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Cost Growth Benchmark and Performance Improvement Plans Under Massachusetts's New Health Care Reform Act

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Introduction

This is the first of a series of occasional comments on the new health care reform act (the "Act"), adopted by the Massachusetts Legislature, which the Governor is expected to sign soon. This alert relates to one of the core cost containment provisions of the Act, benchmarking overall health care cost growth and the obligation of certain providers, provider organizations and carriers to develop and implement performance improvement plans. It is based on these provisions of the Act that the legislative leadership has projected a $200 billion savings in health care costs in Massachusetts over the next 15 years.

Setting the Benchmark

Under the Act, the Legislature annually, in collaboration with the Commonwealth's budget office, will establish an annual "growth rate of potential gross state product" (the "growth rate") reflecting the "average growth rate of the Commonwealth's economy, excluding fluctuations due to the business cycle."

By April 15 of each year, a newly created Health Policy Commission (the "Commission") is to use the growth rate to establish the "health care cost growth benchmark" (the "benchmark") for the Commonwealth's total health care expenditures for the ensuing calendar year. While the benchmark measures aggregate expenditures, as is described below, the Commission is authorized to initiate corrective action under some circumstances for individual health care entities whose costs have exceeded the benchmark in a given year. "Health care entities" is defined to include providers, provider organizations and carriers.

The Act specifies the benchmarks for each year beginning in 2013 (subject to adjustments, as described below), as follows:

- For each year beginning 2013 through 2017, the benchmark is set equal to the growth rate for the particular year, provided that the Act specifies that the growth rate for 2013 is to be 3.6%.
- For each year beginning 2018 through 2022, the benchmark is set equal to the growth rate minus 0.5%.
- For each year beginning in 2023, the benchmark is set equal to the growth rate for the particular year.

The Act sets out a process to adjust the benchmark from the levels specified, for any year beginning 2018 through 2032. That is, unless the Legislature acts otherwise, the growth rate is the benchmark for

2013 through 2017 and for years after 2032. The following rules apply if the Commission determines that the benchmark should be adjusted for any year beginning 2018 through 2032:

- Any proposed adjustment needs to be adopted by a two-thirds vote of the Commission's board.
- Prior to proposing a modification, the Commission is to hold a public hearing.
- The details of the hearing and the information the Commission is to examine to make an adjustment determination are set out in the Act.

Beyond these steps, what happens with the Commission's adjustment proposal depends on the time period, as follows:

- For each year for 2018 through 2022, the Commission may propose to adjust the benchmark, but the adjustment can only be downward, and would be set somewhere between 0.5% of the particular year's cost growth and the amount determined as the cost growth. That is, the Commission cannot propose to increase the benchmark above the annual cost growth level, but it can propose a reduction from that level of less than the otherwise required level of the cost growth minus 0.5%. If the Commission decides to seek an adjustment, it is to submit its proposal to the joint legislative committee on health care financing, which is in turn obliged to hold a hearing on the proposal and report its recommendation to the full Legislature. If the Legislature does not take action on the Commission's proposal within 45 days of the joint committee's hearing, the proposed change automatically becomes effective. The Act does not explicitly authorize the Legislature to modify the Commission's proposal, but it seems reasonable to conclude that it could do so under its general legislative powers.
- For each year beginning 2023 through 2032, the process for modifying the benchmark established in the Act is somewhat different from the prior period. During this period the Commission, after taking public testimony, may propose an adjustment to the benchmark for the particular year. It is not limited to the growth rate as a cap or to a specific floor on the level of reduction from the growth rate that it might propose. As in the earlier years, the proposal is submitted to the joint committee on health care financing for a hearing and recommendations to the Legislature. But the Act is then silent on what the Legislature may do at that point. The Act does not provide for automatic implementation of the proposed change if the Legislature does not act. In fact, the Act is silent on whether the Commission can or cannot implement the adjustment in the absence of legislative approval. It seems reasonable to conclude that it could not do so without that specific authorization.

Performance Improvement Plans

The Commission is charged with monitoring the health care system's behavior against the benchmark. Further, though, the Act gives the Commission certain rights vis-à-vis health care entities (providers, provider organizations, or carriers) that have been identified by another new agency, the Center for Health Information and Analysis (the "Center"). The Center is charged with identifying any providers, provider organizations or carriers that have experienced an increase in health status adjusted total medical expense that is considered "excessive" and that therefore threatens "the ability of the state to meet the health care cost growth benchmark." The Center is directed to provide the Commission with a list of such entities on a confidential basis.

If for any year the percentage change in total health expenditures in the prior year exceeds the benchmark (for 2015 the expenditures in 2013 and 2014 are averaged, as are the benchmarks for those two years), the Commission is mandated to establish procedures to assist these entities "to improve efficiency and reduce cost growth" by requiring them to file and implement performance improvement plans. The Commission may, however, upon application from the entity, waive or extend the filing requirement.

The performance improvement plan is to identify the causes of the entity's cost growth and include specific strategies, adjustments, and action steps the entity proposes to take to improve its cost performance. The plan is to include "specific identifiable and measurable expected outcomes and a

timetable for implementation." The timetable cannot exceed 18 months. The Commission will accept only performance plans that it deems "reasonably likely" to address the underlying cause of the entity's cost growth and that have a "reasonable expectation" for successful implementation. The Commission can work with the entity to generate an acceptable plan.

Once the plan is approved it is to be implemented immediately. The Commission will put on its website the identity of the entity implementing such a plan. While the plan is being implemented the entity is subject to additional reporting requirements and compliance monitoring. During the implementation phase the entity can file amendments, although the amendments must be approved by the Commission.

At the end of the timetable the entity is to report to the Commission on the outcome of the plan implementation. If the plan is found to be unsuccessful, the Commission may (a) extend the timetable, (b) approve proposed amendments, (c) require that the entity submit a new plan, or (d) waive or delay the requirement to file an additional plan. If the plan is successfully completed, the entity's identity is removed from the website.

The Act does not directly address the question of whether the plan, at least once approved by the Commission, is a public document. Therefore its disclosure would be determined by whether it fits into one of the exemptions under the Massachusetts public records law.

No penalties are specified for an entity that does not successfully implement the performance improvement plan, except as noted in the circumstances described below, and other than the need for the entity to continue to respond to the Commission's right to seek amendments or a new plan, as well as the potential public embarrassment of having its identity continue to be displayed on the Commission's website. However there are penalties under the Act if the entity has (a) willfully neglected to file a plan, (b) failed to file an acceptable plan in good faith, (c) failed to implement the plan in good faith, (d) knowingly failed to provide information required by the Act, or (e) knowingly falsified information. For these infractions the Commission may assess a civil penalty of not more than $500,000 (it is not specified whether this is per occurrence or in the aggregate). The Act even exhorts the Commission to seek to promote compliance with the performance improvement plan provisions and to impose a civil penalty only as a last resort.

Conclusion

The Commission's responsibilities for benchmarking growth in aggregate health care expenditures and its ability to require performance improvement plans from "health care entities," including carriers, is core to the eventual success of the Act. Other provisions of the Act address mechanisms for restraining cost increases. But ultimately, if the benchmark is exceeded in any year on an aggregate basis, individual entities may be subject to close scrutiny by the Commission, with the expectation that they will take steps to bring their own costs in line with the benchmark. The Act gives the Commission flexibility in terms of how it works with these health care entities, and, as noted above, encourages a collaborative, not a punitive, relationship between the Commission and the entities subject to the performance improvement plan requirements. Whether collaboration is the hallmark going forward will be largely a function of the extent to which the improvements in cost containment efforts within the private sector, already under way in Massachusetts, will continue. In this regard the new "Massachusetts experiment" should point the way for other states and the federal government in thinking about public/private collaboration to promote cost containment ends.

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