

Massachusetts Health Care Cost Growth Benchmark Factsheets

4: Performance Improvement Plans

To contain health care cost increases, Massachusetts enacted Chapter 224 in 2012, which established a first-in-the-nation target, called a benchmark, for annual growth in total statewide health care spending. Among other things, the law created a Health Policy Commission (HPC) and granted it authority to hold payers and providers accountable for keeping annual cost growth below the benchmark. To inform other states that have adopted similar cost growth benchmark initiatives, this Factsheet series describes the HPC's four accountability tools and how they have been used to date.

Overview

Through the **Performance Improvement Plan (PIP)** process, the HPC is empowered to hold accountable individual payer and provider entities with an annual rate of spending growth that is considered excessive. Each year, CHIA refers health care entities whose health-status adjusted total medical expenditures (HSA TME) exceed the benchmark to the HPC, which then conducts a detailed, confidential examination of the entities' spending performance (of the referred contract of business and across contracts over time), market share, utilization, and other information. Currently, organizations subject to PIPs are limited to payers and managing physician groups because these are the only entity types for which the statutorily required metric of health-status adjusted total medical expenditures exists.

Since 2016, CHIA has referred dozens of entities to HPC that have exceeded the annual cost growth benchmark for one or more contracts or books of business (steps 1-2, next page). The HPC reviews the entities' performance (step 3), decides whether to examine the entity's spending patterns in detail (step 4) and collects additional information to understand the factors that explain spending growth (step 5). If the HPC finds that an organization's spending growth is excessive—that is, that it has significant concerns and that a PIP could result in meaningful, cost-saving reforms—the HPC Board of Commissioners can require the entity to submit a formal PIP (steps 6-8). The entity's PIP must describe the key drivers of spending growth and propose strategies to lower it.

Calculating HSA TME

Referrals to the HPC are based on growth in HSA TME. CHIA calculates HSA TME for two sets of entities: (1) private commercial health plans and privately administered Medicare and Medicaid plans and (2) managing physician groups, which are multi-specialty practices that include primary care providers (PCPs) and are responsible for managing and coordinating the care of their patients.

- For payers, TME is a measure of all amounts paid for their members, including all categories of medical expenses, non-claims-related payments (including provider performance payments) as well as member cost-sharing.
- For managing physician groups, TME is the measure of total medical spending for patients required by their insurance plan to select a PCP.
- In both cases, HSA TME is a measure of all medical spending for a group of patients, adjusted based on age and other demographic characteristics as well as health status, based on the diagnoses and conditions recorded in patients' medical records. TME is not adjusted for differences in covered benefits within payers and between providers. TME is segmented by insurance category (commercial, Medicare, Medicaid) and by service category (hospital inpatient, hospital outpatient, professional, pharmaceutical, etc.).

The Peterson Center on Healthcare commissioned Mathematica to conduct a process evaluation to understand how key stakeholders perceive the influence of the cost growth benchmark on their actions, and the HPC's use of policy levers and strategies to hold payers and providers accountable for meeting the benchmark. The final report will identify lessons from Massachusetts' experience for other states now setting cost growth benchmarks. This factsheet synthesizes information from numerous HPC documents, available at <https://www.mass.gov/orgs/massachusetts-health-policy-commission>.

Massachusetts Health Care Cost Growth Benchmark Factsheets: Performance Improvement Plans, #4. May 2022. Mathematica.

PIP referral and review process

1 CHIA collects expenditure data

CHIA collects data from health care entities on total medical expenses.

2 CHIA refers entities to the HPC

CHIA reviews all data to identify health care entities with excessive growth in health-status adjusted TME for the most recent year of data and refers these entities to the HPC.

Year of data reviewed	# of health care entities referred to the HPC by CHIA
2021	HPC stopped releasing data publicly
2020	
2019	41
2018	26
2017	20
2016	33

3 The HPC notifies referred entities and reviews available data

The HPC provides written notice to all health care entities identified by CHIA as having exceeded the benchmark. For each, the HPC conducts a confidential review and analysis of data regarding payers' and providers' performance across multiple factors.

Criteria that the HPC considers at this stage include an organization's HSA TME, size, market share, long-term spending, financial impact, spending trends over time, and utilization patterns, among others.

4 The HPC Board of Commissioners decides whether to examine the entity's spending in detail

The commissioners deliberate and vote whether to follow up with entities based on findings in step 3.

5 The HPC gathers additional information

The HPC meets selected entities to gather additional data and assess potential explanations for cost growth.

Additional information may include an organization's explanation for growth, data on the impact of care delivery, strategies to control spending, and referral patterns, among others.

6 The HPC Board of Commissioners decides whether to require a formal PIP

The commissioners deliberate and vote whether to require a PIP. See box at right for additional factors the HPC considers; the list is not exhaustive.

An organization can meet with the HPC to explain its cost growth and to ensure that data being used in the determination are correct and current. The HPC may continue monitoring before or instead of requiring a PIP.

In January 2022, the HPC commissioners voted to require the first PIP. Reasons cited for requiring Mass General Brigham to complete this PIP include (1) higher baseline spending for the entity's primary care population on a health-status adjusted and unadjusted basis, (2) above-the-benchmark spending growth rates on primary care patients across multiple years and payers, (3) higher hospital and physician prices than nearly all other Massachusetts providers, and (4) spending growth for primary care patients that was driven more by price than utilization.

7 The HPC informs the organization if a PIP is required

After an affirmative vote, the HPC provides notice to the organization that it is required to file a PIP.

8 Organization files PIP, requests waiver, or requests extension

Within 45 days of receipt of written notice from the HPC, the organization either files a PIP with the HPC or files an application to waive or extend the requirement to file a PIP. In the PIP, the organization identifies the causes of its cost growth and proposes specific strategies, adjustments, actions, and measures it will implement to improve cost performance over a period of up to 18 months.

Strengths and limitations of the PIP process

Strengths

- The PIP process provides deeper insight into payer and provider spending performance.
- The PIP process distinguishes between factors that are within a payer's or provider's control (e.g., prices) and those that are unexpected or outside their control (e.g., enrollment changes, new high drug costs).
- Organizations have generally been willing to cooperate with the HPC to reduce spending growth, even without a formal PIP.
- The PIP process encourages entities to keep spending growth below the benchmark by raising the risk of having to submit a formal PIP if an organization does not take steps to improve spending performance.

Limitations

- Only payers and managing primary care groups can be referred and subject to a PIP; providers are also accountable only for their own primary care patients' spending (not, for example, spending for patients at their hospitals who have primary care providers affiliated with other systems). The HPC recently recommended that the legislature allow other types of organizations to be subject to spending review and PIP.
- Criteria for a PIP referral focuses on annual increases in HSA TME rather than price or spending levels; payers or providers with consistently high spending or prices may not be referred.
- Increasing coding intensity, or upcoding, can inflate patient risk scores and mask spending growth in health-status adjusted measures like HSA TME.
- Incentives to meet the cost growth target are relatively weak. The maximum fee for non-compliance with the PIP process is \$500,000, an amount that is unrelated to the entity's spending levels.

Source: Massachusetts Health Policy Commission, October 6, 2021. Slide 45. <https://www.mass.gov/doc/presentation-1062021-moat-meeting/download>