

A Blueprint for Transforming Massachusetts Health Care



MASSACHUSETTS

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Massachusetts is leading the nation in health care reform, but the task is by no means finished. Expanding access to coverage is only one step—albeit an essential step—toward achieving the best possible health and health care for everyone in Massachusetts. Like the rest of the nation, the Commonwealth is still faced with the urgent need to control the growth of health care spending while significantly improving quality-of-care.

An estimated \$63 billion will be spent on health care in Massachusetts in 2009, and total expenditures are increasing by almost eight percent annually, much faster than general inflation or growth in wages and salaries. As in other every state, health care costs are placing an immense burden on consumers, businesses, and government. To make matters worse, almost no one believes we are getting the best possible value for our health care dollars. The quality of care many patients receive is falling short of where it should be, and there is far too much fragmentation, complexity, unwarranted variation, waste, and inefficiency in our state's health care system.

Massachusetts must address these flaws with the same sense of urgency and commitment to innovation and collaboration that led to the enactment of the 2006 health care reform law. It is in that spirit that we have developed “A Blueprint for Transforming Massachusetts Health Care,” with recommendations on how to build a high-quality, high-value health care system.

Our overarching goal is to improve the health of the Commonwealth by ensuring that every resident will have timely access to safe, effective, affordable, patient-centered care. Blue Cross Blue Shield of

Massachusetts is just one of many stakeholders in the health care system, so we are working closely with hospitals, physicians, consumers, employers, policymakers, researchers, and the state's other health plans to turn this vision into a reality.

The recommendations in this report are designed to help make the transformation of our state's health care system a sustainable reality in no more than five years. The tipping point—when it is more beneficial for everyone involved to embrace change than to resist it—must come even sooner. Given the immensity of the task, the process cannot be timid or piecemeal, which is why our blueprint covers four priority areas where rapid changes need to occur simultaneously:

- ▶ Comprehensive reform of provider payments and incentives
- ▶ Coordination, standardization, and simplification throughout health care
- ▶ Public engagement in improving health and health care
- ▶ Hospital trustee engagement in organizational transformation

It is important to note that there are many other aspects of health care that demand continuous improvement as well—community health, racial and ethnic disparities, primary care workforce development, end-of-life care, and development of electronic health information systems to name a few. Sustainable progress in each of these areas will be far more likely in a transformed, high-performance health care system.



We believe the most promising way to slow the growth in health care costs is to make care safer and more effective.



—Cleve Killingsworth, President and CEO, Blue Cross Blue Shield of Massachusetts

What Will a Transformed Health Care System Look Like?

Instead of...	There will be...
Provider payments based primarily on quantity and degree of specialization (use of services)	Provider payments based on quality of care and outcomes (value of services)
Overuse, underuse, and misuse of medical procedures and resources	A health care system where patients receive the services that will help them the most, at the right time and in the right place
Unwarranted variation in quality of care among physicians and hospitals	Consistently high-quality care
Patients harmed by avoidable medical errors	A high level of safety built into medical practice
A widespread assumption that more expensive care is better care	A widespread consensus that high-quality care is less costly than poor-quality care
Confused, disengaged patients/consumers	Informed and involved patients/consumers
A health care system where uncoordinated care diminishes quality and increases costs	A health care system where comprehensive, coordinated care enhances continuity, effectiveness, and efficiency
Variation, duplication, and excessive administrative complexity for physicians and hospitals	Simplification and standardization of administrative processes and performance measures
Devaluation of primary care and shortages of primary care clinicians	An environment where effective primary care, prevention, and care management are valued and rewarded
Frustrated clinicians under constant pressure to produce more visits, procedures, and tests for their patients	A system that allows clinicians to focus on improving the total health and wellbeing of their patients

Closing the Gaps in Quality and Value

A decade ago, the Institute of Medicine (IOM) organized a comprehensive examination of health care quality in the U.S. and found what they called a “quality chasm” between what is known to be high-quality health care based on scientific evidence and what actually exists in practice. Warning that there were widespread quality defects in communities across the country, the IOM summarized the primary causes of poor quality as:

- ▶ the *underuse* of beneficial care and prevention;
- ▶ the *overuse* of needless, harmful, and costly care; and
- ▶ the *misuse* of medical resources in ways that cause errors and avoidable harm to patients.

Massachusetts is no exception. Independent research studies have documented numerous examples of how underuse, overuse, and misuse in our health care system adversely affect quality and cost performance. For example:

Quality Performance

- ▶ Fewer than half of adults with diabetes in Massachusetts receive recommended preventive care.
- ▶ The state’s overall rate for appropriate colorectal cancer screening is 69 percent, with rates among primary care medical groups ranging from a low of 42 percent to a high of 89 percent.
- ▶ Statewide, 26 percent of heart failure patients leave the hospital without discharge instructions. At the best performing hospital, 100 percent receive discharge instructions.
- ▶ The overall rate of hospital-acquired infections in Massachusetts is two and a half times that of the lowest reporting state (3.2 per 1,000 vs. 1.3 per 1,000).

- ▶ Medicare beneficiaries in Boston are 56 percent more likely to have an avoidable hospital admission than those in San Francisco (81 per 1,000 vs. 52 per 1,000).

Cost Performance

- ▶ The Massachusetts Department of Public Health estimates that eliminating hospital-acquired infections could save as much as \$473 million annually.
- ▶ Unnecessary emergency room visits cost an estimated \$250 million to \$320 million annually.
- ▶ If Massachusetts performed at the level of the highest ranked states in avoidable hospital use and cost, the savings from reduced Medicare hospitalizations and readmissions would total almost \$200 million.
- ▶ Medicare spends 25 percent more per beneficiary in Boston than in San Francisco for high-tech imaging.

In a high-quality, high-value health care system, all patients get the right care, safely delivered in the right place, at the right time. This is an ambitious but achievable goal for Massachusetts.

At this point, however, most health care providers are not equipped to make breakthrough improvements in cost and quality—not because they lack the will—but because they operate within a fragmented, inefficient health care system with shortcomings that have accumulated over many years.

One of the biggest obstacles they face is an antiquated and counterproductive provider payment system, which is why payment reform is at the top of our priority list.

Comprehensive Reform of Provider Payment and Incentives

Priority No.1

PROBLEM: The current payment system rewards providers for volume and complexity rather than for quality care, health outcomes, or value.

SOLUTION: Payers and providers must switch to global payment methods that enable, encourage, and reward safe, effective, affordable, patient-centered care.

The goal of building a more effective and affordable health care system in Massachusetts cannot be achieved without dramatically reshaping the way hospitals, doctors, and other medical professionals are paid.

Since the advent of health insurance, doctors in the U.S. have, for the most part, been paid on a piecework basis—they receive a fee for each office visit or other agreed upon unit of care. As the bulk of medical spending has shifted from episodic care for periodic illnesses and injuries to care for chronic (and often preventable or manageable) conditions, like heart disease, diabetes, and asthma, payment methods have not kept pace. The resulting problems are well documented, as in this summary by President Obama’s Council of Economic Advisers:

- ▶ Fee-for-service payment creates financial incentives for doctors and hospitals to earn revenue based on the volume of services that they deliver rather than on quality, outcomes, cost, or efficiency.
- ▶ In general, payment systems do not reward higher quality and value. In some cases, they actually

reward poor quality, for instance, by paying for costs associated with extra days a patient has to be in the hospital because of a medical error or an avoidable readmission after discharge.

- ▶ Most fee-for-service payment systems do not reward providers for effectively managing patients with chronic illnesses or educating patients about preventing disease through lifestyle changes.

In recent years, Massachusetts health plans have entered into new contractual arrangements with physicians and hospitals that are designed to address flaws in the fee-for-service payment model. The two principal approaches are commonly referred to as pay-for-performance (P4P) and global payments.

Pay-for-Performance: Quality Incentives Within a Fee-for-Service Payment System

The idea behind a typical P4P program is to recognize and reward hospitals, physician groups, and individual physicians for providing high-quality care. For instance, many private and public health insurers offer incremental rate increases or bonus payments to providers that meet annual performance targets or perform above national or local benchmarks on select quality, safety, and patient-experience standards. Typical measurement tools include HEDIS® (Healthcare Effectiveness Data and Information Set) and CAHPS® (Consumer Assessment of Healthcare Providers and Systems). In some cases, P4P programs also allow providers

“There is much potential in reengineering the health care delivery system, but we must be ready and willing to change the reimbursement model to reward better outcomes, better safety, and better service.”

—Denis Cortese, M.D., President and CEO, Mayo Clinic

to benefit financially when they help to reduce the overuse of high-cost tests or medications.

In order to help providers improve their performance scores, health plans typically share data on patients who have not received recommended tests or treatments, and develop reports that providers can use to track their performance against P4P measures.

Health plans and providers often collaborate in reaching out to members who would benefit from screenings and other preventive services. Complementary P4P strategies may include the development of member education and reward programs to encourage healthy behaviors, and products and programs that create incentives for members to choose high-performance providers.

Recognizing that many providers are not equipped to undertake systemic improvements, some health plans add special bonuses to help fund infrastructure development, physician training, clinical and administrative support, and the adoption of health information technology.

While P4P begins to address the problematic incentives in fee-for-service reimbursement by rewarding providers for meeting evidence-based standards of care, it does not change the underlying payment system. Providers are still operating in a fragmented, piecemeal environment, where volume and complexity drive overall payment levels.

Global Payment: A Catalyst for Health System Transformation

In 2008, the Massachusetts legislature created a Special Commission on the Health Care Payment System to “recommend reforms that will provide incentives for cost-effective and patient-centered care.” To the surprise of many observers, the commission’s public- and private-sector members quickly reached consensus that fee-for-service payment methods should be replaced wherever possible in Massachusetts by “global payments with appropriate adjustments and common performance measures” in order to “promote safe, timely, efficient, effective, equitable, patient-centered care and thereby reduce growth in per capita health care costs.”

The central idea behind global payments is that health plans (and/or public payers like Medicaid and Medicare) make annual per-patient payments, along with incentive payments for meeting quality goals, to physicians, hospitals, and other providers that form groups to care for defined populations of patients. Participating physician groups and hospitals then use their cumulative global payments to provide or arrange for all or most of the covered services health plans’ members receive during the year.

Per-patient payments are typically based on the total amount the health plan has paid to the physician

“ [Global] health care payments should cover the cost of efficiently provided care, support investments in system infrastructure, and ensure timely access to high-quality, patient-centered care. Additional payment should reward and promote the delivery of coordinated, patient-centered, high-quality health care that aligns with evidence-based guidelines, where available, and produces superior outcomes and improved health status. ”

—Massachusetts Special Commission on the Health Care Payment System

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group or hospital under fee-for-service, with annual adjustments for inflation. In order to avoid underpaying providers that care for sicker patients, payment levels are also adjusted for health status. For instance, the global payment for a 25-year-old with diabetes is significantly higher than for a 25-year-old with no chronic illness.

Including quality performance incentives with global payments also helps guard against the under-treatment of patients by holding providers accountable for both the delivery of appropriate services and the health outcomes associated with those services. Public reporting of physician and hospital performance will further strengthen that level of accountability.

Global payments are designed to enable clinicians to provide the care that they believe is needed to improve the health of their patients. They are liberated from many of the constraints of traditional payment models, giving them the flexibility to, for example, have email exchanges with patients (e-visits), offer “health coaching” for patients who want to achieve a healthy weight, or provide follow-up home visits for patients after hospitalizations.

When a physician spends extra time with a patient and helps that patient manage a potentially debilitating condition or avoid an unnecessary hospitalization, the patient not only receives better

care, but the overall cost of care is less. With global payments, provider groups that achieve increased efficiency through innovations in care delivery and reductions in unnecessary services are able to retain a portion of the savings and invest in continued improvements.

Although no single type of health care delivery system is uniquely suited to accept global payments, much of the focus in Massachusetts and elsewhere has been on accountable care organizations or ACOs. Conceptually, an ACO is an integrated delivery system that relies on a network of primary care providers, one or more hospitals, and various sub-specialists to provide care to a defined patient population. Under this model, networks of physicians and hospitals are responsible for the quality and total annual cost of care delivered to patients, and they benefit financially if they provide high-quality, lower-cost care.

At Blue Cross Blue Shield of Massachusetts, we believe that global payments with significant quality incentives and appropriate safeguards will lead to improved outcomes and greater value. At all levels of care, providers will be able to practice in ways that are aligned with their core values of doing what is best for each patient’s health and wellbeing. That is why we developed the Alternative Quality Contract, a global payment method that supports our commitment to transforming the health care system.



With new global payment methods and strong organizational support for clinical improvement, providers, patients, and payers would all gain from the elimination of wasteful care and avoidable complications.



—Donald Berwick, M.D., Karen Davis, Ph.D., and Elliott Fisher, M.D.

First Soundings: The Blue Cross Blue Shield of Massachusetts Alternative Quality Contract

The Blue Cross Blue Shield of Massachusetts Alternative Quality Contracts (AOCs) were introduced in 2009, and there are early indications among participating physician groups and hospitals that they are having the desired effect—aligning the incentives of patients, physicians, hospitals, employers, and health plans to advance high-quality, high-value health care. The contracts are for up to five years, so we have time to forge ongoing partnerships with provider groups around our common goals.

AOCs combine a global, or fixed, payment per patient with performance-based incentives that reward providers based on nationally accepted measures of quality and effectiveness. A global budget is developed to cover all services received by the provider's Blue Cross Blue Shield of Massachusetts patients, including ambulatory, inpatient, diagnostic, ancillary, and prescription drug services.

Payment levels are based on historic claims data for the provider organization's Blue Cross Blue Shield of Massachusetts members. Payments are increased annually using an inflation factor and are risk-adjusted

to account for changes in the health status of the patient population. The contract also offers providers annual performance bonuses of up to 10 percent above the global payments for providing high-quality care.

Performance measures and benchmarks fall into three categories—clinical process measures, clinical outcome measures, and patients' ratings of the care experience—and include both ambulatory and inpatient care. They are established at the beginning of the five-year contract and do not change during its term, so providers have an extra incentive to invest in long-term improvement initiatives.

By combining global payments with substantial quality performance incentives, the AOC encourages providers to drive waste out of the system and focus resources on achieving the highest level of clinical outcomes for their patients. Opportunities to achieve savings include, for example, reducing the duplication of services, using more cost-effective services and providers, and eliminating avoidable hospital complications and readmissions. At the same time, we make sure patients have a voice by including their ratings of the care experience in the AOC's standards for quality performance.

Comprehensive reform of provider payments and incentives will:

- ▶ Replace a payment system based on the quantity of services delivered with one based on quality of care and efficiency
- ▶ Create interim and long-term payment models that move from incentives for process improvements to payment based on outcomes and results
- ▶ Support the development of a high-performance health care system, with new, high-quality, cost-effective delivery models
- ▶ Establish methods for financing ongoing investments in transformation

Comprehensive Reform of Provider Payment and Incentives

When AQC groups succeed in meeting their quality and cost goals, everyone benefits.

That's why we structured our internal resources to help them understand their performance data, identify areas to focus on for improvement, share best practices, coordinate care management, and work with us on improving benefit design and member communication.

Examples: Lessons from Two Early Adopters of Global Payment

Atrius Health and Mount Auburn Cambridge Independent Practice Association were among the first provider organizations to enter into five-year Alternative Quality Contracts with Blue Cross Blue Shield of Massachusetts. The groups' leaders, both physicians, talked with us about how well-designed global payments with performance incentives can affect the quality and efficiency of care.

Atrius Health

Atrius Health is an alliance of five nonprofit physician groups—Harvard Vanguard Medical Associates, Dedham Medical Associates, Granite Medical, Southboro Medical Group, and South Shore Medical Group—with 30 practice locations in Eastern Massachusetts. The practices comprise more than 800 physicians and 1,250 other medical professionals in 35 specialties, including adult and pediatric primary care, obstetrics, oncology, cardiology, ophthalmology, sports medicine, allergy, dermatology, surgery, behavioral health, and dental services, and many of their offices house laboratories, imaging, and pharmacies.

Atrius Health has roots that extend back to the early days of “prepaid group practice” and “group-model” HMOs, so the global payment concepts of population-based health improvement

and managing within a per-patient budget are part of their heritage.

According to Atrius Health CEO, Dr. Gene Lindsey, global payment equips the organization to pursue what the Institute for Healthcare Improvement calls the “triple aim” goal—to improve the health of a defined population of patients and each individual patient's experience with his or her care, while simultaneously containing the per capita cost of health care.

In addition to developing a robust electronic medical record and data warehouse, Atrius employs nurse case managers, hospitalists, clinical pharmacists, social workers, and other ancillary staff. They provide health education and promotion, outreach to patients about recommended screenings, complex care for patients with multiple chronic conditions, programs to prevent avoidable hospital readmissions, and clinical programs in genetics, behavioral health, and nutrition.

“Global payments support integrated, coordinated care that is more efficient and that allows physicians to stay focused on improving their patients' health rather than on how many patient visits they have,” says Lindsey. “With fee-for-service, the focus is often diverted from patient-centered caregiving to considering how our actions will affect revenue.”

Fee-for-service payment requires a visit in order for the system or doctor to be paid, Lindsey points out, whereas with global payments, doctors can make it easier for their patients to stay healthy or to recover their health since many of the critical interactions do not need to occur in a traditional face-to-face encounter.

“Much of what is most important to patient health occurs in the home, the workplace, the community, the restaurants where people eat—all the places

where we make decisions that protect us from, or put us at risk for, chronic conditions, injury, and infectious disease,” Lindsey adds. “With global payments we can fund the web portals, text messaging, phone calls, and ancillary personnel necessary to be with the patient where life is actually being lived—in the ‘space between visits.’”

Dr. Lindsey acknowledges that most smaller physician groups do not have the infrastructure required to participate in global payments. “The funding for health information technology that’s in the federal stimulus bill is a step forward, but money alone is not the answer,” he says. “We need to create new ways of organizing medical care that will efficiently enable smaller practices to benefit from the knowledge, experience, and infrastructure that larger, integrated practices have developed, while maintaining much of the independence that they so highly value.”

MACIPA and Mount Auburn Hospital

The Mount Auburn Cambridge Independent Practice Association (MACIPA) is the physician organization affiliated with Mount Auburn Hospital and the Cambridge Health Alliance. MACIPA has 495 physician members, including primary care and 36 medical and surgical sub-specialties.

The physicians work in diverse settings, including small private offices, large private offices, and hospital-owned practices.

MACIPA has many years of experience with receiving per-patient payments from the state’s major health plans under what are usually referred to as “risk contracts.” The Blue Cross Blue Shield of Massachusetts Alternative Quality Contract is the first long-term contract of its kind that includes substantial quality incentives as well. The MACIPA physicians

share responsibility with Mt. Auburn Hospital for efficiency, and the physicians and hospital are subject to different sets of quality performance measures.

MACIPA’s president, Dr. Barbara Spivak, says that the global payment model creates incentives for clinicians to work better together—to do what is the right thing for each patient—“and when you add meaningful financial incentives, it means the doctors will be rewarded for doing higher quality work more efficiently.”

She continues: “We don’t focus on limiting utilization or on cost-cutting, we manage for quality, which means giving the best care possible. With global payments, we can spend more money in some areas to produce better results, and we have also been able to achieve a surplus at the end of every year. That’s been very helpful in getting our physicians to buy into it. The quality component of the AQC creates an added incentive for practices to help their patients stay healthy and to manage chronic conditions.”

MACIPA created a quality department in 2005 and hired a clinical pharmacist to encourage the use of more generics and help physicians make sure their patients are on the right drugs. For instance, MACIPA is working with Blue Cross Blue Shield of Massachusetts to identify patients who are on 10 or more different drugs in order to prevent harmful drug interactions and also to reduce or combine prescriptions, if possible, so patients can save on their copayments.

MACIPA’s community case managers monitor whether patients are getting recommended care, such as colonoscopies for patients over 50, and whether their asthma or diabetes is under control. Hospital case managers see patients in the hospital, check the home to see if it is set up appropriately,

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make sure patients have a follow-up appointment with their primary care provider (PCP), and stay connected to the patient for a month after discharge. Very frail patients may have home visits from a nurse practitioner or receive regular phone calls. For the most part, these patient-centered services would be reimbursed under a standard fee-for-service payment model.

Dr. Spivak acknowledges that the transition to accepting global payments will require a difficult “culture shift” for many physicians and hospitals.

“Individual physicians and small groups will have to join larger networks, whether they are IPA’s, physician hospital organizations, or accountable care organizations, even if they continue to practice as they are now,” she says. “Physicians and hospitals will need to adjust to a new reality in that they will not be able to negotiate for a higher rate every year. At MACIPA, we’re happy to take on the added financial risk in global payments because we think we can do it better and we can do it ethically, which means better care for patients.”

How Do Global Payments Benefit Patients?

We believe that moving from fee-for-service to global payments will help transform the delivery system and improve quality of care for Massachusetts residents. However, since past efforts to manage costs through fixed “capitation” payments created a strong backlash, it is important to address consumer concerns. Here are the answers to some frequently asked questions about global payments:

Q. *If a health insurance plan adopts global payments, will its members have to change doctors or hospitals; will they be more limited in their choices?*

A. Consumers will have the same choice of doctors and hospitals currently offered by their private or public health insurance plans. Global payments encourage a team approach to care in which each patient has a primary care provider (usually a physician) and receives most of his or her care from physicians and hospitals that are receiving global payments from the individual’s health insurer. Benefit plans like HMO’s align most closely with this model, but health insurers will continue to offer other benefit options and pay on a fee-for-service basis for covered services that are not included in their global payments.

Q. *Will doctors and hospitals have an incentive to choose healthier patients over sicker patients, or to “skimp” on care?*

A. Global payments are “risk-adjusted,” so they are higher for providers who care for sicker patients. In addition, providers are rewarded for high-quality caregiving, so there is no financial benefit in avoiding sicker patients or in providing less care than is needed. In addition, groups accepting global payments will be caring for large, defined populations, so the financial impact of high-cost procedures will be spread out over many patients and many providers. In short, replacing fee-for-service with global payments will help reduce the underuse, overuse and misuse of medical services.

Q. *Will global payments result in lower health care costs for consumers?*

A. We believe that a transformed health care system will be more efficient and more effective, and that the current growth trend in health care spending will come down over time. The savings will be shared by consumers, providers, employers, and government payers.

Priority No.2

PROBLEM: Providers deal with multiple private health plans and public payers, each of which has different processes, standards, practices, and requirements. This results in administrative complexity and unnecessary spending and deters provider efforts to maximize the quality and efficiency of patient care.

SOLUTION: Optimize, simplify, and standardize, where possible, the processes, measures, rules, and regulations that govern relationships between providers and health plans, especially those that affect the quality and cost of care and the patient experience.

Every health care stakeholder in Massachusetts has a role to play in achieving administrative simplification. Without it, our state's progress toward safe, effective, affordable, patient-centered care for all residents will be slowed, if not brought to a standstill.

Physicians and hospitals have long complained about complexity, duplication of effort, and lack of consistency in key areas of their relationships with health insurance plans and government regulators. As the Massachusetts Medical Society has stated, "Health care is replete with administrative requirements that add little value, which drains funds from the active delivery of care to patients."

The lack of standardization causes added costs, delay, and frustration in many areas that are important to health plans, providers, and patients alike, such as claims filing and payment, precertification for certain surgical procedures, prior authorization for high-cost imaging, tiered prescription benefits, and the use of quality data and guidelines.

Administrative Simplification: Finding Common Ground in a Competitive Environment

Collaborative efforts to simplify the administration of health care have been underway in Massachusetts for more than a decade. For example:

- ▶ HealthCare Administrative Solutions, Inc. (HCAS) is a nonprofit entity founded by several Massachusetts health plans to collaborate on administrative simplification initiatives. As its first initiative, HCAS implemented a centralized and streamlined provider credentialing process that gives physicians and ancillary providers a single point-of-entry to submit credentialing information that health plans need in order to verify qualification for participation in their networks.
- ▶ The New England Healthcare EDI Network (NEHEN) is a consortium of regional payers and providers who have designed and implemented a secure, electronic solution for reducing administrative costs. The core NEHEN technology supports the exchange of health care transactions, such as eligibility verification, specialty care referrals, prior authorization and precertification, claim submissions and status inquiries, and electronic remittance, in a low-cost, reliable, standardized manner. There are no transaction fees; instead, members pay a flat monthly fee regardless of how many transactions they exchange.
- ▶ The Employer Action Coalition on Healthcare (EACH) is a community-wide collaborative effort focused on standardizing and simplifying administrative processes. Along with Blue Cross Blue Shield of Massachusetts, participants include the Massachusetts Hospital Association, Massachusetts Medical Society, Massachusetts Association of Health Plans, and various employers. EACH has identified four areas of focus: improving

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the process of eligibility verification, eliminating duplicate claims, establishing a standard method of filing appeals, and standardizing select medical policies.

- ▶ The Patrick Administration has formed HealthyMass, through which state agencies, including the Medicaid program and the Group Insurance Commission, are collaborating to simplify the administration of health care across the Commonwealth and to take steps to reduce duplicative or conflicting regulatory requirements. In addition, Massachusetts law now requires that payers and providers adopt statewide, uniform, billing and coding processes by 2012.

A consultant to the Massachusetts Quality and Cost Council pointed out that system-wide administrative simplification faces at least three significant obstacles: anti-trust concerns if insurers work together without explicit legislative authority, overlapping state and federal regulatory authority and reporting requirements, and the fact that health plans have traditionally sought to differentiate themselves from their competitors in areas where standardization might be desirable.


Given the inherent complexity of the health care system, another fundamental challenge will be to stay focused on simplification and the elimination of wasted administrative effort, while also redesigning health care payment and delivery. There is, however, no choice. Health care must become far easier for patients and providers to navigate in order for the goals of transformation to be fully realized.

Uniform Quality Standards: A Key to Health System Improvement

Hospitals, physician practices, health plans, and public and private purchasers draw upon a wide array of data to drive improvements in quality, safety, value, and service and to recognize and reward exemplary performance. There are still many gaps that need to be filled, however, especially in measuring the outcomes of medical care. And while there is a broad consensus within the health care community that, “if it can’t be measured, it can’t be improved,” there is still wide variation in how data are aggregated, reported, and used.

Massachusetts Health Quality Partners (MHQP), an independent organization backed by a coalition of physicians, hospitals, health plans, purchasers, consumers, academics, and government agencies, took the lead in compiling, analyzing, and reporting evidence-based performance measures, starting a decade ago. Their reports on more than 150 of the state’s primary care physician groups are available online and have become the standard for comparing clinical quality and patients’ ratings of their care. The Massachusetts Health Care Quality and Cost Council contracted with MHQP to produce a plan for developing standardized quality and cost measures that will be displayed on the Council’s consumer website beginning in 2010.

At the national level, a growing number of governmental, research, and medical organizations are engaged in developing quality and patient-safety standards and measures for specialty and hospital care



as well. Many of the current quality reports are based on how well providers adhere to evidence-based clinical guidelines for preventing an illness, treating a condition, managing a chronic condition, or preventing a medical error for the patients under their care—what are called process measures.

The latest stage in the refinement of quality measurement is focused on the outcomes of the care process, that is, on whether the clinical objectives have been achieved on behalf of the patient. For example, diabetes can lead to death or disabilities, but when blood sugar levels are under control, people with diabetes can stay healthy for many years. So, in addition to reporting the percentage of patients with diabetes who have their blood sugar levels regularly tested, MHQP tracks the percentage of diabetic patients who are able to keep their levels within a recommended range; physicians use the data to improve both clinical processes and outcomes.

Quality measures are central to the system improvements that payment reform is expected to bring about, including the development of new, integrated practice models like the patient-centered medical home and accountable care organizations. The data also provide health plans with the basis for tiered provider networks and value-based benefits.

Agreement among all of the state's health care stakeholders on a uniform set of "core measures" and on how they will be used for public reporting and incentive programs will help bring focus to areas of performance where improvement would be most beneficial.

Priority No.3

PROBLEM: Individuals and families are not sufficiently involved in medical decision-making; serious illnesses linked to individual behaviors are increasing at an alarming rate; and consumers feel powerless to manage the cost and quality of their health care in the face of advancing technology and insurance complexity.

SOLUTION: Give patients and families access to the information and support they need to become engaged in improving the health care system, and also equip them to adopt healthier lifestyles, prevent and manage chronic conditions, and play a central role in making decisions about their own health and health care.

Consumers must be active participants in the transformation of our health care system—as advocates for quality and value, as informed purchasers of health insurance and health services, as individuals and families practicing healthier behaviors, and as patients able to gain more control over their chronic conditions. In these roles and many more, members of the public can help build a more effective and affordable health care system.

For a variety of reasons, ranging from the availability of information on the Internet to the growing prevalence of health insurance deductibles,

Fragmentation, complexity, and cost of the health care system create huge obstacles for many people, especially those struggling with the most serious and costly medical conditions.

Americans are becoming more actively involved in their health care. But the fragmentation, complexity, and cost of the health care system create huge obstacles for many people, especially those struggling with the most serious and costly medical conditions.

The National Priorities Partnership, a broad-based coalition of health care stakeholders, has identified patient and family engagement as one of six areas where breakthrough improvements will help transform the health care system.

Specifically, they are developing strategies to ensure that:

- ▶ All patients will be asked for feedback on their experience of care, which health care organizations and their staff will then use to improve care.
- ▶ All patients will have access to tools and support systems that enable them to effectively navigate and manage their care.
- ▶ All patients will have access to information and assistance that enables them to make informed decisions about their treatment options.

Well-designed global payment systems support each of these goals by encouraging providers to be more patient-centered. At the same time, we believe that sustained, broad-based campaigns are needed to educate and involve the public in transforming health care. Consumers who learn how to navigate all aspects of the health care system will be more likely to practice healthy behaviors, follow evidence-based medical advice, and demand improved performance and value.

To that end, we have been strong supporters of the Partnership for Healthcare Excellence (The Partnership), an independent, non-profit coalition of Massachusetts doctors and nurses, employers, insurers, policymakers, and advocacy

groups dedicated to helping consumers improve the quality of their health care. The Partnership's high-level goals are to educate the public about the variations in health care quality, equip patients with the information and tools they need to improve the quality of their own care, and encourage individuals to become advocates for enhancing the safety and effectiveness of the health care system.

The Partnership has developed multimedia campaigns and a dynamic website that includes videos featuring Massachusetts consumers, physicians, and other clinicians talking about the benefits of being an engaged patient. The topics they cover begin with the basics: making the most of your time with your doctor, the importance of keeping a medication list, preventing infections, preparing for surgery, and taking an active role in your health care.

Other Consumer Engagement Initiatives

Blue Cross Blue Shield of Massachusetts offers a suite of products, tools, and wellness programs that support our members in becoming engaged health care consumers, including:

- ▶ Tiered products that include lower copayments for members who utilize high-quality, lower-cost physicians and hospitals

- ▶ Value-based plan designs that use lower copayments and enhanced benefits to support members' use of high-value care, such as preventive services and the careful management of chronic conditions, while discouraging low-value care like unnecessary tests and procedures
- ▶ Consumer-directed, high-deductible products that encourage members to be active and informed consumers of health services

These products are accompanied by online tools that members can use to manage their out-of-pocket costs, pick the best providers for their needs, and understand their treatment options. We also offer wellness programs that reward members for taking screening tests and completing personal health improvement plans. A round-the-clock nurse line is available to members seeking advice on urgent medical concerns and to help them avoid unnecessary visits to hospital emergency rooms.

“ Eighty to 90 percent of the health care we receive in our lifetimes is delivered not in hospitals or doctors' offices, but in our homes ...and not by medical staff, but by ourselves and members of our families. So, the way I look at it, consumers, patients, and family members are among the most powerful and least mobilized stakeholders in the health care system. ”

—James Conway, Senior Vice President, Institute for Healthcare Improvement

Priority No.4

PROBLEM: Hospitals have a key role to play in transforming health care by improving quality and patient safety, yet their trustees are faced with many complex and competing internal and external demands and may not be experienced in managing organizational change related to health care quality.

SOLUTION: Engage and train members of hospitals' Boards of Trustees to become quality and safety champions, to make the connection between quality and financial management, and to mandate accountability for organizational change.

The Institute for Healthcare Improvement (IHI), a leader in helping hospitals become safer and more patient-centered, has identified trustee engagement as a key element in organizational improvement. Citing research on high-performance hospitals, IHI points out that better outcomes are associated with hospitals in which: the Board spends more than 25 percent of its time on quality issues; the Board receives a formal quality performance measurement report; there is a high level of interaction between the Board and the medical staff on quality strategy; senior executives' compensation is based in part on quality performance; and the CEO is identified as the person with the greatest impact on quality.

For several years, Blue Cross Blue Shield of Massachusetts has worked with the Massachusetts Hospital Association and the Center for Healthcare Governance to create and offer an education and engagement program for hospital trustees that centers on the Board's role in improving quality and patient safety. A customizable course was designed to enhance Board members' ability to make the clear connections between their work in the boardroom, the performance of their organization, and the

well-being of patients and the community. To support the widespread use of the education program and the trustees' commitment to eliminating significant gaps in quality performance, we also added a governance measure to the incentive portion of our hospital contracts.

In 2009, we developed two other programs that will run concurrently with the core education course:

- ▶ *Trustee Insight*, an education series, features health care leaders from across the country who share their personal experiences and best practices related to hospital Boards. The sessions are open to Massachusetts trustees, CEOs, and other senior administrative and clinical leaders.
- ▶ *Trustee Advantage* provided \$50,000 grants to five of our network hospitals to aggressively pursue quality and safety improvements. The program offers coaching for each hospital's Board and CEO to bring the leadership to a more advanced stage of quality governance. It also provides the five hospital CEOs and select trustees with the opportunity to participate in a shared learning community.

Conclusion

There is no quick or easy way to transform the Massachusetts health care system, with all its complexity and the myriad interests involved. Furthermore, the task is complicated by the fact that leaders in every sector are struggling with the consequences of the economic downturn and the state's fiscal crisis. However, as the passage and subsequent implementation of the 2006 health care reform law has demonstrated, a spirit of shared responsibility among the stakeholders can yield extraordinary results. In fact, a great deal of foundational work is already being done, building on the momentum that was generated by the previous reform effort. For example:

- ▶ The Employers Action Coalition on Health Care, the Eastern Massachusetts Healthcare Initiative, and Greater Boston Aligning Forces for Quality (AF4Q) bring together employers, insurers, providers, consumers, and academics to work on solving complex problems, such as the fragmentation of care, medical errors, administrative complexity, and racial and ethnic disparities.
- ▶ Consumer, community, and labor organizations like Health Care for All, the Greater Boston Interfaith Organization, and the Service Employees International Union continue to monitor the progress of health reform and press for more affordable, equitable, and accessible care.

- ▶ The Massachusetts Coalition for the Prevention of Medical Errors, whose membership includes state agencies, consumer organizations, hospitals, professional associations for clinicians, health plans, employers, policymakers, and researchers, promotes a systems-oriented approach to improving patient safety, identifying the causes of medical errors, and developing and implementing strategies for prevention.

In order for the state's health care transformation to succeed, stakeholder groups must demonstrate that they can take the next essential step beyond collaboration to reach consensus on what a high-performance health care system should look like in Massachusetts and how to begin building it. In mid-2009, they did just that, through their participation on the Massachusetts Special Commission on the Health Care Payment System.

Just seven months after its first meeting, the Special Commission recommended that global payments should become the norm in Massachusetts within five years. Their report pointed out that, while some provider organizations already accept global payments or are prepared to do so, many more will need to make significant infrastructure, technical, and legal changes. The Special Commission views supporting providers in making this transition as a shared responsibility among all stakeholder groups.



Despite having centers of excellence, [the U.S.] health care system falls short. It fails to produce the outcomes and care it could, wastes resources, often fails to provide the right care at the right time, and delivers unacceptably wide variations in quality and safety.



—The Commonwealth Fund Commission on a High Performance Health System

Conclusion



Under the Special Commission’s recommended transition strategy, provider organizations could “initially shift from fee-for-service to shared savings models in which they would begin to participate in limited risk-sharing arrangements with uniform performance incentives and then, ultimately, to full global payment.”

Building a high-quality, high-value health care system for Massachusetts will require a sustained commitment to transformation. It will also demand legislative and regulatory support in removing barriers that stand in the way. As we outlined in this report, payment reform is not the only priority—we must, at the same time, simplify and standardize the administration of health care, involve the public in improving their health and health care, and engage trustees in focusing hospitals on quality and patient safety.

In short, Massachusetts can and must continue to lead the nation in ensuring that every citizen will have timely access to safe, effective, affordable, patient-centered care. If national health reforms are enacted, our hope is that the law will give an extra boost to the transformative process already underway in Massachusetts. If there is no national reform, our state will be faced with an even more urgent need to accelerate the pace of change. Otherwise, the gains we have made in expanding access to care will be seriously jeopardized by a fragmented health care system that continues to produce rapidly rising health care costs and suboptimal value for everyone concerned.

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Notes



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