MASSACHUSETTS
HEALTH POLICY COMMISSION

HEARING TO DETERMINE THE 2024

HEALTH CARE COST GROWTH BENCHMARK

BENCHMARK MODIFICATION PROCESS

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In 2012, Massachusetts became the first state to establish a target for sustainable health care spending growth.

CHAPTER 224 OF THE ACTS OF 2012

An Act **Improving the Quality** of Health Care and **Reducing Costs** through Increased **Transparency**, **Efficiency**, and **Innovation.**

GOAL

Reduce total health care spending growth to meet the **Health Care Cost Growth Benchmark**, which is set by the HPC and tied to the state's overall economic growth.

VISION

A **transparent, innovative, and equitable** healthcare system that is **accountable** for producing **better health** and **better care** at a **lower cost** for all the people of the Commonwealth.

The Health Care Cost Growth Benchmark

- The HPC sets a **prospective target** for controlling the growth of total health care expenditures across all payers (public and private) and is tied to the state's long-term economic growth rate.
- The health care cost growth benchmark is **not a hard cap on spending growth or provider-specific prices** but is a measurable goal for moderating excessive health care spending growth and **advancing health care affordability**.
- To promote accountability for meeting the state's benchmark target, the HPC can require health care providers and health plans to implement **Performance Improvement Plans** (PIPs) and submit to public monitoring.
- A PIP of an individual provider or health plan may be required only after a **retrospective, comprehensive, and multi-factor review** of the entity's performance by the HPC, including evaluating cost drivers outside of the entity's control and the entity's market position, among other factors.

TOTAL HEALTH CARE EXPENDITURES

Definition: Annual per capita sum of all health care expenditures in the Commonwealth from public and private sources

Includes:

- All categories of medical expenses and all non-claims related payments to providers
- All patient cost-sharing amounts, such as deductibles and copayments
- Administrative cost of private health insurance

The HPC's authority to modify the benchmark is prescribed by law and subject to potential legislative review.

1-5 years

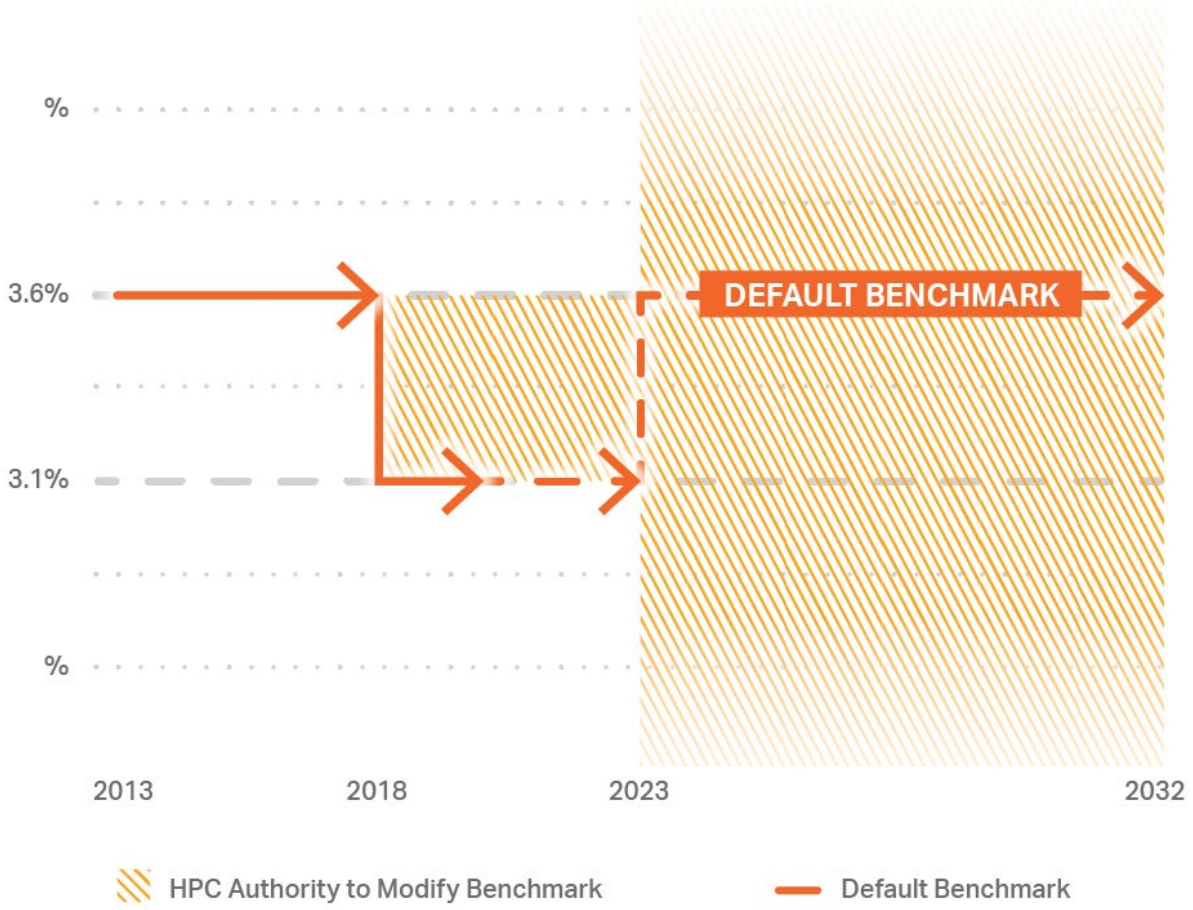
Benchmark established by law at PGSP (3.6%)

6-10 years

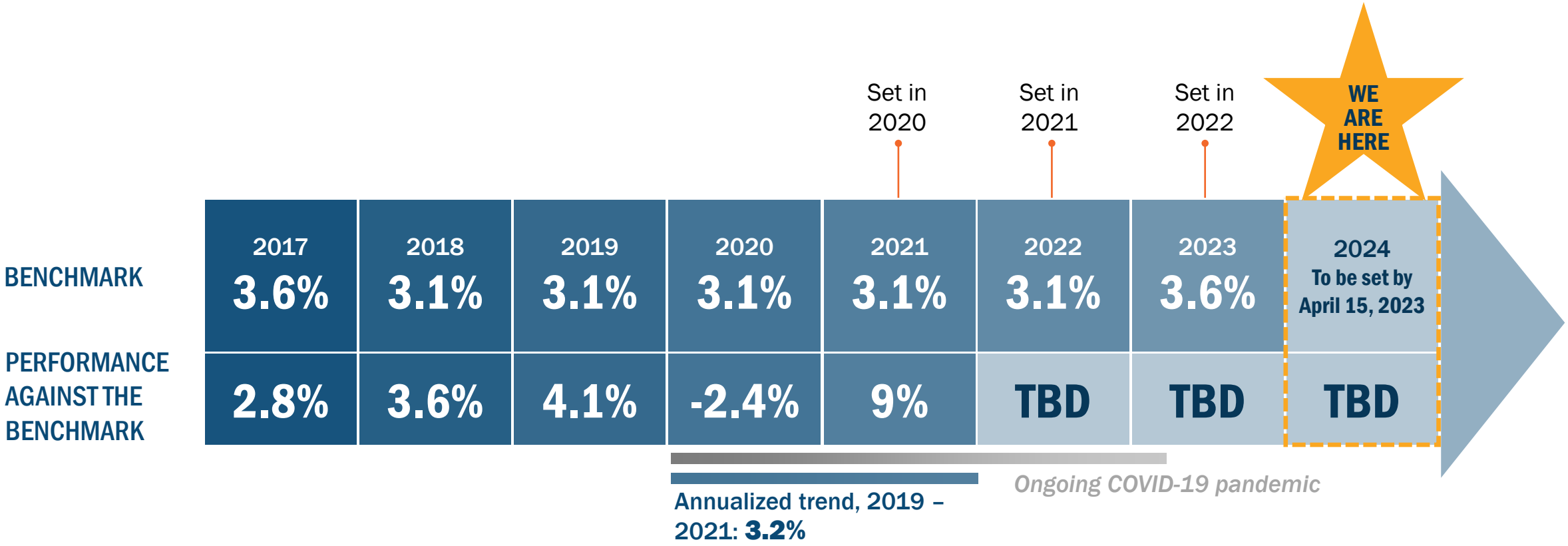
Benchmark established by law at a default rate of at PGSP minus 0.5% (3.1%); HPC can modify the benchmark up to 3.6%, subject to legislative review.

10-20 years

Benchmark established by law at a default rate of PGSP; HPC can modify to any amount, subject to legislative review.



The health care cost growth benchmark is set prospectively for the upcoming calendar year, while actual performance is measured retrospectively.



Benchmark Modification Process: Key Steps

HPC PROCESS TO MODIFY

- The HPC's Board must hold a **public hearing** prior to making any modification of the benchmark.
- Hearing must consider **data** and **stakeholder testimony** on whether modification of the benchmark is warranted.
- Members of the Joint Committee on Health Care Financing participate in the hearing.
- If the HPC's Board votes to maintain the benchmark at the default rate of 3.6%, the **annual process is complete**.
- If the HPC's Board votes to modify the benchmark to any other rate, the HPC must submit notice of its intent to modify the benchmark to the Joint Committee **for further legislative review**.

POTENTIAL LEGISLATIVE REVIEW

- Following notice from the HPC of an intent to modify, the Joint Committee may hold a public hearing within 30 days.
- The Joint Committee may submit findings and legislative recommendations, including on whether to affirm or reject the HPC's proposed modification, to the General Court within 30 days of hearing.
- Unless the General Court enacts legislation establishing an alternative benchmark within 45 days of the public hearing, the HPC Board's modification of the benchmark takes effect.

Benchmark Modification Process: 2023 Timeline

January 24, 2023
3.6% PGSP established in consensus revenue process

March 15, 2023
Public hearing of HPC Board and Joint Committee on potential modification of benchmark

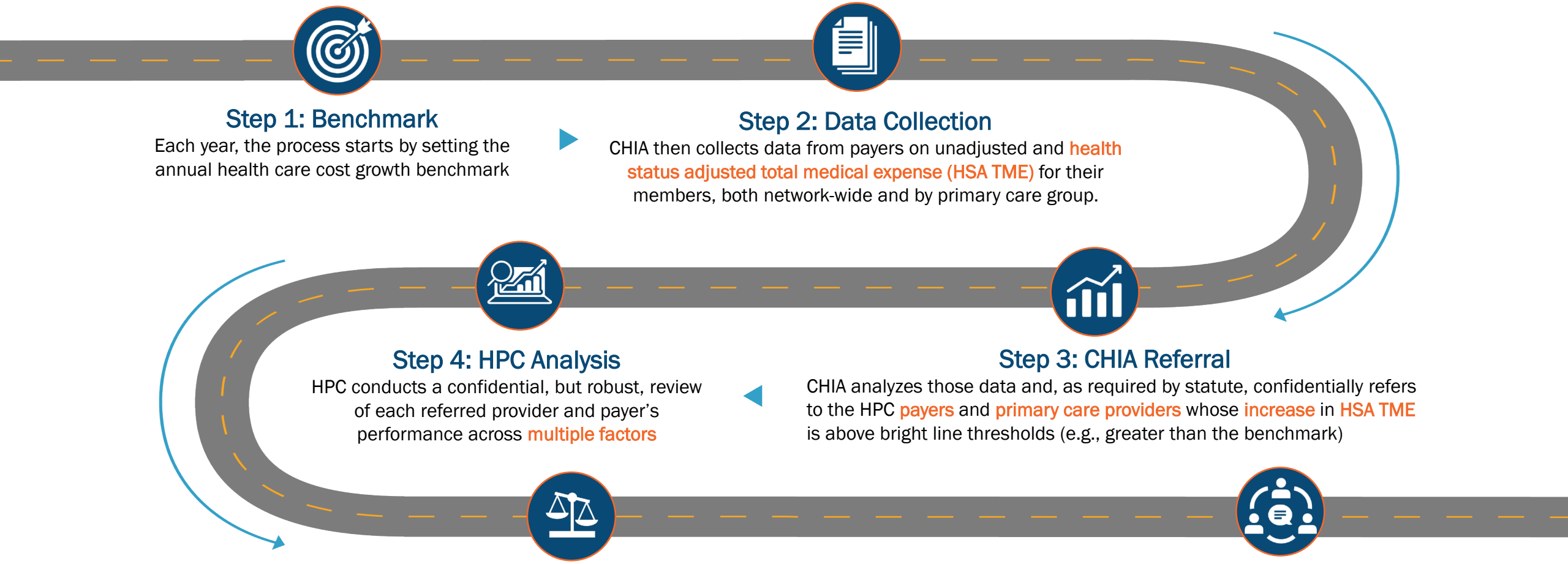
April 12, 2023
HPC Board votes whether to modify benchmark; if HPC Board votes to modify, it submits notice of intent to modify to Joint Committee on Health Care Financing

April 15, 2023
Statutory deadline for HPC Board to set benchmark

April/May 2023
Joint Committee may hold a hearing within 30 days of notice

May/June 2023
Joint Committee may report findings and recommended legislation to General Court within 30 days of hearing; the HPC Board's vote to modify takes effect unless the General Court rejects the proposed modification and enacts legislation establishing the benchmark within 45 days of the hearing.

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 $500,000 can be assessed as a last resort in certain circumstances.

CHIA's referral of entities is based on a bright-line test of their spending growth, whereas the HPC is charged with contextualizing that growth for each referred entity.

The HPC may require any entity referred to it by CHIA to complete a Performance Improvement Plan if, after a review of regulatory factors, it identifies significant concerns about the Entity's costs and determines that a Performance Improvement Plan could result in meaningful, cost-saving reforms.

REGULATORY FACTORS	
a	Baseline spending and spending trends over time, including by service category;
b	Pricing patterns and trends over time;
c	Utilization patterns and trends over time;
d	Population(s) served, payer mix, product lines, and services provided;
e	Size and market share;
f	Financial condition, including administrative spending and cost structure;
g	Ongoing strategies or investments to improve efficiency or reduce spending growth over time;
h	Factors leading to increased costs that are outside the CHIA-identified Entity's control; and
i	Any other factors the Commission considers relevant.

Mass General Brigham (MGB) is currently implementing the first Performance Improvement Plan, with a total savings estimate of nearly $200 million over 18 months.

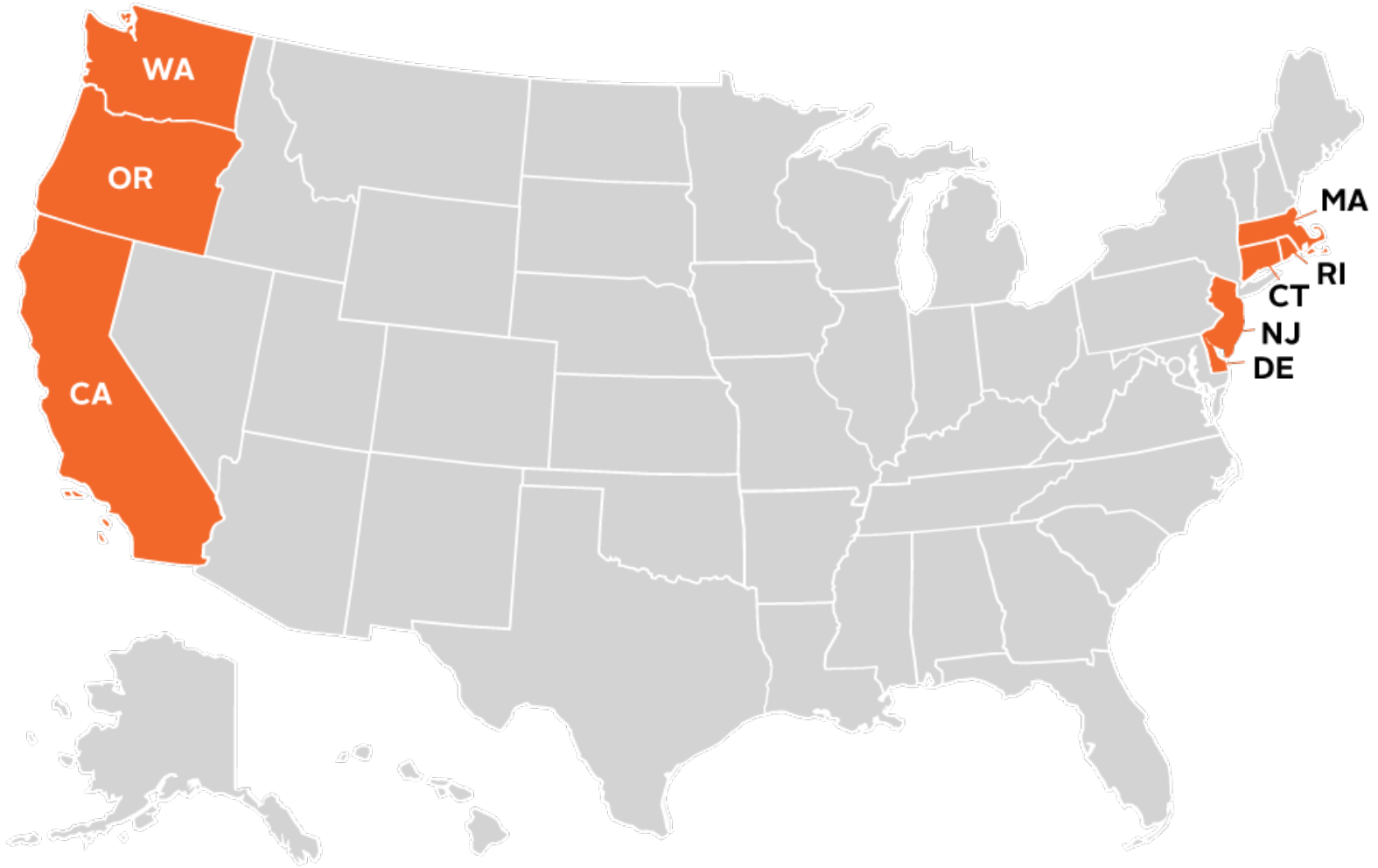
- Mass General Brigham (MGB) is currently implementing a Performance Improvement Plan (PIP). The Health Policy Commission required the plan after finding that MGB's spending growth presented significant concern and that a PIP could result in meaningful, cost-saving reforms.
- The HPC approved MGB's PIP in September of 2022. Implementation will run from October 2022 through March 2024.
- MGB's plan is organized into four categories of activities: Price Reductions, Reducing Utilization, Shifting Care to Lower Cost Sites, and Accountability through Value-Based Care.
- MGB estimates that the PIP will **save $127.8M annually**.
- MGB must report periodically to the HPC throughout the implementation period, and for a reasonable period of time thereafter, to allow the HPC to evaluate MGB's progress toward its stated goals.
- At the conclusion of the PIP, the HPC must determine whether it was successful.

MGB Performance Improvement Plan: Annual Savings Estimates

Category	Strategies	Savings Estimate (M)
Price Reductions	Outpatient AMC Rates	$59.8
	MG West	$15.3
	ConnectorCare	$11.9
	Other Insurance Product	$3
Reducing Utilization	Integrated Care Management Program	$15.3
	Utilization Management	$17.1
Shifting Care to Lower Cost Sites	Hospital at Home	$1.3
	Virtual Care	$4.1
Accountability Through Value-Based Care	MGB Health Plan product innovations (Commercial, Medicare and MassHealth)	Not quantified
	Total	**$127.8**

Eight states have now established statewide health care cost growth targets, cumulatively representing one in five residents in the U.S.

Many other states are building on the Massachusetts model and are adopting new strategies to promote transparency, oversight, and accountability.



How states use cost-growth benchmark programs to contain health care costs. The National Academy for State Health Policy. (2022, February 1). Retrieved from https://www.nashp.org/how-states-use-cost-growth-benchmark-programs-to-contain-health-care-costs/