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center
for health
information
and analysis

Final Methodology for Referring Health Care Entities to the Health Policy Commission
Adopted April 2017

The Center for Health Information and Analysis (CHIA), pursuant to M.G.L. c. 12C, § 18, is required to confidentially refer health care entities "whose increase in health status adjusted total medical expense is considered excessive and who threaten the ability of the state to meet the health care cost growth benchmark" to the Health Policy Commission (HPC).[1] Referred entities may be required by the HPC to implement a performance improvement plan (PIP) pursuant to M.G.L. c. 6D, § 10. This memorandum details the final methodology to be used by CHIA for determining when health care entities will be subject to confidential referral to the HPC.

On November 22, 2016, CHIA issued a proposed methodology for referring health care entities on its website and requested public comment from interested parties. The deadline for providing comments was 5:00pm EST on Friday, December 9, 2016. Based on our review of total medical expenses (TME) data, discussion with stakeholders, and review of public comments, CHIA has made several revisions to the proposed confidential referral methodology, including the following:

- **Use of Final TME Data** – CHIA will only assess whether health care entities meet the conditions for confidential referral to the HPC using final TME data. As a result, CHIA referrals based on TME data submitted in 2015 will be based on CY 2013 and CY 2014 performance;

- **Use of Unadjusted TME Growth as a component of referral assessment** – For this element, CHIA will assess whether or not health care entities' unadjusted TME growth was greater than or equal to the benchmark. We had proposed to assess whether unadjusted TME growth was greater than or equal to 85 percent of the benchmark;

- **Health Status Adjusted (HSA) TME Level as a component of referral assessment**– For this element, CHIA will assess whether or not a given physician group's HSA TME level was greater than or equal to the 75th percentile in a given payer network. We had proposed to assess whether HSA TME level was greater than or equal to a given payer network average;

- **Member Month Threshold element** – CHIA will include all reported member months when calculating a given health care entity's share of statewide member months. We had proposed to

[1] Health status adjusted total medical expenses is defined as "as the total cost of care for the patient population associated with a provider group based on allowed claims for all categories of medical expenses and all non-claims related payments to providers, adjusted by health status, and expressed on a per member per month basis." See 957 CMR 2.00 for additional information on definitions and data specifications. Available from http://www.chiamass.gov/assets/docs/g/chia-regs/957-2-00-payer-data-emergency-adopted-reg.pdf for more information.

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exclude member months for entities with fewer than 36,000 member months from this calculation.

CHIA considered all comments carefully and appreciates the interest and input from valued members of the health care community.

Health Care Entity Referral Logic for Physician Groups

Physician group[2] level expenditure, health status, and member month data from payer TME submissions will be used to assess each entity. The following logic will be applied to determine whether a physician group will be referred to the HPC:

- Groups are separately assessed for managed patients of each payer within each insurance category (e.g., Payer A/Commercial Full-Claim, Payer B/MassHealth Managed Care, etc.) [3];

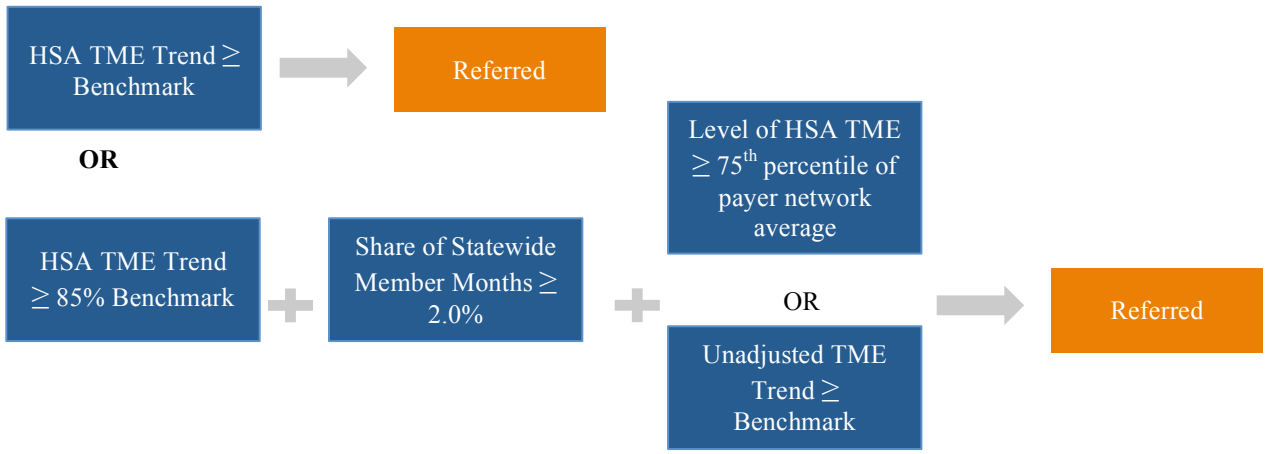
- Pediatric and non-pediatric groups are assessed separately within each insurance category so that pediatric member months are excluded from non-pediatric assessments and vice versa;

- Data for any physician group with fewer than 36,000 member months is excluded from the HSA TME analysis, but is included in the calculation of statewide share of member months

- Only data attributable to those Massachusetts resident members who selected a primary care provider is used for CY 2015 data assessments. Beginning with CY 2016 data, assessments may also include data for members who have been attributed to a primary care provider;[4]

- Share of statewide member months is calculated using data for the most recent calendar year in the analysis and aggregated member month data for all payers that report TME data to CHIA. A provider group's share of statewide member months is calculated within an insurance category (e.g., Commercial-Full Claim) and the same value is used across payer contracts within each insurance category;[5]

[2] Currently, physician groups and physician local practice groups are the only providers eligible to be referred to the HPC because TME is only attributed to primary care providers (rather than hospitals or other provider types).
[3] For example, in CY 2014 CHIA will separately assess whether to refer Provider Group A to the HPC based on its BCBS of MA, Harvard Pilgrim, Tufts, Fallon, and Neighborhood Health contracts in the Commercial Full-Claim insurance category.
[4] Beginning with CY 2015 data submissions, payers were also required to report spending for members that have been attributed to a primary care provider pursuant to a contract (rather than simply as required by plan design that requires a member to select a primary care provider). CHIA will report HSA TME with this data in future years, when there is sufficient data to perform longitudinal analyses. For additional information, see CHIA Administrative Bulletin 16-04: http://www.chiamass.gov/assets/docs/g/chia-ab/16-04.pdf.
[5] As noted above, all calculations for pediatric and non-pediatric physician groups are performed separately, including the share of statewide member months.



Health Care Entity Referral Logic for Payers

Zip code level expenditure, health status, and member month data from payer TME submissions will be used to assess each entity. The following logic will be applied to determine whether a payer will be referred to the HPC:

- Payers are separately assessed for each insurance category for which they have business (e.g., Commercial Full-Claim, MassHealth Managed Care, etc.);
- Zip code level expenditure, health status, and member month data is aggregated to the statewide level for each payer for the assessment in each insurance category;
- Share of member months is calculated using data for the most recent calendar year in the analysis;
- Payers with fewer than 36,000 member months in a given insurance category are not considered for referral to the HPC for that insurance category; however, member month data for such payers is included in the calculation of each payer's share of statewide member months.