Prices tend to be lower.

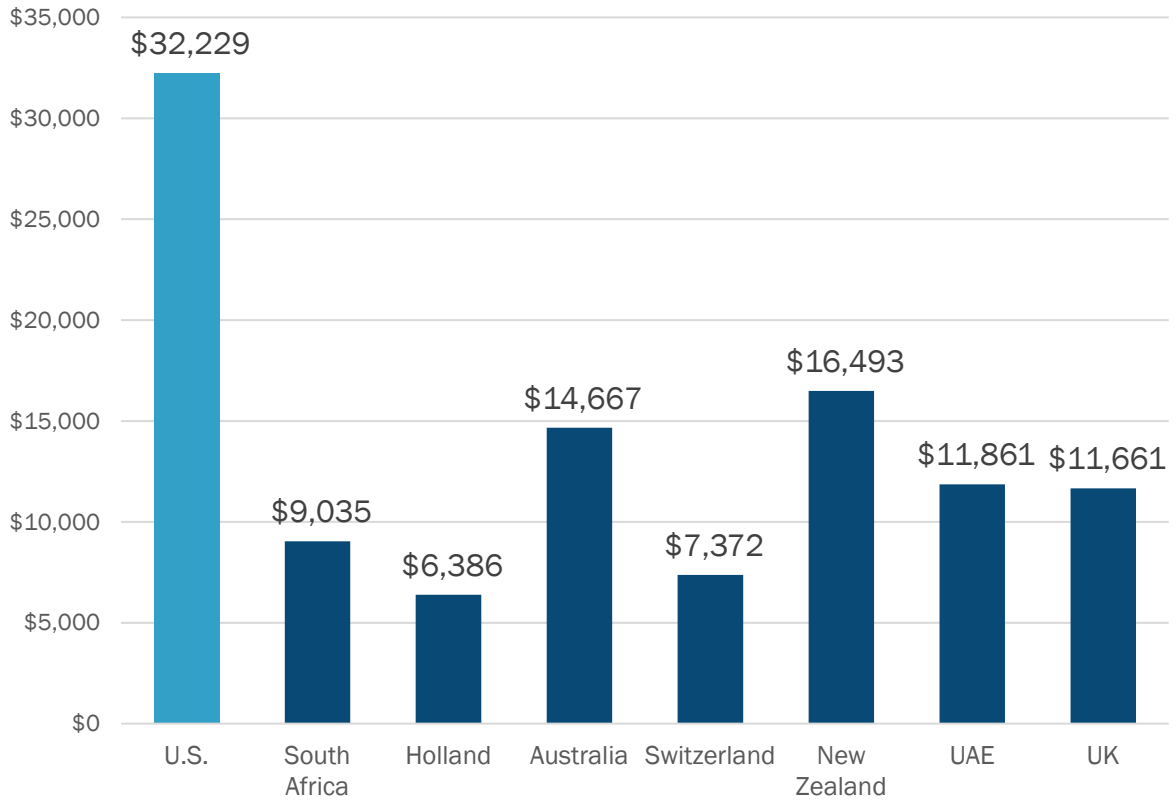
Prices can vary tremendously across providers of the same type due to leverage (e.g., acute care hospitals).

https://www.mass.gov/doc/2015-cost-trends-report-provider-price-variation/download

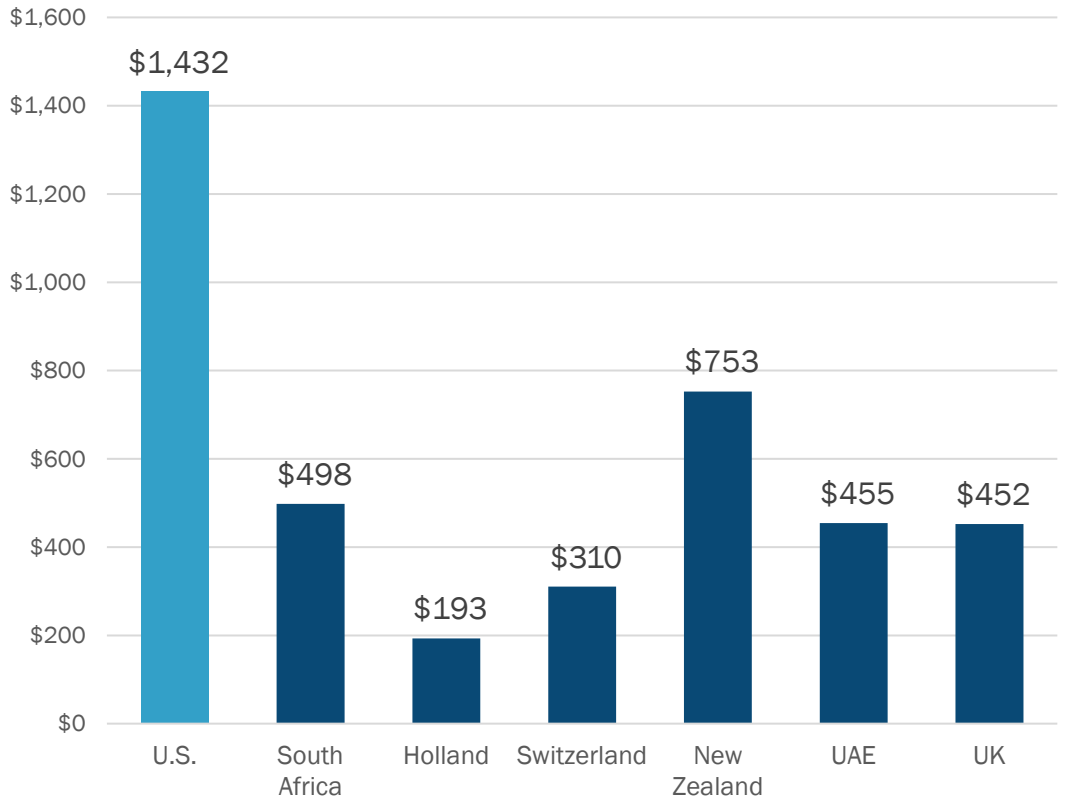
U.S. prices for hospital admissions and imaging are far above international prices.

Median prices of select health care services by country, 2017

Hospital Admission for Angioplasty



MRI Scan



Sources: Health Care Cost Institute. International comparisons of health care prices from the 2017 iFHP survey. Dec, 2019. Available at: https://healthcostinstitute.org/hcci-research/international-comparisons-of-health-care-prices-2017-ifhp-survey

High and variable prices, often misaligned with value, drive additional problems in the health care system.

- **Unsustainable and unaffordable health care premiums and out of pocket expenses**
- **Expansions of high-priced services** (e.g., imaging, cancer treatment, orthopedic centers)
- **Under-provision of services that are priced relatively low** (e.g., primary care, behavioral health care).
- **Consolidation of services into large systems that are generally hospital-based**, where negotiation leverage is higher.
  - This leads to further additional hospital use and spending.
- **Adverse effects on health equity**
  - Providers serving public payer patients often receive lower commercial prices and have fewer resources to care for them.

Sources: Post, B., Alinezhad, F., Mukherjee, S., & Young, G. J. (2023). Hospital-Physician Integration Is Associated With Greater Use Of Cardiac Catheterization And Angioplasty. Health affairs (Project Hope), 42(5), 606–614. https://doi.org/10.1377/hlthaff.2022.01294

To evaluate excessive pricing, Medicare fee-for-service prices represent a reasonable point of comparison.

- Medicare prices are designed to reflect costs ***for an efficient provider***. These payment rates are developed based on estimates of input costs of service provision, accounting for both operating and capital expenses.
  - **For inpatient hospital services**, Medicare payment rates include **further adjustments** for hospitals with a disproportionate share of low-income patients, medical residents, regional wages, cost outliers, and geographically isolated hospitals.
  - **For outpatient hospital and physician services**, Medicare payment rates include **geographic adjustments** to reflect differences in area input costs (Massachusetts has 2 geographies).
- Medicare payment rates are sometimes adjusted for various quality metrics and **increase each year according to an index reflecting inflationary increases in input costs**.
- Medicare payment rates may, in fact, be **too high** as a benchmark for commercial payment rates in cases where elderly patients require more resources to treat than non-elderly patients for the same conditions.

Sources: MedPac. Payment basics. Available at: https://www.medpac.gov/document-type/payment-basic/

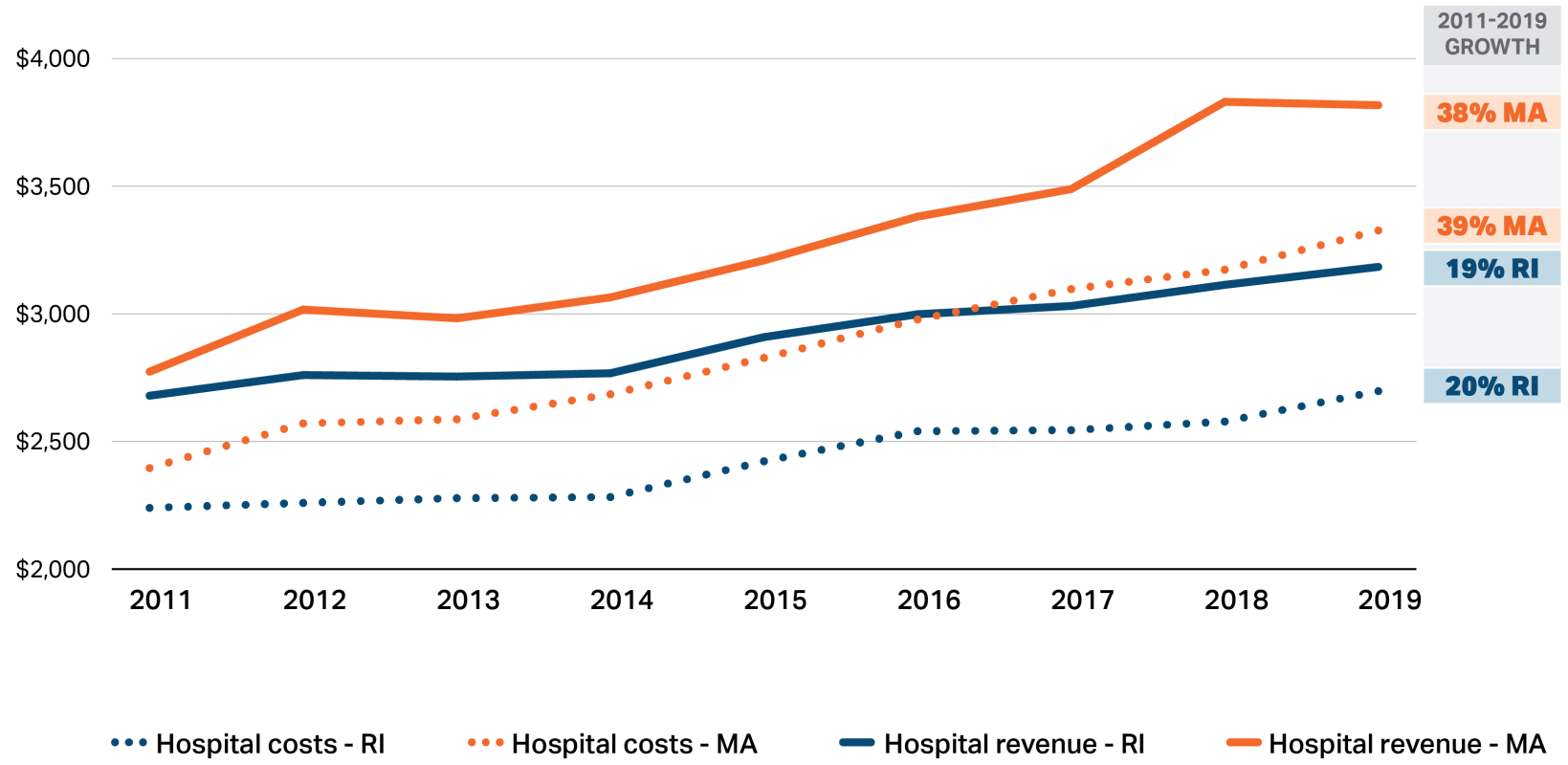
While many providers state Medicare payment rates are below their costs, this is often due to high and growing cost structures.

- Many providers state that Medicare payment rates are below their costs of providing care.
- However, MedPAC in their 2023 report to Congress found that [emphasis added][1]:
  - *"Some have suggested that, in the hospital sector, costs are largely outside the control of hospitals and that hospitals shift costs onto private insurers to offset Medicare losses. This belief assumes that costs are immutable and not influenced by whether the hospital is under financial pressure.*
  - ***Providers that are under pressure to constrain costs generally have managed to slow their growth in costs more than those who face less pressure…*** *In other words, when providers (particularly nonprofit providers) receive high payment rates from insurers, they face less pressure to keep their costs low."*
  - *We find that costs do vary in response to financial pressure and that low margins on Medicare patients* ***can result from a high cost structure that has developed in reaction to high private-payer rates****."*
- This dynamic played out in Rhode Island, which implemented constraints on hospital price increases in 2010.

Sources: MedPAC. Report to Congress, Mar, 2023. Available at: https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf

Rhode Island hospitals reduced their cost growth in response to price growth constraints and maintained the same margins as hospitals in Massachusetts where both revenue and costs grew twice as fast.

Trends in acute hospital operating costs and net patient revenue per capita in MA and RI, 2011-2019

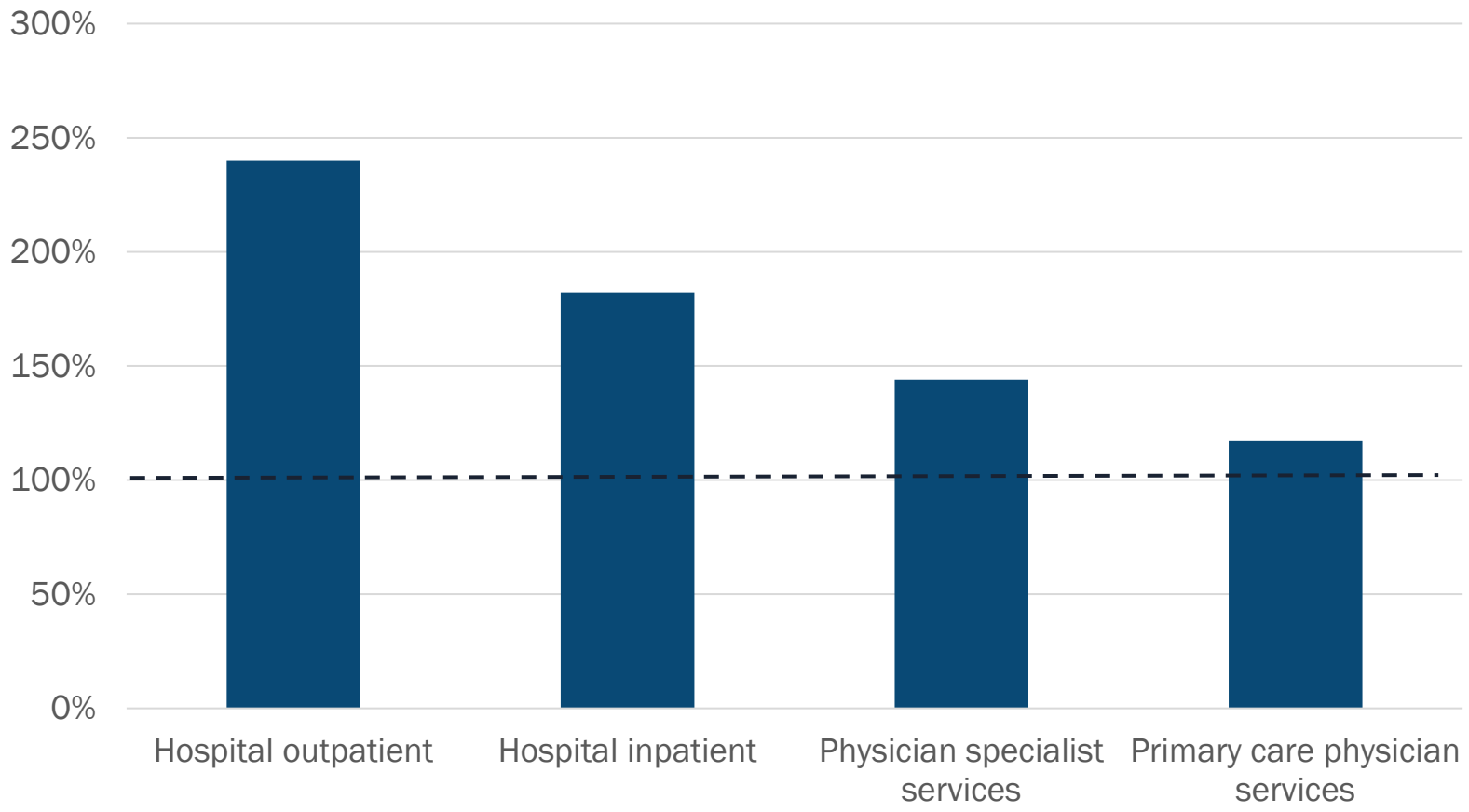


Note: Hospital operating costs are the portion of operating expenses related only to hospital patient care and eligible for reimbursement per Medicare federal regulations, sometimes referred to as Medicare Allowed Costs.
Sources: Hospital costs and revenues from NASHP hospital cost tool for the 2011-2019 period. Population from Census for 2011-2019 period. See also Baum, Aaron, et al. "Health care spending slowed after Rhode Island applied affordability standards to commercial insurers." Health Affairs 38.2 (2019): 237-245.

- In 2011, hospitals' costs of care were similar in RI and MA.
- After passage of the affordability standards, RI hospitals' underlying costs of care grew only half as fast ($460 per capita per year) as in Massachusetts ($930).
- Other New England states have cost and revenue trends comparable to MA.

The HPC analysis of excessive prices will focus on categories of care with the highest prices relative to a reasonable point of comparison.

Average commercial prices (National) relative to Medicare, by category of care: Medicare = 100%



- Commercial prices are **highest** (relative to Medicare) for **hospital outpatient services**[1]
  - *Though they are also high for hospital inpatient and physician specialist services*
- The analysis will also include an examination of **prescription and administered drugs**.

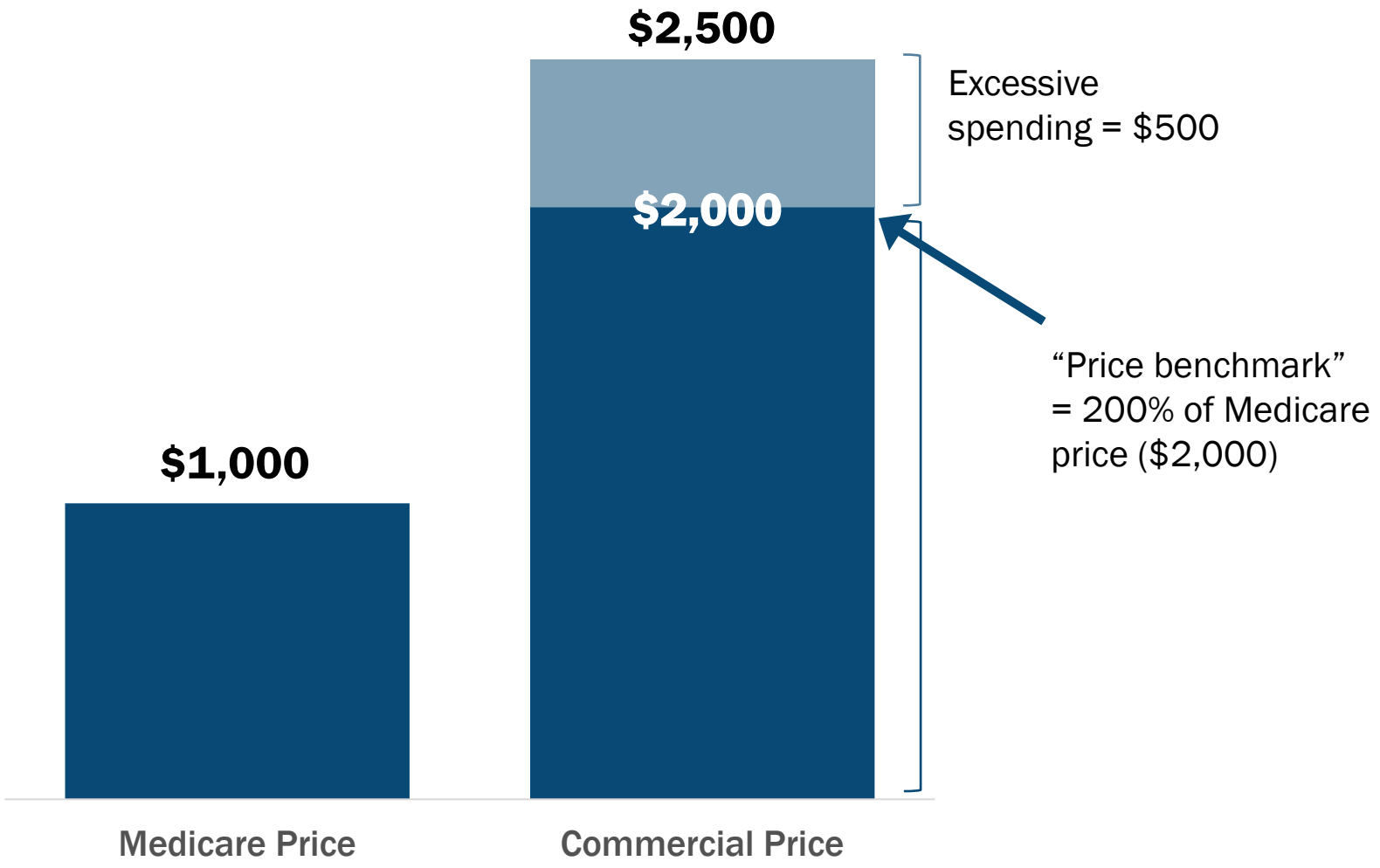
Sources: Congressional Budget Office. The prices that commercial health insurers and Medicare pay for hospitals' and physician's services. Jan, 2022. Available at: https://www.cbo.gov/publication/57778#_idTextAnchor002

For purposes of the analysis, the HPC defines excessive prices using specific price benchmarks for HOPD, prescription drugs, inpatient services, and imaging and specialty procedures.

- The HPC uses **200% of Medicare's price** for HOPD services as a conservative (generous) point of comparison, but one that is common in other analyses, and allows for possible unobserved differences in quality or input costs.
  - The Committee for a Responsible Federal Budget found 11% of hospital spending to be over this level, nationally.[1]
  - Oregon limits hospital prices for its state employee plan to 185% to 200% of Medicare prices[2]
- For **imaging and some specialty procedures**, Medicare pays more when the service is performed in a HOPD setting than in an office setting, whereas **MedPAC has recommended site-neutral payment**.[3]
  - The HPC estimates excessive spending: 1) relative to 200% of the HOPD rate and 2) relative to 200% of the office rate
- For **hospital inpatient services**, the HPC uses 200% of MassHealth rates.
  - Medicare rates may be inaccurate (and are often lower than MassHealth) for complex maternity or pediatric services
  - MassHealth rates are broadly similar to Medicare rates, not including teaching adjustments
- For **prescription drugs**, the HPC uses 120% of the average price from six comparator countries (Australia, Canada, France, Germany, Japan, and the UK).
  - This is based on the Elijah E. Cummings Lower Drug Costs Now Act, which passed the U.S. House of Representatives in 2019

Sources: 1. The Committee for a Responsible Federal Budget. Capping hospital prices. Available at: https://www.crfb.org/papers/capping-hospital-prices
2. NASHP, "How Oregon is Limiting Hospital Payments and Cost Growth For State Employee Health Planshttps://nashp.org/how-oregon-is-limiting-hospital-payments-and-cost-growth-for-state-employee-health-plans/. Note this limit does not apply to some hospitals such as rural hospitals and those having a high public payer patient mix.
3. MedPAC. April 2023 public meeting. Aligning fee-for-service payment rates across ambulatory settings. Available at: https://www.medpac.gov/wp-content/uploads/2022/07/Tab-D-Site-neutral-April-2023-SEC.pdf

The definition of excessive spending is "a hypothetical payment for a health care service with 200% of Medicare as the 'price benchmark'."



- For this service, the insurer pays the provider $2,500. Medicare would have paid $1,000. The commercial payment is **250% of Medicare** ($2,500/$1,000)*100%, or 2.5 times higher than Medicare's price.
- If the price benchmark for this service = 200% of Medicare ($2,000), then $500 of the payment is "excessive".

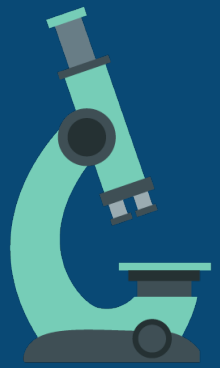
Price Benchmarks for Analyses of Excessive Prices

SERVICE CATEGORY	HOW MEDICARE PAYS	PRICE BENCHMARK
Labs	Site-neutral	200% of Medicare
Specialty Procedures	Site-specific, MedPAC supports site-neutral for services modeled today	200% of Medicare office price
Imaging	Site-specific, MedPAC supports site-neutral for services modeled today	(1) 200% of Medicare office price (2) 200% of Medicare HOPD price
Colonoscopy/Endoscopy	Site-specific (office, ASC, HOPD)	200% of Medicare site-specific price
Inpatient Stays	Hospitals are paid a fixed rate per DRG with hospital specific adjustments	(1) 200% of MassHealth payment (2) 200% of Medicare payment
Clinician-Administered Drugs	Non-340B entities: drug average sales price (ASP) + 6% 340B entities: ASP – 22.5%[1]	200% of Medicare[2]
Prescription Drugs	N/A	120% of average price from 6 comparator countries

Notes: MedPAC= Medicare Payment Advisory Commission; HOPD= hospital outpatient department; ASC= ambulatory surgical center; DRG= diagnosis-related group.

1. Since 2018, CMS reimbursed administered drugs based on participation in the 340B Drug Pricing Program. Due to a court ruling in 2022, CMS now pays ASP + 6% for all providers regardless of 340B status.
2. For clinician-administered drugs, the HPC does not currently model excessive spending with respect to the underlying manufacturer price of the drug, (for which Medicare rates are based upon), but analyses of international benchmark suggest that, like other branded drugs, even Medicare pays substantially more than other countries.

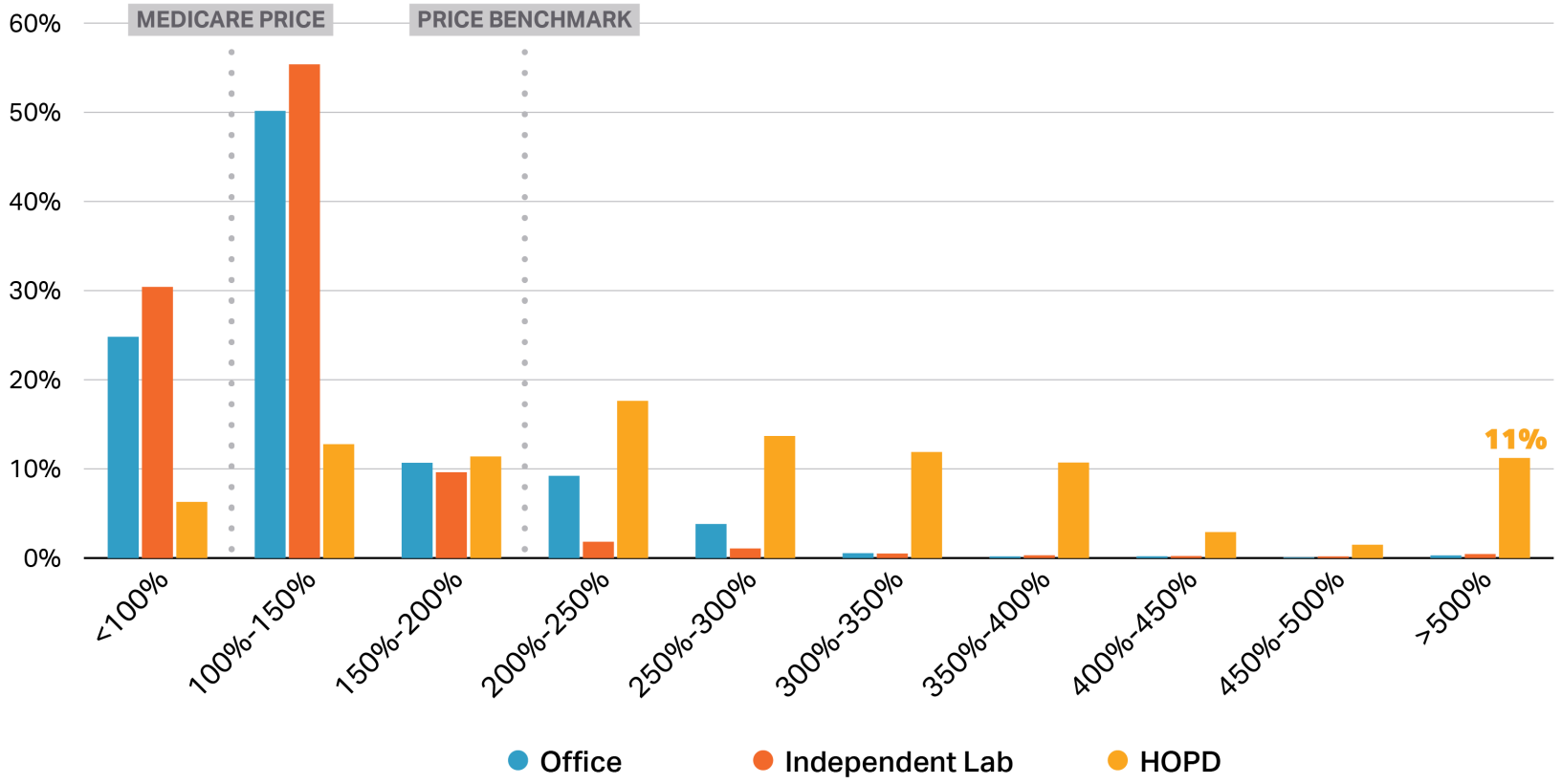
Clinical Laboratory Services



- Most clinical laboratory services are commodity-like services with the majority of these services being performed across multiple settings of care (e.g., cholesterol testing). They currently account for **$1 billion** (3.9%) of total commercial expenditures in Massachusetts.
- **Medicare pays the same** for lab tests regardless of care setting, though most **commercial payers pay more when labs are performed in HOPDs**.
- In 2021 in Massachusetts, 51% of labs were performed in a hospital outpatient department, 32% in an independent laboratory (e.g., Quest, LabCorporation), and 17% in office settings.
- For the following analysis, HPC considered 1,132 lab services that were common across hospital outpatient departments, offices, and independent labs and were included on the Medicare Clinical Laboratory Fee Schedule. Labs done during an inpatient stay, observation stay, or emergency department visit were excluded.

70% of labs performed in HOPD settings were paid in excess of 200% of Medicare's price. 11% of those were paid more than 5 times Medicare's price.

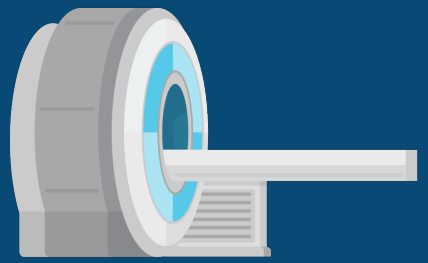
Percentage of lab services paid at shown ranges relative to what Medicare would pay, by setting of care, 2021



Note: Graph is left inclusive. Includes encounters for all Medicare covered lab services. Percentages are calculated as the aggregate utilization in each bin divided by total utilization for each setting of care.
Sources: HPC analysis of the Center for Health Information and Analysis (CHIA) All-Payer Claims Database, 2018-2021, V 2021; HPC analysis of information from the Centers for Medicare and Medicaid Services, Clinical Laboratory Fee Schedule (2021)

- Lab services make up approximately 4% of commercial health care spending.
- 70% of lab services performed in HOPDs were paid more than 200% of Medicare's price (as were 14% of those performed in office settings and 5% of those performed in independent labs).
- Roughly 23% of all lab spending was above 200% of Medicare's price.

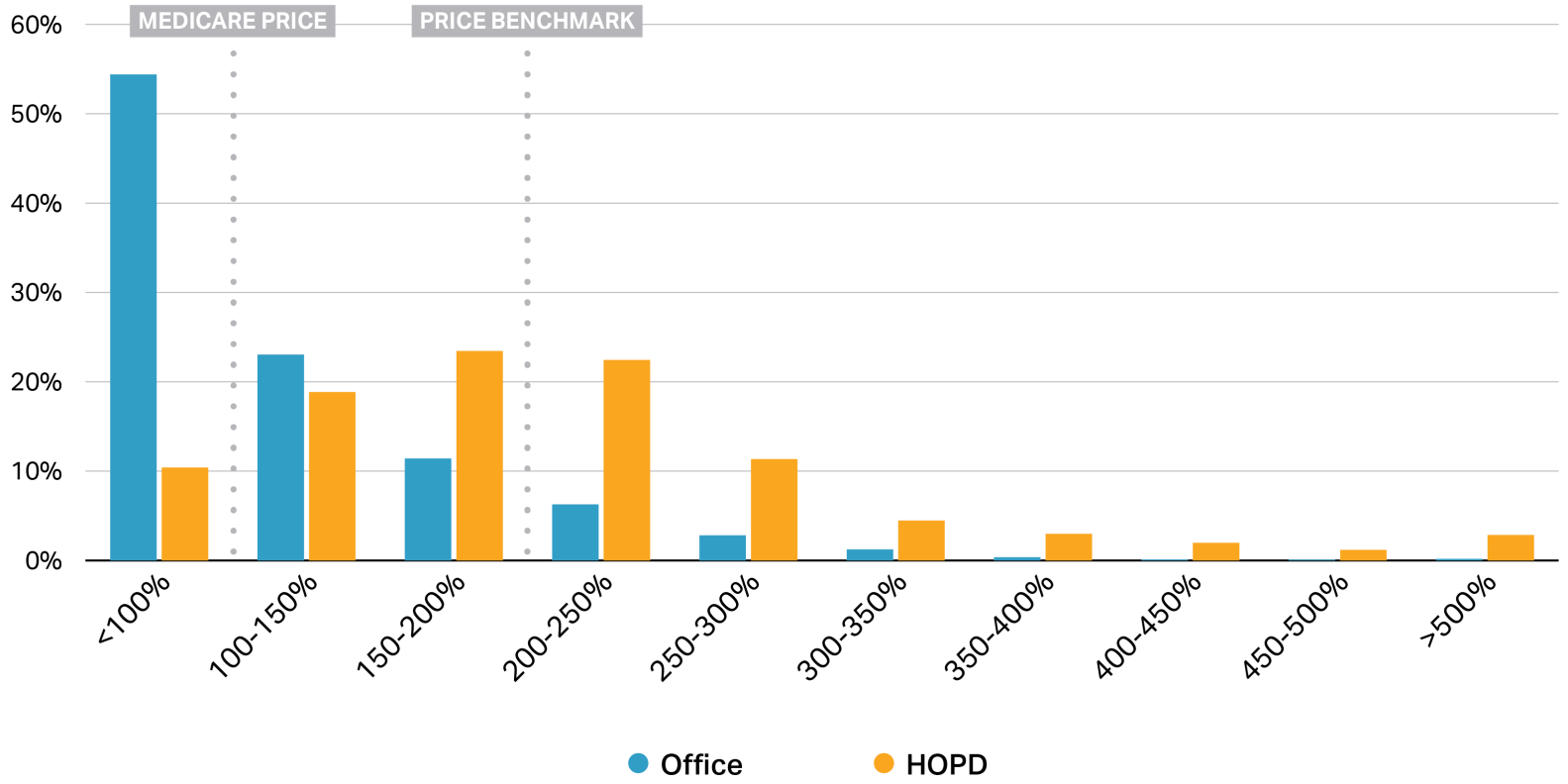
Imaging



- Imaging services encompass a wide-array of technologies including **X-Rays, CT scans, MRI scans, ultrasounds, mammography, nuclear medicine scans, and positron emission scans (PET) scans**. Imaging can be both diagnostic and therapeutic. Many imaging services are performed across a wide-range of providers and can be offered safely and effectively across sites of care. They comprise about **5.5%** of commercial health care spending.
- Medicare has different payment rates for imaging based on the site of care, with HOPDs generally receiving substantially higher payments than physician offices for the same service. MedPAC recently recommended that many imaging services should be paid on a **site neutral basis** with the same fee schedule. The HPC compared commercial prices both to 200% of Medicare's HOPD price and 200% of Medicare's office price, though summary estimates of excessive spending will use the more conservative HOPD price as a point of comparison.
- In 2021, **56% of imaging services were performed in a hospital outpatient department**, 34% in office settings, and the remaining 10% across other settings (e.g., independent imaging centers, urgent care centers, and other clinics).
- For the following analysis, HPC considered 571 imaging services that were common across hospital outpatient departments and office settings. Imaging services performed in other ambulatory settings, or during an inpatient/observation stay, or emergency department visit were excluded.

47% of imaging services performed in HOPD settings were paid in excess of 200% of Medicare's HOPD price.

Percentage of imaging services paid at shown ranges relative to what Medicare would pay a HOPD, by setting of care, 2021

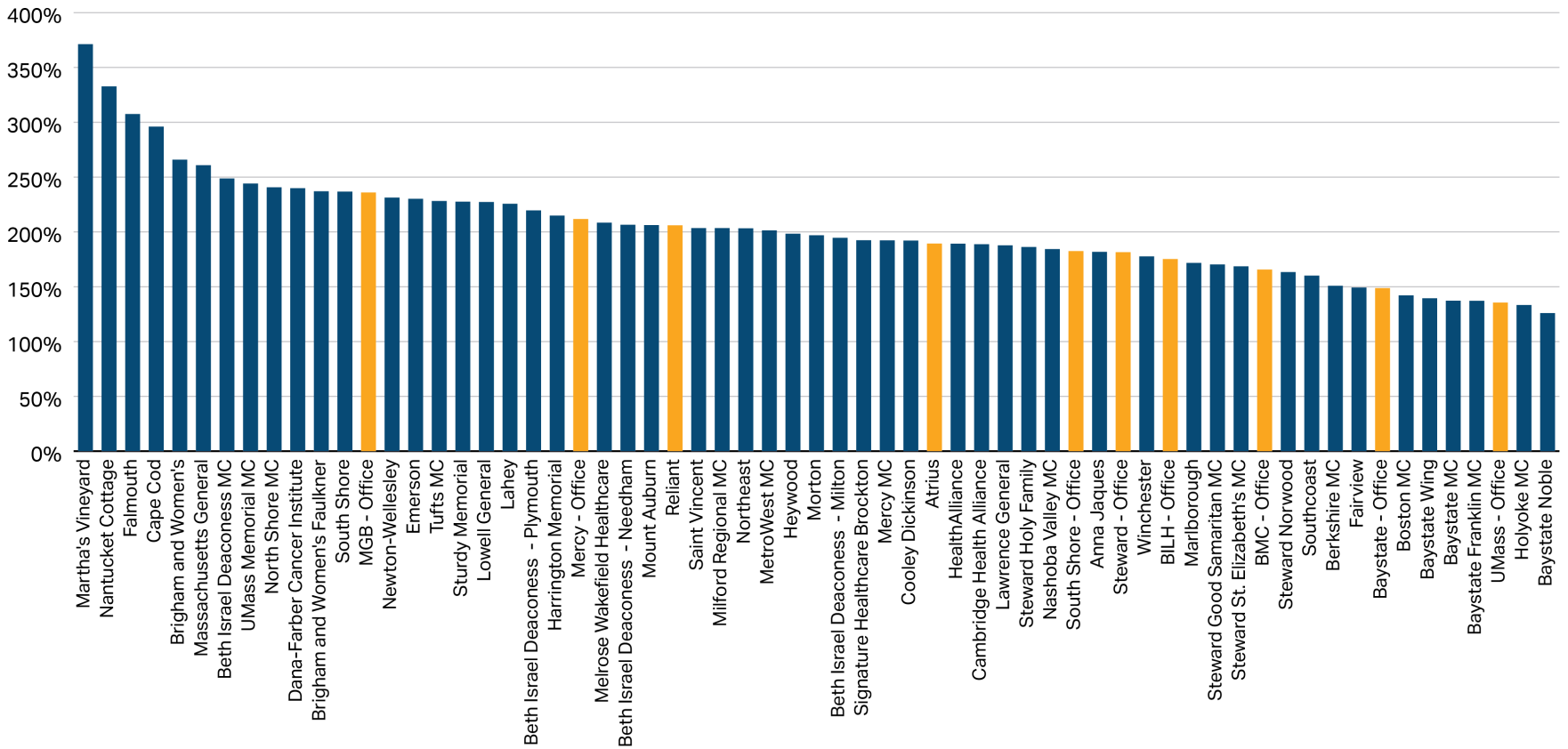


Note: Includes encounters for all Medicare covered imaging services. Benchmarks are applied at the level of a procedure code, and reflect the Medicare Physician Fee Schedule professional component and facility payment from the Outpatient Prospective Payment System (OPPS). For services where there is no corresponding OPPS payment (e.g., mammography), the global MPFS payment amount (which corresponds to the entire payment for relevant professional and technical components of an when delivered in an office setting) was applied. Percentages are calculated as the aggregate utilization in each bin divided by total utilization for each care setting.
Sources: HPC analysis of the Center for Health Information and Analysis (CHIA) All-Payer Claims Database, 2021, V 2021; HPC analysis of information from the Centers for Medicare and Medicaid Services, Medicare Physician Fee Schedule (2021)

- Imaging services make up approximately 5.5% of commercial health care spending.
- 47% of imaging services performed in HOPDs were paid more than 200% of Medicare's HOPD price, as were 11% of imaging services performed in an office setting.
- 22.5% of all imaging spending was above 200% of Medicare's HOPD price.

For mammography, the most common commercial imaging service, prices relative to Medicare varied by a factor of 3.7 across hospitals in 2021.

Mammography price (CPT code 77067) relative to Medicare (office rate), by provider and provider type, 2021



Notes: Claim lines for the same person on the same date are combined to capture total spending inclusive of professional and technical components which may be billed separately. The Medicare price is the global payment for office-based services, and is assigned based on the appropriate locality in Massachusetts. Providers with at least 300 mammography encounters are included in the figure, and then are sorted by price relative to Medicare.(1) See more details at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-419#419.22

Sources: HPC analysis of the Center for Health Information and Analysis (CHIA) All-Payer Claims Database, 2021, V 2021; HPC analysis of information from the Centers for Medicare and Medicaid Services, Medicare Physician Fee Schedule (2021)

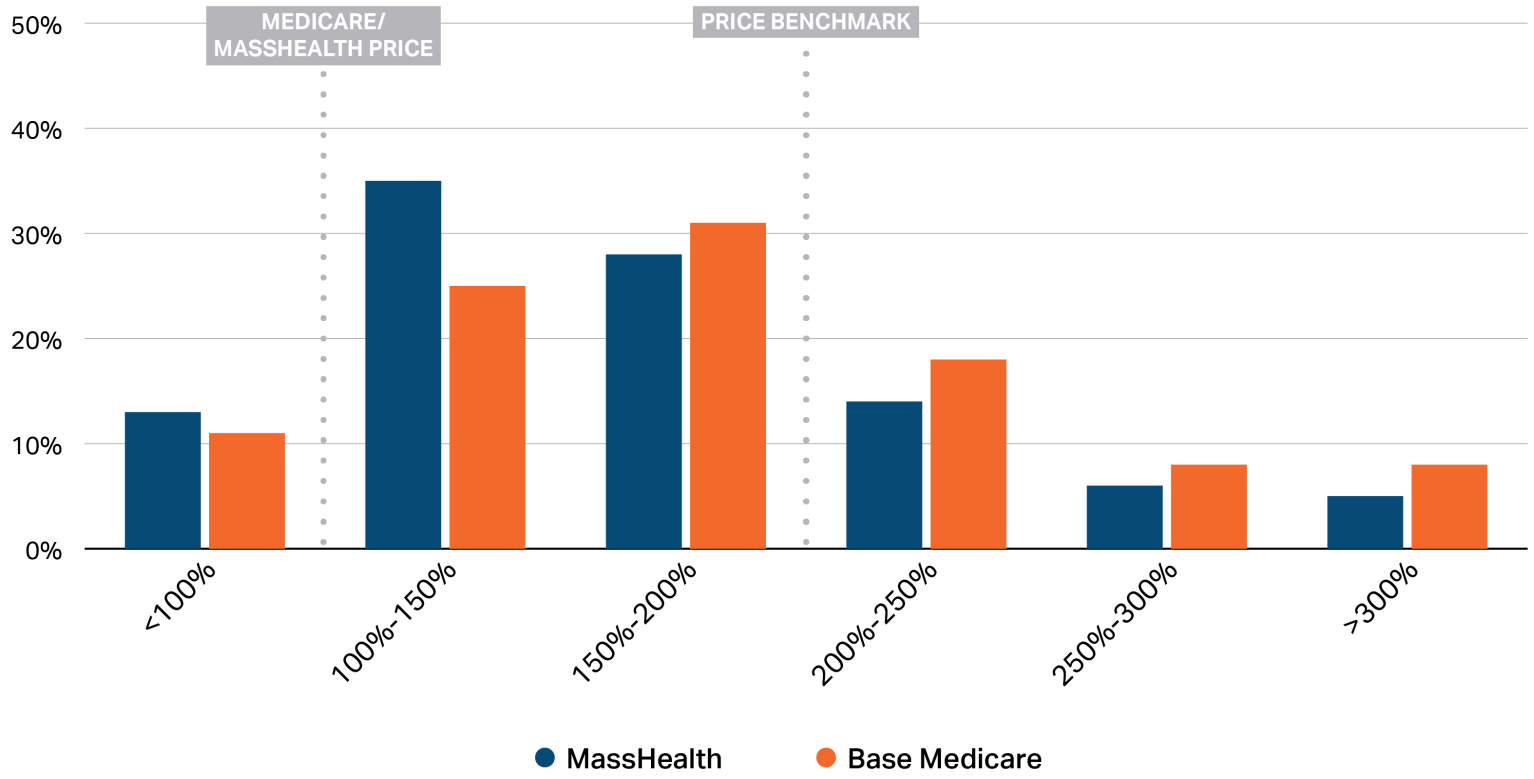
- Unlike other imaging services, mammography services are unique as they are paid under the Medicare Physician Fee Schedule (office) regardless of the care delivery site.[1]
- Mammography imaging services account for 10% of all imaging volume, and 9% of all imaging spending.
- The average mammography service in 2021 was paid 205% of the Medicare office price.
- Hospital-based providers tend to have higher prices.

Inpatient Services

- Total spending on hospital inpatient stays comprised **19.9% of commercial healthcare spending in 2021**, with 83% of this spending received by hospitals directly (and the remainder going to physicians and other professionals).
- Payers pay for hospital **inpatient stays** based on a combination of the assigned case type (Diagnosis Related Group) and an associated severity. Medicare uses a different version of DRGs (MS-DRG) than do most commercial payers and MassHealth (APR-DRG). The APR-DRG system includes more severity levels and more accurately reflects complexity in maternity and pediatric stays.
- **Medicare's** payment is further adjusted based on the number of medical residents and DSH status. These teaching and DSH Medicare payment adjustments are excluded from our comparison.
- **MassHealth** payments, which are similar in magnitude to Medicare's base payment for the non-maternity adult population, include geographic adjustments and extra payments for some high complexity pediatric stays.

25% of hospital inpatient stays were paid more than 200% of MassHealth's rate and 32% were paid more than 200% of Medicare's base payment.

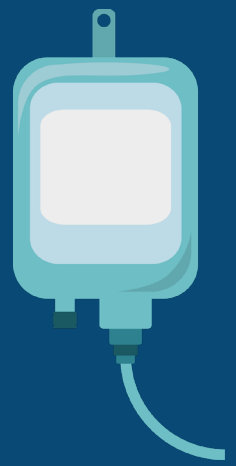
Distribution of inpatient facility commercial prices by percentage of MassHealth and base Medicare payment, 2021



Notes: Excludes outliers in length of stay within each DRG, and major payment outliers. Only facility payments are included in estimates of excess spending. Including professional payments for inpatient stays would increase $ amount of spending. Comparison to MassHealth and Medicare does not include the effect of carve-out drugs and outliers, therefore actual savings could be slightly lower. Medicare payment rate excludes payments for medical residents and DSH status (base).
Sources: HPC analysis of: (1) Center for Health Information and Analysis All-Payer Claims Database v2021. (2) Centers for Medicare and Medicaid Services (CMS) IIPS final rule FY 2021, MassHealth FY 2021 Final Notices to Acute Hospitals.

- 25% of commercial inpatient stays were paid more than 200% of MassHealth's rate while 32% of stays were paid more than 200% of Medicare's base rate.
- Overall, 9% of inpatient spending exceeded 200% of Mass Health's rate.
- 15% of inpatient spending exceeded 200% of Medicare's base rate.

Clinician-Administered Drugs



Clinician-administered drugs are medications administered by physicians or other health care professionals through injections or infusion, in an office or outpatient setting. Administered drugs, excluding vaccines and the cost to administer the drug, make up approximately **5.9% of commercial health care spending.**

For most clinician administered drugs, **Medicare Part B pays providers the manufacturer's average sales price (ASP) plus 6%.** For payments from commercial insurers, providers often negotiate prices that are substantially higher than this.

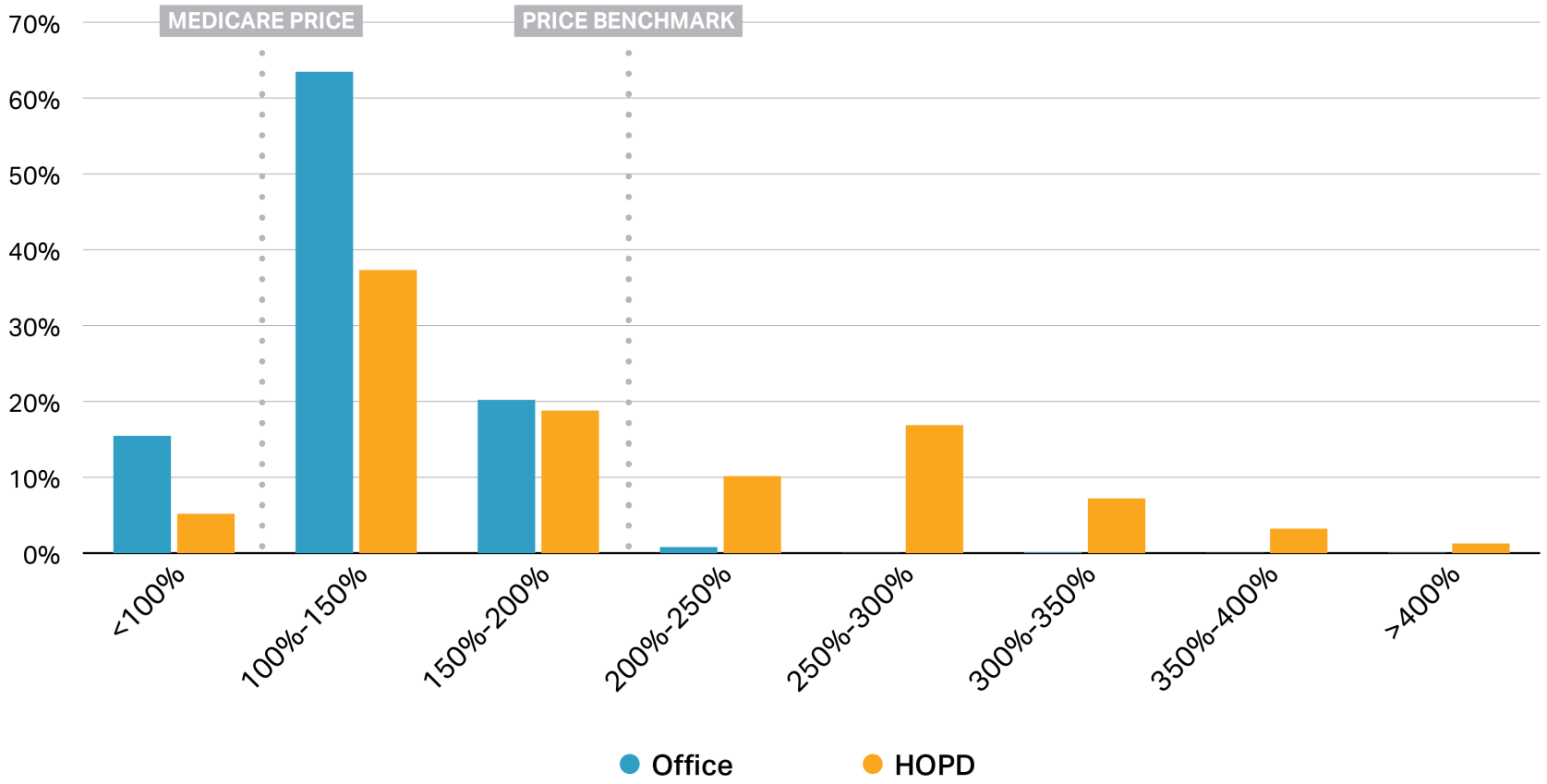
In 2021 in Massachusetts, 64% of clinician-administered drugs (excluding vaccines) were administered in a hospital outpatient department and 36% in an office setting.

For the following analysis, HPC considered 15 clinician-administered drugs that were the highest spending drugs across hospital outpatient departments and office settings in 2021. Drugs administered during an inpatient stay, observation stay, or emergency department visit were excluded.

Notes: Some providers are able to obtain the drugs at a lower price via participation in the 340B Drug Pricing Program. Prior to 2023, Medicare paid such providers less, in accordance with the lower acquisition cost. As of 2023, all providers are paid equivalently due to a court ruling in 2022. Our analysis is based on 2021 data, thus we calculated Medicare price based on CMS policy at the time.

39% of administered drug encounters in HOPD settings were paid in excess of 200% of Medicare's price. 12% of those were paid more than 3 times Medicare's price.

Percentage of administered drug encounters paid at shown ranges relative to what Medicare would pay, by setting of care, 2021



Notes: Graph is left inclusive. Data represents aggregate utilization in each bin over total utilization for each setting of care based on 15 drugs including Ocrevus (J2350), Keytruda (J9271), Entyvio (J3380), Opdivo (J9299), Remicade (J1745), Neulasta (J2505), Inflectra (Q5103), Sandostatin Lar Depot (J2323), Perjeta (J9306), Tysabri (J2357), Rituxan (J9312), Darzalex Faspro (J9144), Mvasi (Q5107), Alimta (J9305), and Yervoy (J9228). Data includes reductions in Medicare reimbursements (average sales price minus 22.5%) based on participation in the 340B Drug Pricing Program. Sources: HPC analysis of Center for Health Information and Analysis Massachusetts All-Payer Claims Database, 2021, V 2021. HPC analysis of information from the Centers for Medicare and Medicaid Services, ASP Drug Pricing Files (2020-2021).

- The top 15 administered drugs by spending, excluding the cost to administer the drug, make up approximately 2.9% of commercial health care spending.
- 39% of administered drug encounters performed in HOPDs were paid more than 200% of Medicare's price (as were 1% of those performed in office settings).
- Roughly 14% of all administered drug spending was above 200% of Medicare's price.

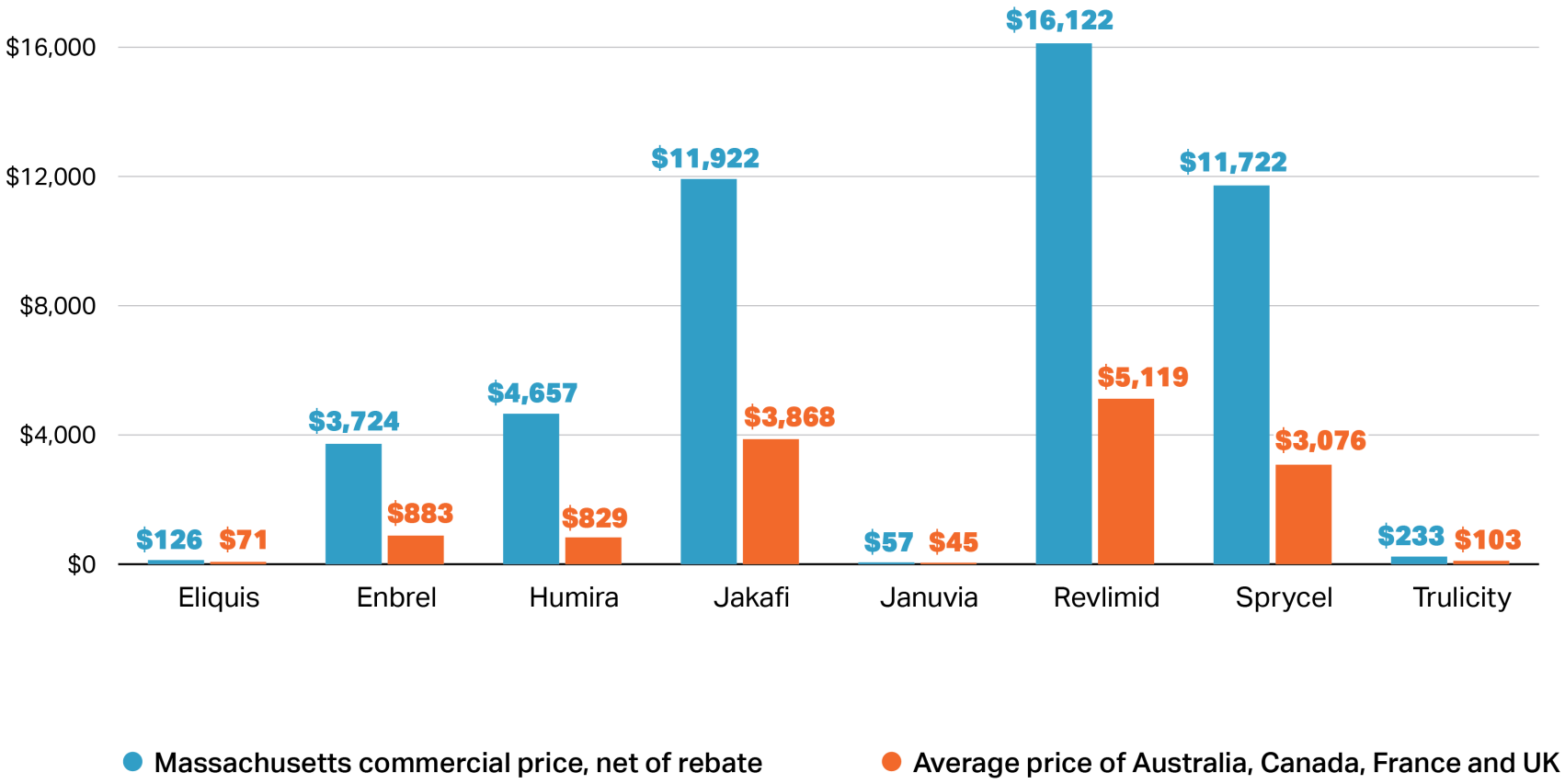
Prescription Drugs

- Prescription drugs refer to prescription medications filled at pharmacies or through mail order.
- Prescription drugs have consistently been one of the **fastest growing service categories in spending**: CHIA reported that total net-of-rebate pharmacy spending increased at an annualized rate of **7.5%** from 2019 to 2021.[1]
- Spending is heavily driven by a **small number of high-cost, branded products**. In Massachusetts, while branded drugs make up fewer than 15% of commercial prescription drug claims, they represent nearly **80% of drug spending**, even after accounting for manufacturer rebates and comprise **14.4%** of commercial health care spending.[2]
- Americans pay higher prices for prescription drugs than any other country in the world.[3] Unlike many other countries, the U.S. does not directly regulate or negotiate the price of drugs. A 2021 Rand Corporation study found that U.S. drug prices were 2.56 times higher than the average of 32 OECD countries.[4]
- The HPC modeled excessive spending on branded drugs using 120% of average prices from 6 comparator countries as a benchmark as has been proposed in recent national legislation that passed in the U.S. House of Representatives.[5]

Sources: 1. Center for Health Information and Analysis, Annual Report on the Performance of the Massachusetts Health Care System, 2023. 2. HPC analysis of Center for Health Information and Analysis Massachusetts All-Payer Claims Database, 2021, V 2021. 3. ASPE. Trends in prescription drug spending, 2016-2021. Available at: https://aspe.hhs.gov/reports/trends-prescription-drug-spending 4. Rand Corporation. International prescription drug price comparisons, current empirical estimates and comparisons with previous studies. 2021. Available at: https://www.rand.org/pubs/research_reports/RR2956.html. 5. In December 2019, the U.S. House of Representatives passed H.R.3, the Elijah E. Cummings Lower Drug Costs Now Act, which included a provision to limit drug prices at 120% of the average list price across six countries (Australia, Canada, France, Germany, Japan, and the UK).

Massachusetts commercial prices for select branded drugs range from 177% to 562% of the average of four peer nations.

2021 Massachusetts and international prices of select branded drugs, per month supply



Notes: International prices were as of December 2021. Drug-specific commercial rebates were obtained from SSR Health and applied to prices analyzed in the APCD. Drugs that were initially selected were either in the top 25 highest spending drugs and/or were on the list of top 100 highest spending drugs with a cost greater than $10k per claim for at least 2 of the 3 major payer types (commercial, Medicare, and Medicaid). Figure shows drugs for which prices from all four countries were publicly available.
Sources: SSR Health; Australia Fee Schedule; Canada (Quebec) List of Medications; French Public Drug Database; NHS Prescription Services. Massachusetts price based on HPC analysis of Center for Health Information and Analysis Massachusetts All-Payer Claims database, 2021, V2021. Data from five commercial payers are included. Anthem was excluded due to lack of data availability.

- International reference pricing is widely used around the world as an element of drug price regulation, and has seen growing interest among U.S. policymakers.
- Using a benchmark proposed in the Elijah E. Cummings Lower Drug Costs Now Act, the HPC found $1.9 billion in excess prescription branded drug spending in the Massachusetts commercial market.

Overall, 27% of spending in these categories was found to be excessive due to high prices. This excessive spending amounted to $2.9 billion in 2021.

Estimated excessive spending using example benchmark for seven service categories, 2021

Service category	Modeled spending (millions), 2021	Price benchmark	% of spending over the price benchmark	Excessive spending ($, millions)	Excessive spending (% of TME)
Labs	$963M	200% of Medicare	22.9%	$220M	0.9%
Specialty Services	$79	200% of Medicare (Office)	50.3%	$40	0.2%
Imaging	$1,372	*200% of Medicare - Office*	*34.5%*	*$473*	*1.9%*
		200% of Medicare – HOPD*	22.5%	$308	1.2%
Endoscopy/Colonoscopy	$340	200% of Medicare	3.6%	$12	0.05%
Inpatient Stays	$3,836	200% of MassHealth	9.4%	$343	1.4%
Clinician-Administered drugs	$637	200% of Medicare	13.7%	$87	0.4%
Prescription Drugs	$3,579	120% of international prices	52.0%	$1,859	7.5%
Total	$10,804 (43% of TME)		26.6%	$2,870 (11.5% of TME)	11.5%

Notes: *To calculate total excessive spending, the HPC used the more conservative imaging benchmark, 200% of Medicare – HOPD.

Conclusions and Future Work

CONCLUSIONS

- Excessive health care prices represent a substantial amount of spending that does not add significant value. This spending should be a priority for interventions that aim to slow the growth of health care spending.
- In just the categories of spending examined (which comprise 43% of commercial spending), unnecessary spending due to excessive prices represents 12% of commercial TME, almost twice as much as total spending on primary care.

FUTURE PRICE WORK

- **2023 Cost Trends Report Price Chartpack (September 2023)**
  - Including analyses of variation in price by provider
- **Options for Controlling Commercial Prices (~Fall 2023)**
  - Examination of different mechanisms for controlling prices
- **2023 Provider Price Variation Update (~Fall 2023)**
  - Examination of factors predictive of higher and lower commercial prices

Agenda

Call to Order

Approval of Minutes **(VOTE)**

DataPoints Issue #24: Persistent Cost-Sharing for Contraception in Massachusetts, 2017 – 2020

Findings from the 2023 Health Care Cost Trends Report: Excessive Pricing in the Massachusetts Health Care System

SCHEDULE OF UPCOMING MEETINGS

Reducing Unnecessary Administrative Complexity

2023 Public Meeting Calendar

HPC

– JANUARY –

S	M	T	W	T	F	S
1	2	3	4	5	6	7
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– MARCH –

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– APRIL –

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– JULY –

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– AUGUST –

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– SEPTEMBER –

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– OCTOBER –

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– NOVEMBER –

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– DECEMBER –

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BOARD MEETINGS

Wednesday, January 25
Wednesday, April 12
Wednesday, June 7
Wednesday, July 12
Wednesday, September 13
Wednesday, December 13

COMMITTEE MEETINGS

Tuesday, January 24 (ANF, 2:00 PM)
Wednesday, February 15
Wednesday, May 10
Monday, July 10 (ANF, 2:00 PM)
Wednesday, October 4

ADVISORY COUNCIL

Wednesday, February 8
Wednesday, May 24
Wednesday, September 20
Wednesday, December 6

SPECIAL EVENTS

Thursday, March 2 – OPP Regulation Hearing
Wednesday, March 15 – Benchmark Hearing
Wednesday, March 29 – Health Care Workforce Event
Wednesday, November 8 – Cost Trends Hearing

All meetings will be held virtually unless otherwise noted. This schedule is subject to change, and additional meetings and hearings may be added.

2023 ANNUAL HEALTH CARE COST TRENDS HEARING

When:
Wednesday, November 8, 2023

Livestream:
tinyurl.com/hpc-video

Where:
Suffolk University Law School
120 Tremont Street, Boston

MASSACHUSETTS
HEALTH POLICY COMMISSION

Agenda

Call to Order

Approval of Minutes **(VOTE)**

DataPoints Issue #24: Persistent Cost-Sharing for Contraception in Massachusetts, 2017 – 2020

Findings from the 2023 Health Care Cost Trends Report: Excessive Pricing in the Massachusetts Health Care System

Schedule of Upcoming Meetings

REDUCING UNNECESSARY ADMINISTRATIVE COMPLEXITY

- Guest Presentation from The Network for Excellence in Health Innovation (NEHI): Automation of Prior Authorization
- Policy Options for Reducing Unnecessary Administrative Complexity

Agenda

Call to Order

Approval of Minutes **(VOTE)**

DataPoints Issue #24: Persistent Cost-Sharing for Contraception in Massachusetts, 2017 – 2020

Findings from the 2023 Health Care Cost Trends Report: Excessive Pricing in the Massachusetts Health Care System

Schedule of Upcoming Meetings

Reducing Unnecessary Administrative Complexity

- **GUEST PRESENTATION FROM THE NETWORK FOR EXCELLENCE IN HEALTH INNOVATION (NEHI): AUTOMATION OF PRIOR AUTHORIZATION**
  - Policy Options for Reducing Unnecessary Administrative Complexity

HPC 2023 Agenda for Action

In 2023, the HPC is pursuing an ambitious action plan to reduce health care cost growth, promote affordability, and advance equity, in addition to ongoing workstreams and responsibilities.

This comprehensive plan will prioritize disseminating data-driven insights and policy recommendations to address the critical challenges facing the health care system today: the workforce crisis, high costs, and persistent health inequities.

1. **Bolster the HPC's Cost Containment Activities**
2. **Address Health Care Workforce Challenges and Identify Solutions**
3. **Advance Health Equity**
4. **Enhance Pharmaceutical Pricing Transparency and Accountability**
5. **Reduce Unnecessary Administrative Complexity**

Current HPC Policy Priorities to Reduce Unnecessary Complexity

5 Reduce Unnecessary Administrative Complexity

a. Partner with stakeholders and the Network for Excellence in Health Innovation (NEHI) and the Mass Health Data Consortium (MHDC) to promote prior authorization automation.

b. Identify other priority areas for streamlining, simplification, or standardization and convene stakeholders to develop and advance solutions.

c. Participate on new Special Commission to Develop Common Medical Necessity Criteria in Behavioral Health.

d. Continue staff support and policy leadership of the Quality Measurement Alignment Taskforce (QMAT), including convening a workgroup to advise on an electronic clinical quality measure repository.

Administrative complexity is a major driver of health care spending.

Administrative costs have been estimated to be as high as **34% of total health care spending nationally** or $812 billion annually, significantly greater than other countries.[1]

Many of these costs are driven by the complexity of a system that includes multiple private and public payers, all with different rules and processes.

Billing and insurance-related activities – a subset of health care administration that includes claims processing, referral management, prior authorization, and more – were estimated to cost US payers and providers **$496 billion** annually.[2]

Reducing administrative complexity could benefit the system without jeopardizing quality or access, such as by:

- Reducing time, cost, and administrative burden for patients, providers, and payers
- Allowing providers to reallocate staff time and resources to higher-value activities
- Addressing drivers of clinician burnout
- Reducing delays in care

1. Himmelstein, Campbell, and Woolhandler. Health Care Administrative Costs in the United States and Canada, 2017. Annals of Internal Medicine. 2020. 272 (2). 2. Gee and Spiro. Excess Administrative Costs Burden the U.S. Health Care System. Center for American Progress. 2019. Available at: https://www.americanprogress.org/article/excess-administrative-costs-burden-u-s-health-care-system/

At the end of 2019, the HPC identified prior authorization as a priority area for further work.

- The HPC surveyed a wide range of stakeholders and found **significant stakeholder interest in prior authorization (PA).**
  - Consistent with national surveys, MA providers report dedicating significant staff time and resources to navigating and complying with each payer's unique PA policies.
  - Consistent with recent academic findings, MA payers note that PA is an important tool for keeping down costs and broad removal of PA requirements could increase spending.
- Prior authorization reform continues to receive significant attention from **state and federal policy makers.**
- The unnecessary complexity associated with prior authorization **directly impacts patients**. For example, patients may experience delays in care while PA requests are being submitted and processed, even when their requests are ultimately approved.
- Prior Authorization is **exemplary of many of the complexities and redundancies inherent in other health care transactions**, and policy makers may be able to apply improvements to other transactions.

Prior Authorization: Implications for Cost, Quality, Access, and Equity

- There is ample evidence that PA policies can **reduce spending** for targeted services.[1,2]
  - Such savings likely persist even when accounting for payer and provider **administrative costs**.[1]
  - However, the complexity and variation in PA processes contributes to **inefficiency and unnecessary spending**.[3,4,5]

- PA can provide important clinical benefits, but the administrative complexity raises **quality, access, and equity** concerns.
  - PA may help target **low value care** and dangerous **drug interactions,** and act as a **clinical decision support tool**.[6]
  - Yet PA complexity can also lead to the **delay, deferral, or avoidance** of appropriate care, including based on inappropriate denials.[2,7,8]
  - Researchers have documented **greater associated burden**, such as care delay or deferral, on groups known to experience health disparities, who may struggle to navigate the administrative requirements.[1,9]

- Beyond cost and quality impacts, PA complexity also contributes to **clinician burnout**.[10]
  - The U.S. Surgeon General has cited **PA inefficiencies as a driver of clinician burnout** and called for direct reforms.[11]

1. Rationing Medicine Through Bureaucracy: Authorization Restrictions in Medicare Zarek C. Brot-Goldberg, Samantha Burn, Timothy Layton, and Boris Vabson NBER Working Paper No. 30878 January 2023; 2. Park et. al. The Effect of Formulary Restrictions on Patient and Payer Outcomes: A Systematic Literature Review. J Managed Care Spec Pharm. 2017;23(8): 893-901. 3. Lenahan et. al. Variation in Use and Content of Prescription Drug Step Therapy Protocols, Within and Across Health Plans. Health Affairs. 2021. 40(11). 4. Chambers et. al. Little Consistency in Evidence Cited by Commercial Plans for Specialty Drug Coverage. *Health Affairs*. 2019. 38(11). https://doi.org/10.1377/hlthaff.2019.00201; 5. Lew T, Bethishou L, Shieh L. Earlier identification of medications needing prior authorization can reduce delays in hospital discharge. California Journal of Health System Pharmacists. 2018;30(3):80-85; 6. 2018-2019 Academy of Managed Care Pharmacy Professional Practice Committee. Prior Authorization and Utilization Management Concepts in Managed Care Pharmacy. J Mang Care Spec Pharm. 2019. 25(6); 7. Smith et. al. Prior authorization in gynecologic oncology: An analysis of clinical impact. Gynecologic oncology. 2022. 2167(3). 8. Office of the Inspector General. Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials. September 2018. Available at: https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf 9.Kyle MA, Frakt AB. Patient administrative burden in the US health care system. Health Serv Res. 2021;1-11. https://doi.org/10.1111/1475-6773. 13861 10. A Crisis in Health Care: A Call to Action on Physician Burnout. Partnership with the Massachusetts Medical Society, Massachusetts Health and Hospital Association, Harvard T.H. Chan School of Public Health, and Harvard Global Health Institute. https://www.massmed.org/Publications/Research,-Studies,-and-Reports/Physician-Burnout-Report-2018/; 11. The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce. Addressing Health Worker Burnout. 2022. Available at: https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf

Examples of Prior Authorization Complexity, According to MA Stakeholders

Volume of Authorizations

Despite agreement that PA is an appropriate UM tool in some circumstances, many see its application as unreasonably broad, especially for patients with extended courses of treatment

Lack of Standardization

Significant variation in payer processes related to PA requirements, approval criteria, medical necessity criteria, and submission processes

Time to Approval

Requests can take multiple business days to approve, which can make accessing same-day care difficult, and approvals are only valid for a fixed amount of time

Mid-Year Changes

Payers can update their PA policies mid-year, and on different timelines, without a grace period to allow providers to update their systems

Retroactive Denials

Approved services are sometimes retroactively denied based on, e.g., medical necessity, a day-of decision to bill a related but distinct CPT code, or technicalities

Patient Plan Switching

Because of the lack of standardization across payers and products, patients who experience a change in coverage may have to repeat authorization processes

Source: HPC discussions with Massachusetts market participants, 2019-2020 and 2023

One Approach to Reduce PA Complexity: Automation

The HPC has been providing support for a new initiative on PA conducted by the **Network for Excellence in Health Innovation** (NEHI) and the **Massachusetts Health Data Consortium** (MHDC).

The project goal was to assess the opportunities, benefits, and barriers to **automate prior authorization** in Massachusetts.

Though not a solution for all PA pain points, automating prior authorization has support from a wide range of stakeholders and could provide **real-world process improvements** for MA payers, providers, and patients, such as by:

- Reducing **provider uncertainty** about when PA is required, which could eliminate a significant number of PAs submitted currently;
- Decreasing the **time** from PA submission to disposition;
- Reducing payer and provider **manual paperwork**;
- Establishing a **data foundation** against which to evaluate PA volume and variation; and
- Providing opportunities for **greater standardization** of PA programs across payers.

Massachusetts Health Data Consortium

NEHEN

NEHI Network for Excellence in Health Innovation

Prior Authorization Automation Recommendations to the Health Policy Commission

NEHI & MHDC

May 10, 2023

Lauren Bedel, MPH

Senior Health Policy & Program Associate

Network for Excellence in Health Innovation

Denny Brennan

Executive Director & CEO

Massachusetts Health Data Consortium

David Delano

Senior Director

Massachusetts Health Data Consortium

&

Executive Director

New England Healthcare Exchange Network Inc

Wendy Warring, JD

President & CEO

Network for Excellence in Health Innovation

Massachusetts Health Data Consortium

NEHI Network for Excellence in Health Innovation

Massachusetts Health Data Consortium

MHDC's **vision** is a patient-centered health data economy that engages individuals to manage their health as they see fit.

MHDC's **mission** is to be a trusted facilitator of the health information and technology transformation required to achieve a person-centered health data economy.

Network for Excellence in Health Innovation

NEHI's **vision** is to be a trusted voice in shaping policies and activities that address unmet needs, drive better health outcomes, and provide equitable access to effective innovations.

NEHI's **mission** is to solve complex problems and achieve value in health care by fostering interdisciplinary collaboration and innovation.

Agenda

Network for Excellence in Health Innovation

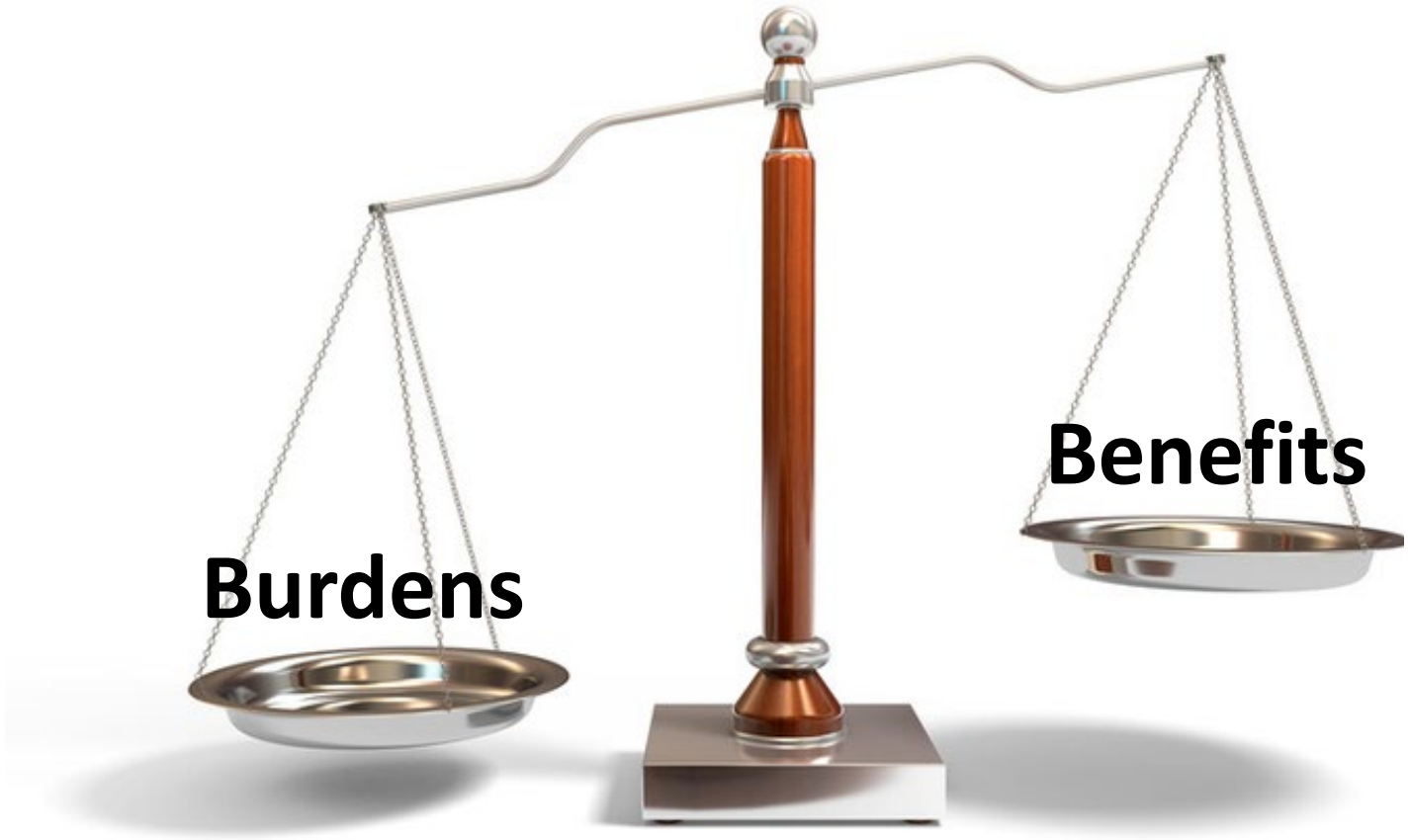
Background

Recommendations

Implementation Next Steps

Questions & Discussion

The burdens of prior authorization are increasing, despite its benefits



The Balance…

Benefits:

- Protects patient safety
- Avoids medically unnecessary care
- Contains costs

Burdens:

- Delays patient care
- Increases payers' & providers' costs and time
- Places financial risk on the provider and patient

NEHI Network for Excellence in Health Innovation

Previous project on streamlining PA

Issues Considered

- Frequency with which PA is applied
- Variation among payers in services/pharmaceuticals subject to PA
- Variation in PA criteria
- Variation in documentation required by plans to satisfy medical necessity

Identified Solutions

- Remove PA for certain services with high rates of approval
- Remove PA for certain physicians based on their performance (gold-carding)
- Create incentives for full automation of PA
- Remove PAs for physicians in ACOs or risk-based arrangements
- Embed care pathways/utilization management on a condition basis
- Substitute payer PA with use of clinical decision support tools
- Remove multiple and repeat PAs for a continuous course of treatment
- Expand use of family/group codes
- Establish processes that require collaboration
- Create economic incentives to reduce PA
- Share data that incentivizes collaborative change

Though not a panacea, automating PA processes will benefit every stakeholder

- Reduce delays in **patient** care (93% AMA survey respondents say PA causes delays in care)
  - According to a McKinsey report, patients often wait a week for a PA decision which can cause them to forego treatment. Automation, especially with AI, can reduce timing to hours from weeks.
- Relieves burden and costs for providers and payers
  - For **providers**: removes the friction associated with payer variation in PA requirements and reduces staff time providing responsive documentation. Notice of a PA requirement is "automatic" and necessary documentation is likewise transmitted "automatically." The 2022 CAQH Index estimates providers will save 11 minutes/transaction by automating PA.
  - For **payers**: shrinks the processing of unnecessary documentation and inquiries from providers. Automation provides immediate clarity on whether a service requires authorization based on the payers' rules.
- Facilitates system-wide reforms
  - Eases the derivation and reporting of standardized data elements

More Efficient Processes Translate to Cost Savings

- CAQH per transaction cost savings opportunity*: $9.60
  - Providers: $5.93
  - Payers: $3.67

- CAQH projects that the healthcare industry (providers & payers) could save $449M based on PA volumes nationally

- Note: Our project did not quantify stakeholders' savings; savings will depend on the personnel currently devoted to prior authorization processes—a discoverable fact

* CAQH defines cost per transaction as the "labor costs (e.g., salaries, wages, personnel benefits, and related overhead costs) associated with… transactions as reported by… providers."

What is “automation” of prior authorization?

- Adoption of an end-end PA request (i.e., request → response) completed electronically using a defined set of data exchange standards and technologies
  - Process exhibits little or no need for human intervention
  - The same data standards are used by the entire community
- Automation is not the same as digitization
  - The use of web portals or interactive voice responses is not “automation”

NEHI Network for Excellence in Health Innovation

Simplified end-end automation workflow

01

Provider decides on an order/ treatment/etc.

02

Prior authorization & coverage requirements automatically shared between Payer & Provider systems

03

Payer gathers information for the prior authorization request from the Provider's EMR

04

Provider has the opportunity to review the data that was automatically pulled from the EMR

05

Payer/Intermediary processes request & Payer sends decision

06

(Possible) Payer requests additional info/documents from Provider

Benefits of an end-end automation workflow

01

Provider decides on an order/ treatment/etc.

02

Provider receives immediate response as to whether prior authorization is required or not

03

Data needed to satisfy medical necessity criteria is pulled automatically from the EMR, eliminating the need for manual data entry in most cases

04

Documentation is submitted electronically, rather than via telephone or facsimile, saving both provider and payer time

05

Decision is sent to the EMR in real time, reducing delays in patient care

How do we automate?

- **Application Programming Interface (API):** Connects apps via web-based standards
  - Example: Travelocity
  - In context: Provider's Clinical Decision Support (CDS) API connects to the payer's API service and pulls information and options based on the patient & request to determine whether PA is needed

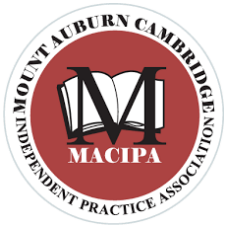
- **Fast Healthcare Interoperability Resource (FHIR):** A framework of structured data definitions organized into 'resources' for APIs to use as stand-alone data exchanges or integrated with other web-based services
  - Defines data elements
  - Serves as the transport mechanism
  - In context: Provider can launch a SMART on FHIR App from the EMR that can automatically pull data satisfying the payer's medical necessity criteria and auto-populate the questionnaire

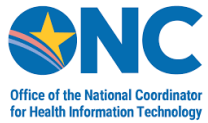
The Federal Government is advancing interoperability & requiring PA process changes, including automation

- Requires all impacted payers to implement and maintain a FHIR Prior Authorization Requirements, Documentation, and Decision (PARDD) API
- The proposed rule also includes calls for data reporting that would increase transparency and understanding of the efficiency and efficacy of the PA process.

- Proposed rule (CMS-0057-P)
  - Released 12/6/22
  - Comment period closed 3/13/23
  - Effective 1/1/26 (3 years)
- Applies to:
  - Medicare Advantage (MA) organizations,
  - State Medicaid and CHIP FFS programs,
  - Medicaid managed care plans
  - CHIP managed care entities
  - QHP issuers on FFEs

Our project tested receptivity and requirements with the goal of automating in 2 years





Commonwealth of Massachusetts
Executive Office of Health and Human Services

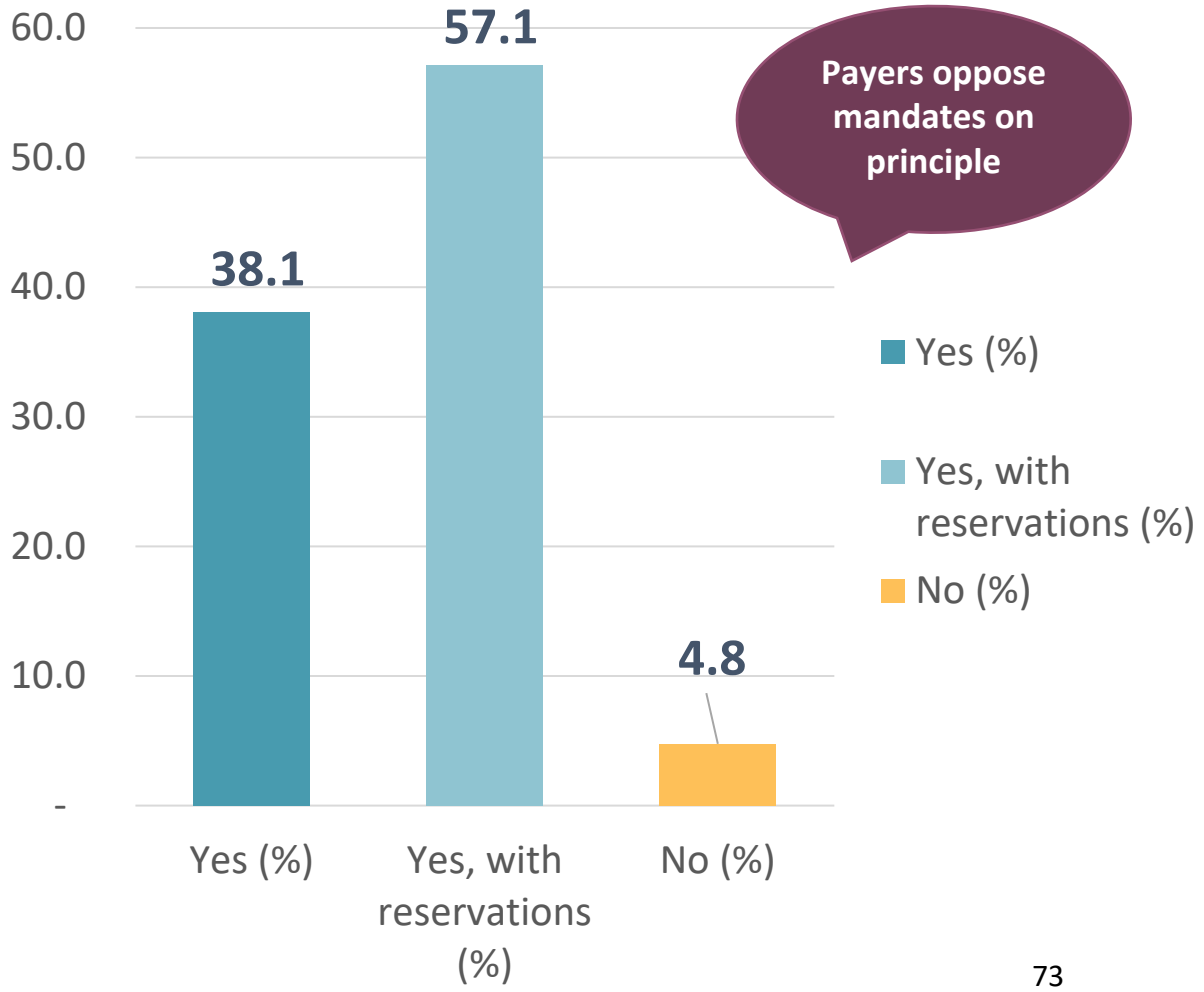
Recommendations to the HPC

The Automation Advisory Group (TAAG) was aligned:

- Massachusetts can and should take a leadership role in promoting the automation of prior authorization
- Organization and coordination will improve implementation
- Implementation efforts should start now. Full compliance with federal directives will require at least the time allotted.
- The Da Vinci implementation guides are a strong base for an automation roadmap. There is no need to reinvent the wheel.
- Providers and Payers will need technical and financial support in varying degrees.

Move automation forward now. Use state legislative/regulatory authority to mandate automation based on a technical roadmap

- A state mandate moves all stakeholders forward together and can clarify the process and outcomes expected
  - Vest oversight authority with a state agency (e.g., DOI, EOHHS, or HPC)
- Use the Da Vinci Guidelines as a foundation for the technical roadmap
  - The Da Vinci Implementation Guides do not conflict with the Federal Rule



Why Should the State Get Involved in Automation of PA?

- The State can ensure that **all** payers move forward together
  - Insurers may comply with the federal rule by automating prior authorization for covered product lines, creating a hybrid manual/automated environment; this defeats many of the benefits for providers
- Specification of technical requirements and timing will maximize benefits for all stakeholders (e.g., requiring CRD by a date certain will have an immediate impact on all stakeholders) and create efficiencies in implementation and operation
  - The federal government's rule making strictures did not allow it to rely on the DaVinci Guidelines, which are consistent with the federal rule but offer significantly more guidance and clarity
  - Specification of technical requirements will reduce unwarranted variation and address distinct stakeholder concerns
  - A state designed implementation process can accommodate flexibility without losing the benefits of standardization
- State oversight aligns automation with the data requirements for additional reforms

The industry has been testing & refining automation of PA with increasing support

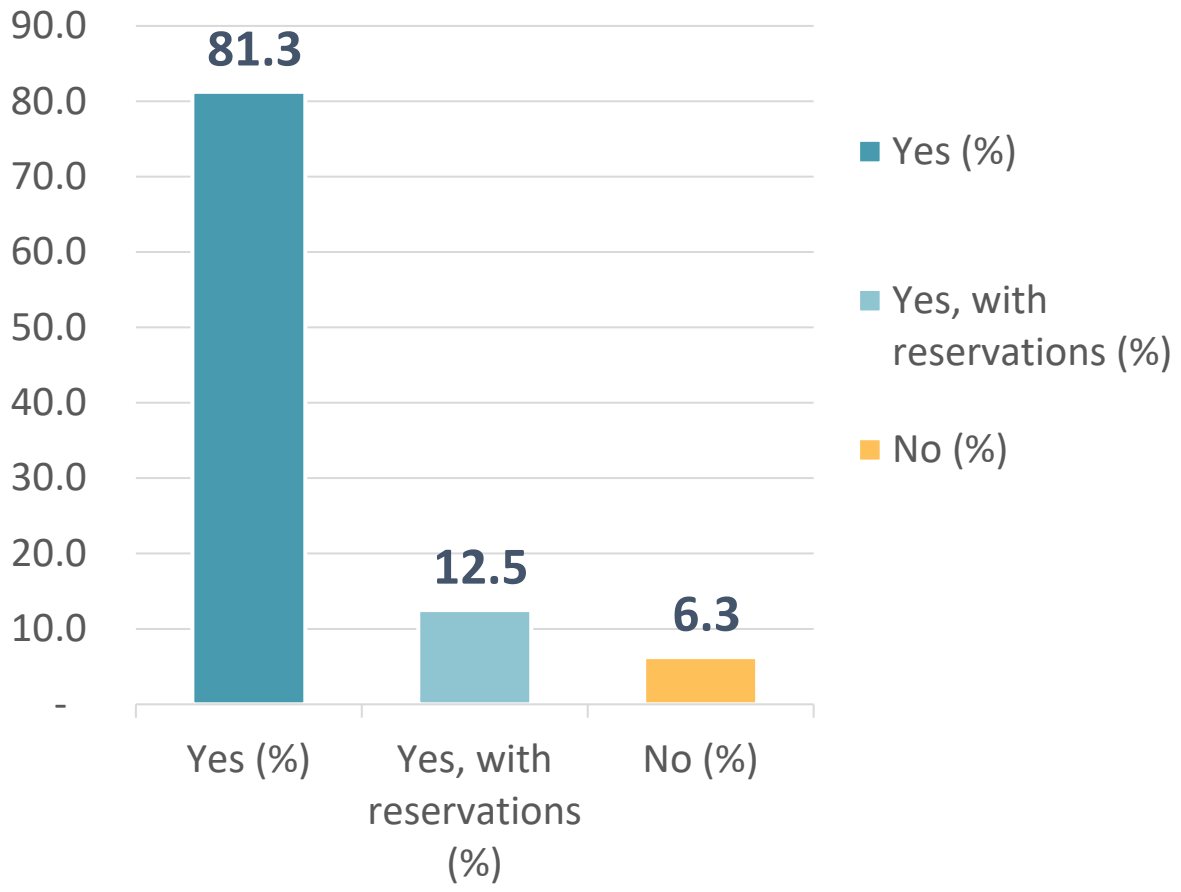
- The **Da Vinci Project** has developed implementation guides for automating PA
  - Guides are often referenced in automation discussions due to broad stakeholder input
- The Da Vinci Project is an HL7 FHIR accelerator project
  - Members include prominent payer, provider, and vendor organizations
  - Goal: to accelerate the adoption of FHIR standards across payers and providers

- **Health Level 7 (HL7)** is a standards developing organization for the exchange, integration, sharing, and retrieval of electronic health information
- Offers members and participating organizations opportunities to participate in workgroups, projects, & initiatives

Modifications of the Da Vinci Guides address key stakeholder concerns

- Require a unique identifier of each PA bundle to provide **a clear record of payer responses** to a PA request in the event of a claim dispute
- Eliminate the option of a “no response” from the payer; payer’s response must state whether PA is required or not. This **avoids unnecessary submissions and further communication**.
- Specify use of prefetch templates for gathering additional information by the payer. The template defines the data needed at the time of a PA request. This **allows for a more efficient (faster) transaction and overcomes issues of trust**.
- Require the use of structured questionnaires with Clinical Query Language (CQL) logic embedded, ensuring that payers are not recreating current forms, which often differ by payer. This **reduces variation and manual data entry**. It provides a more efficient way to collect data automatically from the EMR.

Recognize the need for technical assistance

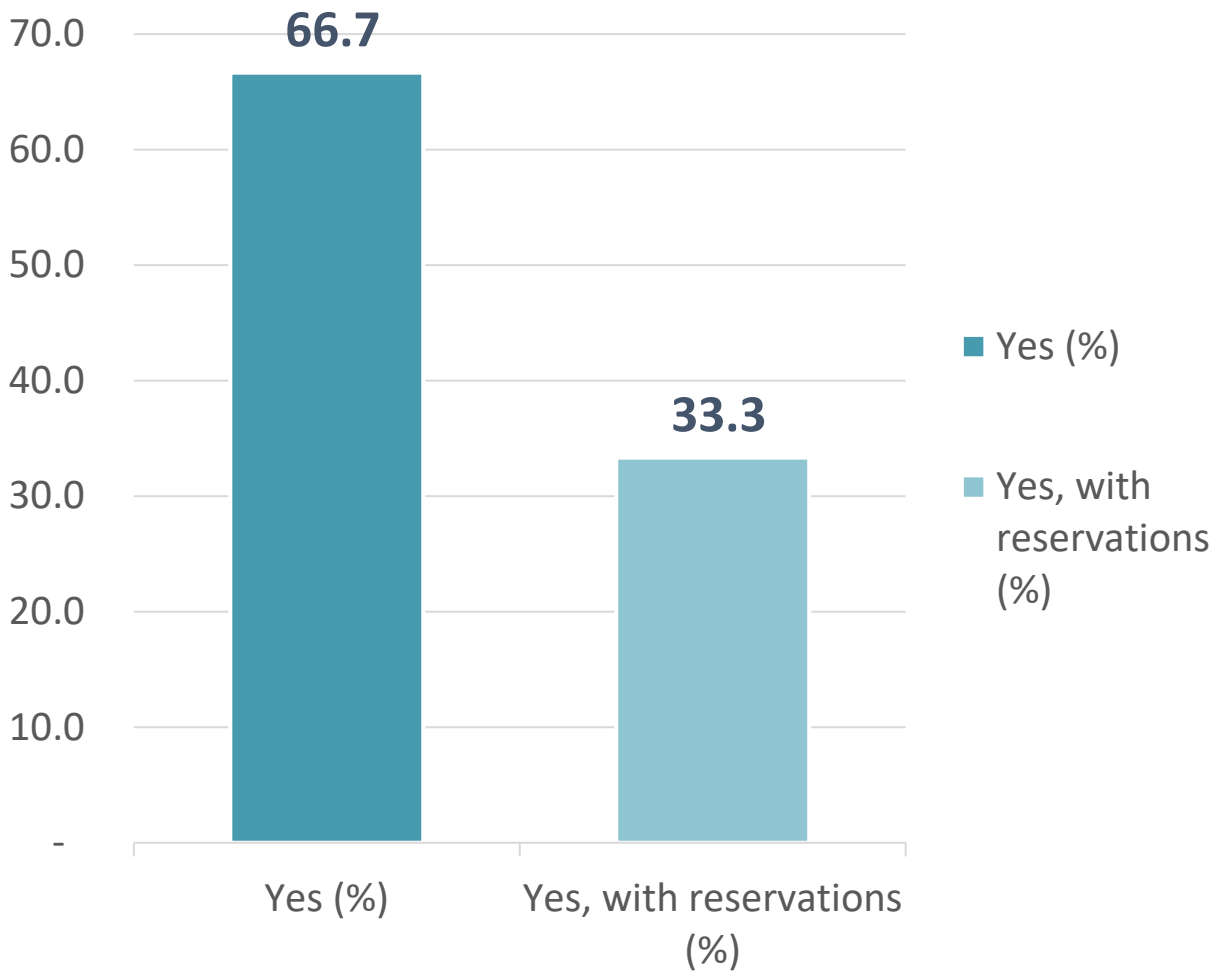


Establish a statewide Technical Assistance Center

- Resolve technical issues in the implementation of the automation roadmap; maintain consistency with the Federal Rule
- Provide a resource for assisting providers and payers with implementation efforts, including the identification of vendors to close capacity gaps

Work with ONC to speed EMR certification requirements that support automation

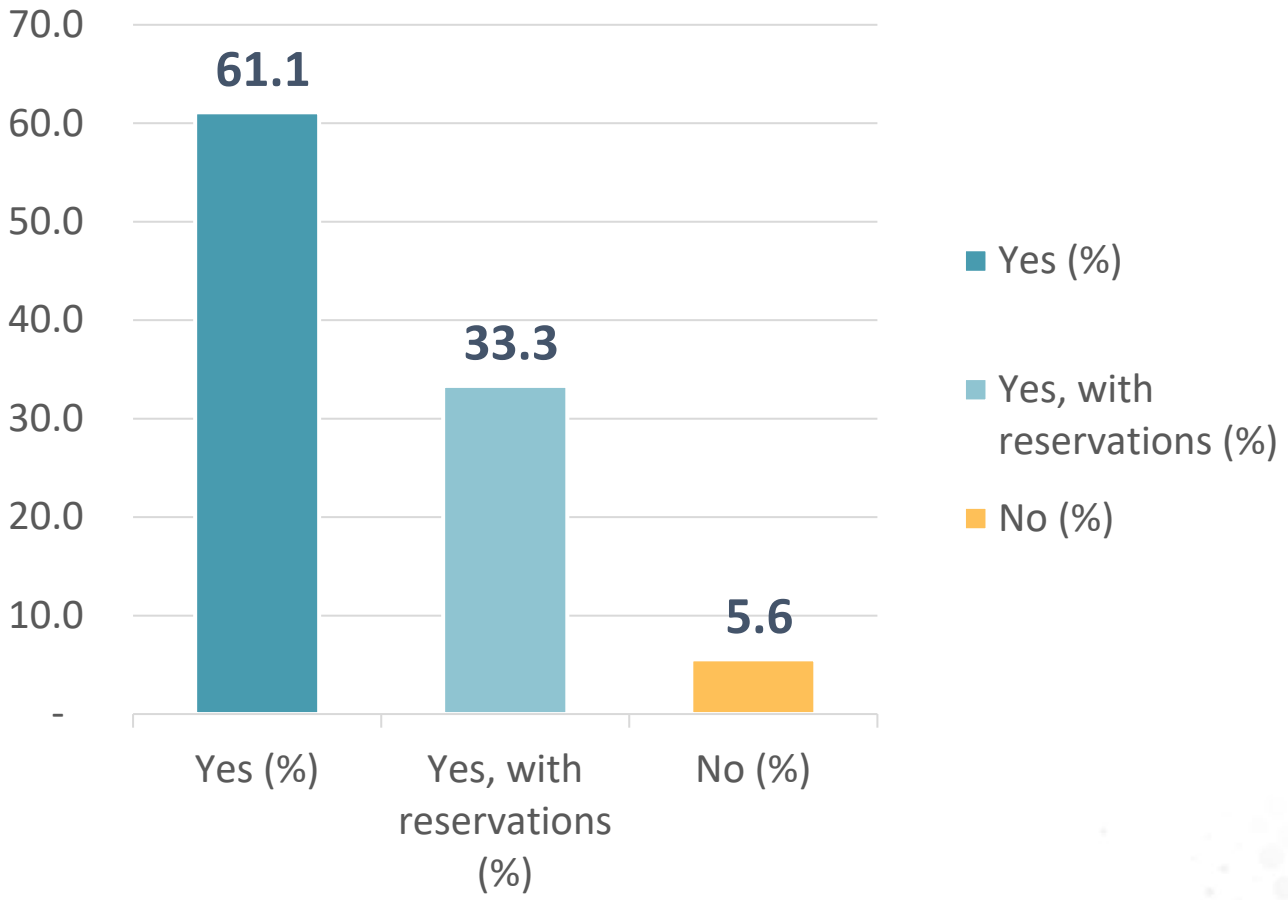
Require reporting related to desired outcomes



- Efficiency and effectiveness of PA (e.g., time to response; provider adoption rate)
- Opportunities to reduce unnecessary variation in PA processes
- Savings achieved due to automation

Establish ongoing collaboration to advise on needed data and additional reforms

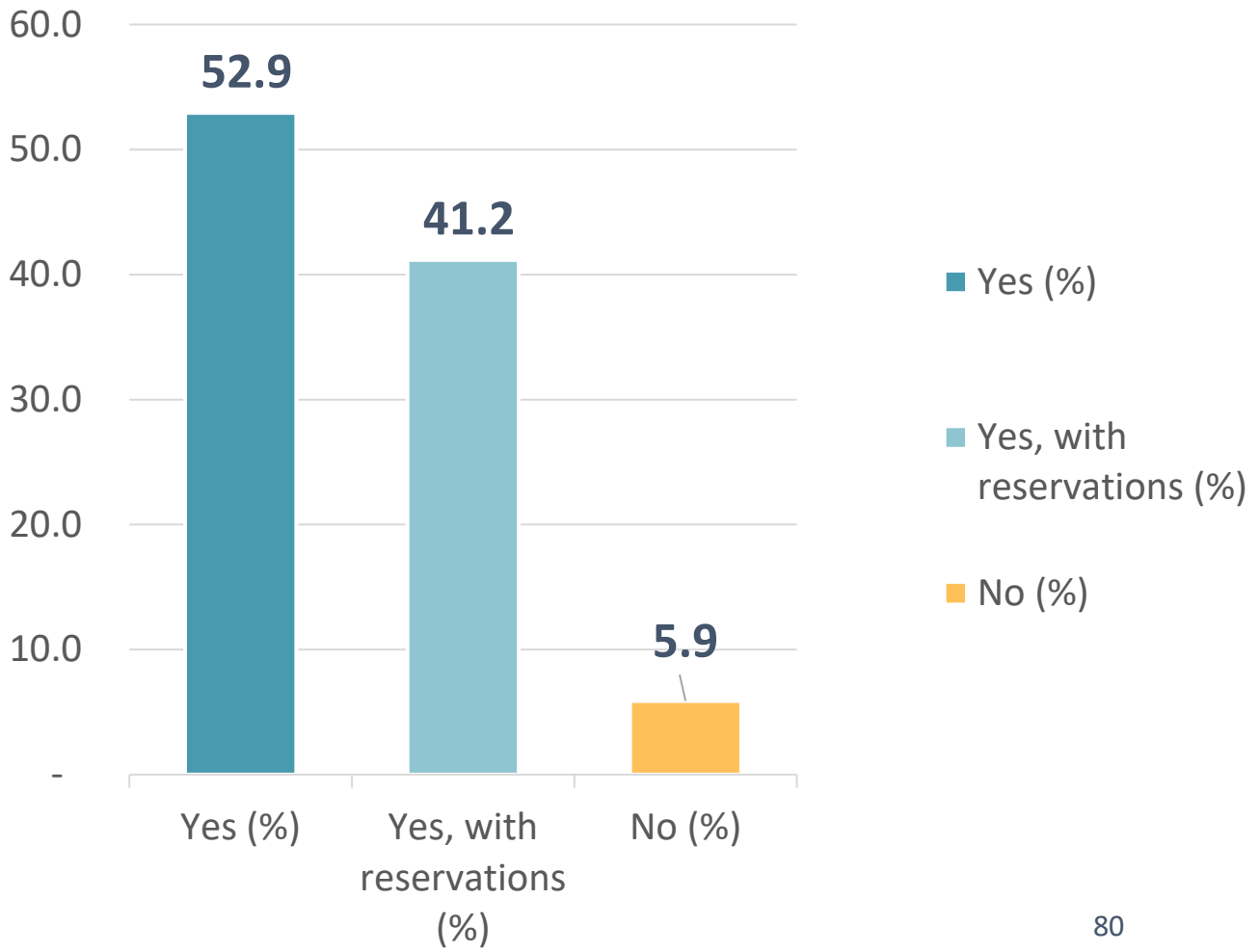
- Create a multi-stakeholder Task Force to ensure ongoing examination of PA issues from a multi-stakeholder perspective
- Include representation from the Mass Collaborative, patient and consumer advocates, and diverse payers and providers
- Functions:
  - Provide advice to state authorities on the slate of measures on which payers and providers will report annually
  - Recommending to the state additional PA reforms that reduce administrative burden and use of low-value care



Provide need-based financial assistance

- There was a significant concern by payers and providers regarding implementation costs

- Under a subscription model for centralized automation services, total annual infrastructure costs for **full automation of the PA process will likely range from $30K to $600K per participating organization.**



Massachusetts is primed to take the lead

- **MA has a running start**
  - Mass Collaborative (BCBSMA, MAHP, MHA, MHDC, MMS) work on standardization of PA forms
  - Steering Committee consensus from first project
  - Extensive MA stakeholder engagement in current project
- **MA has a history of successful health IT implementation**
  - EMR adoption
  - Event Notification Service (ENS)
- **Trusted MA organizations and vendors with the proper technical expertise are already leading & sponsoring piloting efforts**
  - MHDC/NEHEN progress with BCBSMA, NEBH, and Olive
  - MHDC's facilitation of ENS implementation
  - Project co-sponsors: Cohere Health, ZeOmega, Change Healthcare, Hook
- **Multiple bills filed that address PA and the need for healthcare information exchange.**

Start Now: ePrior Authorization Implementation Timeline

NEHI Network for Excellence in Health Innovation

May 2023

TAAG (Phase 1) work is completed

Presentation of implementation strategy to HPC

Oct 2023

Conformance criteria complete

End-point directory drafted

Technology inventory completed

Task Force members confirmed

Responses to RFPs reviewed and vendor partners selected

Payer and provider participation agreements drafted

Apr 2024

First tranch of CRD* prototyping completed

Second tranche of CRD prototyping starts

Second tranche of participation agreements signed

Task Force meeting #2

Oct 2024

Third tranche of CRD* prototypes completed

First implementation of DTR/PAS** prototypes completed

Final tranche of participation agreements signed

Apr 2025

Third tranche of DTR/PAS prototyping (if necessary) complete

Site-specific transaction testing (Tranches 1, 2) starts

Initial reporting requirements complete

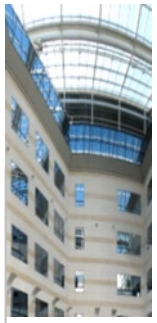
Oct 2025

Site-specific transaction testing (Tranches 3, 4) complete

Reporting testing complete

Site-specific production (Tranches 1,2) starts














Jul 2023

Task Force roster complete

HPC ePA review and recommendations complete

RFPs to ePA vendors issued

Payer and provider conformance criteria drafted

Jan 2024

First tranche of participation agreements signed

First tranche of CRD* prototyping starts

End-point directory completed

Task Force meeting #1

Jul 2024

Second tranche of CRD prototyping completed

Third tranche of participation agreements signed

Third tranche of CRD prototyping starts

Jan 2025

Final tranche of CRD implementations complete

Second tranche of DTR/PAS prototyping completed

Funding support in place

Reporting requirements, aligned with CMS, completed

Jul 2025

Site-specific transaction testing (Tranches 1,2) complete

Site-specific transaction testing (Tranches 3, 4) starts

Reporting testing continues

Jan 2026

Site-specific production (Tranches 3, 4) starts

ePA production complete

CMS-aligned reporting complete

Implementation Planning Complete, Conformance Criteria Complete, and Task Force Convened → Participation Agreements, Funding Support and ePA Prototyping Complete → Site-Specific Transaction Testing Complete, Production and Reporting Begins

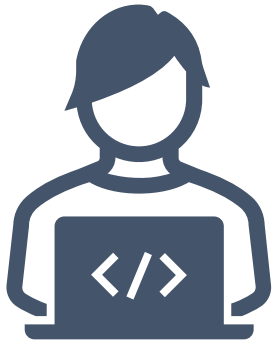
* CRD: Coverage Requirements Discovery will assist providers in submitting unnecessary PA requests to payers.

** DTR/PAS: Documentation Templates and Rules/Prior Authorization Support complete the automated exchange of documents and approval of requests.

Proposed next steps that can be accomplished prior to a mandate

Initiate a

Multi-stakeholder Task Force



Establish a

Technical Assistance Center

NEHI Network for Excellence in Health Innovation

Questions & Discussion

NEHI Network for Excellence in Health Innovation

Thank You!

APPENDIX

TAAG members

Organization	Representative
BCBSMA	Lee Green, Mike Katzman & Shane Rawson
Berkshire Health Systems	Bill Young & Lucas Markland
Boston Children's Primary Care Alliance	Dr. Jen Hyde
Boston Medical Center Health System/WellSense	Arthur Harvey
Centers for Medicare & Medicaid Services (CMS)	Alex Mugge
Change Healthcare	Andrew Johnson & Mark Fleming
Cohere Health	Niall O'Connor
Community Care Cooperative (C3)	Bill Fleischmann
Counterpoint Solutions	Sandy Vance
Epic	Heath Hanwick & Graham Pedersen
Fallon Health	Dr. Mark Dichter, John Budaj & Patrick Leblanc
Health New England	Casey Hossa & Dr. Kate McIntosh
Health Policy Commission	Kara Vidal & Gina Dello Russo
Hook	Lorenzo Granato & Kevin Carroll
Massachusetts Association of Health Plans (MAHP)	Liz Leahy & Alyson Durlin

TAAG members continued

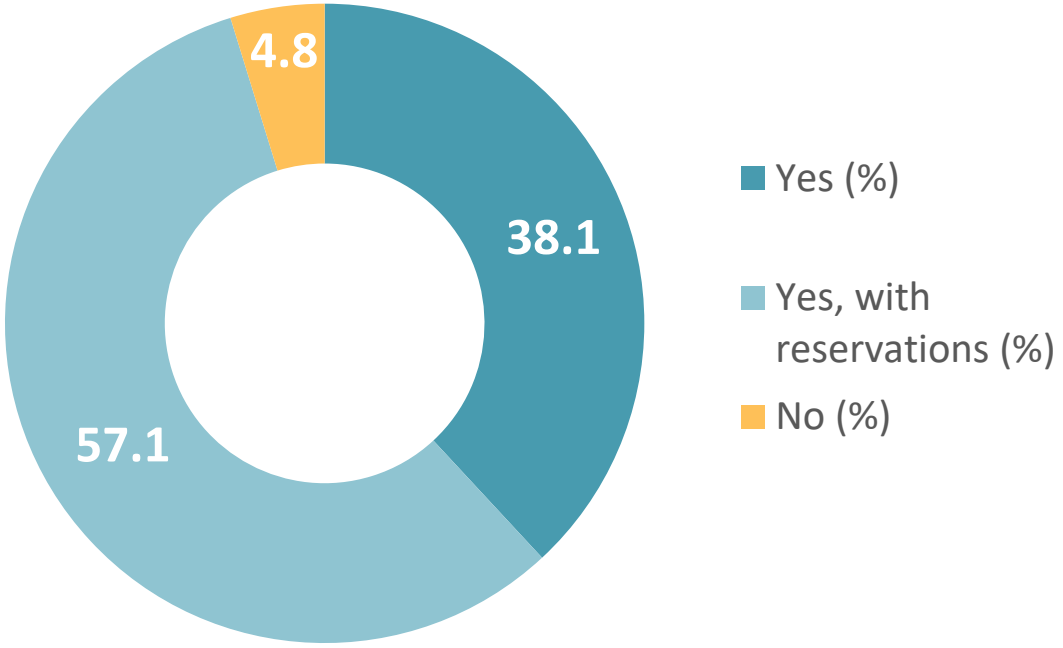
Organization	Representative
Massachusetts Executive Office of Health and Human Services (EOHHS)	Lauren Peters
Massachusetts Health & Hospital Association (MHA)	Karen Granoff
Massachusetts Medical Society (MMS)	Yael Miller
MassHealth	Dr. Jatin Dave
MEDITECH	Mike Cordeiro & Philip Alcaidinho
Mass General Brigham (MGB)	Laurie Finigan & Tasha Hogeboom
Mt Auburn Cambridge Independent Practice Association	Dr. Barbara Spivak
New England Quality Care Alliance	Dr. Alain Chaoui
Olive	Matt Cunningham & Doug Fitzgerald
Office of the National Coordinator for Health Information Technology (ONC)	Beth Myers
Point32Health	Cara Libman, Hemant Hora, Maria Fitzgerald, Vijay Bhatt, others
Point-of-Care-Partners (POCP)/HL7 Da Vinci	Jocelyn Keegan & Kendra Obrist
Reliant Medical Group	Mike Hebert
Self	Dr. John Glaser
Steward Health Care	David Colarusso
ZeOmega	Tony Sheng & Mike Gould

The Automation Advisory Group (TAAG) Recommendation Endorsements

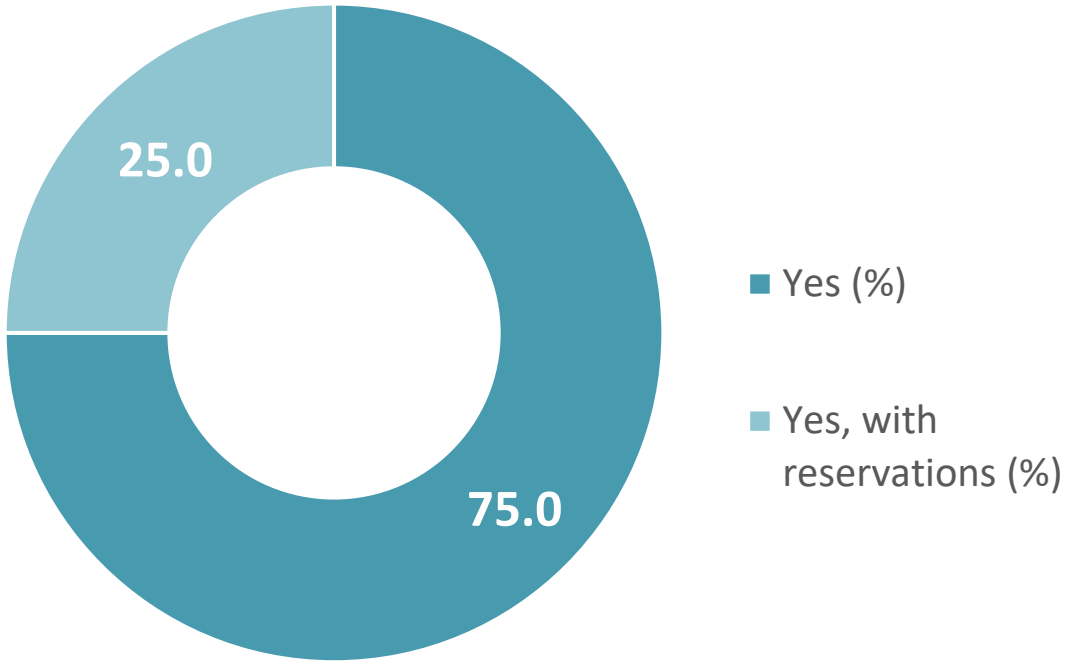
We asked TAAG to indicate their support for our recommendations.

“Are you supportive of a statewide automation mandate?”

- 21 responses from TAAG
  - Yes (8): 4 payer representatives; 1 provider representative; 2 vendor representatives; 1 additional representative
  - Yes, with reservations (12): 5 payer representatives; 4 provider representatives; 3 vendor representatives
  - No (1): 1 payer representative
  - Reservations included:
    - A mandate for automation must align with the Federal Rule (i.e., standards, scope, and timelines for implementation)
    - MAHP voiced a general reticence to any mandates, but is supportive of automation.

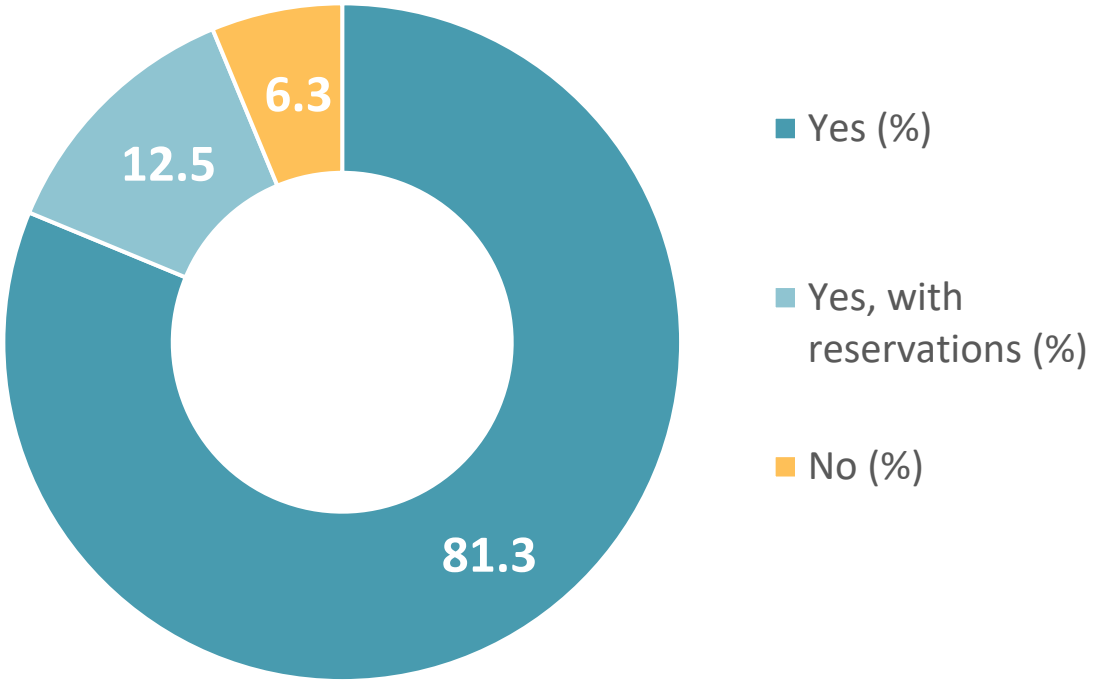


“Do you support automation requirements that incorporate the Da Vinci Implementation Guides?”



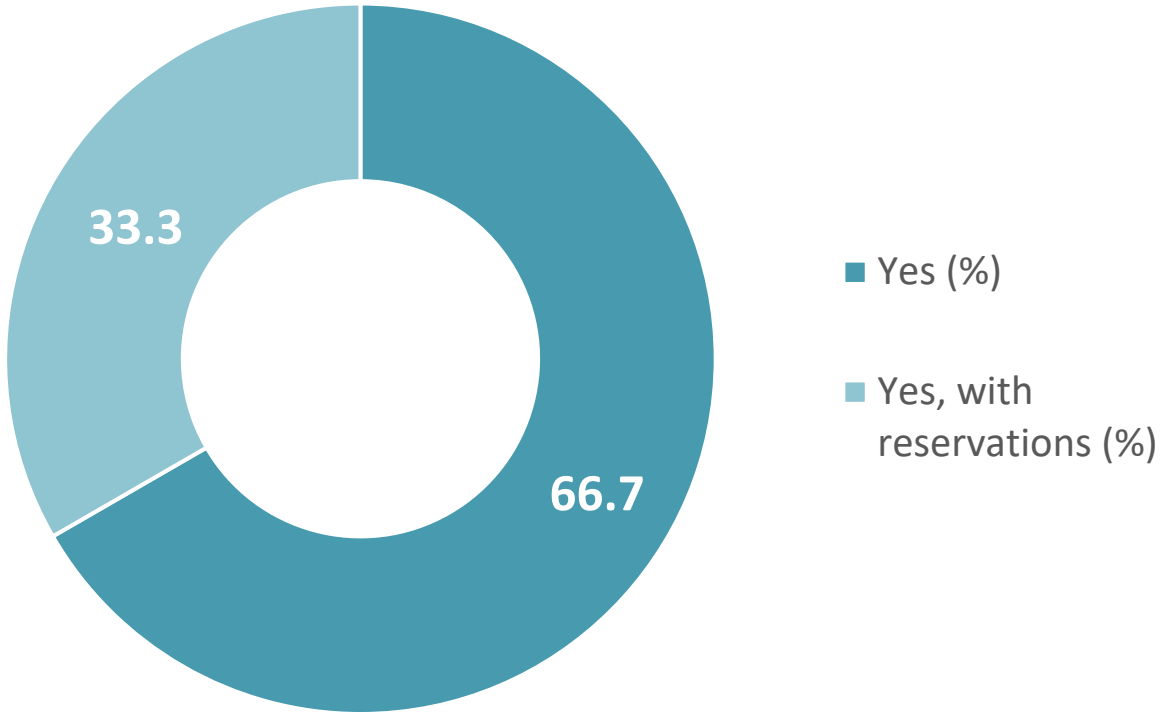
- 16 responses from TAAG
  - Yes (12): 6 payer representatives; 5 vendor representatives; 1 additional representative
  - Yes, with reservations (4): 1 payer representative; 1 provider representative; 2 vendor representatives
  - Reservations included:
    - The mandate should allow for use of updated versions of the Da Vinci Implementation Guides.
    - Payers are supportive of automation, though aware that HIPAA-mandated X12 278 transactions must also be supported (this requires work to maintain both processes).

“Do you think the state should establish a technical assistance center that provides advice, training, and coordination of the automation process?”



- 16 responses from TAAG
  - Yes (13): 8 payer representatives; 1 provider representative; 4 vendor representatives
  - Yes, with reservations (2): 1 provider representative; 1 vendor representative
  - No (1): 1 payer representative
  - No reservations voiced

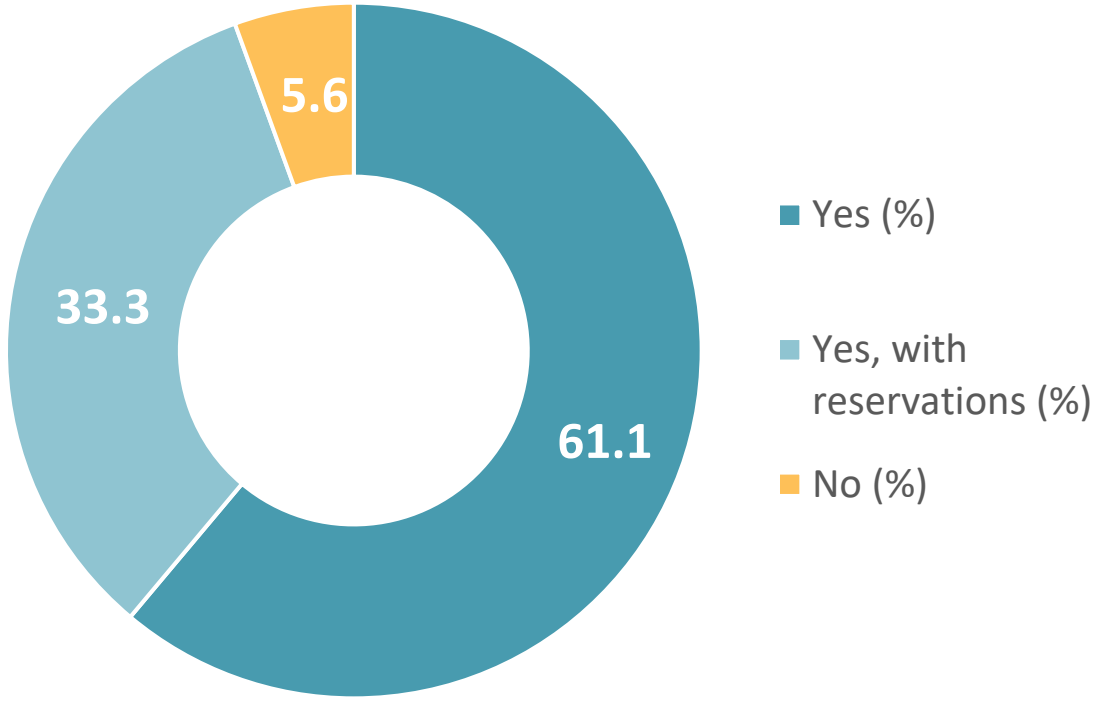
"Are you supportive of developing reporting requirements through a collaborative process with multiple stakeholders for the purpose of evaluating the impact of automation?"



- 21 responses from TAAG
  - Yes (14): 6 payer representatives; 4 provider representatives; 3 vendor representatives; 1 additional representative
  - Yes, with reservations (7): 4 payer representatives; 1 provider representative; 2 vendor representatives
  - Reservations included:
    - Any collaborative work to develop reporting requirements must contain protections for health plans' proprietary data.
    - Reporting requirements must align with reporting requirements outlined in the Federal Rule and be derived from the automation process.

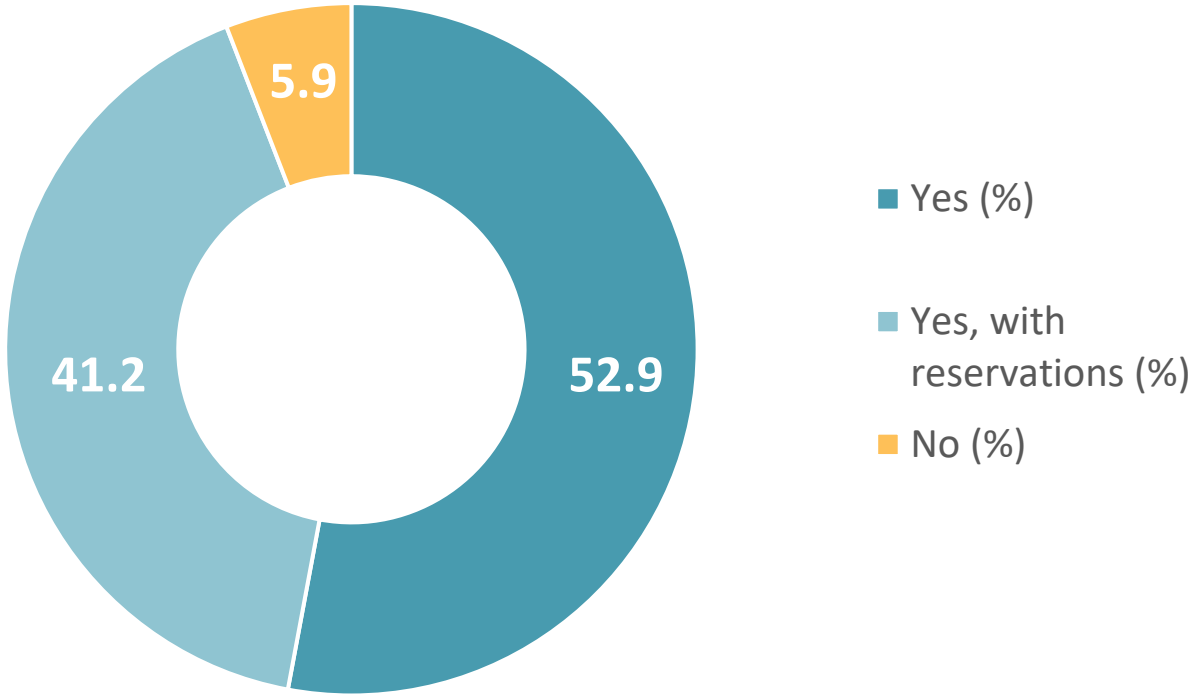
“Are you supportive of establishing a multi-stakeholder prior authorization task force that develops metrics for evaluating the impact of automation on PA outcomes?

- 18 responses from TAAG
  - Yes (11): 5 payer representatives; 1 provider representative; 4 vendor representatives; 1 additional representative
  - Yes, with reservations (6): 3 payer representatives; 1 provider representative; 2 vendor representatives
  - No (1): 1 payer representative
  - Reservations included:
    - MAHP again voiced a general reticence to any mandates, but is supportive of a multi-stakeholder task force
    - Future PA reforms should be derived from the data that automation will produce.
    - Time to collect and analyze such data must be accounted for prior to attempting any future PA reforms



If the state mandates automation of prior authorization, do you think the state will need to provide financial support to payers and providers to enable automation?

- 17 responses from TAAG
  - Yes (9): 6 payer representatives; 2 vendor representatives; 1 additional representative
  - Yes, with reservations (7): 3 payer representatives; 2 provider representatives; 2 vendor representatives
  - No (1): 1 vendor representative
  - No reservations voiced



Detailed estimate of implementation costs for payers

NEHI Network for Excellence in Health Innovation

Coverage Requirements Discovery (CRD)

- A subscription model (e.g., through MHDC/NEHEN) could serve to coordinate and manage automated prior authorization among subscribed payers
  - Subscribed payers could obtain access for an estimated range of **$20K to $400K/year**

Cost Breakdown

Documentation, Templates & Rules (DTR)

- We estimate individual payers must spend **$500K to $2M** to translate medical necessity criteria into machine-readable (electronic) questionnaires, though these are a **one-time cost**
- A subscription model (e.g., through MHDC/NEHEN) could act as a centralized service that offers subscribed payers the infrastructure & technology for a DTR rules engine
  - Subscribed payers could obtain access for an estimated **$10K to $200K/year**

Many costs can be shared by centralizing some of the functions. **Under a subscription model for centralized automation services, total annual infrastructure costs for full automation of the PA process will likely range from $30K to $600K.**

Agenda

Call to Order

Approval of Minutes **(VOTE)**

DataPoints Issue #24: Persistent Cost-Sharing for Contraception in Massachusetts, 2017 – 2020

Findings from the 2023 Health Care Cost Trends Report: Excessive Pricing in the Massachusetts Health Care System

Schedule of Upcoming Meetings

Reducing Unnecessary Administrative Complexity

- Guest Presentation from The Network for Excellence in Health Innovation (NEHI): Automation of Prior Authorization

POLICY OPTIONS FOR REDUCING UNNECESSARY ADMINISTRATIVE COMPLEXITY

Prior Authorization Reforms

In Massachusetts, past attempts have been made **to address PA complexity** include:

- Chapter 224 required payers use **standard PA request forms**. While extensive, collaborative efforts have been made to develop these forms, the process has been resource intensive and, to date, standard forms have only been developed for a subset of services.
- DOI directed payers to relax PA requirements for certain services during the **COVID emergency**, but the directive was temporary.
- The recently passed **Mental Health ABC Act** prohibits PA for acute mental health treatment and established a special commission to recommend a common set of medical necessity criteria for BH services. These reforms hold promise but are narrow in scope.

Automating prior authorization according to a statewide roadmap and a set of uniform standards could reduce some of the cost and burden of prior authorization for payers, providers, and patients, while also providing a source of data to inform other PA reforms.

There may also be opportunities to seek **broader reforms** that could address additional pain points in the process.

Examples of Prior Authorization Complexity and Potential Solutions

HPC

Volume of Authorizations

E.g., mandatory gold-carding, elimination of PA for services with high approval rates, higher provider payment for services requiring PA

Lack of Standardization

E.g., uniform medical necessity criteria, uniform set of services requiring PA, uniform policies for use of family codes and for bundled PAs

Time to Approval

E.g., requiring PAs be valid for longer after approval, public reporting on time to disposition rates

Mid-Year Changes

E.g., limiting when PA policy changes can go into effect, strengthening notice requirements, limiting circumstances when changes can be made

Retroactive Denials

E.g., limiting timeframe for retroactive denials, limiting allowable circumstances for retroactive denials

Patient Plan Switching

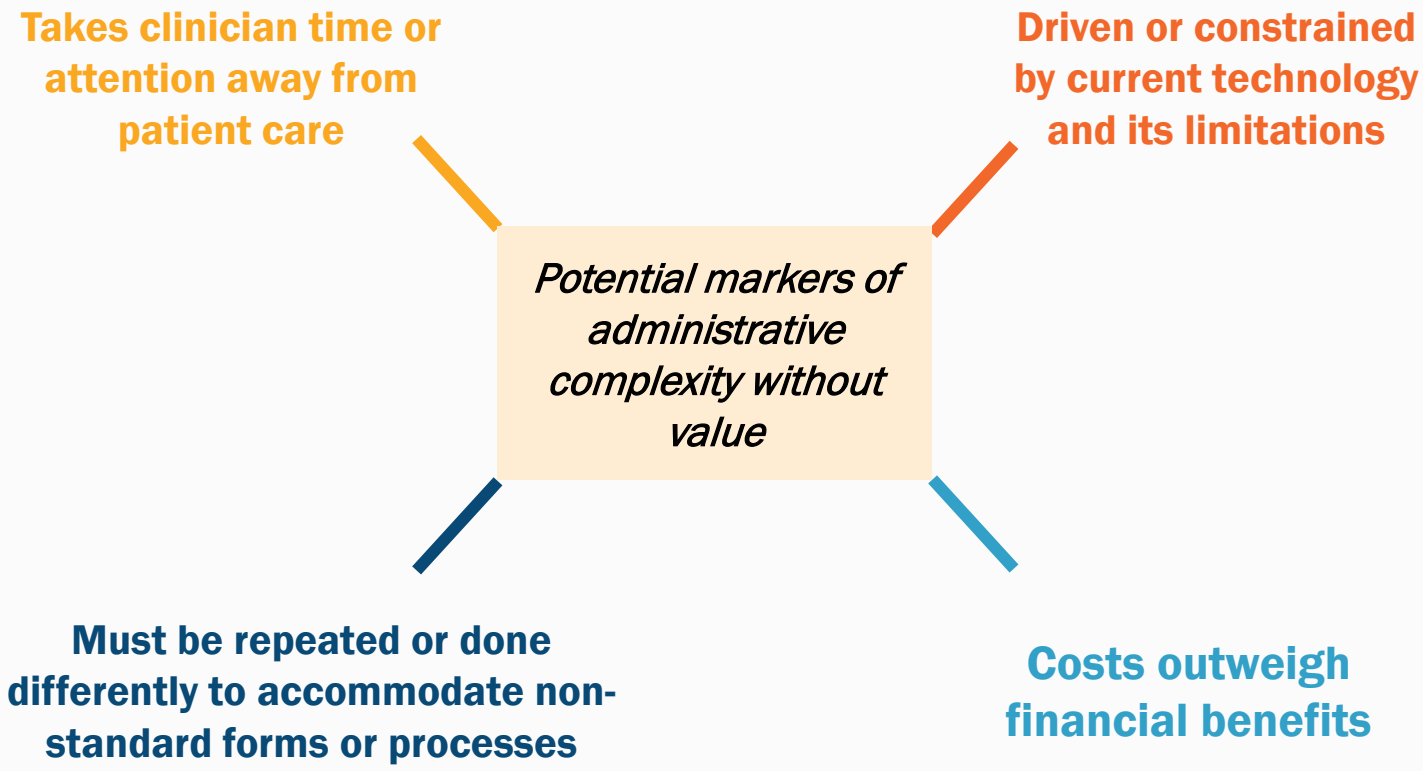
E.g., prohibiting requirement that patients who switch health plans get a new PA for previously-approved treatments for a certain amount of time

Automation would alleviate some of these pain points, but there may be opportunities for additional reform.

Other Areas of Administrative Complexity

Are there other areas of complexity that the HPC should prioritize?

EXAMPLE MARKERS OF COMPLEXITY WITHOUT VALUE:



EXAMPLE AREAS OF COMPLEXITY:

- Billing and Claims Processing
- Clinical Documentation and Coding
- Clinician Licensure
- Electronic Health Record Interoperability
- Eligibility/Benefit Verification and Coordination of Benefits
- Prior Authorization
- Provider Credentialing
- Provider Directory Management
- Quality Measurement and Reporting
- Referral Management
- Variations in Benefit
- Variations in Payer-Provider Contract Terms

Potential Next Steps

1. Continue to work with NEHI and MHDC to advance automation in Massachusetts
2. Continued research on policy opportunities to streamline prior authorization
3. Prepare regulatory and/or statutory policy recommendations for state action

Agenda

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Approval of Minutes **(VOTE)**

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CARE DELIVERY TRANSFORMATION

Appendix

Data and Methods

DATA

- HPC analysis of the Center for Health Information and Analysis (CHIA) Massachusetts All-Payer Claims Database v.2021.
- HPC included 6 commercial payers for this analysis.
- Medicare and MassHealth prices were constructed using publicly available fee schedules.

METHODS

- In APCD 2021, HPC created prices for seven distinct service categories.
  - Prices accounted for modifiers that could impact cost as well as other same-day services that may alter the prices for these services.
  - Price trimming was applied to excluded claim lines with prices more than 10 times the statewide median or less than 20% of the statewide median for a given procedure code.
  - Excessive spending was extrapolated to the Massachusetts commercial market excluding Connector plan membership. Roughly 38% of statewide commercial members were captured in the APCD by the 6 payers.
- For some services, a comparison price could not be identified from the relevant fee schedule. These were excluded from analysis. Accordingly, estimates of excessive spending are conservative.

Notes: More details on these services and their price benchmarks will be provided in the 2023 Cost Trends Report Technical Appendices. Payers include AllWays, Anthem, BlueCross BlueShield MA, Health New England, Point32 Health (Harvard Pilgrim Health Care and Tufts Health Plan).

Select Specialty "Crossover" Services

This set of services include procedures such as **steroid joint injections** (often used to relieve chronic pain), **testing services (such as breathing capacity or hearing)**, **non-gastrointestinal endoscopies** (such as for the sinuses), among others that are performed in both office and HOPD settings.

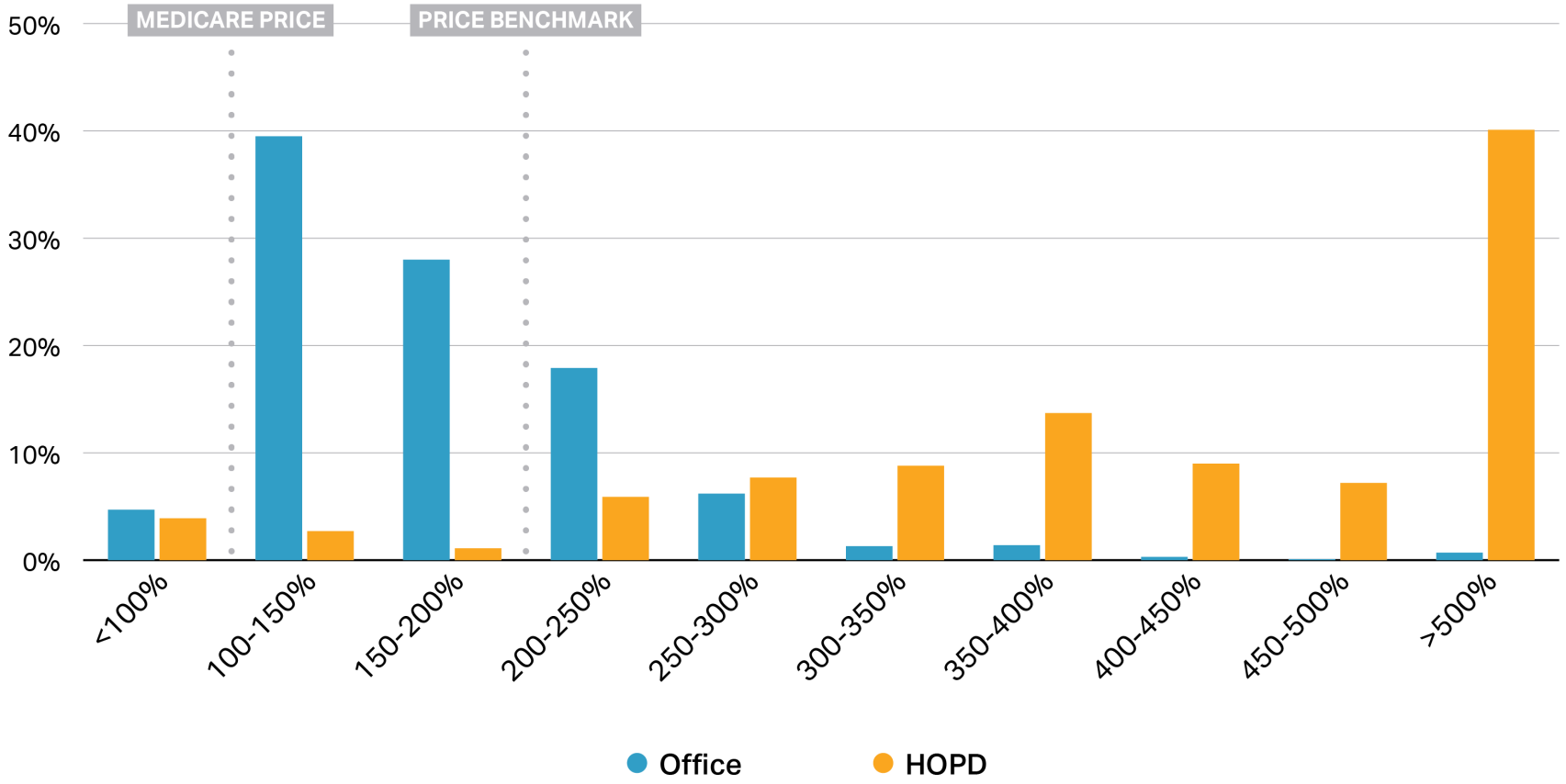
In 2021, 52% of these crossover service encounters were administered in a hospital outpatient department and 48% in an office setting.

While the current Medicare fee schedule has different payment rates by setting, the Medicare Payment Advisory Committee recommended in April 2023 that certain services be paid the same regardless of location. For this analysis, HPC used the Medicare office payments (non-facility price) for benchmarking.

For the following analysis, HPC considered 12 procedures that occurred in both HOPD and office settings and are not included in other sections of this presentation.

92% of select crossover services performed in HOPD settings were paid in excess of 200% of Medicare's office price. 40% of those were paid more than 5 times Medicare's office price.

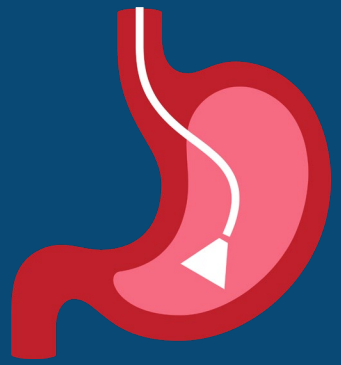
Percentage of crossover services paid at shown ranges relative to what Medicare office price would pay, by setting of care, 2021



Note: Distribution is calculated by encounter prices classified into one of ten bins based on comparison to Medicare price for a specific procedure code and location (Boston or other Massachusetts). The 12 CPT codes are: 11042, 20553, 29075, 31237, 62321, 62323, 64450, 64483, 64493, 64615, 92557, and 92567.
Sources: HPC analysis of the Center for Health Information and Analysis (CHIA) All-Payer Claims Database, 2021, V 2021; HPC analysis of prices information from the HPC analysis of information from the Centers for Medicare and Medicaid Services, Medicare Physician Fee Schedule (2021).

- These are common services that can occur in office and hospital outpatient departments safely.
- 92% of these services performed in HOPD settings were paid in excess of 200% of Medicare's office price, compared to 28% of services performed in office settings.
- Roughly 50% of all service spending was above 200% of Medicare's office price.

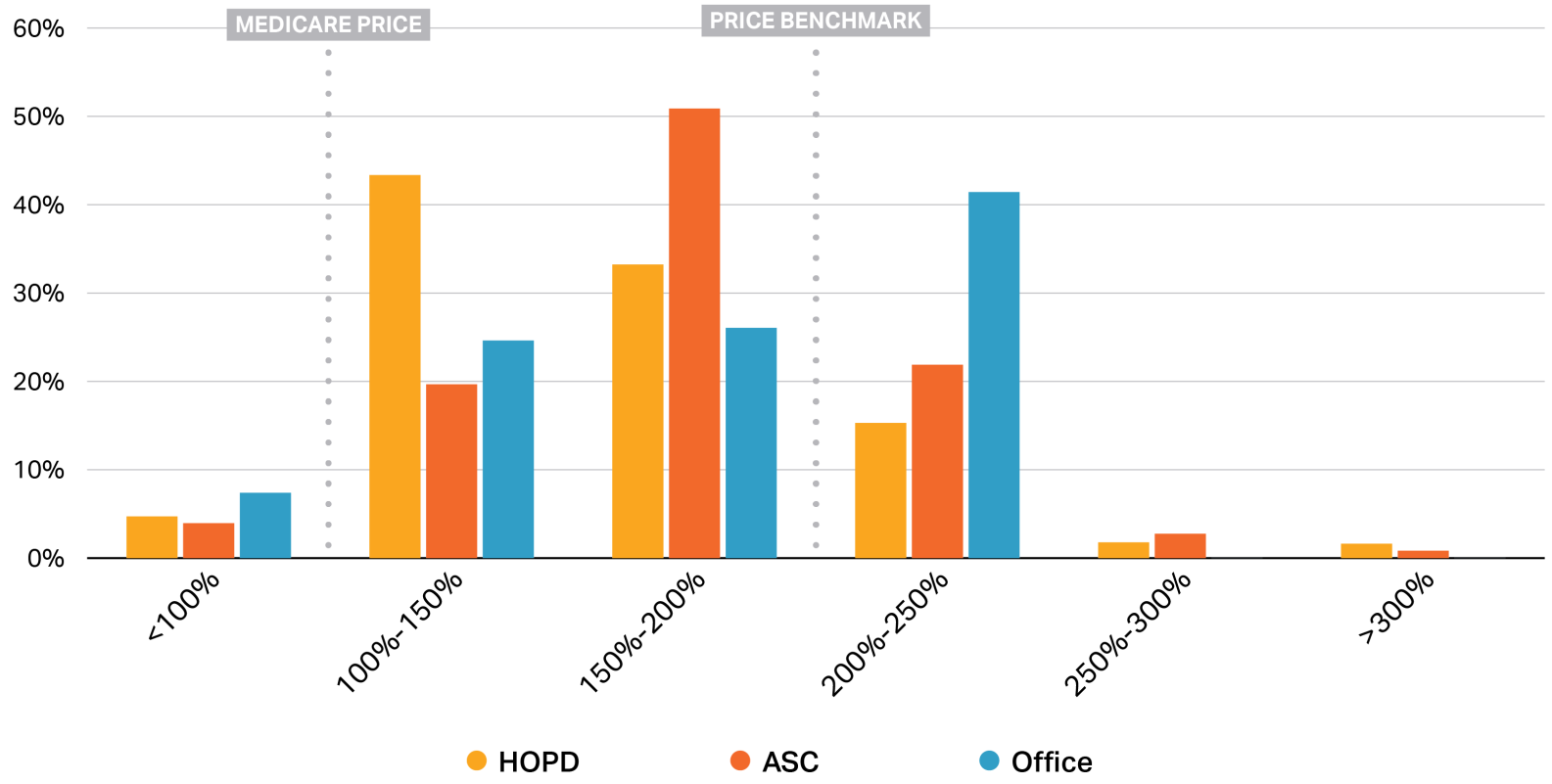
Colonoscopy and Endoscopy



- Colonoscopies and other endoscopies are common medical services performed by trained specialists. Although they are specialized procedures, these services are commonly performed across a variety of settings including HOPDs, ambulatory surgical centers (ASCs), and physician offices. These services accounted for 1.4% of commercial health care spending in 2021.
- In 2021, **66% of endoscopies among commercially-insured patients took place in HOPDs**, 29% took place in ASCs, and 5% took place in offices.
- Medicare prices for endoscopies are based on different fee schedules, depending on the site of care. The professional component of endoscopies is priced according the Physician Fee Schedule, the facility component for those performed at HOPDs is priced according to the Outpatient Prospective Payment System (OPPS) and the facility component of endoscopies performed at ASCs is priced according to the ASC Payment System.

22% of endoscopy encounters had prices greater than 200% of the Medicare price for the setting in which they were performed.

Percentage of endoscopies paid at shown ranges relative to what Medicare would pay, by setting of care, 2021

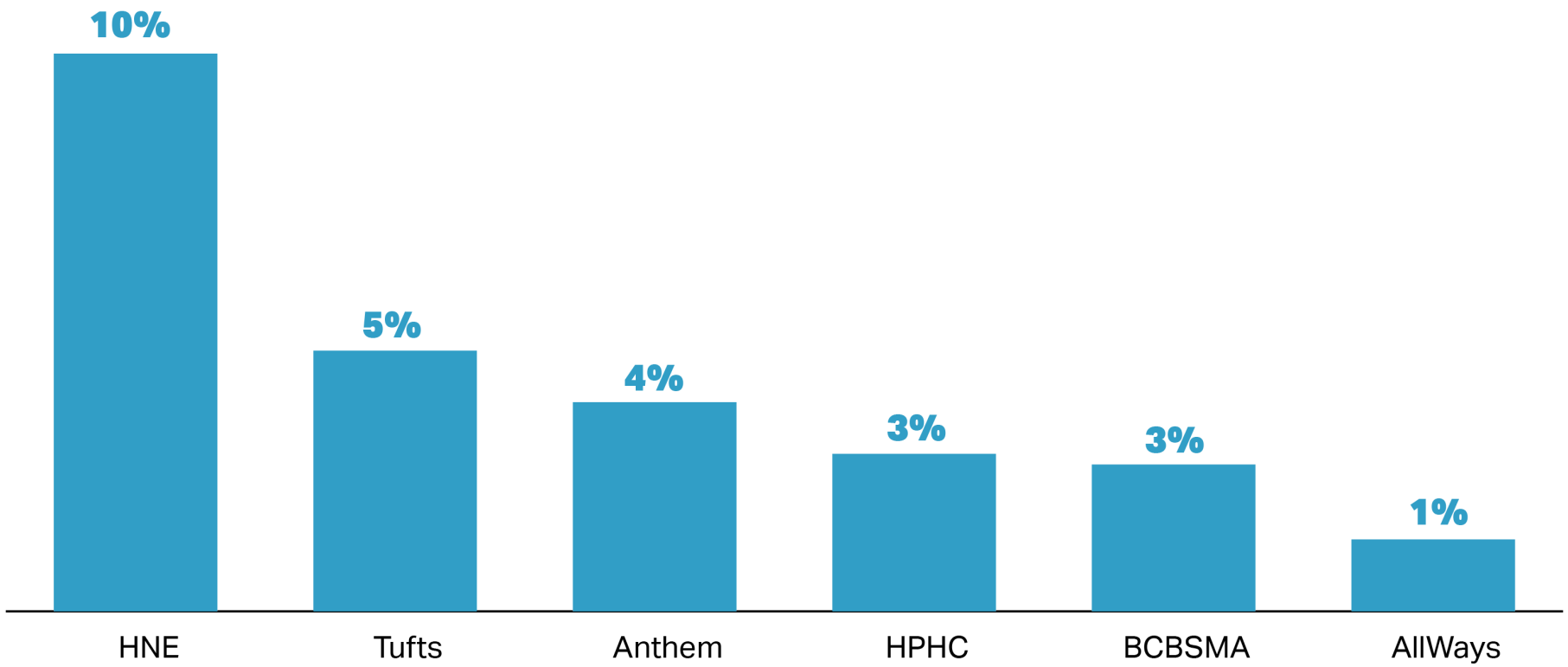


Notes: Includes all encounters where at least one endoscopy was performed, as defined by CCS and/or BETOS, with matching procedure codes on the highest-priced professional and the highest-priced facility claims. Percentages are calculated as the aggregate utilization in each bin divided by total utilization for each setting of care.
Sources: (1) HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v2021, 2019-2021. (2) Centers for Medicare and Medicaid Services (CMS) Hospital Outpatient Prospective Payment (OPPS), Ambulatory Payment Classifications (APC), and Ambulatory Surgery Center (ASC) Payment information for 2021.

- Endoscopies, excluding anesthesia and other ancillary services, comprise approximately 1.4% of commercial health care spending.
- 25% of endoscopies occurring in ASCs, 19% of endoscopies occurring in HOPDs, and 41% of endoscopies occurring in offices had commercial prices higher than 200% of the Medicare price for that setting.
- Approximately 3.6% of endoscopy spending was above 200% of the Medicare price for a given setting.

The percentage of spending above 200% of the Medicare price for endoscopy services varied by payer as well as provider.

Estimated percentage of endoscopy spending over 200% of what Medicare would pay, by payer, 2021



Notes: Includes all encounters where at least one endoscopy was performed, as defined by CCS and/or BETOS, with matching procedure codes on the highest-priced professional and the highest-priced facility claims. Amount of spending over 200% of what Medicare would pay is the difference between the allowed amount and 200% of what Medicare would pay, calculated for each encounter.
Sources: (1) HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v2021, 2019-2021. (2) Centers for Medicare and Medicaid Services (CMS) Hospital Outpatient Prospective Payment (OPPS), Ambulatory Payment Classifications (APC), and Ambulatory Surgery Center (ASC) Payment information for 2021.