MASSACHUSETTS
HEALTH POLICY COMMISSION

HPC 2021 Policy Recommendation #1: Strengthen Accountability for Excessive Spending

October 6, 2021

HPC 2021 Policy Recommendations

AREAS OF FOCUS

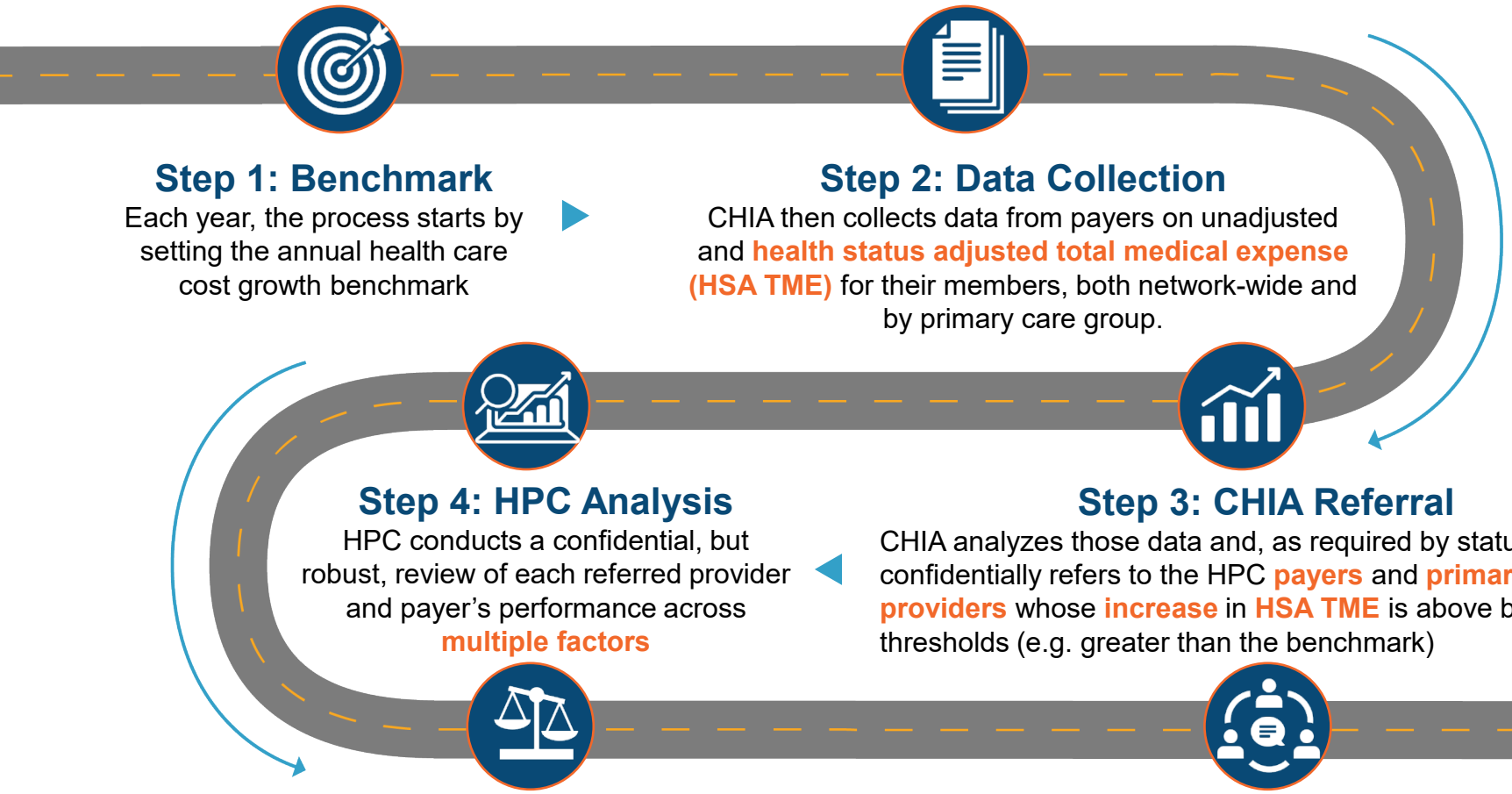
1	2	3	4	5
Strengthen Accountability for Excessive Spending	Constrain Excessive Provider Prices	Make Health Plans Accountable for Affordability	Advance Health Equity for All	Implement Targeted Strategies and Policies

1 **Strengthen Accountability for Excessive Spending.** Strengthen the mechanisms for holding providers, payers, and other health care actors responsible for spending performance by improving the metrics used in the annual performance improvement plan (PIP) process, increasing financial penalties for above-benchmark spending or non-compliance, and considering additional tools to reflect and respond to underlying variation in the relative level of provider prices.

Recommendation 1: Strengthening Accountability for the Benchmark

1. PIPs Process and Limitations
2. Impact of Increased Coding Intensity
3. Improving Accountability

Accountability for the Health Care Cost Growth Benchmark: An Overview



Step 1: Benchmark

Each year, the process starts by setting the annual health care cost growth benchmark

Step 2: Data Collection

CHIA then collects data from payers on unadjusted and **health status adjusted total medical expense (HSA TME)** for their members, both network-wide and by primary care group.

Step 3: CHIA Referral

CHIA analyzes those data and, as required by statute, confidentially refers to the HPC **payers** and **primary care providers** whose **increase** in **HSA TME** is above bright line thresholds (e.g. greater than the benchmark)

Step 4: HPC Analysis

HPC conducts a confidential, but robust, review of each referred provider and payer's performance across **multiple factors**

Step 5: Decision to Require a PIP

After reviewing all available information, including confidential information from payers and providers under review, the **HPC Board votes** to require a PIP if it identifies significant concerns and finds that a PIP could result in meaningful, cost-saving reforms. The entity's identity is public once a PIP is required.

Step 6: PIP Implementation

The payer or provider must propose the PIP and is subject to **ongoing monitoring** by the HPC during the **18-month implementation**. A fine of up to than $500,000 can be assessed as a last resort in certain circumstances.

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Accountability for the Health Care Cost Growth Benchmark: CHIA Referral

CHIA is required by statute to refer providers and payers to the HPC based on an **increase** in **health-status adjusted total medical expense (HSA TME)**.

- Total medical expense (TME) is a measure of **all medical spending** (rx, hospital, physician office visits, etc.) **for a group of patients.** Provider TME reflects all spending by the provider's *primary care patients*, regardless of where the spending occurred.
- Health status adjusted (HSA) means that the spending figures are then **adjusted** based on demographic information and health conditions in patients' medical records **to reflect the health status** of the population.
- HSA TME exists only for **payers** and **primary care providers**. It does not exist for other provider types (e.g., hospitals)
- CHIA has created **two bright line thresholds** for referral to the HPC:
  1. HSA TME growth ≥ the benchmark; OR
  2. HSA TME growth ≥ 85% of the benchmark if the payer or provider is large (≥ 2% of statewide member months) and has either high unadjusted growth (≥ the benchmark) or, for providers, a high baseline level of spending (≥ the 75th percentile).

High unadjusted spending growth, a high spending level, or high prices (which can impact other entities' TME and statewide THCE) alone **do not trigger referral**.

Reflecting on Five Years of Accountability Under the PIPs Process: Strengths and Limitations

Strengths

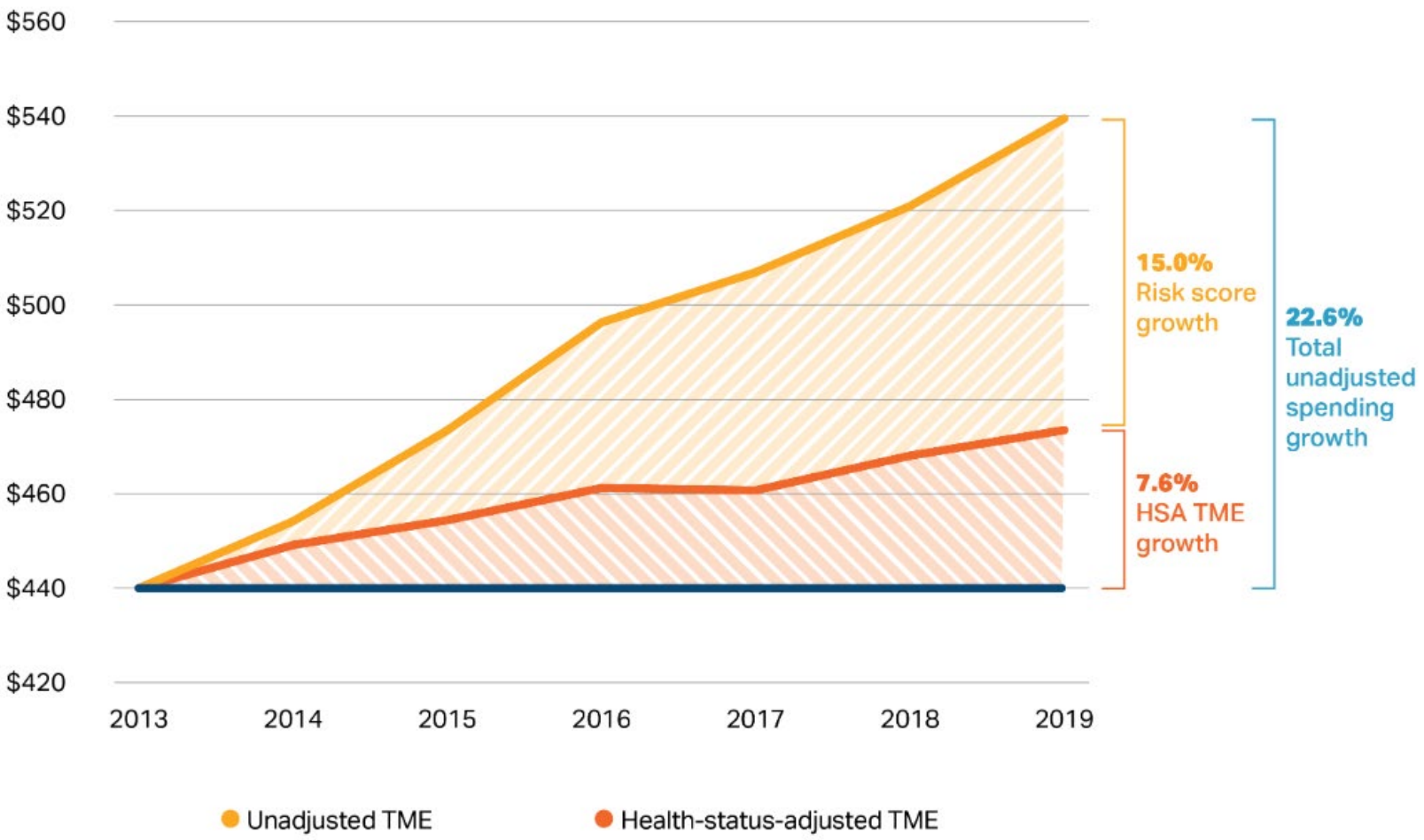
- The CHIA and HPC processes are **well-coordinated**.
- HPC's review of individual payer and provider performance has been effective in distinguishing between factors that are more **within their control** (e.g., prices) and those that are **unexpected or outside of their control** (enrollment changes, new high-cost drugs, COVID).
- Payers and providers have **appreciated the greater insight** into their own performance.
- Payers and providers have been **willing to work with HPC** on an ongoing basis to address spending trends, even without a public PIP.

Limitations

- By statute, PIP referrals must be based on **increases** in **HSA TME**, but:
  - Health status adjustment is impacted by medical coding changes, **masking spending growth** for many entities; and
  - Entities with **high spending *levels*** or providers with **high *prices*** that impact other entities' TME and statewide THCE may not be referred.
- Under the statute, **only payers and primary care providers** can be referred and subject to a PIP.
  - Providers are only accountable for their **primary care patients'** spending (not, e.g., hospital spending for patients with outside PCPs) .
- **Penalties are low** and unrelated to spending levels.

HSA TME does not fully reflect spending growth: risk scores have grown 15% in 6 years, obscuring two-thirds of spending growth.

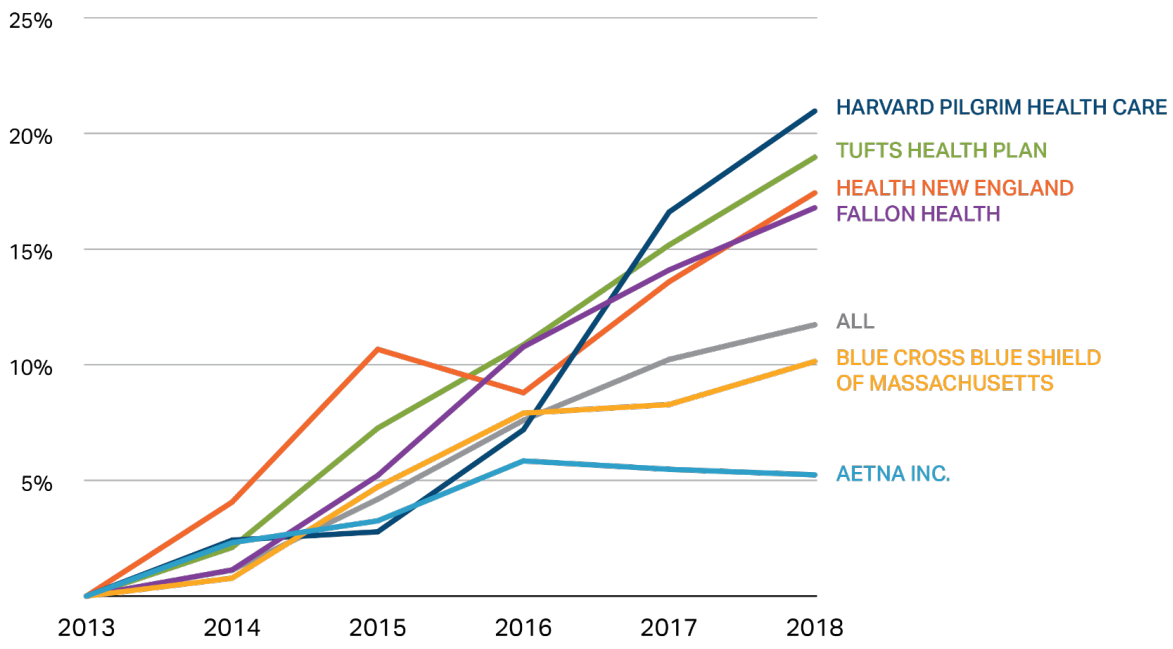
Total spending growth, risk score growth and HSA TME growth, 2013 to 2019 for Massachusetts commercial payers



Notes: United, Cigna, BMC Healthnet, Minuteman, Celticare and NHP (now Allways) excluded due to data anomalies or wide membership fluctuations
Source: Massachusetts Center for Health Information and Analysis, 2016 and 2018 databooks.

Population health changes don't explain risk score growth.

Change in average risk score for all members, by payer, 2013-2018



- Changes in the age-sex mix of the commercial population explains **0.5%** of the **11.7%** increase.
- **No increase** in underlying burden of chronic disease (BRFSS, 2013-6).
  - Arthritis, diabetes up
  - Asthma, COPD down
- No change in life expectancy.

The growth of risk scores from 2013-2018 is equivalent to **430,000** more privately-insured Massachusetts residents with complex diabetes or **920,000** more residents with cerebral palsy.

Notes: Risk scores normalized to 1.0 in 2013. United, Cigna, BMC Healthnet, Minuteman, NHP and Celticare excluded due to data anomalies or fluctuating membership.

Sources: CHIA TME databooks, 2016 and 2018. Federal Register vol 78 no. 47 March 11, 2013, Adult Risk Adjustment Model Factors. Burden of chronic disease analyzed using the CDC's BRFSS survey; rates of arthritis and diabetes among Massachusetts residents increased while COPD and asthma decreased from 2013 to 2016. Life expectancy was unchanged. Impact of population aging assessed using insurer demographic data combined with age/sex/spending profiles from the APCD.

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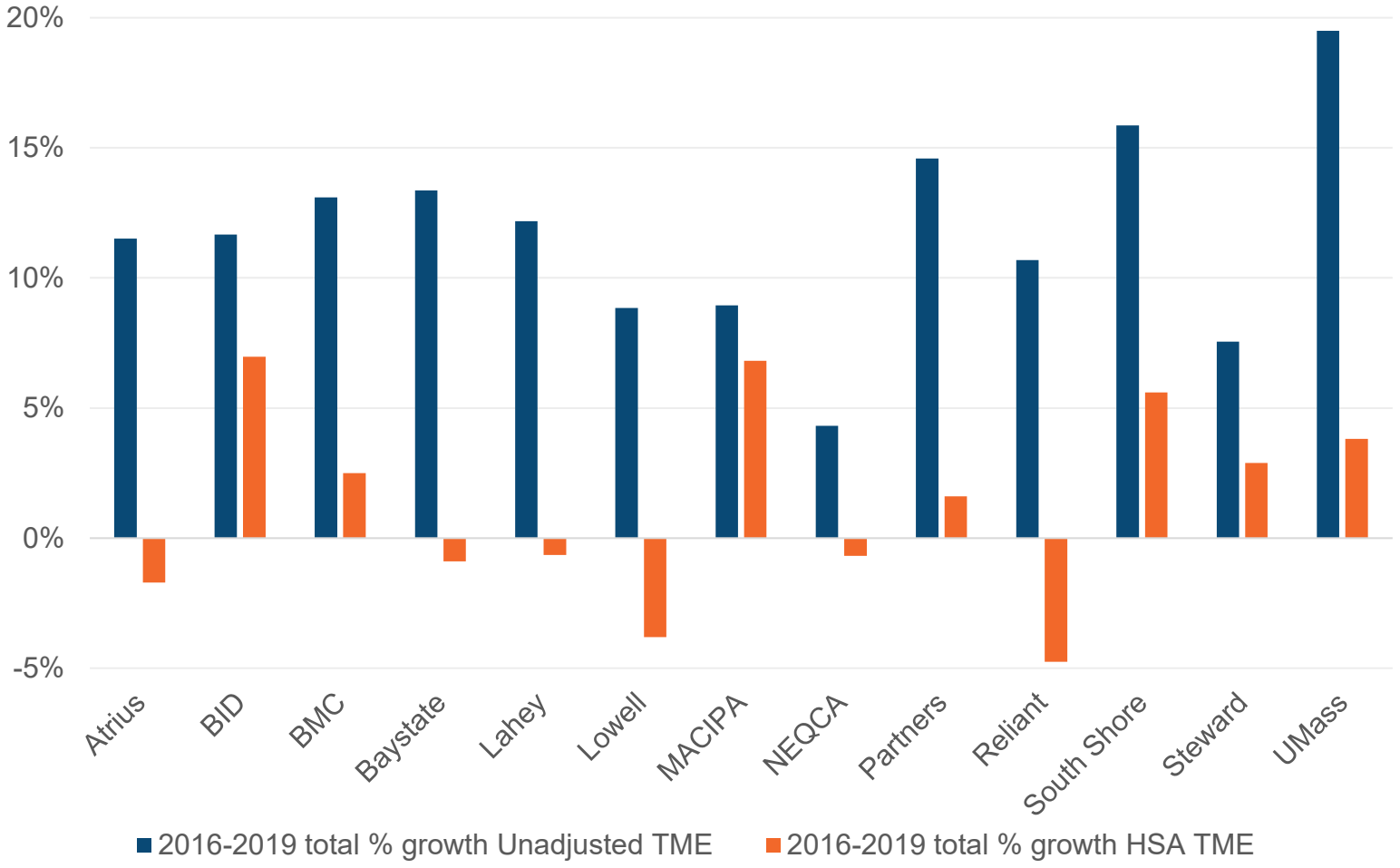
HSA TME growth was below unadjusted TME growth for all major provider groups from 2016-2019.

Percentage increase in unadjusted and health-status adjusted (HSA) TME by provider group for attributed BCBS members, 2016-9



Notes: PPO members are included only where assigned to a provider organization through a PCP. Only commercial members covered by Blue Cross Blue Shield of Massachusetts (BCBSMA) are included and provider organizations are excluded if the total number of member months across these payers is below 100,000 in any of 2016-2019. Sources: HPC analysis of Center for Health Information and Analysis TME databooks. Data for 2017-9 are based on CHIA's 2021 Annual Report. Data for 2016 are based on CHIA's 2019 Annual Report and are included by computing the percentage growth in TME from 2016 to 2017 in the 2019 Annual report applied to the 2017 values in the 2021 Annual Report to preserve within-databook consistency.

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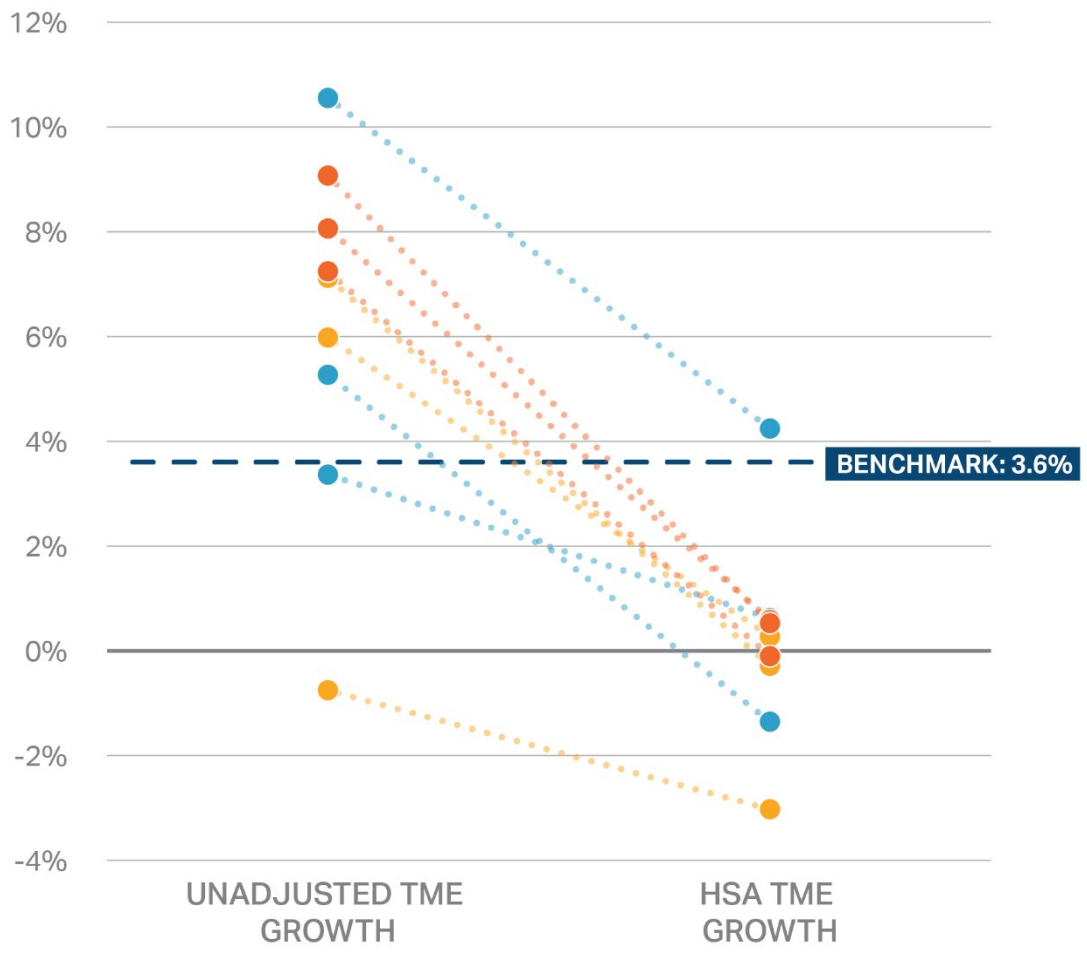
Most entities with unadjusted TME growth over the benchmark have HSA TME growth below the benchmark and are not referred.

Percentage increase in unadjusted vs. health-status adjusted (HSA) TME for three large provider groups and the three major payers.



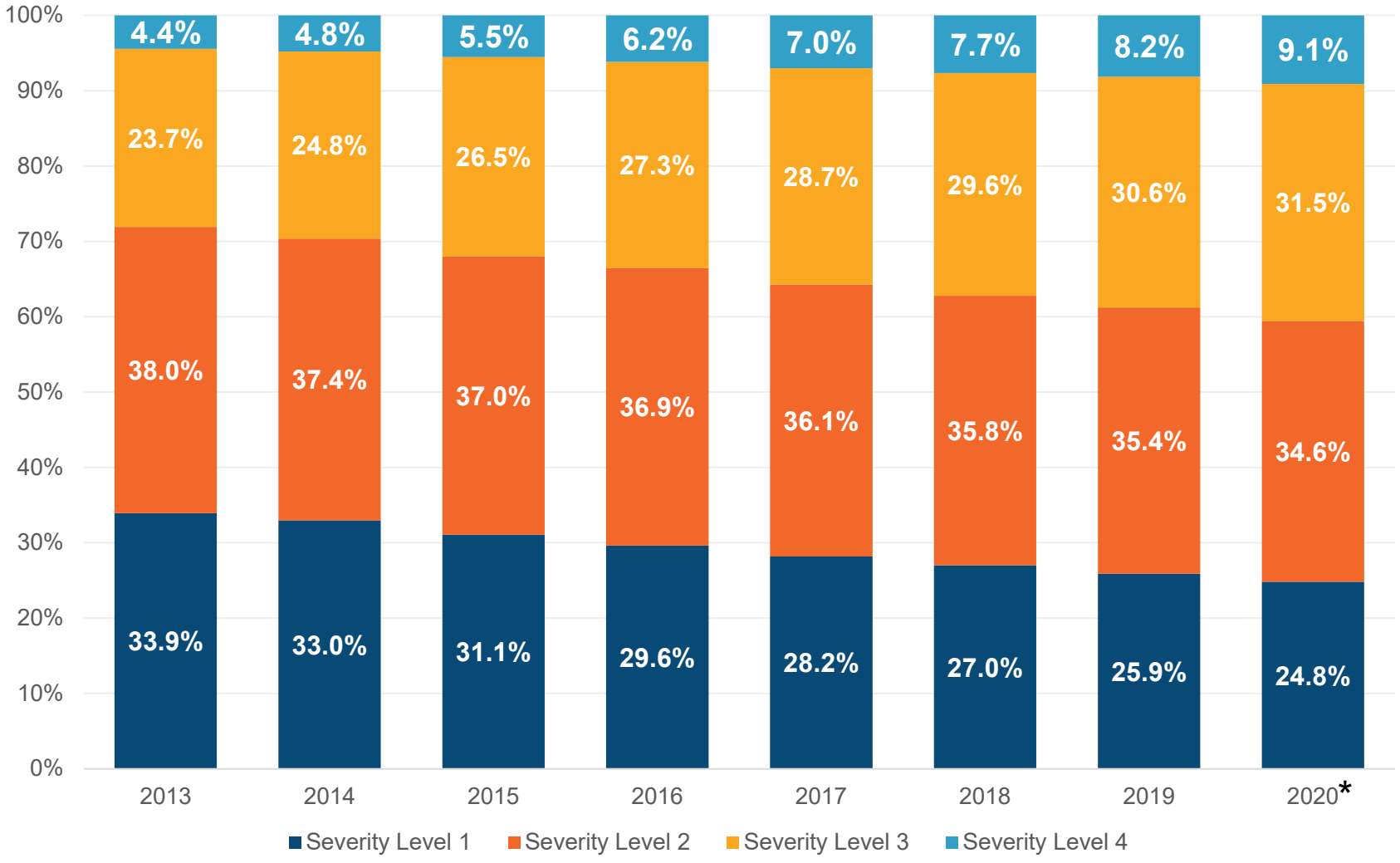
For example, in one year, among 71 payer-provider contracts, unadjusted TME growth exceeded the benchmark for 47 (66%), but only 17 (24%) had HSA TME growth that exceeded the benchmark, triggering referral.

The chart on the left shows this dynamic for a representative subset of providers and payers.

Notes: The number of referred contracts shown on this slide may not reflect the actual number of referrals as CHIA refers some contracts or books of business with HSA TME growth below 3.6% in accordance with its published referral methodology.
Sources: Center for Health Information Analysis

Hospital admissions continue to be coded at increasingly higher severity levels.

Change in number of hospital admissions at each severity/complications level, 2013-2020

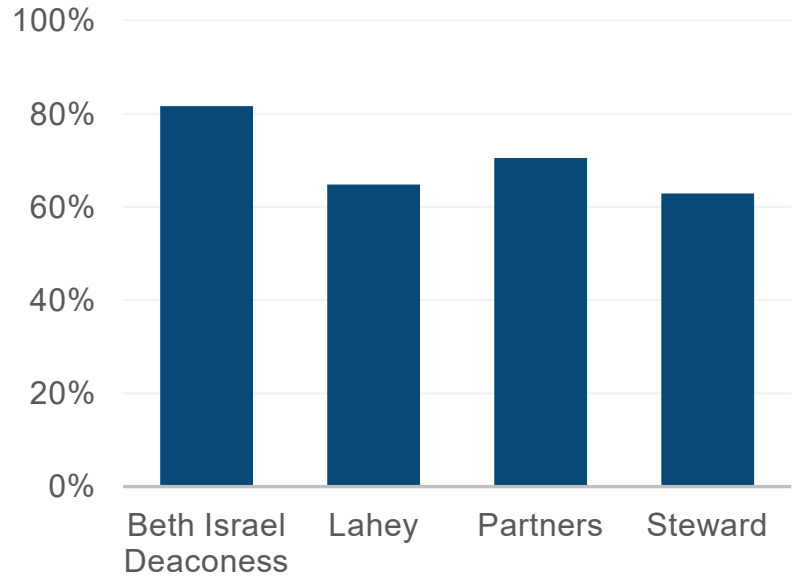


Notes: APR-DRG Level 1 is least severe and Level 4 is most severe. *COVID hospitalizations have been excluded from 2020 data.
Sources: CHIA HIDD Acute Case-mix Database, 2013-2020; MS-DRG classification system, APR-DRG classification system

By statute, only part of the health care system is held accountable for controlling spending growth, and tools to reduce spending are limited.

- By statute, only **payers** and **primary care providers** are accountable for spending growth.
- Providers are only accountable for their **primary care patients' spending**
  - For example, hospitals are not accountable for their patients' spending if those patients have outside PCPs, and the majority of discharges at major hospital systems in Massachusetts are for patients with PCPs outside of the system.
  - If higher-priced hospitals **raise prices** or **increase volume** from patients with outside PCPs, there is limited impact on their own TME growth.

Percent of Discharges at System Hospitals among patients with a Non-System PCP
BCBS Commercial, 2016



- By statute, the maximum penalty that any entity can receive for non-compliance with the PIPs process is **$500,000**, which may be far below an entity's contribution to spending growth.
- The PIPs process is unable to directly address another of the major drivers of health care spending in the state – provider prices.