Committee on the Quality of Medical Practice 9/12/19

- **MMS Goal:** Physicians: Physicians will enjoy a satisfying career in medicine that is grounded in high-quality care, intellectual growth, and financial sustainability in an inclusive environment with minimal regulatory burden.

- **MMS Objectives:** Physicians
  1. Reduce unnecessary regulations and administrative burdens.
  2. Advance physician wellness, professional growth and satisfaction, and promote inclusive work environments.
  3. Increase physicians' financial sustainability within the health care environment.

- **Review of Strategic Initiative Physician 1:** Identify and implement three high impact initiatives to advocate for the reduction of unnecessary regulations and administrative burdens

Physicians #1: Critical: Identify and implement **three high impact initiatives** to advocate for the **reduction of unnecessary regulations and administrative burdens**

- Streamline and reduce **Licensure/ Credentialing/Provider Directory** time frame

- Reduce and/or Eliminate **Prior Authorization** requirements

- Reduce **Quality Measurement** burden

Streamline and Reduce Licensure/ Credentialing/Provider Directory Time Frame

Licensure and Credentialing

Consulting Study of end to end Credentialing process by Applied Management Systems (AMS) completed end of 2016 :

Conclusion: Takes 8-16 months to complete end to end credentialing:

From: State Licensure to Provider Credentialing to Health Plan Credentialing

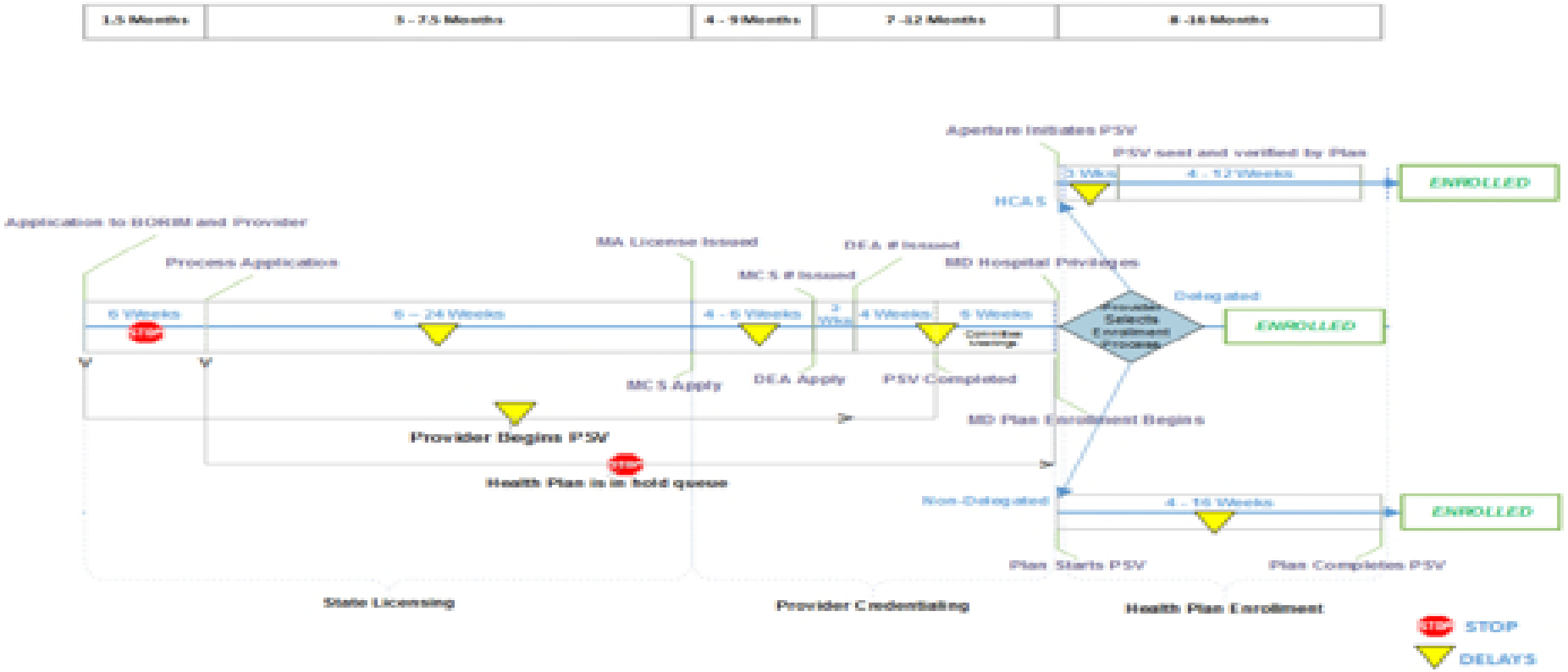
Key Pain Points from AMS Study

- Massachusetts Controlled Substance Registration(MCSR)
- Health Plan Credentialing through HCAS/CAQH
- BORIM Initial Licensure

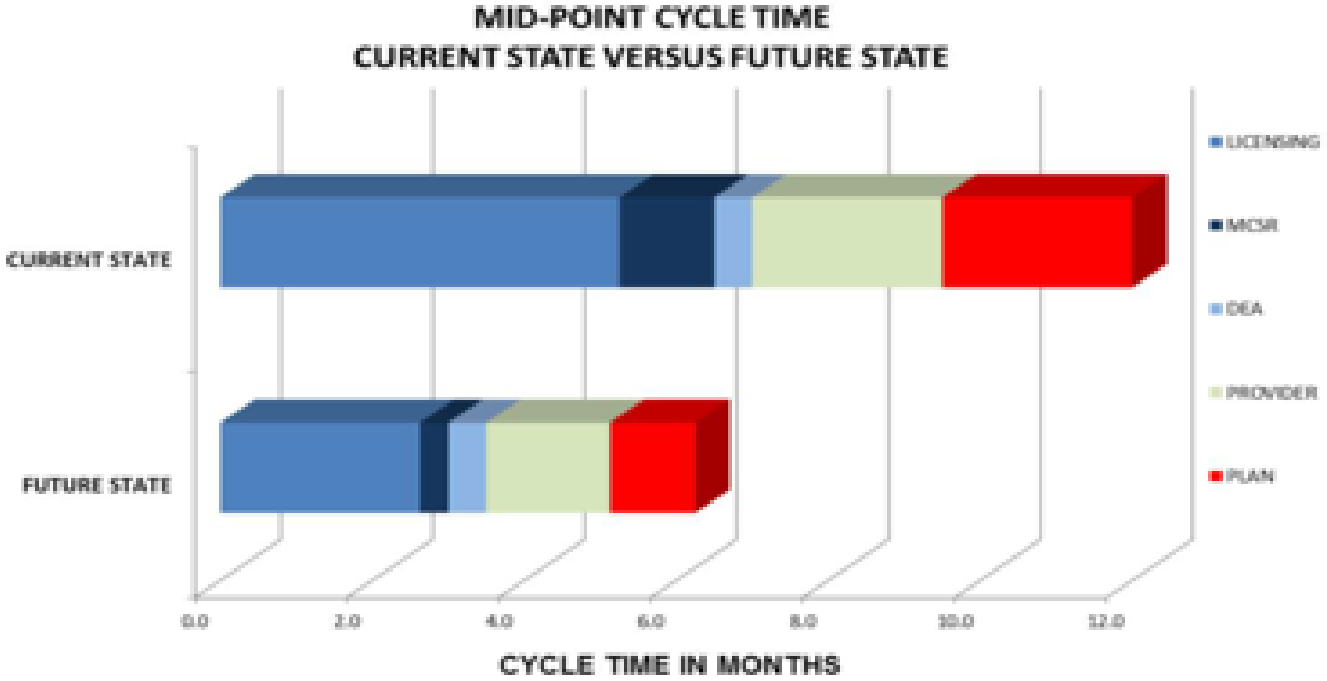
Current State (as of 2016) – Few Changes to Date

CURRENT STATE

END-TO-END CREDENTIALING CYCLE TIME



Shared Interest in End-to-End Process Improvements



MID-POINT	LICENSING	MCSR	DEA	PROVIDER	PLAN	OVERALL
CURRENT STATE	5.3	1.25	0.5	2.5	2.5	12
FUTURE STATE	2.6	0.4	0.5	1.6	1.1	6.3

Improvements across the end-to-end credentialing and enrollment process will shorten the cycle time for providers and help ensure access to care for patients.

Advocacy to streamline MCSR: lead to

DPH Mass Controlled Substance Registration

Online MCSR Process Launched January 2019 !

- To include initial and renewal applications – shared with MHA's PHIC members and they were very pleased!

GOALS:

- expedite application and renewal process,
- reduce paper dependency,
- provide email notifications prior to expiration
- Improve data quality and reduce administrative error
- The online system boasts faster application processing, credit/debit transactions, and daily updates of MCSR status through Check-A-License for both registrants and the public. MCSR registrants will also notice that the MCSR certificate is now wallet-sized.
- **MassCollaborative worked closely with DPH to ensure our respective members are informed through broad education efforts**

Extensive Advocacy with BORIM

BORIM Licensing Division is implementing a series of initiatives to improve its efficiency and service:

- **The resulting plan should take the BORIM licensure process from 57-88 days to under a month:**
- This will: Reduce processing times by up to two months; Improve the application experience, and Strengthen credentialing verification.

There are 5 Operational Initiatives that will facilitate this evolution:

1. ***Performance metrics***
2. ***Application Form Redesign*** **(63 pages to 31 pages**) Training staff: Require new form 9/1
3. ***Application communications***: Train licensing staff: Pilot template 9/1
4. ***E- Licensing RFR*** – move initial application process on-line– Estimated launch 9/6
5. ***Application Completeness*** – pilot application completeness review.

The process will now:

1. Require initial licensees to use **the Federation Credentials Verification Service**.
2. **Streamline malpractice documentation requirements.**
3. On a quarterly basis, starting on June 1 and for calendar year quarter 3 (July – Sept) **grant the Executive Director authority to confer administrative approval** for licenses that do not require Licensing Committee review.

Health Plan Provider Directory

- **The Problem:** Health Plan provider directory information inaccurate – CMS and DOI concerns and studies
- **The Advocacy**: MMS- MHA push for streamlined solutions
- **The Solution**: MAHP, HCAS and BCBS unite: Pick CAQH Proview Direct Assure
- **The Plan:** Two year process leading to a uniform single entry portal for health plan provider directory information; MMS apart of workgroup to identify opportunities and challenges to implementation
- **What to expect:** Over next two years: time intensive: Ultimately, every 90 days attribute information and/or update when changes occur

Reduce and/or Eliminate **Prior Authorization** Requirements

PA Areas to discuss tonight

- Chapter 224 – uniform forms
- Problem of PA
- Policy – Solutions to the problems
- Advocacy – who we have met with and sent letters of change to

Provider forms per Chapter 224

Prior Authorization

- **Chapter 224 of the Acts of 2012** included a provision requiring payers, and entities acting on behalf of a payer, to use and accept only the uniform prior authorization forms developed and implemented by the Division of Insurance for specified services and benefits. In developing the forms, the DOI must seek input from interested stakeholders, use forms that have been mutually agreed upon by payers and providers, consider other electronic standards pertaining to electronic Prior Authorization (ePA), and ensure the forms are consistent with existing forms used by CMS. The form is limited to two pages and must be made available electronically.

- The DOI has permitted the Mass Collaborative to develop standard prior authorization forms and submit them to the DOI for approval.

- With the help of SMEs, the Mass Collaborative Strategy and Operations group has developed standardized PA forms for:
  - BH Level of Care
  - rTMS
  - Neuropsych/Psychological Assessment
  - Prescription Drug
  - Synagis
  - Hepatitis C Treatment
  - MRI/MRA/CT/CTA
  - Cardiac Imaging
  - PET CT
  - Non-OB Ultrasound

Prior Authorization: Definition Problem/Challenge

- **The Problem:**
  - Prior Authorization is the prior approval for treatment of diagnostic, procedural, therapeutic services as well as prescriptions and medical devices and is intended to act as a safety, cost savings and fraud and abuse measure.
  - Physicians and their practices and patients experience it as being costly, time consuming and of no legitimate value.*
  - Prior authorizations (PA) adds immense administrative complexity to physician offices in a manner not consistent with high-quality, high-value provision of medical care. *

- **The Challenge:**
  - In value based care- with more providers owning the financial risk, PA is maintained as a solution too.
  - Therefore, there needs to be an awareness and balance to PA

- *AMA Prior Auth Study

Prior Authorization: Key Statistics

The AMA released its 2018 Prior Authorization Physician Survey results earlier this year, and of the 1,000 practicing physicians surveyed:

- 65% report waiting at least one business day for a prior authorization decision, and 26% reported waiting at least three business days
- 91% report care delays associated with prior authorization
- 75% report that prior authorization can lead to treatment abandonment
- 91% report that prior authorization can have a negative impact on patient clinical outcomes
- 86% of physicians say that prior authorization burdens are high or extremely high
- 88% of physicians report that prior authorization burdens have increased over the last five years
- But perhaps most concerning is that 28% of respondents reported prior authorization has led to a serious adverse event (e.g., death, hospitalization, disability) for a patient in their care.

- AMA 2018 surveys and report on Prior Authorization

Prior Authorizations: Policy

- Mandate more timely turnarounds, including:
    - One day turnaround for urgent care and
    - Two-day turnarounds for all other PAs
- For chronic medications and procedures for chronic illness, do not require prior authorization approvals.
- “Gold Card” providers for set procedures for those who have EHR decision support or those who continuously demonstrate effective management of total cost of care.
- Eliminate low value PAs, e.g. where there is a 99% chance of being authorized anyway.
- Adopt AMA AHA AHIP BCBSA MGMA APHA Consensus Statement – still a long way to go.

Prior Authorization: Policy

- Do not require prior authorization for ACOs with downside risk - allow for mutual decision.
- Do not require re-initiation of step therapy prior authorization or other PA approvals when patient changes health plans.
- Do Not require PA for when patient change health plans, for generic drugs.
- Do not require PA for generic drugs

Meeting with CMS: Eliminate and/or Reduce Prior Authorization Requirements

September 9, 2019

Dear Members of Congress:

The undersigned patient, physician, health care professional, and other health care stakeholder organizations strongly support the *Improving Seniors' Timely Access to Care Act of 2019* (H.R. 3107) recently introduced by Reps. Suzan DelBene (D-WA), Mike Kelly (R-PA), Roger Marshall, MD (R-KS), and Ami Bera, MD (D-CA). This bipartisan legislation would help protect patients from unnecessary delays in care by streamlining and standardizing prior authorization under the Medicare Advantage program, providing much-needed oversight and transparency of health insurance for America's seniors. We urge you to join your colleagues in supporting this important legislation.

Based on a consensus statement on prior authorization reform adopted by leading national organizations representing physicians, medical groups, hospitals, pharmacists, and health plans, the legislation would facilitate electronic prior authorization, improve transparency for beneficiaries and providers alike, and increase Centers for Medicare & Medicaid Services (CMS) oversight on how Medicare Advantage plans use prior authorization. Specifically, the bill would:

- Create an electronic prior authorization program including the electronic transmission of prior authorization requests and responses and a real-time process for items and services that are routinely approved;
- Improve transparency by requiring plans to report to CMS on the extent of their use of prior authorization and the rate of approvals or denials;
- Require plans to adopt transparent prior authorization programs that are reviewed annually, adhere to evidence-based medical guidelines, and include continuity of care for individuals transitioning between coverage policies to minimize any disruption in care;
- Hold plans accountable for making timely prior authorization determinations and to provide rationales for denials; and
- Prohibit additional prior authorization for medically-necessary services performed during a surgical or invasive procedure that already received, or did not initially require, prior authorization.

Louisiana State Medical Society
Rheumatology Alliance of Louisiana
Maine Medical Association
Maine Society of Eye Physicians and Surgeons
Maryland Chapter, American College of Cardiology
Maryland DC Society of Clinical Oncology
Maryland Society for the Rheumatic Diseases
Maryland Society of Eye Physicians and Surgeons
MedChi, The Maryland State Medical Society
Massachusetts Society of Clinical Oncologists
Massachusetts Medical Society
Michigan Society of Eye Physicians and Surgeons
Michigan Society of Hematology & Oncology
Michigan State Medical Society
Minnesota Medical Association
Minnesota Neurosurgical Society

HPC: Massachusetts Medical Society's Perspectives on HPC Priority Area: Administrative Complexity

Issue #2: Prior authorization: Prior authorizations (PA) add immense administrative complexity to physician offices in a manner not consistent with high-quality, high-value provision of medical care. The process is said to be intended to act as a safety and cost savings measure. Physicians and their practices and patients however experience it as being costly, time consuming and of no legitimate value.

Survey Results (15 completed surveys)

Top Priority Areas		
	By Total Points	By Total "High" Rankings
1	Variations in Benefit Design (19)	Variations in Benefit Design (7)
2	Prior Authorization (19)	Prior Authorization (6)
3	Provider Credentialing (17)	Provider Credentialing (6)
4	Eligibility/ Benefit Verification & Coordination of Benefits (17)	
5	Billing & Claims Processing (17)	
6	EHR Interoperability (17)	

Each of the top priority areas were identified by multiple types of organizations (i.e., a combination of payers, providers, employers and patient advocates)

HPC

Fail First Coalition – MMS is a member

- **A coalition of patient advocacy groups — 41 and counting** — has been working on this issue in Massachusetts for 8 years.
- **The bill is H1853/S1235: An Act relative to Fail First and Patient Safety.**
- **Not seeking step therapy be banned rather:**
  - **Seeks the process to be more transparent and easier to manage for both patients and doctors.**
  - **Seeking doctor to be able to override a protocol in medically necessary circumstances such as if the patient has tried and failed on the drug previously or if the patient is stable on their current prescription medication.**
  - **Seeking the insurer to respond to appeals in a timely manner.**
- Ohio just became the latest state to reform fail first protocols earlier this year with several other states considering similar legislation. At least 21 states have already enacted laws reforming step therapy practices so that patients can get faster access to the medication their doctor knows has the best shot of working. In a state that is known as a leader when it comes to healthcare, with some of the best doctors and hospitals in the country, why are we not putting patients first?

Due to HPC findings

- Mass. Association of Health Plans offered for MMS to provide a “Gold Card” Proposal

- We will review some features and considerations of this with Sarika Aggarwal MD

Reduce **Quality Measurement** Burden

Excessive Quality Measurement Burden

Importance of reducing measurement burden

Even strongest advocates of Quality Measurement like Dr. Berwick and IHI are recognizing the needs to balance and reduce measurement burden

Era Two: What to Preserve

- Transparency
- Sensible Payment Methods
- Patient Engagement
- Incivility and Cynicism
- Measurement Gone Wild
- Over-Reliance on Incentives
- Transactions vs. Relationships

Era Three: Nine Steps

Wrong Route

1. Stop Excessive Measurement
2. Abandon Complex Incentives
3. Decrease Focus on Finance
4. Avoid Professional Prerogative at the Expense of the Whole
5. Recommit to Improvement Science

Right Route

Source: Recent Presentation at IHI

Quality Measurement Alignment

Quality Measure Reduction and Alignment: MMS strongly supports comprehensive quality assessment. MMS has long been concerned with the proliferation of redundant misaligned quality measures which have increased the burden of reporting without meaningfully improving quality assessment.

Key statistics:

- US physician spends up to 785 hours per physician per year (15.1 hours per week) and more than $15.4 billion dealing with the reporting of quality measures.
- While much is to be gained from quality measurement, the current system is unnecessarily costly, greater effort is needed to standardize measures and make them easier to report.

Solutions:

- Adoption a reduced number of total measures collected (to no more than 15)by all health plans, employers and ACOs/APMs in the state, and adoption of the State Quality Alignment Task Force's core measure set – updated as needed.
- Standardize and align measures (specifications and benchmarks) across all commercial, state and federal health plans.
- Do not incentivize non-standardization of measures.
- Where feasible, have health plans extract quality data from claims information.
- Reported quality measures should be accepted by all health plans for patients who switch health plans within the same quality measurement year.

- https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.1258

EOHHS State Quality Alignment Task Force presentation: Reduce Quality Measures

- Limited numbers of aligned/uniform QM across plans
- Best way to reduce the number of measures: Uniformity across plans
- Measures should be:
  - Valid and Up to date (scientifically proven)
  - Under the physicians' control
  - Aligned with national organizations (CQMC, CMS)
  - Clinically Relevant
  - Able to be extracted automatically from the EHR
  - Reported at the right level (ACO versus practice)
- Aligned, uniform QM across plans
- Eliminate Bad measures: … HEDIS, out of date, BP control in elderly, etc.

On going advocacy:

NCQA: Reduce Quality Measurement Requirements

Massachusetts Medical Society

Massachusetts Health & Hospital Association

Discussion:

Review of Strategic Initiative Physician 1: Identify and implement three high impact initiatives to advocate for the reduction of unnecessary regulations and administrative burdens

- Licensure/Credentialing/Provider Directory
  - Advocacy for streamlined processes
- PA
  - Advocacy for elimination and or reduction of PA
  - Advocacy for movement to electronic systems
  - Advocacy for Gold Carding

- Quality Measure
  - Advocacy for reduction of total measures

Gold Card Discussion

- Dr. Sarika Aggarwal

BORIM BURNOUT Resolution For Decision

The resolution directs:

1. That the MMS will encourage the Board of Registration in Medicine and other physician institutions (physician associations, hospitals, and other licensing bodies) to reconsider having “probing questions” about a physician’s mental health, addiction, or substance use on applications for medical licensure/credentialing or renewal, or to allow only questions that focus on the presence or absence of current impairments that impact physician practice and competence. (D)

2. That the MMS will encourage the Board of Registration in Medicine and other physician institutions to offer “safe haven” non-reporting to applicants for licensure/credentialing who are receiving appropriate treatment for mental health or substance use and that the non-reporting would be based on monitoring and good standing with the recommendations of a state physician health program. (D)

Exemption for Reports of Drug or Alcohol Misuse to the Board under M.G.L. c.112 §5F

- (a) Requirements for Reporting Exemption to Apply.
- A health care provider who is required to report a physician to the Board is exempt from filing such a report if all four of the following conditions are present:
- 1**. Reasonable Basis to Believe Impairment**. The health care provider has a reasonable basis to believe that the physician is or has been impaired by, dependent upon or misusing alcohol or drugs such that a report could be required
- 2. **No Violation of Law or Regulation**. **The physician has not violated any statute or regulation, including M.G.L. 94C, and including any Board statute or regulation**; and
- 3. **No Allegation of Patient Harm or Impairment at the Workplace or While on Call**. The physician's involvement with alcohol or drugs has not involved an allegation of patient harm **or any impairment occurring at the workplace or while the physician is "on call"** and
- 4. **Confirmation of Compliance with the Treatment Program**. The physician is currently in compliance with a drug or alcohol program, and the health care provider obtains direct confirmation from such drug or alcohol program, within 30 days of acquiring the "reasonable basis to believe" that the physician is in compliance with such program. If the health care provider fails to obtain direct confirmation from such program or if the physician at any time fails to comply with such program, the exemption to the reporting requirement ceases and the health care provider must report the impairment.

Reporting of Drug or Alcohol Misuse

- BORIM expanded the requirements to qualify for an exemption from reporting physician drug or alcohol misuse.
- The previous conditions for exemption only required having a reasonable basis to believe impairment, having no allegation of patient harm, and confirming compliance with a treatment program.
- Now, in order to be exempt from reporting drug or alcohol misuse, the physician whose conduct is in question also must not have violated any law or regulation and must not have been impaired at the workplace or while on call.
- BORIM has issued guidance on this issue via FAQs, which clarify that drug or alcohol use that is the subject matter of the impairment does not preclude the use of the exemption in the absence of any other violation of statute or regulation.
- As such, the 5F exemption may still be used when there is a reasonable basis to believe a physician is impaired due to drug or alcohol misuse so long as there is no other violation of statute or regulation, there is no patient harm, there is no impairment at the workplace or while on call, and when the physician is confirmed to be in compliance with a treatment program.
- The interpretation of the phrase “at the workplace” has been left undefined, and we are continuing to seek greater clarification in this regard.

Advocate for Adoption of Consensus statement by CMS

Given stagnation of state legislative efforts, the AMA urges CMS to serve as a leader and model meaningful prior authorization reforms for commercial insurers—both to protect patients' health and reduce practice burdens—by developing a comprehensive strategy that addresses all areas of the Consensus Statement:

- Selective application of prior authorization to only "outliers" (vs. bluntly across all physicians)
- Review/adjustment of prior authorization lists to remove services/drugs that represent low-value prior authorizations
- Transparency of prior authorization requirements and their clinical basis to patients and physicians
- Protections of patient continuity of care
- Automation to improve prior authorization transparency and process efficiency