MASSACHUSETTS
HEALTH POLICY COMMISSION

HPC Board Meeting

January 25, 2022

Agenda

CALL TO ORDER

APPROVAL OF MINUTES **(VOTE)**

EXECUTIVE SESSION **(VOTE)**

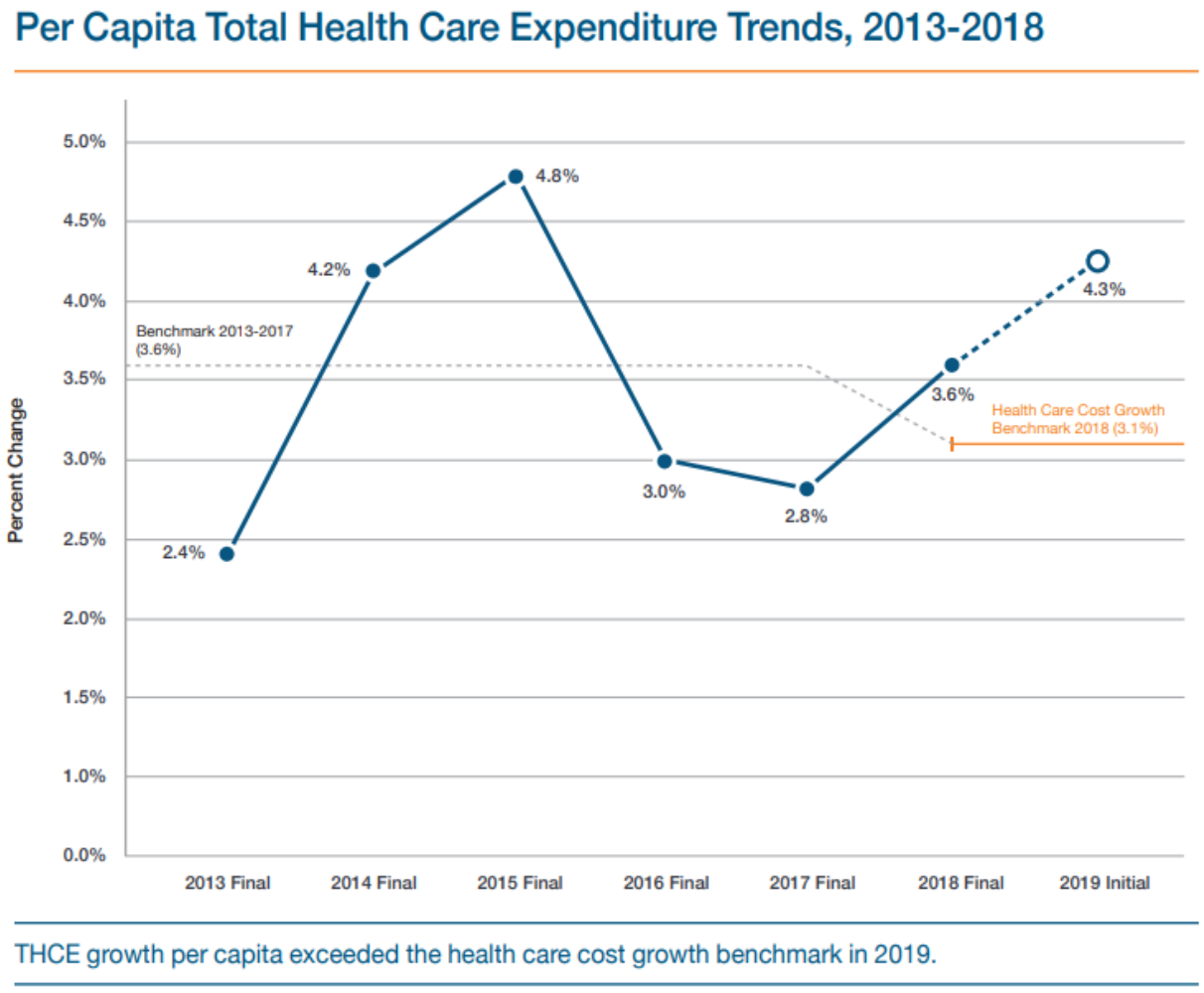
PERFORMANCE IMPROVEMENT PLAN PROCESS

MASS GENERAL BRIGHAM DETERMINATION OF NEED PROCESS: HPC PUBLIC COMMENT **(VOTE)**

EXECUTIVE DIRECTOR'S REPORT

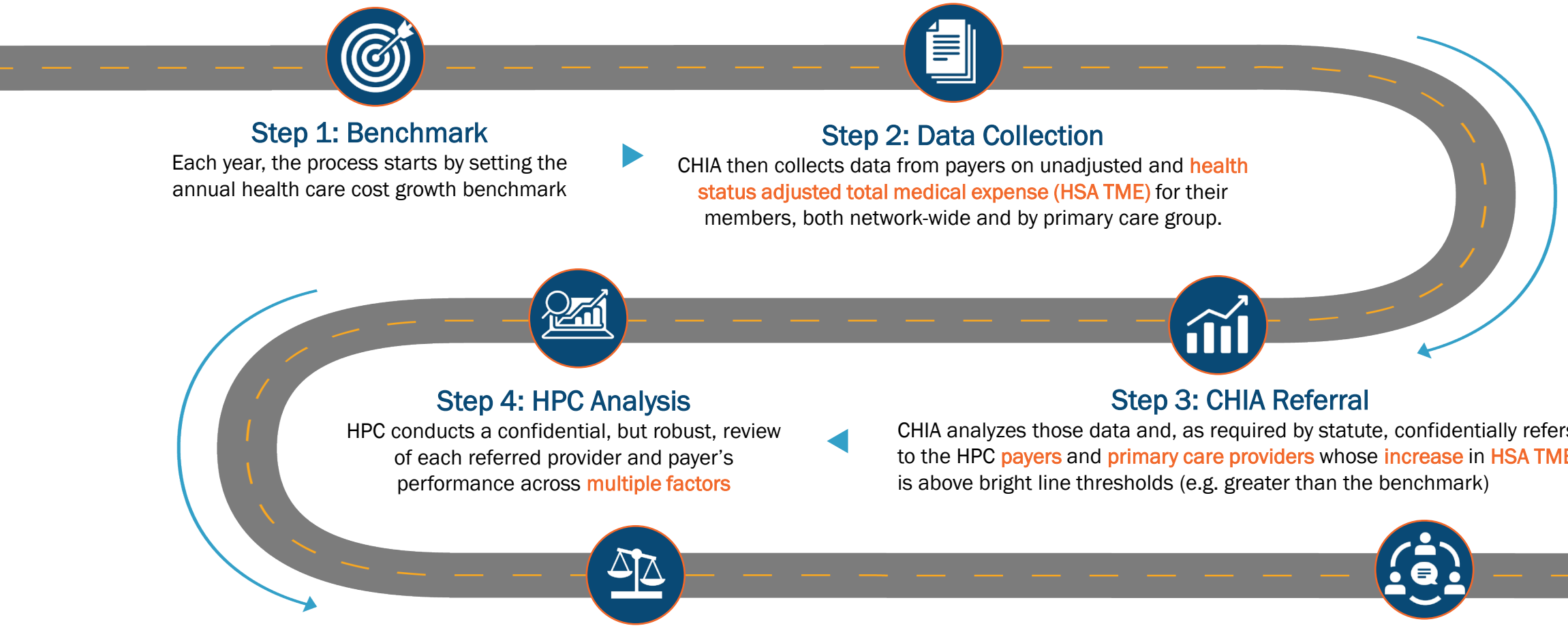
SCHEDULE OF UPCOMING MEETINGS

Overview of Performance Improvement Plans: Purpose



- From 2017-2018 and 2018-2019, statewide Total Health Care Expenditures grew faster than the benchmark, at 3.6% and 4.3%, respectively.
- The HPC can hold individual payers and providers accountable for their spending growth relative to the benchmark by requiring them to develop and implement a Performance Improvement Plan, or PIP.
- A PIP developed by the entity must contain strategies, action steps, and measurable expected outcomes to improve the payer or provider's spending performance.

Accountability for the Health Care Cost Growth Benchmark



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.

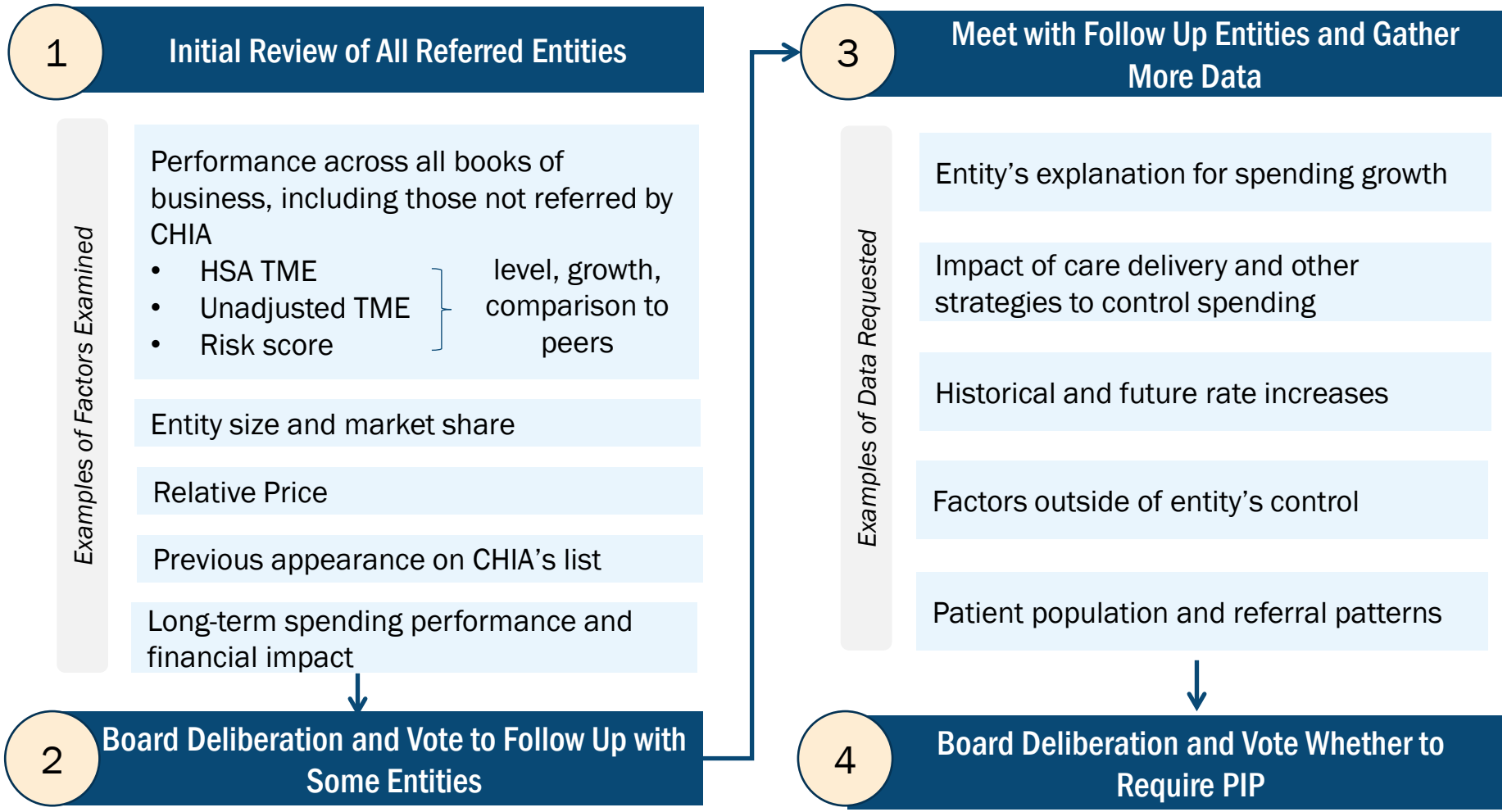
We are here

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.

Overview of Performance Improvement Plans: HPC Review

After referral of payers and providers by CHIA, the HPC conducts a confidential, robust, and multi-factored review of each referred entity, in consultation with its Commissioners.



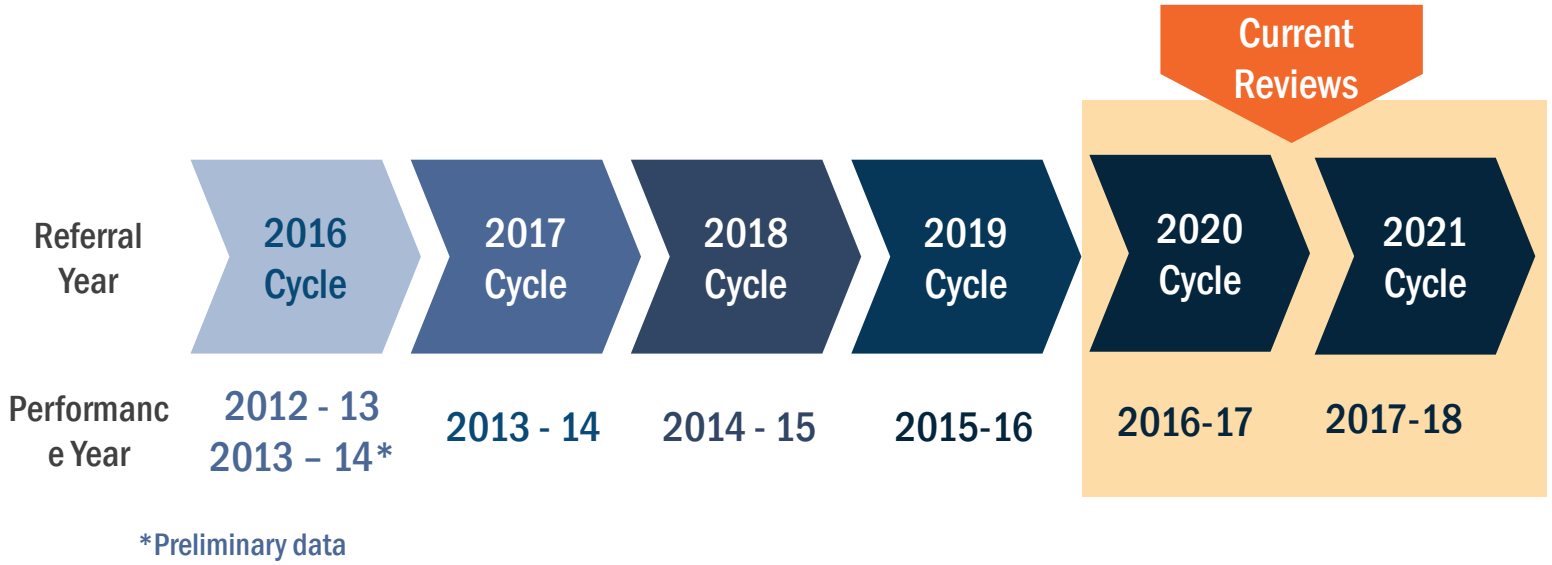
Overview of Performance Improvement Plans: Factors Review by the Commission

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.

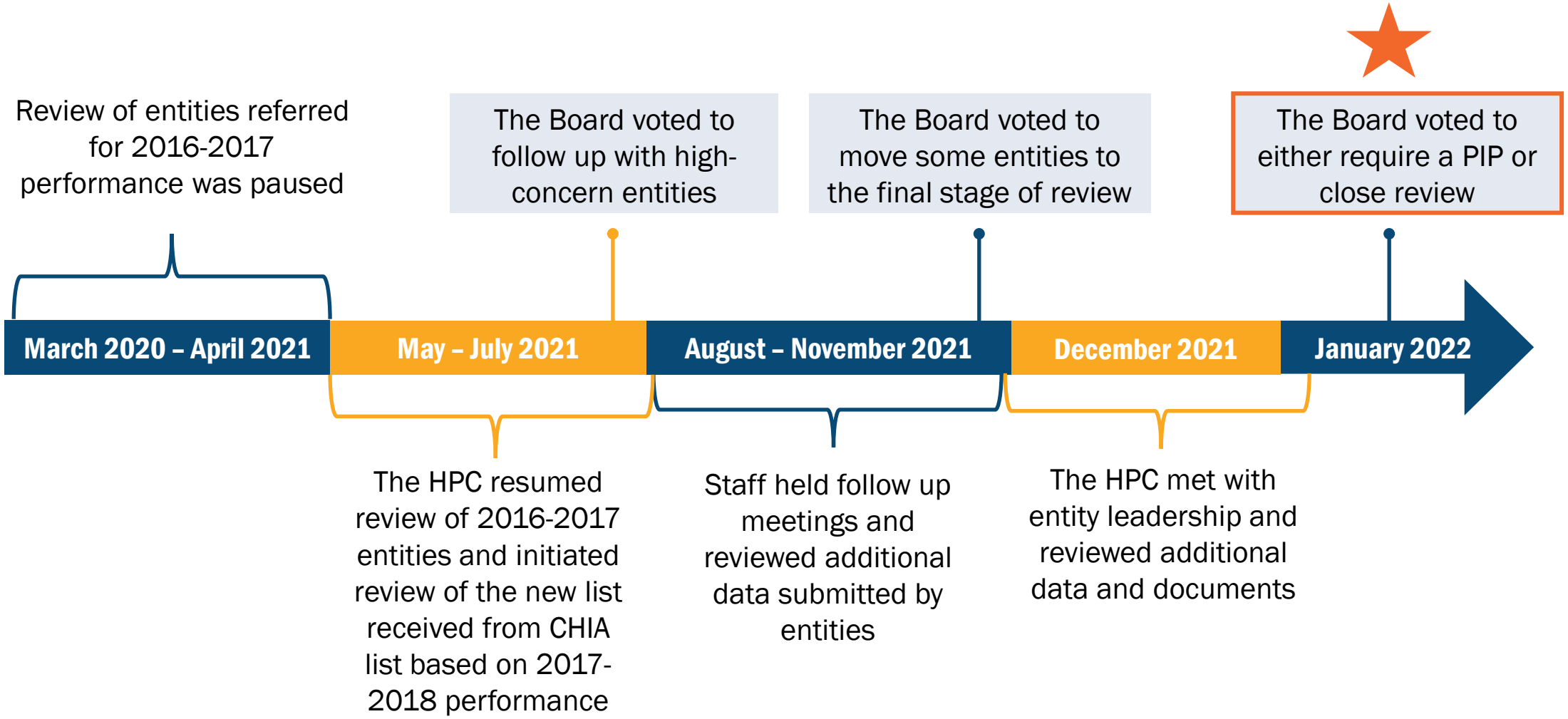
REGULATORY FACTORS	
a	Baseline spending and spending trends over time, including by service category;
b	Pricing patterns and trends over time;
c	Utilization patterns and trends over time;
d	Population(s) served, payer mix, product lines, and services provided;
e	Size and market share;
f	Financial condition, 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.

Performance Improvement Plans: Program History

- The HPC has been reviewing spending trends in the PIPs process for six years.
- With each additional year of data, the HPC has been better able to differentiate between spending increases driven by time-limited factors (e.g., high-cost outliers; employers or physician groups leaving or entering networks) and persistent patterns that raise more significant concerns.



Timeline of 2020 and 2021 PIPs Reviews



PIPs Vote in Executive Session

The Board has voted to require a Performance Improvement Plan from Mass General Brigham.

In reviewing MGB's long term spending trends and the regulatory factors[1], the HPC found that:

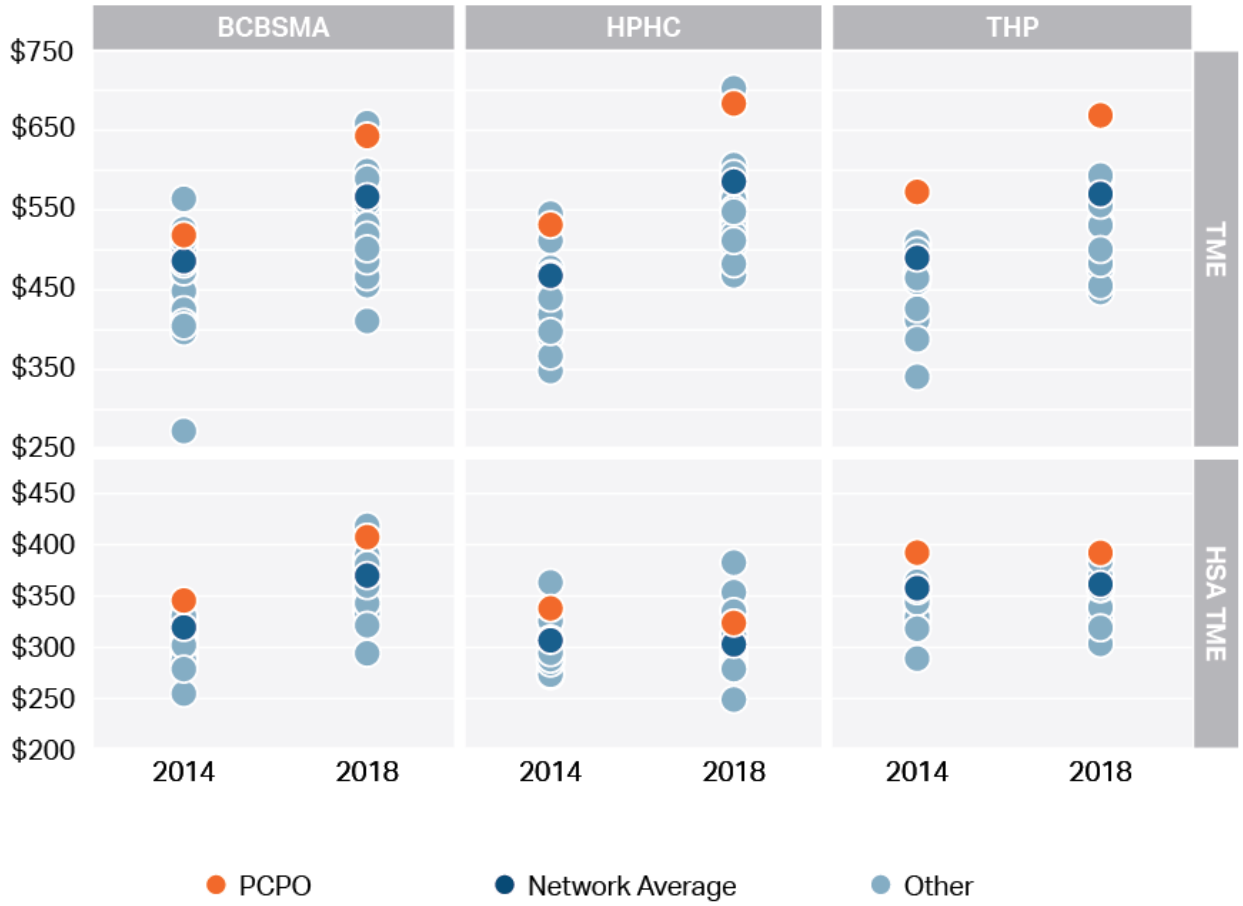
- Spending performance for MGB raises significant concerns and has likely already impacted the state's ability to meet the health care cost growth benchmark.
- Unless addressed, MGB's spending performance is likely to continue to impact the state's ability to meet the benchmark.
- The information provided by MGB in meetings and in response to HPC's requests did not allay the concerns identified by the HPC in its analyses of MGB's performance.

The HPC determined that a Performance Improvement Plan could result in meaningful, cost-saving reforms.

1. The Board examined a wide array of both public and confidential data sources during the PIPs review. In accordance with its statute, the HPC is only releasing confidential information in summary form or when it has determined that such disclosure should be made in the public interest after taking into account any privacy, trade secret or anticompetitive considerations.

Summary Performance: Mass General Brigham

Unadjusted TME and HSA TME Levels

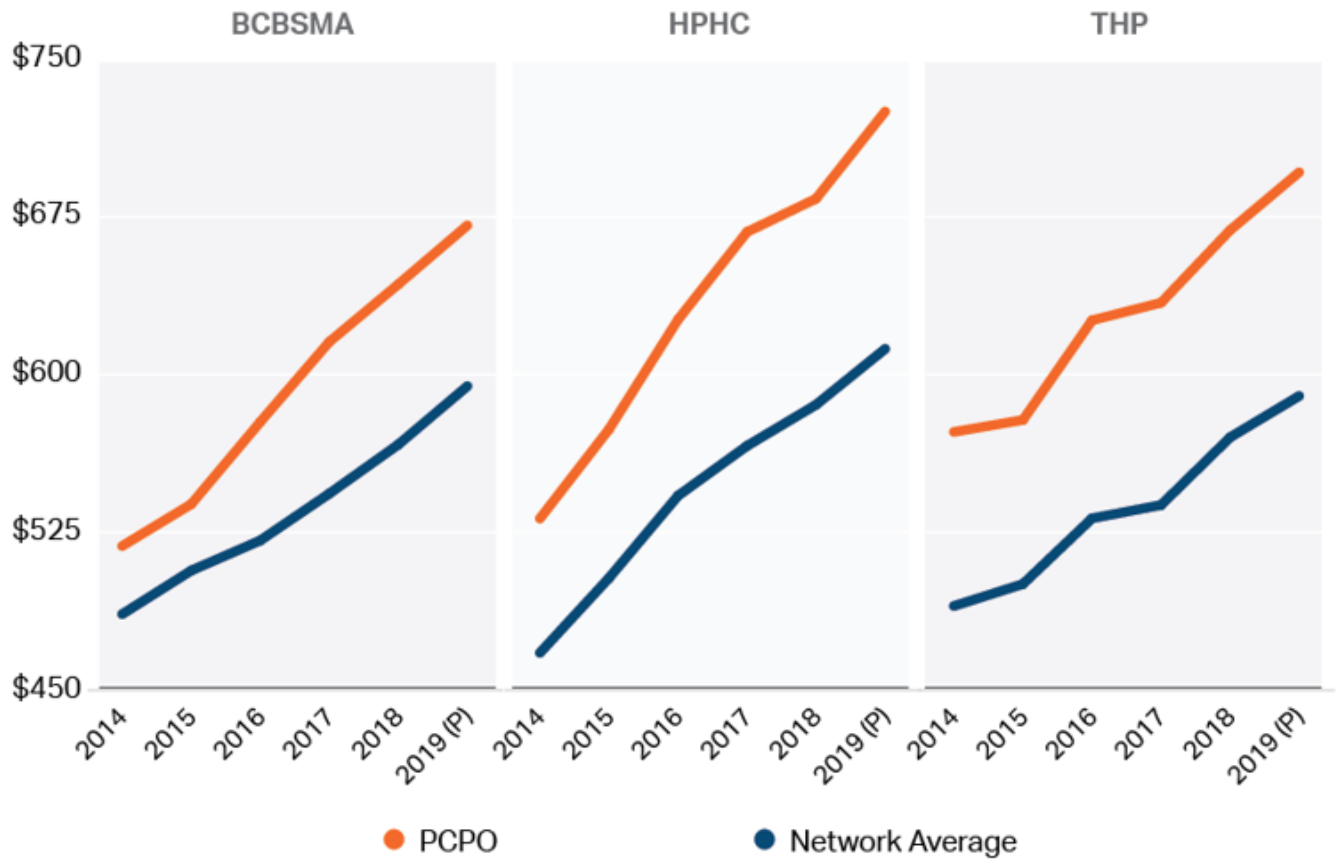


Partners Community Physicians Organization (PCPO), the largest physician group within MGB, has unadjusted and HSA TME levels are substantially higher than network averages and are consistently among the highest in the state for the big three commercial payers.

Based on HPC analysis of CHIA Confidential Total Medical Expense Data: 2014-2019.

Summary Performance: Mass General Brigham

Unadjusted TME Growth

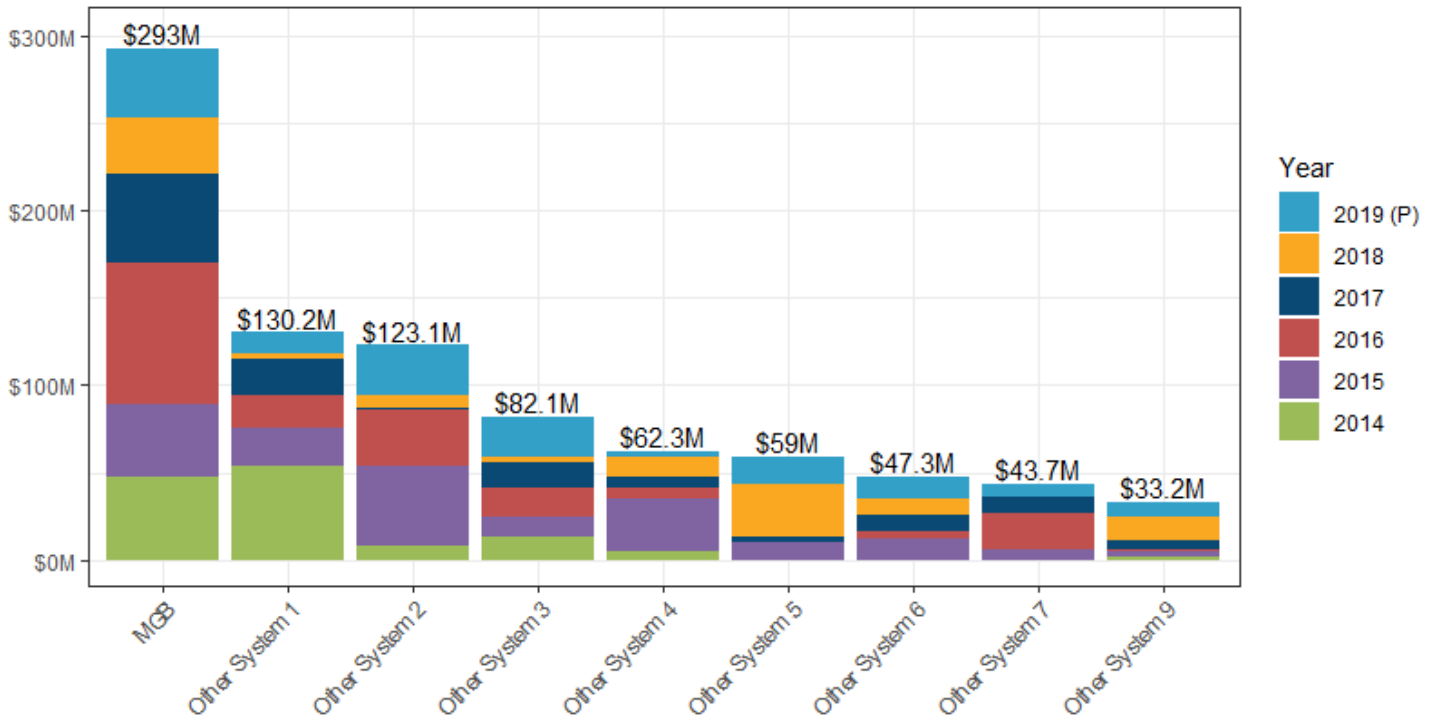


- PCPO's unadjusted TME has generally grown apace or even faster than these payers' network average in most years.
- Even in APM contracts, spending for MGB's primary care patients is growing at rates above the benchmark across multiple years and multiple payers.

Based on HPC analysis of CHIA Confidential Total Medical Expense Data: 2014-2019. -

Summary Performance: Mass General Brigham

Cumulative Financial Impact of Above-Benchmark Commercial Spending Growth (2014 – 2019)



- MGB has had more cumulative commercial spending growth in excess of the benchmark from 2014-2019 than any other provider, totaling $293 million.
- These figures represent unadjusted spending. Because MGB has stated that its primary care patients' health status was not worsening over time, health status adjusted growth understates the spending growth for MGB's primary care patients.

Based on HPC analysis of CHIA Confidential Total Medical Expense Data: 2014-2019. This number represents unadjusted (actual) spending above the benchmark in those contracts with unadjusted spending growth above the benchmark. The figure is presented at the system level and spending for MGB therefore includes the total for PCPO and other affiliated entities for which TME data are available (e.g., CD Practice Associates). The total excludes non-commercial spending and insurance products that either do not require PCP selection (e.g., PPO) or which have carve-outs (i.e., many self-insured plans). Not all of this spending constitutes revenue to the MGB system.

Summary Performance: Mass General Brigham

REGULATORY FACTORS		ASSESSMENT
a.	Baseline spending and spending trends over time, including by service category;	• MGB's commercial contracts with above-benchmark unadjusted TME growth have had a cumulative impact of $293 million from 2014-2019, significantly more than any other provider or system. • The commercial spending levels (HSA and unadjusted) for MGB's primary care patients are high compared to other providers, and its unadjusted TME has grown apace or even faster than network averages. • Even in APM contracts, spending for MGB's primary care patients is growing at rates above the benchmark across multiple years and multiple payers.
b.	Pricing patterns and trends over time;	• MGB's hospital and physician prices are higher than nearly all other providers in the Commonwealth.
c.	Utilization patterns and trends over time;	• The HPC's analysis of key spending drivers for MGB show that for the categories of spending driving growth, price and mix have been bigger drivers than utilization.
d.	Population(s) served, payer mix, product lines, and services provided;	• MGB's patients are more likely to be higher income and commercially insured as compared to most other providers. • MGB provides a number of high acuity services, including quaternary services, and is a major provider of behavioral health services. However, MGH's and BWH's case mix index is not significantly higher than other institutions in Massachusetts with lower price points.
e.	Size and market share;	• MGB is the largest health care system in the Commonwealth by most metrics (13.3% of commercial lives in 2018 and 20% of discharges, 28% of inpatient NPSR, and 24% of outpatient NPSR in FY19). • MGB has significantly more new or expanded facilities than other Massachusetts providers since 2014 based on RPO and DPH filings.

Summary Performance: Mass General Brigham

	REGULATORY FACTORS	ASSESSMENT
f.	Financial condition, including administrative spending and cost structure;	• MGB has significantly more resources than other systems, and its financial performance has been consistently strong. • MGB's assets, net assets, and operating revenue are greater than the next four largest systems combined.
g.	Ongoing strategies or investments to improve efficiency or reduce spending growth over time;	• MGB stated that its strategies to control costs going forward would be a continuation of its current efforts, including payer-blind clinical and care management programs, shifting patients to lower-cost settings, and taking on more risk in its payer contracts. • MGB did not provide data or evidence that continuing these strategies would be effective to keep its spending growth below the benchmark. • Additional risk exposure may incentivize MGB to lower its spending but, as demonstrated by MGB's high spending growth in APM contracts, participation in risk contracts is not itself a guarantee of lowered spending.
h.	Factors leading to increased costs that are outside the CHIA-identified Entity's control	• MGB stated that pharmacy costs are a consistent cost driver in its TME. • However, HPC analysis of the 2017-2018 TME data did not identify pharmacy as a top driver in any of PCPO's contracts.
i.	Any other factors the Commission considers relevant.	• From 2013-2019, risk scores for PCPO's primary care patients grew in excess of network averages for all three of the largest payers. Cumulative growth ranged from 29.9% to 45.1% over that time period. • MGB stated that its primary care patients' health status was not worsening over time.

Next Steps: Filing of a Proposed PIP, Waiver Request, or Extension Request

- Within 45 days of receiving a PIP Notice, MGB must file:
  - A PIP proposal;
  - A request for a waiver; or
  - A request for an extension.
- The Board votes on whether to grant waivers or extension requests longer than 45 days.
- The Board must also vote on whether to approve a proposed PIP (see following slide).
- Proposals or requests must be filed using standardized forms, available on the HPC website. Entities are encouraged to partner with and utilize the assistance of the HPC during the development of the PIP proposal.
- Any final PIP proposal or waiver request, excluding certain nonpublic materials, shall be a public record and will be posted on the HPC's website.
- Please see the PIPs Webpage for further details.

SECTIONS OF A PIP PROPOSAL	
I	Description of Your Organization
II	Target
III	Causes of Growth
IV	Interventions and Evidence
V	Measures
VI	Reporting and Revising
VII	Impacts and Other Filings
VIII	Sustainability
IX	Timeline
X	Requests for Technical Assistance

Next Steps: Assessment of a Proposed PIP

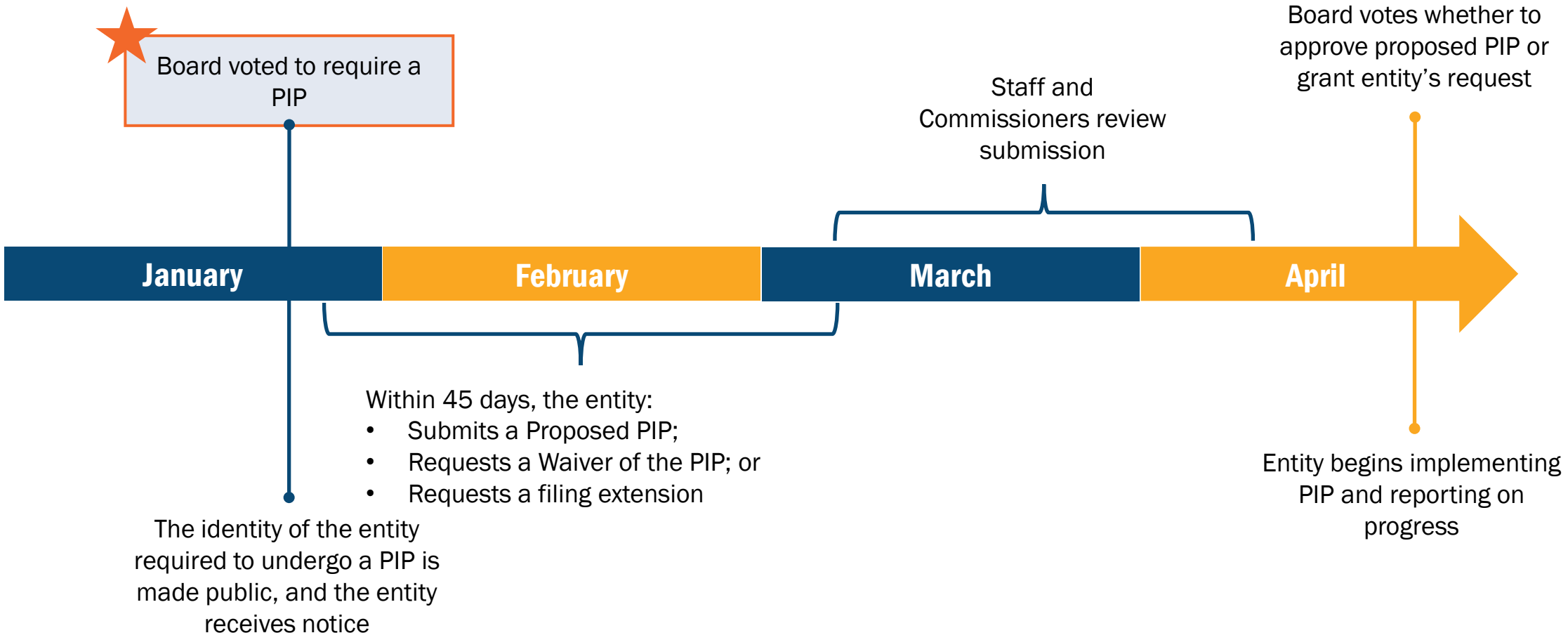
STANDARD FOR APPROVAL

- The Board shall approve a proposed PIP if it determines that the PIP:
  - Is reasonably likely to successfully address the underlying causes of the entity's cost growth; and
  - That the entity will be capable of successfully implementing the plan.

REGULATORY FACTORS FOR CONSIDERATION

- Whether the PIP proposes a strategy or activity that has a reasonable economic, business, or medical rationale with a sufficient evidence base;
- The scope and likelihood of potential savings and the potential impact on the Commonwealth's ability to meet the benchmark
- Whether savings and efficiencies are likely to continue after implementation
- The extent to which a proposed PIP carries a risk of negative consequences that would be inconsistent with other policy goals of the Commonwealth; and
- Any other factors the Commission determines to be in the public interest.

Timeline



All dates are approximate