



**STATE STRATEGIES TO IMPROVE QUALITY AND EFFICIENCY:  
MAKING THE MOST OF OPPORTUNITIES IN  
NATIONAL HEALTH REFORM**

Jill Rosenthal, Anne Gauthier, and Abigail Arons

December 2010

**ABSTRACT:** There is an acknowledged need for extensive reform to the health care delivery system in the United States. The Patient Protection and Affordable Care Act offers unprecedented opportunities to transform care delivery, with numerous provisions that support systemic improvements. States have an imperative to greatly improve system efficiency if they are to effectively and sustainably implement the law's changes, particularly mandatory coverage expansion. This report examines specific Affordable Care Act provisions that support state system improvement goals and profiles efforts in 10 states: Colorado, Kansas, Maine, Massachusetts, Minnesota, Oregon, Pennsylvania, Rhode Island, Vermont, and Washington. The report highlights the opportunities and challenges that federal health care reform will bring and offers suggestions for how state and national leaders can streamline implementation.

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff. To learn more about new Commonwealth Fund publications when they become available, visit the Fund's Web site and [register to receive e-mail alerts](#). Commonwealth Fund pub. no. 1464.



# CONTENTS

List of Exhibits.....	iv
About the Authors.....	v
Acknowledgments.....	vi
Executive Summary.....	vii
Introduction.....	1
Methodology.....	3
Five Key Components of Improving Quality and Efficiency: How States Are Meeting the Challenge.....	5
Health System Performance Component #1: Data Collection, Aggregation, and Standardization.....	7
Health System Performance Component #2: Public Reporting.....	11
Health System Performance Component #3: Payment Reform.....	14
Health System Performance Component #4: Consumer Engagement.....	17
Health System Performance Component #5: Provider Engagement.....	20
Key Themes from States.....	23
Conclusion.....	25
Appendix A. Profiles of Ten State Multi-Stakeholder Health System Improvement Initiatives	
Colorado.....	27
Kansas.....	29
Maine.....	32
Massachusetts.....	34
Minnesota.....	38
Oregon.....	40
Pennsylvania.....	43
Rhode Island.....	45
Vermont.....	49
Washington.....	51
Appendix B. Key Contacts/Informants.....	55
Notes.....	57

## LIST OF EXHIBITS

Exhibit ES-1.	Current or Developing State Improvement Activities .....	x
Exhibit 1.	Major Affordable Care Act Provisions That Address Five Components of Improving Quality and Efficiency.....	4
Exhibit 2.	Affordable Care Act Provisions Related to State Data Collection and Standardization Goals .....	10
Exhibit 3.	Affordable Care Act Provisions Related to State Public Reporting Goals .....	13
Exhibit 4.	Affordable Care Act Provisions Related to State Payment Reform Goals .....	16
Exhibit 5.	Affordable Care Act Provisions Related to State Consumer Engagement Goals.....	19
Exhibit 6.	Affordable Care Act Provisions Related to State Provider Engagement Goals .....	22

## ABOUT THE AUTHORS

**Jill Rosenthal, M.P.H.**, is a program director at the National Academy for State Health Policy (NASHP), where she directs projects that focus on health systems performance, quality and patient safety, and child health and development. She provides policy analysis and technical assistance to states on these and other issues, including health promotion/disease prevention and health disparities. She currently directs the Assuring Better Child Health and Development (ABCD) III program, an initiative funded by The Commonwealth Fund. Ms. Rosenthal joined NASHP in 2000 after moving to Maine from West Virginia where she served as program manager in that state's Center for Rural Health Development. Previously, she worked as a field director for the West Virginia Bureau for Public Health's Tobacco Control Program. Ms. Rosenthal is a graduate of Colgate University, and holds a master's degree in public health from the University of North Carolina at Chapel Hill.

**Anne Gauthier, M.S.**, is senior fellow at NASHP, where she directs projects on state efforts to improve health system performance, including studies of payment reform innovations, state roles in strengthening primary and chronic care, and accountable care organizations. She is the project director for the Health Resources and Services Administration's State Health Access Program policy assistance contract, which assists 13 states in expanding coverage to new populations, improving enrollment and retention, and implementing delivery and payment reforms. Prior to joining NASHP in July 2009, she was assistant vice president of The Commonwealth Fund and deputy director of the Fund's Commission on a High Performance Health System. Prior to joining the Fund in May 2005, she was vice president of Academy Health. She has also held positions at the National Leadership Commission on Health Care and in the congressional Office of Technology Assessment. Ms. Gauthier holds an M.S. in health administration from the University of Massachusetts School of Public Health. She can be e-mailed at [agauthier@nashp.org](mailto:agauthier@nashp.org).

**Abigail Arons** is a master of public affairs student at the LBJ School of Public Affairs at the University of Texas at Austin, where she is concentrating in health policy. During the writing of this report, she was an intern for NASHP, and has also worked doing research for the Children's Hospital Association of Texas, and the Texas Legislative Council. She holds a B.A. from Smith College in mathematics.

## ACKNOWLEDGMENTS

As this paper is about opportunity and leadership, we first and foremost thank the public- and private-sector officials who have taken bold steps to improve quality and efficiency, for their leadership, their hard work, and their commitment to doing more. We also appreciate their willingness to give generously of their time to share lessons with us through interviews, e-mails, and an interactive conference call. They are listed in [Appendix B](#). We also greatly appreciate the excellent research assistance of Christina Miller, research assistant, and review by Neva Kaye, NASHP senior program director. We thank The Commonwealth Fund for supporting this project, and Ed Schor, the Fund's vice president for State Health Policy and Practices, for his review and comments. Any errors or omissions are those of the authors.

---

*Editorial support was provided by Nandi J. Brown.*

## EXECUTIVE SUMMARY

There is significant opportunity and need to improve health system performance in the United States. Within our own borders there is wide variation in performance across states on indicators of access, quality, and costs, illustrating that although there is much we need to learn, better performance is clearly achievable with targeted policies and actions. Although politicians and the press emphasize the insurance coverage expansions and market reforms in the sweeping health reform bill passed last spring, it is less well known that the Patient Protection and Affordable Care Act of 2010 in fact contains numerous provisions to promote reforms in the health care delivery system itself. Depending on how it is implemented, the law offers a unique opportunity to drive real change in the health care delivery system, so that people across the U.S. receive far better and more affordable care.

States are key players in the implementation of national health care reform. State leaders have an imperative to improve health care system quality and efficiency if they are to effectively and sustainably implement the changes driven by the Affordable Care Act as well as the earlier American Recovery and Reinvestment Act of 2009 (ARRA). This report explores how states can capitalize on the new authority, tools, and resources available through the two laws to reform delivery systems and improve system performance.

The report examines 10 states' initiatives to improve quality and efficiency, and looks at how these states' leaders plan to build on federal health reform in their own improvement efforts. The profiled states—Colorado, Kansas, Maine, Massachusetts, Minnesota, Oregon, Pennsylvania, Rhode Island, Vermont, and Washington—were selected based on 2009 findings indicating that these states were leaders in coordinating quality improvement strategies through public–private partnerships, and that these states' efforts were being integrated into broader state health care reform agendas. This report builds on that 2009 report to address how the profiled states have continued to move forward since the passage of health reform.

The 2009 report suggests five key target areas states can use to improve quality and efficiency: data collection and standardization, data transparency and public reporting, payment reform, and both consumer and provider engagement. This report examines Affordable Care Act provisions most pertinent to addressing these target areas, summarizing how the profiled states have already addressed these target areas and how

they intend to use the new law to continue their reform efforts. For each target area, the report outlines the issue's importance, examines how the profiled states are already addressing the issue, looks at the most applicable provisions, and discusses how the profiled states intend to use the Affordable Care Act to go forward. Exhibit ES-1 summarizes how the states profiled in this report are already addressing aspects of the five necessary components of a quality and efficiency agenda.

State activities to pursue reform include:

- forming task forces and boards to provide governance, rules, regulation, and infrastructure to health reform implementation;
- incorporating new data measures, including meaningful-use requirements, into current data collection efforts;
- exploring new payment reform initiatives and their potential alignment with current state strategies;
- engaging consumers in reform efforts, including providing education and outreach about reform and incorporating consumer input into policies and activities;
- engaging providers in accepting reform's changes, including outreach and education and incorporating provider input into policies and activities;
- investigating exchanges as a mechanism to drive quality and efficiency; and
- collaborating with the federal government, sharing lessons learned from successful projects, and giving input to federal reform policies and activities.

Discussions with state representatives on how to get the most impact from health reform revealed several common themes:

- States see national health care reform as an opportunity to truly transform the health care delivery system in the United States.
- The Affordable Care Act gives states momentum to build on the quality and efficiency efforts they started with ARRA in 2009.
- The act's quality and efficiency provisions should not be divorced from coverage expansion provisions.
- States face staffing and financial challenges in implementing the law's provisions, and they will need support.
- Strong leadership is critical to advancing states' quality improvement agendas.



- National leaders can capitalize on the efforts and lessons of leading states in rolling out quality and efficiency provisions of the Affordable Care Act.

This report provides concrete examples of successful quality improvement efforts, highlighting how interested states can use the momentum of national health care reform to build on past improvement efforts and successes and develop new initiatives. The report also makes the recommendation that national leaders both capitalize on successful state experiences and assist states in rolling out provisions of the Affordable Care Act. Finally, [Appendix A](#) provides more in-depth profiles of the 10 states profiled in this report, highlighting their efforts to improve quality and efficiency in their health systems.

**Exhibit ES-1. Current or Developing State Improvement Activities**

State	Data collection and aggregation		Public reporting and transparency	Payment reform and alignment of financial incentives		Consumer engagement			Provider engagement		
	All-payer claims database	Statewide standardized metrics		Statewide health care Web portal providing data or consumer information	Established payment reform principles	Alternative payment models (e.g., medical homes)	Active consumer representation on advisory boards	Shared decision-making initiatives	Active provider representation on advisory boards	Access to data for internal quality improvement/peer evaluation	Education and technical assistance
Colorado	2	2	2	1	1	1	3	1	2	3	
Kansas	2	1	1	3	2	1	3	1	1	2	
Maine	1	1	1		1	1		1	2	1	
Massachusetts	2	2	1	1	2	1	2	1	2	2	
Minnesota	1	1	2	1	1	1		1	1		
Oregon	2	2	1	3	2	1		1	1		
Pennsylvania		1	3		1	1	1	1	1	1	
Rhode Island	2	1	1	1	1	1		1		1	
Vermont	1	1	2		1	1	1	1	1	1	
Washington	3		1	1	1	1	1	1	1	1	

1=In place.

2=In development.

3=Under consideration.

# **STATE STRATEGIES TO IMPROVE QUALITY AND EFFICIENCY: MAKING THE MOST OF OPPORTUNITIES IN NATIONAL HEALTH REFORM**

## **INTRODUCTION**

There is significant opportunity and a tremendous need to improve health system performance in the United States. The U.S. health care system is the most costly in the world, yet it ranks last or next to last on five dimensions of a high-performance health system: quality, access, efficiency, equity, and healthy lives.<sup>1</sup> Within our own borders, there is wide variation in performance across states on indicators of access, quality, and costs, illustrating that although there is much to learn about improving quality and efficiency, better performance is clearly achievable with targeted policies and actions.<sup>2</sup>

Although politicians and the press emphasize the insurance coverage expansions and market reforms in the sweeping health reform bill passed last spring, it is less well known that the Patient Protection and Affordable Care Act contains numerous provisions that promote delivery system reforms with the potential to have far-reaching effects on performance.<sup>3</sup> Depending on how it is implemented, the law offers a unique opportunity to drive real change in the health care delivery system, so that Americans receive far better and more affordable care.

States have a significant role to play in the implementation of national health reform and new opportunities and tools to improve the quality and efficiency of the health care system. The Affordable Care Act brings many changes, but it also provides for program design, regulation, policy, and practice changes that build on states' already significant health care system reform efforts. It gives states new opportunities—new authority, tools, and resources—that, if adopted successfully, will have a profound effect on the ultimate success of reform in providing affordable quality care. States also have an imperative to improve quality and efficiency if they are to effectively and sustainably implement the components of reform that expand coverage and access to care. Affordable Care Act provisions offer both the opportunity and the obligation to not only cover more people but to be intentional about shaping the delivery system in a way that promotes efficient, high-quality care. According to state leaders, “demanding quality and efficiency from the health care system” is one of 10 aspects of federal health reform that states must get right if their reform efforts are to be successful.<sup>4</sup>

At the same time that states view delivery system reforms as essential to the overall success of health reform, they face challenges in implementing the new law. Many states face severe budget constraints that limit their ability to even conduct daily

business, let alone launch broad new initiatives. Leaders in these states may feel compelled to focus scarce resources on the Affordable Care Act's mandatory coverage and access components rather than on the optional delivery system reforms. However, the opportunity is there for states to expand coverage while still making tangible system improvements. Among other techniques, states profiled in this report are maximizing scant local resources by using public-private partnerships to coordinate and conduct quality improvement efforts. These partnerships strive to achieve targeted care delivery system improvements using performance measurement, data transparency, payment reform, and consumer and provider engagement at the clinical and policy levels.<sup>5</sup> These efforts are being integrated into broader state health care reform agendas.

The purpose of this report is to explore how states can capitalize on the Affordable Care Act, and on 2009's American Recovery and Reinvestment Act (ARRA), to reform delivery systems and improve system performance. The report highlights initiatives from 10 states previously identified as leaders in using public-private partnerships to advance quality improvement, examining these states' anticipated challenges and perceived opportunities to use federal health reform to move forward. The report provides specific ideas for how other states can capitalize on the new legislation to make substantial quality and efficiency improvements in their health care systems. And it provides key examples to inform the federal guidance and regulations that will be needed to implement the bill.

This report examines the Affordable Care Act and state reform efforts through the framework of five target areas that must be addressed if true care delivery system improvement efforts are to succeed. The states profiled in this report were selected in part because of their efforts in addressing these five key components of improving quality and efficiency:

- data collection, aggregation, and standardization, for performance measurement;
- public reporting and transparency of data, to drive accountability;
- payment reform and alignment of financial incentives, to encourage value-based purchasing;
- consumer engagement, to drive policy change and to encourage care self-management; and
- provider engagement, to drive policy change and to transform care delivery on the ground.<sup>6,7</sup>

## Methodology

National Academy for State Health Policy (NASHP) staff began this project by revisiting a report issued in June 2009 that highlighted the accomplishments of and lessons learned from quality improvement partnerships in 10 states—Colorado, Kansas, Maine, Massachusetts, Minnesota, Oregon, Pennsylvania, Rhode Island, Vermont, and Washington. These states were chosen as leaders in establishing broad-based partnerships, most with both public- and private-sector representation and long-term commitments, and all with transparent agendas and the intent to make systemic, statewide improvements in care delivery.<sup>8</sup> Many of the profiled partnerships were already linked to broader state health reform initiatives at that time. NASHP staff reviewed the Affordable Care Act to identify provisions most closely related to quality and efficiency and categorized the provisions according to the five-component framework from the June 2009 report.

Using this framework, NASHP contacted a public-sector representative in each the 10 states profiled in the previous report to get updates on their initiatives, identify progress in each of five strategic areas, and explore their plans to incorporate newly available opportunities into ongoing quality improvement initiatives (see [Appendix A](#) for profiles of each state). After gathering input from the states, NASHP convened a conference call of representatives from these states to discuss 1) the areas of the Affordable Care Act's greatest impact on state quality improvement agendas and activities, 2) the opportunities and challenges that states foresee health reform presenting to quality improvement initiatives, and 3) what states want from the federal government as health care reform rolls out quality improvement initiatives (see [Appendix B](#) for state contacts). The profiled states reviewed a draft of this report and provided comments prior to its completion.

Exhibit 1 outlines major quality improvement provisions of the Affordable Care Act in the context of how they address the five components identified as key for improving health system performance. The fact that all noted provisions address more than one target area illustrates how these components are interconnected (for example, data is necessary for measuring performance, and consumers can use publicly reported data to make informed decisions about providers).

**Exhibit 1. Major Affordable Care Act Provisions That Address Five Components of Improving Quality and Efficiency**

	Data collection, aggregation, and standardization	Public reporting	Payment reform and alignment of financial incentives	Consumer engagement	Provider engagement
<b>New entities created in the Affordable Care Act</b>					
Center for Quality Improvement and Patient Safety	✓	✓	✓	✓	✓
Interagency Working Group on Health Care Quality	✓		✓	✓	✓
Patient-Centered Outcomes Research Institute	✓	✓			✓
Center for Medicare and Medicaid Innovation			✓	✓	
Independent Payment Advisory Board		✓	✓	✓	✓
<b>New initiatives launched by the Affordable Care Act</b>					
National Strategy to Improve Health Care Quality	✓	✓	✓	✓	✓
Medicaid Quality Measurement Program	✓	✓	✓		
Program to Facilitate Shared Decision-Making				✓	✓
<b>Other pertinent themes</b>					
Hospital-acquired conditions	✓	✓	✓	✓	✓
Value-based purchasing	✓	✓	✓		✓
Innovative payment models	✓	✓	✓		✓
Payments and penalties under the physician quality reporting initiative	✓	✓		✓	✓
Standardized quality measures	✓	✓	✓	✓	✓

## **FIVE KEY COMPONENTS OF IMPROVING QUALITY AND EFFICIENCY: HOW STATES ARE MEETING THE CHALLENGE**

This section uses the framework of the five key components states can use to improve quality and efficiency to look at how states are already addressing the specific challenges, as well as how they intend to use the Affordable Care Act to build on their efforts. For each component, there is a brief introduction to the issue, examples of how profiled states are approaching the issue, the opportunities and challenges presented by national health reform, a table summarizing state goals for addressing the issue and the most pertinent reform provisions, and examples of how profiled states plan to build on, expand, and integrate their activities as the result of national health reform.

One overarching goal that nearly all health care system stakeholders share is the coordination of resources and activities across stakeholder groups rather than the fragmented and frequently duplicative care delivery systems currently in place; there is broad recognition of the need to align the multitude of payers, providers, and systems of care in the United States in order to improve system performance. In enacting the Affordable Care Act, lawmakers recognized the need to coordinate and align strategies at the federal level, and to partner with the private sector and with states to improve health care quality and efficiency.

The 10 states profiled in this report have developed statewide goals and coordinated health policy agendas for improving health care quality and system efficiency.<sup>9</sup> These states recognize that broad-based partnerships can create a critical mass of stakeholders who can be strategic and intentional about approaches to improving quality and value in the health care system. They rely on strong thought leaders, commit to transparent processes and projects, and strive for long-term sustainability. They share a dedication to multi-stakeholder and public–private collaboration, and believe that improving the health system depends on the input and participation of differing perspectives and the ability to draw from countless skill sets and areas of expertise.<sup>10</sup>

The states profiled in this report have already recognized the value of collaboration across agencies and branches of government, as well as with the private sector, to improve system performance. The Affordable Care Act contains a number of provisions that address the goal of increased coordination:

- The National Strategy to Improve Health Care Quality will emphasize quality and efficiency in the health care delivery system, and establish priorities for system improvement (Section 3011(a)). State and federal agencies, with private-sector input, will develop a plan to implement the strategy (Section 3011(b)).

- The Center for Quality Improvement and Patient Safety, to be established through the Agency for Healthcare Research and Quality (AHRQ), will identify best practices, develop tools, disseminate information, and build capacity at the state and local level. The center will award grants for technical assistance and project support (Section 3501).
- The Interagency Working Group on Health Care Quality will coordinate reform efforts (to avoid duplication), develop streamlined processes for reporting and compliance, and assess the alignment of efforts in the public and private sectors (Section 3012).

State public–private quality improvement partnerships are using their experience in coordinating and aligning strategies to prepare for health reform opportunities. Perhaps as critically, they are examining how their quality improvement and system performance initiatives relate to other aspects of health reform. For instance, although this report focuses on the Affordable Care Act, many of the profiled states viewed the American Recovery and Reinvestment Act of 2009 (ARRA) as the first step in national health reform. ARRA’s Health Information Technology for Economic and Clinical Health (HITECH) Act allocated more than \$49 billion for federal investments in health information technology (HIT). It established a new office within the Department of Health and Human Services (HHS): the Office of the National Coordinator for Health Information Technology (ONC), which is charged with distributing funds, through Medicare and Medicaid, to support and incentivize HIT adoption. Many data collection and standardization initiatives mentioned by profiled states were supported through ARRA, and state leaders are leveraging momentum to prepare for implementation of the Affordable Care Act.

In addition to coordination with information technology and health information exchange (HIE) initiatives, states recognize that delivery system reform is critical to the overall success of health reform. As states develop exchanges and expand Medicaid eligibility, they will face increased financial challenges, and expanding coverage will be contingent on the ability to improve quality and contain costs. As such, it is increasingly important for states to have a coordinated and streamlined approach to responding effectively to health care reform. The examples that follow describe how states are building on their existing partnerships and integrating quality and efficiency agendas into broader health reform initiatives:

**Colorado** created the Interagency Health Reform Implementation Board to provide governance, rules and regulations, and the administrative infrastructure to facilitate



planning for Affordable Care Act implementation. The board comprises cabinet members and a director of health reform implementation. Subject-specific task groups will be formed as needed and existing boards and commissions will be included for advisory purposes. CIVHC, Colorado's Center for Improving Value in Health Care, is working closely with the board to identify its role in the implementation process; CIVHC will likely be responsible for most of the payment reform activities in the federal law. CIVHC is also closely monitoring the Affordable Care Act for strategies that intersect with its statewide work on engaging consumers, redesigning the delivery system, and increasing access to data.

**Maine's** State Health Plan charges two executive branch entities, the Steering Committee on Health Reform and the Advisory Council on Health Systems Development, with analyzing the federal law and making recommendations to the incoming administration and the Joint Select Committee on Health Reform. Of the steering committee's five core charges, one focuses on delivery system and payment reform. The steering committee and advisory council will develop criteria to prioritize grant opportunities; the criteria might include "priority in the State Health Plan, related initiatives under way in Maine, broad coalition of support, level of state funding required (lower is better)."<sup>11</sup>

**Pennsylvania's** Governor Rendell used an executive order to create the Health Care Reform Implementation Advisory Committee, made up of cabinet members, stakeholders, and members of the four legislative caucuses.

**Washington** State's Governor Gregoire used an executive order in April 2010 to establish the Health Care Cabinet to oversee federal health reform implementation. Among the cabinet's charges are maintaining key partnerships, such as that with the Puget Sound Health Alliance; developing a plan to consolidate duties, functions, and powers with respect to public purchasing of health care; and "assuring ongoing information sharing and coordination of efforts with the Office of Insurance Commissioner so that delivery system improvements are coordinated with insurance reforms."<sup>12</sup>

### **Health System Performance Component #1: Data Collection, Aggregation, and Standardization**

Measuring performance is the foundation on which quality improvement efforts are based: data drives improvement and accountability. Access to data is considered critical to engaging stakeholders, encouraging adoption of evidence-based practices, driving

value-based purchasing, and informing consumers in their efforts to select high-quality care, and data will be increasingly important to successful health reform implementation.

Profiled states have found mechanisms to aggregate data across systems, to assess performance of the health care system overall, develop priorities for improvement, track improvement over time, report on provider and health plan performance and quality of care, and monitor population health. Four of the states profiled in this report (Maine, Massachusetts, Minnesota, and Vermont) have developed all-payer claims databases, and four (Colorado, Oregon, Rhode Island, Washington) are in the process of developing one. In addition, seven states (Kansas, Maine, Massachusetts, Minnesota, Pennsylvania, Rhode Island, and Vermont) have statewide standardized metrics and two states (Colorado and Oregon) are in the development process. Their progress in streamlining and coordinating data will help these states prepare for health reform.

Examples of state approaches to data collection, aggregation, and standardization prior to the Affordable Care Act include:

- As part of a 2007 administrative simplification bill, **Minnesota** will require the use of interoperable electronic health records (EHRs) by 2015.<sup>13</sup> After passing its 2008 state health reform bill, Minnesota began developing a statewide standardized quality reporting system. Measures are based on existing indicators, with an emphasis on outcomes rather than process; the state sought to select measures that would not place a large administrative burden on providers. Clinics and hospitals were required to begin reporting on the measures in January 2010. In addition, Minnesota developed the Provider Peer Grouping, a composite measure that compares providers on overall value (including quality and cost); data collection began in July 2009. Finally, Minnesota developed standard quality reporting measures for its “baskets of care” bundled payment initiative (see [Appendix A](#) for a description of Minnesota’s baskets-of-care initiative).
- **Vermont’s** evaluation infrastructure is based on various levels of data, with each level aggregated in its own multipayer database. First, the centralized clinical registry compiles common elements from EHRs across the state’s providers; the goal of the registry is to use the same data that is collected in everyday clinical practice to drive evaluation and improvement. Second, the database is an aggregated central repository for claims data from all commercial payers and Medicaid, and the state seeks to include Medicare data as well. Next, Vermont conducts statewide chart reviews, along with National Committee for Quality

Assurance (NCQA) scoring; the state contracts with the University of Vermont as an independent and objective NCQA scorer. Vermont anticipates eliminating chart reviews and NCQA scoring once the centralized clinical registry is fully functioning and comprehensive. Finally, the state maintains a number of statewide public health registries to track patterns of prevalence and utilization; unlike many other states, Vermont wants to develop its public health registries to be interoperable with its other health care data systems.

*Health Reform Challenges and Opportunities.* Despite some success, states face challenges in the lack of standardized measures, incomplete data sets where there are any data at all, and a lack of streamlined data aggregation. They also continue to struggle with a lack of access to Medicare data. Among other changes, the Affordable Care Act is expected to lead to the development of new provider-level quality measures, the selection of a core set of quality measures for adult health care under Medicaid, and the release of Medicare claims data. If requirements and incentives for reporting data are developed, states may be enabled to more accurately measure population health.

States react positively to the fact that national health reform advances efforts to tie EHRs into performance reporting. EHRs are a potentially disruptive technology that can move the delivery system to a preventive, population-based management focus rather than a disease-based system. The quality reporting required from providers as part of HIE and HIT meaningful-use criteria, along with the coverage expansions, will generate new data to support quality and efficiency improvements. According to a September 2010 Commonwealth Fund publication, states with all-payer data sets will have critical trend data to guide health care reform transitions and will be well positioned to respond to health care reform challenges.<sup>14</sup> States can use the Affordable Care Act to update strategic and operational HIE plans developed under ARRA; these updates would reflect the new data provisions and refine the approach to placing subsets of data in the public domain to be used to drive improvement.<sup>15</sup>

Regarding data collection challenges under health care reform, states express concern that small practices in rural areas will be unable to keep up with both HIT implementation and reporting requirements, especially when required reporting will include quality and efficiency metrics in addition to claims data.

Exhibit 2 looks at state data collection, aggregation, and standardization goals and the Affordable Care Act provisions that offer the best opportunities or challenges for

states to achieve their goals. In particular, states would like the authority to create standard measures, obtain complete data sets, and streamline data aggregation.

**Exhibit 2. Affordable Care Act Provisions Related to State Data Collection and Standardization Goals**

<b>State goal</b>	<b>Related Affordable Care Act provision</b>
<b>Creation of standard measures</b>	<p>AHRQ will set priorities and fund the development of new provider-level quality measures for acute and chronic primary and preventive care. Emphasis will be placed on metrics for which data can be easily collected and freely and publicly available (Section 3013).</p> <p>Multiple stakeholders will convene to establish a quality measure development process and to select and review measures for reporting and payment in federal programs (Section 3013(a)(1), as modified by 10304).</p> <p>The new Medicaid Quality Measurement Program will develop and select a core set of quality measures for adult health care under Medicaid (Section 2701).</p>
<b>More complete data sets, to allow population-based approaches</b>	<p>Medicare claims data will be released, for the purpose of evaluating provider and supplier performance (Section 10332).</p> <p>Incentive payments for physicians to report under the Physician Quality Reporting Initiative will continue, and a new penalty will be imposed on physicians who fail to adequately report data (Section 3002(a)-(b)).</p> <p>Various entities will be required to report quality data for value-based purchasing. These include critical-access hospitals, ambulatory surgical centers, long-term care facilities, inpatient rehabilitation and psychiatric facilities, hospice providers, certain cancer hospitals, and participants in certain demonstration projects (Sections 2703, 3001(b)(1), 3004, 3005, 3006, as modified by 10301, and 3401(f), as modified by 10322(a)).</p> <p>Health plans participating in exchanges will be required to create a quality improvement strategy that includes quality reporting (Section 1311(g)(1)(A)).</p> <p>HHS and the Centers for Disease Control and Prevention will issue a national (and state) Diabetes Report Card, aggregating data on quality of care and outcomes for patients with diabetes, to be used to inform policy decisions (Section 10407(b)).</p>
<b>Streamlined data aggregation</b>	<p>Federal and state program data, including certain quality measures, will be integrated into a single “program integrity” database (Section 6402(a)).</p> <p>Quality reporting will be integrated with the use of electronic health records (Section 3002(d)).</p>

Examples of state plans to align their data collection, aggregation, and standardization efforts with the Affordable Care Act include:

- **Kansas** plans to incorporate the new national measures developed through health reform and the newly available Medicare data into its comprehensive set of

indicators administered by the Kansas Health Policy Authority's Data Consortium. Data collection started in 2009, and the collected data are used to drive data-driven decision-making around quality and efficiency, access to care, affordability and sustainability, and health and wellness.

- **Oregon** anticipates drawing on new national quality metrics in the creation of its state quality scorecard and in its public purchasing initiative. Oregon is particularly interested in the national health reform provisions that require linking quality reporting to HIT, because ARRA incentives for HIT adoption should help to speed their ability to obtain this information. Oregon is working with its regional extension center grantee, its Office of Rural Health, and provider organizations to help keep rural practices from falling behind.
- **Pennsylvania** will incorporate national measures resulting from the Affordable Care Act into its learning collaborative efforts. Practices participating in the learning collaboratives agree to regularly report on pre-specified quality measures to guide their improvement efforts.
- **Rhode Island** foresees working with the Rhode Island Quality Institute under a federal Beacon Community Cooperative Agreement grant to enhance HIT infrastructure.<sup>16</sup> In this partnership, Rhode Island is developing and implementing an all-payer claims database under the statutory authority of the Department of Health to enhance transparency, ensure the successful implementation of the Affordable Care Act, and evaluate the impact of changes in the state's health care delivery system.

### **Health System Performance Component #2: Public Reporting**

Transparency through public reporting of quality and cost data drives change by helping providers see benchmarks of and variations in performance measures while also assisting patients in making informed decisions about care. Public reports enable comparisons on procedures and outcomes, enhance knowledge about mechanisms to improve health care quality, and provide incentives for providers to invest in and improve quality.

Profiled states have expanded public reporting beyond acute-care settings, and developed coordinated strategies to publicly report various sources of data in a meaningful way. Kansas, Maine, Massachusetts, and Oregon have developed statewide dashboards, and Colorado, Minnesota, Vermont are in the process of doing so. State efforts to publicly report data align with the intent of the Affordable Care Act to increase

transparency of quality and cost data. While Washington State does not own the Web site run by the Puget Sound Health Alliance, the state endorses the site and reports data through it.

Examples of state-coordinated approaches to public reporting and data transparency prior to federal health reform include:

- **Colorado:** The key statewide metrics selected by CIVHC's data and transparency advisory group will be the basis for a statewide dashboard to be rolled out in fall 2011. CIVHC is also responsible for implementation of a statewide all-payer claims database, from which data will be consolidated with other metrics in order to create a single Web site where consumers can obtain information on health care value; the site will present both cost and quality metrics.
- **Massachusetts:** The Health Care Quality and Cost Council (HCQCC) maintains a consumer-friendly Web site, called *My Health Care Options* (<http://hcqcc.hcf.state.ma.us/>), which includes quality and cost measures collected from acute-care hospital providers. Currently Massachusetts uses a database of fully insured claims to populate *My Health Care Options* but will begin using all-payer claims data once it is available. The cost measures display the median paid amount for a procedure at a particular hospital and include text to help consumers understand what that dollar amount means to them. Massachusetts plans to add Serious Reportable Event data to the site in 2010.

*Health Reform Challenges and Opportunities.* Despite recognition of its importance, information that consumers, providers, and purchasers need to inform decisions may not be publicly available. The Affordable Care Act includes provisions to make available new kinds of information on the quality of physician and hospital care. It may also help to expand publicly reported data beyond acute-care facilities (e.g., ambulatory surgical centers, long-term care facilities, and inpatient rehabilitation and psychiatric facilities); states have strong interest in reporting on these data.

Already consumers and purchasers find it challenging to use the disparate and somewhat limited currently available public data to make informed decisions. If the Affordable Care Act's public reporting provisions create a parallel system or compete with state efforts to align and simplify publicly available quality data, there may be even more consumer confusion. States question how new federal reporting will relate to state measures and advise national policymakers to consider developing mechanisms for

linking data. Although states intend to move forward with planned public reporting initiatives, they fear that in the future they will need to realign efforts to coincide with federal reform.

Exhibit 3 describes reform provisions that relate to states’ desire for publicly reported data.

**Exhibit 3. Affordable Care Act Provisions Related to State Public Reporting Goals**

State goal	Related Affordable Care Act provision
<p><b>Publicly reported data to inform decision-making</b></p>	<p>The Department of Health and Human Services (HHS) will collect, aggregate, and publicly report data on quality and resource use, and publish summarized quality data (provider- and condition-specific) on public Web sites (Section 3015).</p> <p>HHS will develop Physician Compare, a Web site where Medicare beneficiaries will be able to view quality and patient experience measures for physicians (Section 10331).</p> <p>The Independent Payment and Advisory Board will issue annual reports on access, cost, and quality of health care for Medicare beneficiaries (Section 3403(a)).</p> <p>Health plans participating in exchanges will be required to create a quality improvement strategy that includes quality reporting (Section 1311(g)(1)(A)).</p> <p>Financial relationships among providers, suppliers, and manufacturers will be publicly disclosed (Section 6002).</p> <p>Data from newly created quality reporting initiatives will be publicly available (Sections 2703, 3001(b)(1), 3004, 3005, 3006, as modified by 10301, and 3401(f), as modified by 10322(a)).</p> <p>The Centers for Medicare and Medicaid Services (CMS) will publicly report the hospital-acquired condition data it already collects (Sections 3013(b), as amended by 10303(b)).</p>

Examples of state plans to align their public reporting and transparency initiatives with the Affordable Care Act include:

- **Kansas**’s health indicator/measure data are publicly available through an online dashboard, which presents state- and county-level data as well as national and peer-state benchmarks for comparison. Kansas is investing in a user-friendly database that integrates data from multiple sources, and anticipates great interest in the Physician Compare Web site that is to be developed at the national level.
- **Pennsylvania** plans to work toward making new quality measures available to the public for the practices in its learning collaboratives, which are making

infrastructure and care delivery improvements through implementation of a patient-centered medical home and chronic care model.

### **Health System Performance Component #3: Payment Reform**

Reforming payment systems and aligning financial incentives through medical home, accountable care organization (ACO), and other models, rewards the delivery of high-quality health care. Payment reform initiatives also provide financial incentives for placing greater emphasis on primary care, disease prevention, patient-centered care, and care coordination. A recent survey of national opinion leaders found that special payment arrangements and incentives like those in the Affordable Care Act will be critical to fostering system integration.<sup>17</sup>

Profiled states have supported and streamlined payment reform initiatives to encourage broad-scale reform. It is widely recognized that payment and delivery system reform requires the participation of all payers, and all of the profiled states are in planning or implementation stages of pilot-testing and expanding public-private multipayer payment reform strategies. They are investigating medical home and chronic care models, ACOs, and other models of bundled and global payments to improve care coordination and reduce preventable hospitalizations and readmissions. Colorado, Massachusetts, and Oregon are in various stages of planning comprehensive payment reform strategies. In addition to bringing the state's leverage as a purchaser to these initiatives, a number of states are also using or exploring regulatory approaches to aligning financial incentives with high value. These initiatives will prepare states to apply for payment reform demonstrations and pilots that are part of the Affordable Care Act, and to align their current purchasing power within Medicaid, Children's Health Insurance Plan, and public employee benefits programs with the new exchanges.

Examples of state approaches to payment reform and alignment of financial incentives prior to federal health reform include:

- **Minnesota** is designing a bundled payment program as part of state health reform. The state developed seven "baskets of care," a collection of services that would be paid for separately under a fee-for-service system but that providers usually combine in delivering a full diagnostic or treatment procedure. Minnesota's state health reform also called for a statewide health care home approach, which will be used as a foundation for ACOs. The state also takes part in efforts to align and standardize quality incentive payments through participation in such groups as Bridges to Excellence.



- **Pennsylvania**'s Chronic Care Initiative continues as a multipayer partnership, with support from all large payers (commercial, Medicaid, and Medicare Advantage), except Medicare fee-for-service. The three most recent learning collaboratives are funded by small state start-up grants only. Chronic Care Initiative practices and payers make a three-year commitment to participating in regional learning collaboratives that are implementing a combination of patient-centered medical home and chronic care models. Pennsylvania is using four payment models in the learning collaboratives.
- Much of **Rhode Island**'s payment reform activity has taken place through the Office of the Health Insurance Commissioner (OHIC) and Medicaid:
  - OHIC required health plans to double the percentage of their medical spending that supports primary care within the next five years.
  - OHIC leads Rhode Island's multipayer medical home initiative, the Chronic Care Sustainability Initiative, with support from and the participation of Medicaid and the Department of Health. All commercial plans and Medicaid pay participating primary care practices across the state on a per-member per-month basis to support advanced medical home activities, with a bonus for providers based on metrics tied to chronic care and shared financing by payers of nurses hired by the practices to coordinate care. Evaluation results show significant improvement on performance measures, especially for diabetes, and decreases in emergency room visits and hospitalizations.
  - Medicaid's pay-for-performance contracts pay health plans for quality improvement and efficiency.

*Health Reform Challenges and Opportunities.* Despite state efforts to develop and test coordinated payment reform models, the lack of participation by Medicare has hindered their efforts to affect broader systems change. Many states hope to include Medicare, along with Medicaid and private plans, in future payment reform efforts that might be supported by Affordable Care Act funds. The act includes provisions to support primary care by increasing Medicaid and Medicare primary care payment rates.

Health reform tools include pilots and demonstrations of a variety of models as well as the broad authority held by the Center for Medicare and Medicaid Innovation. States expressed interest in building on their current Medicaid and multipayer demonstration activities to test bundled payments, global capitated payments, and

pediatric accountable care organizations as well as in the new Medicare pilot for bundled payments.

States expressed several concerns about the roll-out of Affordable Care Act payment reforms and the potential for lack of a coordinated approach. There is concern that participation in Medicare’s medical home pilot might preclude participation in another project with an overlapping population, or that federal guidelines will conflict with rather than build on current state payment reform approaches. Given the urgency for payment reform, states felt that payment and care redesign should have higher priority than evaluation purity and fear of polluting the physician group practice demonstration. Otherwise the federal government, while attempting to build on state experiences, in effect will hold states back.

Exhibit 4 describes Affordable Care Act provisions that pertain to state payment reform goals. State goals relate to availability of innovative and tested payment reform models, Medicare participation in payment reform, and financial incentives to reduce hospital-acquired conditions.

**Exhibit 4. Affordable Care Act Provisions Related to State Payment Reform Goals**

<b>State goal</b>	<b>Related Affordable Care Act provision</b>
<b>Innovative and tested payment reform models</b>	<p>The new Center for Medicare and Medicaid Innovation at CMS will test new payment models, focusing on quality improvement and cost (Section 3021).</p> <p>States will have an option to implement a health home program for individuals with chronic conditions, to include a team of health professionals providing coordinated care (Section 2703).</p> <p>HHS is permitted to develop guidelines for insurance plans to offer value-based benefit design (Section 1001).</p> <p>HHS will establish Medicaid demonstration projects to test bundled payments, global capitated payments, and pediatric ACOs (Sections 2705, 2706 and 3023, as modified by 10308).</p>
<b>Medicare participation in payment reform</b>	<p>Medicare payments to certain providers will be adjusted to account for productivity (Section 3401).</p> <p>A modifier based on value (quality in relation to cost) will be added to the Medicare fee-for-service physician payment formula (Section 3007).</p> <p>HHS will implement value-based purchasing programs for Medicare payments to acute-care hospitals (Section 3001(a)).</p> <p>HHS will develop plans or pilot programs to use value-based purchasing for Medicare payments to other facilities, including skilled nursing facilities, home health agencies, and ambulatory surgical centers. HHS will implement demonstration projects to test value-based purchasing at critical-access hospitals (Sections 3001(b), 3006, as modified by 10301, and 10326).</p>

	<p>The Independent Payment Advisory Board will develop proposals to improve the quality of care in Medicare (Section 3403(a)).</p> <p>The new Medicare Shared Savings Program will permit providers to organize into an ACO (Section 3022).</p> <p>HHS will establish a Medicare pilot for bundled payments (Section 3023, as modified by 10308).</p>
<b>Financial incentives to reduce hospital-acquired conditions</b>	<p>HHS will reduce Medicare payments for services related to preventable readmissions and hospital-acquired conditions at low-performing hospitals (Sections 3008 and 3025, as modified by 10309).</p> <p>Neither the federal government nor state governments will make Medicaid payments for hospital-acquired conditions (Section 2702).</p>

Examples of state plans to align payment reform strategies with the Affordable Care Act include:

- **Maine** is looking to capitalize on the development of exchanges as an additional vehicle for its payment reform agenda.
- **Massachusetts** seeks to work with the federal government so that lessons learned from its ACO and bundled payment pilots will be used to inform the design of pilots called for in the Affordable Care Act.
- **Oregon** notes that federal reform provisions addressing health care-acquired infections will provide increased direction and support for current work in patient safety. Oregon is also combining purchasing power in its new Health Care Authority that will include all state coverage programs and the state employee health plan. Its Health Policy Board Committee on Incentives and Outcomes is designing a payment reform strategy for the state and anticipates taking advantage of federal pilot programs.

#### **Health System Performance Component #4: Consumer Engagement**

Consumers can drive health care quality and efficiency improvements as active stakeholders in quality improvement initiatives and through the decisions they make as patients and family members, and states need input from consumers who will be affected by policies and programs. Also, patient self-management will be essential to achieving costs savings anticipated through medical home and chronic care initiatives.

Profiled states involve consumers in strategic planning as members of advisory boards and work groups; design and make available information to educate and support consumers in making decisions about their care; and provide tools to encourage active involvement of patients in monitoring chronic conditions. Maine and Oregon have

capitalized on Aligning Forces for Quality (AF4Q) grants to support consumer involvement in broader initiatives. State leaders recognize that as health reform is implemented, consumer feedback will become even more critical for ensuring that new policies and programs reflect the needs of the public.

Examples of state approaches to engaging consumers prior to the Affordable Care Act include:

- **Colorado:** A key long-term objective for CIVHC is that all initiatives will contribute to a consumer-centered experience. CIVHC created an advisory group dedicated to engaging consumers and improving access to patient-centered care. Representatives from this advisory group also sit on other CIVHC advisory groups to provide a “consumer lens” for all decisions and recommendations. As an example, consumer groups on the payment reform advisory group work to ensure that patients’ needs will be addressed under any approach to payment reform.
- **Massachusetts** engages consumers explicitly as with representation on the HCQCC advisory council. Also, its 2009 Roadmap to Cost Containment explicitly recommended consumer engagement as one of the 11 outlined strategies; consumer engagement includes a multifaceted campaign to increase awareness of the health care system in general and of specific treatment options for individual care. As part of Chapter 305 of the Acts of 2010, HCQCC convened an Expert Panel in End-of-Life Care. The panel released a draft of its recommendations in February 2010, with suggestions including next steps for implementing a patient-centered end-of-life care delivery system based on best practices.<sup>18</sup>
- **Washington** became the first state to establish a “Shared Decision Making/ Patient Decisions Aids” demonstration project, through legislation in 2007. Washington convened a multi-stakeholder shared decision-making collaborative and developed plans for two patient decision aid pilot projects. One pilot began in January 2009 and the second in January 2010. Washington plans to evaluate the effect of both pilots on utilization and costs, and to evaluate the return on investment of the patient decisions aids.

*Health Reform Challenges and Opportunities.* Despite efforts to engage consumers, states have struggled to find ways for consumers to become a driving force

for quality improvement. The Affordable Care Act will encourage more widespread inclusion of consumers in decision-making at various levels. In addition to funding state ombudsman offices and consumer assistance programs to support consumers in understanding their health care options, the act provides opportunities to further attract consumer attention by reporting on patient experience measures, encouraging best practice models in shared decision-making, and including consumers in planning.

Despite enormous opportunity in the health reform law for states to empower consumers as allies, there is concern that health reform could be perceived as limiting choice. Public messaging, education, and outreach will be critical.

Exhibit 5 describes state goals in consumer engagement to drive change and encourage care self-management and the reform components that may offer opportunities or challenges to advance their initiatives in this area. State goals relate to inclusion of consumers in strategy development and tools to help consumers make informed decisions.

**Exhibit 5. Affordable Care Act Provisions Related to State Consumer Engagement Goals**

<b>State goal</b>	<b>Related Affordable Care Act provision</b>
<b>Inclusion of consumers in quality improvement strategy development</b>	A consumer advisory council will advise the Independent Payment Advisory Board on the impact of payment reforms on consumers (Section 3403, as modified by 10320).  Exchanges will be required to engage consumers (Section 1311(d)(4), (i)(3)).
<b>New or improved tools to help consumers with informed decision-making</b>	HHS will require health plans participating in exchanges to develop a quality improvement plan that includes patient-centered education (Section 1311(g)(1)(B)).  The new Program to Facilitate Shared Decision-Making will award grants to develop standards for patient decision aids, and to disseminate best practices for shared decision-making (Section 3506).  The Center for Medicare and Medicaid Innovation will be authorized to test payment models that support shared decision-making, according to the standards developed by the new shared decision-making program (Section 3021).  The Patient Navigator grant program will continue, with a newly extended grant duration, and new minimum core proficiencies for patient navigators receiving grants (Section 3510).

Examples of state plans to engage consumers using Affordable Care Act reforms include:

- **Colorado**'s CIVHC has had early discussions around public will-building for national health reform as part of its consumer engagement strategy. CIVHC intends to take on the role of educating the public on issues surrounding health reform and build consumer buy-in for reform efforts.
- **Maine** created a Web site (<http://www.maine.gov/healthreform>) to provide a central place for consumers to review information about the Affordable Care Act and its impact on the state. The site includes links to federal and state agencies, the Maine Legislature's Joint Select Committee on Health Reform, and other sources of information.
- **Pennsylvania** incorporates consumer self-management into all of its learning collaboratives. One collaborative is operating a shared decision-making pilot for patients with preference-sensitive conditions, using Health Dialog decision aids.

### **Health System Performance Component #5: Provider Engagement**

Provider participation and buy-in is critical to efforts to design and implement new policies and practices to advance high-quality, cost-effective care for patients. On the delivery side, getting results like those in model pilots means a significant change from business as usual, and while providers are committed to providing quality care, they need access to information about practices that get better results and how best to adopt them. For example, providers need support to redesign office systems and practice flow, and a number of states are providing such assistance.

Profiled states offer providers opportunities to participate in advisory groups and work groups to identify policy changes and develop state recommendations. States are also offering providers various incentives and tools such as training, coaching, and financial incentives to pilot-test and spread improvements. Provider involvement can lead to provider buy-in for change, clinical practice improvement, and improved relationships between providers and state purchasers and regulators. Providers report that collaboration with state officials on quality improvement initiatives enables them to help shape policy, and to receive public acknowledgment of their efforts.<sup>19</sup> States that engage providers in reform efforts stand a better chance of gaining provider buy-in for those efforts.

Examples of state approaches to engaging providers prior to the Affordable Care Act include:

- **Rhode Island**'s providers have been heavily involved in delivery system reform efforts. The Primary Care Physicians Advisory Committee (PCPAC) and another provider coalition advised the Office of the Health Insurance Commissioner on its new insurer requirement to increase expenditures for primary care. PCPAC is currently examining and advising the Department of Health on ways to use its regulatory authority to improve patient care coordination between hospitals and primary care practices under the medical home model. A provider coalition also advises the Chronic Care Sustainability Initiative (CSI), which uses coaching and sharing between practices to support participating providers.
- **Vermont:** Providers are involved in the Blueprint at multiple levels. In addition to having providers serve on the central committee, each hospital service area has a provider-driven work group. The work groups coordinate community health teams, teams of various health professionals that coordinate care and educate patients and providers. Vermont also has two demonstration projects that support providers: shared learning collaboratives and facilitator-coach teams that use data to work with practices and plan ongoing quality improvement. Both projects will rely on Vermont's new data dashboard to inform discussions with providers. Blueprint is funding its private partner, the Vermont Program for Quality in Health Care (VPQHC), to facilitate the shared learning collaboratives. The VPQHC collaboratives work with federally qualified health centers (FQHCs) and practices to prepare them for becoming medical homes, and help practices prepare for NCQA scoring.

*Health Reform Challenges and Opportunities.* State challenges in engaging providers include perverse payment incentives, coaching and training needs, and, in some cases, resistance to change. The Affordable Care Act will support development and dissemination of clinical best practices and support for primary care. Provisions include incentives for providers to organize and deliver care in new ways that promote coordination and patient-centered care. States will have opportunities to apply for grants to create interdisciplinary teams to support primary care physicians in creating medical homes—Vermont's Community Health Teams are an example. States will also have the opportunity to function as hubs for AHRQ's Primary Care Extension Program to support, assist, and educate primary care providers on a variety of topics.

Health reform may provide opportunities for states and providers to become more aligned around population health. One state noted that if ACO incentives are designed well, providers may be more likely to support prevention policy agendas (that is, if

preventing avoidable hospitalizations is rewarded, physicians may promote evidence-based policies that improve health, such as mandatory restaurant posting of calories). States caution that national health reform implementation needs to include a process for input as programs develop to ensure they are workable for states and providers.

Exhibit 6 describes Affordable Care Act provisions that will address state provider engagement goals. Some provisions relate to federal actions that may not affect states but that can provide models for states to follow in engaging providers.

**Exhibit 6. Affordable Care Act Provisions Related to State Provider Engagement Goals**

<b>State goal</b>	<b>Related Affordable Care Act provision</b>
<b>Engage providers as partners in quality improvement initiatives and policymaking</b>	<p>Providers will be required to implement certain quality improvement strategies in order to contract with health plans in exchanges (Section 1311).</p> <p>The Independent Payment Advisory Board will include providers (Section 3403, as modified by 10320).</p>
<b>Support providers seeking to improve quality</b>	<p>Physicians will receive reports and data analysis on their reported quality data as part of the physician feedback program (Sections 3002(e) and 3003).</p> <p>HHS will award grants for developing health professional curricula on patient safety and quality improvement (Section 3508).</p> <p>The Institute of Medicine will conduct a study to determine best practices for developing clinical practice guidelines (Section 10303(c)).</p> <p>The new private, nonprofit Patient-Centered Outcomes Research Institute will conduct comparative clinical effectiveness research to be disseminated broadly by AHRQ (Section 6301, as modified by 10602).</p> <p>HHS will award grants to states to create interdisciplinary teams to support primary care physicians in creating medical homes (Section 3502, as modified by 10321).</p> <p>AHRQ will establish a Primary Care Extension Program to support, assist, and educate primary care providers on a variety of topics. HHS will award grants to states to establish state hubs under the program, to coordinate with quality improvement organizations and area health education centers (Section 5405, as modified by 10501).</p> <p>HHS will award grants to support community-based collaborative care networks, in which a safety-net hospital and all local FQHCs will coordinate and integrate health care services (Section 10333).</p>

Examples of state plans to engage providers in Affordable Care Act reforms include:



- **Massachusetts** recognizes that providers will require extensive support in the transition to a reformed delivery system. The state plans to promote learning among providers and institutions, support providers in transitioning to ACOs and in the effective use of HIT, and train providers in best practices for governance and contracting, patient-centered care management, patient safety, health information technology, data analysis, and medical home primary care practice redesign.
- **Rhode Island**'s lieutenant governor has convened a large work group of providers, consumers, state agencies, and other stakeholders to advise the state on challenges and opportunities in the state's implementation of national health reform. State officials expect to partner with providers on implementing health reform provisions that focus on payment realignment as well as delivery system reform. Rhode Island partners with providers through its multipayer patient-centered medical home project, which currently includes all commercial payers and Medicaid, and the state applied to add Medicare under a recent federal demonstration opportunity.

## **KEY THEMES FROM STATES**

As part of this project, representatives from profiled states gave input on the areas where the Affordable Care Act will likely have the greatest impact on their quality improvement agendas and activities, the opportunities and challenges that states anticipate health reform will present to state quality improvement initiatives, and their requests of the federal government as the law's quality improvement initiatives are rolled out nationally.

Through these discussions, key themes emerged that may assist state and federal officials in preparing to implement the quality and efficiency provisions of the reform law.

### **Health care reform offers the opportunity for genuine health care system transformation.**

States perceive health reform as a critical opportunity to realize the vision of a transformed delivery system that delivers high-quality and affordable care. National reform has the attention of the leading stakeholders, and states can play a crucial role in capturing political and community support for transformative change. Leaders recognize that reform implementation could either advance delivery system transformation or simply unload new resources into the system without encouraging or requiring change. Effective and successful implementation will depend on widespread, multi-stakeholder support. To take advantage of the potentials of reform, state agencies need to collaborate

to align their reform efforts, in partnership with consumers, providers, and private-sector partners and across the five key components outlined in this report.

**The Affordable Care Act provides opportunities for states to build on the momentum of quality and efficiency efforts they started with the American Recovery and Reinvestment Act.**

In many ways, the health reform law interfaces with, and supplements, current state initiatives, particularly for states that are already advanced in their quality improvement efforts. As states continue to move forward with their improvement work, the law will allow them to scale up their projects in a new way. For instance, quality reporting required from providers to meet ARRA's meaningful-use criteria, combined with the Affordable Care Act's coverage expansions and implementation of health information exchanges, will generate new data that can be used to improve quality and efficiency. New reform opportunities will enhance existing efforts, and offer funding to help states that would like to begin system reform.

**Quality and efficiency provisions of the Affordable Care Act should not be divorced from coverage expansion provisions.**

The convergence of coverage expansions and delivery system reforms is both a huge opportunity and a huge challenge. States recognize the imperative to address quality and efficiency if coverage expansion components of reform are to be sustainable. States view designing exchanges, expanding Medicaid, and encouraging commercial insurance carriers to participate with Medicaid and Medicare innovation projects as important opportunities to shape delivery systems and drive improvement. As coverage expansions move forward, there is an opportunity to think critically about how states want their coverage programs to be designed. The resource squeeze that states face could be a catalyst for creative quality improvement thinking.

**States face drastic staff and financial challenges in implementing the Affordable Care Act provisions and they need support in implementation.**

States are facing pressure to make mandatory coverage expansions in the face of drastic budget and resource shortfalls and a lack of the necessary infrastructure to implement quality and efficiency provisions; some states may not be in a position to succeed. States will seek federal assistance beyond competitive grant opportunities (which tax resources simply in developing proposals) to provide resources that they need to keep their reform agendas on track. State leaders would greatly benefit from using successful models from other states to develop their own projects, so as not to waste limited resources. States will also need flexibility in how they implement reform so that varying needs can be met.

**Strong leadership is critical to advancing states’ quality and efficiency agendas.**

Transformative improvements in quality and efficiency require money and data to flow in new and initially uncomfortable ways. While it may seem obvious, the importance of strong leadership in building strategic partnerships and coordinated strategies cannot be overstated—it is seen in each and every case of successful improvement implementations. It is far easier for state agencies and departments to work independently and focus on what they perceive they “have to” do than to pursue quality and efficiency agendas across agencies and departments, as well as with private-sector partners. However, as reform efforts serve to expand an already complex delivery system, it will be increasingly important for states to have a coordinated and streamlined approach if implementation is to be genuinely effective.

**Federal officials can learn from the efforts and lessons of leading states in rolling out quality and efficiency provisions of the Affordable Care Act.**

The states profiled in this report continue to build on their momentum rather than waiting for further guidance from the federal government. There are many areas of the health reform law in which state-level decision-makers have substantial authority to make choices and chart the course for how best to implement federal reform. However, states do worry that they will need to realign their local projects to align with new federal reform initiatives. States that are already leading the way, such as with payment reform pilots and demonstrations, seek to have HHS use their successful projects as models for national efforts, and also allow states the flexibility to keep implementing their successful projects even if they do not entirely align with federal regulations.

States raise the need for a strong federal–state partnership in reform implementation. State input can assist the federal government in ensuring that guidelines and initiatives are workable and flexible so that states can test various approaches. Given the relatively longer timeline for many quality and efficiency provisions, as opposed to coverage expansions, national leaders could conduct a series of conversations with states to discuss practical elements and learn from their experiences as they develop guidelines. How reform is implemented will determine whether it supports state goals for innovation and quality improvement.

**CONCLUSION**

The Affordable Care Act touches on many state functions and goals related to improving quality and efficiency of the health care system; the Affordable Care Act also mandates expanded coverage and access to care. The legislation contains many provisions that may

support significant health care system improvements, but, at the same time, it raises implementation challenges for states, particularly those facing a severe lack of resources.

States will benefit from opportunities to provide input and feedback as federal programs and guidelines are developed, opportunities to learn lessons and best practices from each other, and the resources and tools to support their decision-making. It will be critical for the federal government to learn from states and for states to provide guidance on their successful efforts. Also, states that adopt a coordinated, strategic approach to implementation may be best able to stretch limited resources and take advantage of opportunities to align their goals with the federal approach. We encourage federal officials to engage in structured conversations with states now in order to develop the new state–federal partnerships that will be necessary to transform the health care system.

## APPENDIX A. PROFILES OF TEN STATE MULTI-STAKEHOLDER HEALTH SYSTEM IMPROVEMENT INITIATIVES<sup>20</sup>

---

### COLORADO

#### Overview

Colorado's Center for Improving Value in Health Care (CIVHC) was established in February 2008 by executive order as part of Governor Bill Ritter's "Building Blocks to Health Care Reform" plan.<sup>21</sup> CIVHC was created as an interdisciplinary, multi-stakeholder entity, to coordinate, identify, and pursue strategies for quality improvement and cost containment. In April 2009, Governor Ritter appointed community members and five ex-officio members to the CIVHC board; members represented state agencies and departments (Division of Insurance, Department of Health Care Policy and Financing, Department of Human Services, Department of Public Health and Environment); CMS; health plans; providers (hospitals, community health centers, clinics, health care systems); HIT organizations; consumers; and foundations.

In September 2009, CIVHC hired a permanent executive director. With his arrival, CIVHC was able to finalize its long-term goals of promoting consumer-centered care, improving population health, bending the cost curve and increasing transparency; CIVHC also developed a strategic plan to achieve these goals. CIVHC has convened five advisory groups to identify strategies to reach its goals through data collection and transparency, consumer engagement, business engagement, delivery system redesign, and payment reform. Originally established and governed by the Colorado Department of Health Care Policy and Financing, CIVHC is in the process of being approved for 501(c)(3) status, and it will retain its key function of coordinating quality improvement efforts across the state to ensure that activities are cohesive and to avoid duplication of efforts.

#### Data Collection and Standardization

CIVHC's data and transparency advisory group is working with various stakeholders including private foundations, health care systems, Medicaid, and public health agencies to establish metrics to evaluate CIVHC's success in achieving its goals and to ultimately drive change. CIVHC will also be responsible for implementation of a statewide all-payer claims database, from which data extraction will begin by summer 2011.

### **Public Reporting**

The key statewide metrics selected by CIVHC's data and transparency advisory group will be the basis for a statewide dashboard to be rolled out in fall 2011. This data will be combined with data from the all-payer database and with other metrics to create a single Web site where all stakeholders can obtain information on health care value.

### **Payment Reform**

CIVHC is planning a payment reform strategy for the state of Colorado. CIVHC's payment reform advisory group includes representatives from stakeholder groups throughout the state. Since its first meeting in April 2010, the advisory group has completed an inventory of ongoing payment reform efforts in Colorado and other states, and of efforts taking place nationally. The group has also finalized a set of core payment reform principles to guide its work. The group plans to lead payment reform pilots with multipayer participation, gather stakeholder feedback, and identify barriers (including state and federal regulations) that might preclude broad participation in payment reform initiatives. The group will also identify payment reform opportunities in the Affordable Care Act for Colorado, which CIVHC will lead.

### **Consumer Engagement**

A key long-term objective for CIVHC is for all initiatives to contribute to a consumer-centered experience. An advisory group dedicated to engaging consumers and improving access to patient-centered care has been meeting for several months. Representatives from the consumer engagement advisory group also sit on CIVHC's other advisory groups to provide a "consumer lens" for all decisions and recommendations. As an example, consumer groups on the payment reform advisory group work to ensure that patients' needs will be addressed under any approach to payment reform. CIVHC's discussions around public will-building for national health reform comprise a second tenet of Colorado's consumer engagement strategy. CIVHC hopes to take on the role of educating the public about health reform; build consumer buy-in for reform efforts; and help consumers successfully navigate the state's health care system by supporting consumer-centered initiatives and providing comparative data on health care quality and costs. CIVHC holds quarterly public meetings and uses other forums to provide opportunities for meaningful input.

### **Provider Engagement**

CIVHC's delivery system redesign advisory group is working to improve the way health care is delivered by advancing initiatives that will encourage communication and integration between health care facilities and providers. Initial areas of focus include

increasing access to palliative care, which improves the quality of life of patients (and their families) at the end of life; reducing avoidable hospital readmissions by encouraging providers to focus on managing patients' care in a coordinated, collaborative way; and limiting unnecessary, acute, and emergency care utilization, particularly for patients with chronic illnesses, by providing comprehensive and coordinated care. To support these initiatives, CIVHC will offer a Web site providing comparative quality information and other materials. Providers will be able to use that information to identify opportunities to improve the quality of care they deliver, while consumers will be able to compare quality and ensure they are accessing the best possible care.

### **Health Reform**

Colorado has created the Interagency Health Reform Implementation Board to provide the governance, rules and regulation, and administrative infrastructure to facilitate planning and implementation of the Affordable Care Act. The Board comprises cabinet members and a director of health reform implementation. Subject-specific task groups will be formed as needed and existing boards and commissions will be included for advisory purposes. CIVHC is working closely with the board to clarify its role in the implementation process, and will likely be responsible for most payment reform activities. CIVHC is also closely monitoring the Affordable Care Act for strategies that intersect with its statewide work on engaging consumers, redesigning the delivery system, and increasing access to data.

---

## **KANSAS**

### **Overview**

In 2005, the Kansas legislature created the Kansas Health Policy Authority (KHPA), a new state agency within the executive branch. Today, KHPA continues to coordinate data-driven policymaking and implementation, overseeing functions from data collection through analysis to dissemination. KHPA also oversees purchasing for Medicaid, Children's Health Improvement Program (CHIP), the State Employee Health Benefits Plan, and State Workers' Compensation. KHPA is governed by a 17-member board: nine voting members appointed jointly by the governor, the speaker of the house, and the senate president, and eight ex-officio members.

In 2006, the KHPA board chartered the Data Consortium, an advisory group with the mandate to make recommendations on health data and policy. The consortium includes representatives of government agencies, hospitals, physicians, insurers, purchasers, and consumers.<sup>22</sup> The Data Consortium has five work groups, covering

quality and efficiency, access to care, affordability and sustainability, health and wellness, and health professions workforce data. The consortium works closely with multiple stakeholders to maintain buy-in.

### **Data Collection and Standardization**

In 2008, KHPA's Data Consortium undertook a one-year, collaborative, public forum process to select the numerous health outcome, access, quality, and cost measures that would make up Kansas's comprehensive set of indicators. The first round of the data was collected in 2009 and is being used to drive data-driven decision-making around quality and efficiency, access to care, affordability and sustainability, and health and wellness. In deciding which measures to use, the Data Consortium sought data that would be relevant for policymaking and would be a minimal burden to collect and report. Kansas uses national standard measure sets, including NCQA, Healthy People, and the National Health Disparities Report. Now that national health reform has been enacted, Kansas will incorporate the new national measures and newly available Medicare data into its data set.

To facilitate efficient data collection and reporting, KHPA works with licensure boards, insurance carriers, state agencies, and private partners to ensure that HIT systems are interoperable and that data is standardized.

### **Public Reporting**

Kansas's national measures data is publicly available through an online dashboard that provides both state-level data and national and peer-state benchmarks for comparison. The Web site, [http://www.khpa.ks.gov/data\\_consortium/data\\_consortium\\_health\\_indicators/overview.htm](http://www.khpa.ks.gov/data_consortium/data_consortium_health_indicators/overview.htm), is updated continuously as new data becomes available. Kansas is investing in a Data Analytic Interface, which will be a user-friendly database that integrates data from multiple sources. Officials hope that the new Physician Compare developed through the Affordable Care Act will provide consumers with a new level of data.

### **Payment Reform**

After participating in the State Quality Improvement Institute, Kansas included payment reform as one of its four strategic priorities for FY 2011. Kansas is developing a medical home model as defined in a 2008 state statute<sup>23</sup> and drawing on national standards. A medical home stakeholder group met from summer 2008 through early 2009; in March 2009 the Kansas Medical Home Initiative was folded into the state's HIT initiative, and the state continues to work on developing a medical home pilot in both its Medicaid and State Employee Health Plan programs. KHPA is exploring immediate reforms with



hospitals and integrated health systems to incentivize care coordination and reduce preventable hospitalizations and readmissions. KHPA is also considering longer-term reforms such as global payment with ACOs.

### **Consumer Engagement**

KHPA continues to work with a consumer advisory council to gather input on policy recommendations. KHPA collaborated with medical and public libraries to develop Kansas Health Online, a Web site to “promote health literacy and consumer engagement in health-related decision making” (<http://www.kansashealthonline.org/>).

### **Provider Engagement**

KHPA is working with the Kansas Primary Care Coalition to develop standards for Kansas’s new medical homes initiative. Kansas has efforts underway to provide feedback to providers on quality measures in order to improve performance and outcomes. One such effort is an inter-state collaboration with Missouri as part of the Aligning Forces for Quality (AH4Q) initiative. The new data sets, collected as part of ARRA HIE/HIT meaningful-use reporting requirements, will allow Kansas to give providers enhanced quality improvement feedback.

### **Health Reform**

Some Kansas state officials predict that federal health reform will recast state quality improvement efforts mostly as cost control efforts. Kansas faces a budget crisis that in particular makes coverage expansion a difficult prospect. The state is in a difficult position, because the coverage expansion coincides with a resource reduction. With limited resources being asked to cover a much greater number of people, states have a strong incentive to make quality and efficiency improvement a high priority; this tight spot could actually be a catalyst to spur creative reform thinking. For quality improvement to become a priority in Kansas, state leaders will need to work to empower its quality improvement communities to take on a leading policy role.

Kansas officials view the data provisions in the Affordable Care Act as especially promising. All-payer data sets, ARRA meaningful-use quality reporting, coverage expansions, and health information exchange implementation will generate a wealth of new data that can be used to improve health and reduce spending. In order to take advantage of the new data, Kansas and the federal government must first establish explicit goals for obtaining, managing, and using data in new ways.

---

## MAINE

### **Overview**

Maine's state health reform began in 2003 when Governor John Baldacci created the Governor's Office of Policy and Finance and charged it with developing a health reform plan for the state. That same year, in 2003, Maine passed its landmark health reform legislation, Dirigo Health Reform, which included access, cost, and quality provisions. The legislation created the Maine Quality Forum (MQF) as part of the Dirigo Health Agency. MQF works in partnership with nonprofit partners the Maine Health Management Coalition (MHMC) and Quality Counts (QC) to coordinate and align quality improvement efforts. MQF, MHMC, and QC recently worked together to implement a medical homes pilot.

In July 2010, Maine released its 2010-2012 State Health Plan. In the plan, Maine aims to reduce health care costs by strengthening public health and prevention, supporting strategies that reduce avoidable hospitalizations and emergency department use, and restructuring payment to reward efficiency and prevention. The State Health Plan also outlines a strategy for implementing national health reform in Maine.

### **Data Collection and Standardization**

MQF, MHMC, and QC continue to coordinate performance reporting in Maine. Since 2009, Maine has expanded its set of quality reporting measures to include care transitions measures. Maine had the first all-payer database in the nation, and efforts continue to compile and organize data from multiple sources. Maine is developing a roadmap for building an infrastructure for health data, analysis, and research, to support payment and delivery system reform. In addition, Maine received stimulus funds through the Centers for Disease Control to expand the capacity of the Maine Center for Disease Control (the state's health department) for infection prevention and control. This strategy includes expanding a current set of measures on hospital-acquired infections and systematically collecting the newly available data.

### **Public Reporting**

New care transitions measures are now included in Maine's Hospital Quality Snapshots, and Maine CDC's hospital-acquired infection program has an extensive public reporting focus as well; information on both the quality snapshots and Maine CDC's infection program is available at <http://www.mqf-online.com/summary/intro.aspx#MHQ>. At the physician level, the 2009 legislature enacted a law to facilitate physician performance reporting. Maine plans to draw on existing Web sites and data sources to coordinate the

new reporting. Because of the issue's importance to consumers, new measures will include patient experience of care.

### **Payment Reform**

Maine initiated a medical home pilot at 26 sites in January 2010. The pilot involves up-front care coordination payments, with participation from Medicaid and three (Anthem, Harvard Pilgrim and Aetna) of the four commercial insurers in the state participating.<sup>24</sup> Maine has applied for Medicare participation as well, and is interested in other Medicare demonstration project opportunities like bundled payments or ACOs; several medical centers have developed plans to implement ACOs. Maine is also testing payment reform options stemming from public purchasing and state regulation.

### **Consumer Engagement**

Maine is using an Aligning Forces for Quality (AF4Q) grant that QC received to support consumer engagement. For instance, a plan to develop a better consumer Web site grew out of feedback from consumer focus groups supported by AF4Q. AF4Q supports training consumers in relevant health care issues to help them become more effective participants in their care. One goal of the State Health Plan is to promote efforts to educate, engage, and support consumers in self-care and management. Consumers are represented on the governing board of the patient-centered medical home pilot.

In 2009, Maine's state legislature authorized MQF to convene a study group on shared decision-making. The MQF group conducted an extensive analysis and examined the possibility of covering shared decision-making activities in Medicaid. In May 2010, the study group released a report concluding there was insufficient evidence, in regards to establishing best payment methodologies or indicating significant cost-savings, at the time to establish a comprehensive shared decision-making program.<sup>25</sup>

### **Provider Engagement**

Several providers in the state have formed ACOs, and MHMC is active in facilitating this process. One goal of the State Health Plan is to convene learning collaboratives to engage public health and clinical communities in developing effective and coordinated improvement initiatives.

### **Health Reform**

A key focus of Maine's state health reform was defining the state's role in delivery system reform. A consensus developed that the state had two primary roles: allowing private sector initiatives to progress when working well, and using the full power of state

influence in other areas, such as in Medicaid and public purchasing. With the Affordable Care Act, state officials are looking to add a third role: using the exchanges as vehicles for payment reform.

Maine's State Health Plan charges two executive branch entities, the Health Reform Implementation Steering Committee and the Advisory Council on Health System Development, with implementing national health reform "in a thoughtful and transparent manner."<sup>26</sup> One of the steering committee's tasks is to focus on delivery system and payment reform. The steering committee and the advisory council will develop criteria to prioritize grant opportunities; the criteria might include "priority in the State Health Plan, related initiatives underway in Maine, broad coalition of support, level of state funding required."<sup>27</sup> Maine is focusing on the development of an exchange, until the quality elements of health reform are more clearly defined.

---

## **MASSACHUSETTS**

### **Overview**

In 2006, Massachusetts enacted landmark state health reform legislation: Chapter 58 of the Acts of 2006. The key delivery system component of the reform was establishing the Health Care Quality and Cost Council (HCQCC) within, but not subject to the control of, the Executive Office of Health and Human Services (EOHHS). HCQCC, composed of 15 health care stakeholders with a broad range of experience in the public and private sectors, promotes public transparency of the quality and cost of health care in the Commonwealth, develops recommendations for containing health care costs, and facilitates access to information on health care quality improvement efforts. In 2008, Massachusetts enacted Chapter 305, a second set of reforms to promote cost containment and transparency; Chapter 305 established the Special Payment Commission on the Health Care Payment System.

HCQCC works in conjunction with the Massachusetts Division of Health Care Finance and Policy (DHCFP), also within the EOHHS, which strives to improve health care quality and contain health care costs by critically examining the Massachusetts health care delivery system and providing objective information, developing and recommending policies, and implementing strategies that benefit the residents of the Commonwealth.

## **Data Collection and Standardization**

HCQCC currently maintains a database of health claims for fully insured patients. Chapter 305 of the Acts of 2008 gave DHCFP its broad authority to collect health care data (“without limitation”). As such, DHCFP adopted regulations, effective July 23, 2010, governing the collection and release of health care data from private and public payers. The all-payer claims database will include data on the fully insured, the self-insured, Medicare, and Medicaid. In addition to allowing for a deeper understanding of health care cost, quality, and utilization, the database will serve as the central repository for all health care claims submission for Massachusetts state agencies. Payers will be able to submit claims data to just one agency, resulting in administrative simplification. DHCFP aims to begin providing the required data extracts to sister agencies in summer 2011. HCQCC will no longer need to maintain its fully insured claims database once the all-payer database is developed.

In July 2009, HCQCC approved the creation of the Expert Panel on Performance Measurement (EPPM), with members representing physicians, hospitals, consumers, and public and private health plans. The EPPM was charged with making recommendations on a statewide scorecard of measures to monitor state goals including benchmark targets; making recommendations on uniform measures of provider performance that may be used for creating incentives, tracking health improvements, and tracking quality of care; developing a strategic framework for systems measures that promote more care coordination, integration, patient centered care, alignment with new payment models, and reductions in disparities by race and ethnicity. The ACO work group of the EPPM will recommend a set of measures on system-wide performance of an ACO.

In the spring of 2010, EPPM developed a Statewide Scorecard to track Massachusetts’ progress toward achieving health goals. The Scorecard is based on national measure sets, and compares outcomes to national benchmarks, where possible. HCQCC tries to integrate racial and ethnic disparity measures throughout the scorecard rather than creating a stand-alone category. Moreover, Chapter 288 of the Acts of 2010 created an advisory committee, chaired by the Commissioner of DHCFP, to recommend a standard set of quality measures for each health care provider facility, medical group, or provider group in the Commonwealth, to be reported publicly by the Department of Public Health.

## **Public Reporting**

HCQCC maintains a consumer-friendly Web site, *My Health Care Options* (<http://hcqcc.hcf.state.ma.us/>), which includes data on quality and cost measures for acute

hospital providers and medical groups. This data comes from CMS's Hospital Compare Web site (<http://hospitalcompare.hhs.gov/>), AHRQ's Web site (<http://www.ahrq.gov/>), the Leapfrog Group ([www.leapfroggroup.org](http://www.leapfroggroup.org)), and HCQCC's database of fully insured claims. When the all-payer claims database is operational, it will be used to populate the consumer Web site. The cost measures display the median amount paid for a procedure at a particular hospital and include text to help the consumer understand what that dollar amount means to him or her. Massachusetts added Serious Reportable Event data in 2010. The state has plans to add new quality, cost, and physician group ambulatory care measures. DHCFC publicly reports its analysis of the Massachusetts health care delivery system and costs on its agency Web site, [www.mass.gov/dhcfp](http://www.mass.gov/dhcfp).

### **Payment Reform**

The Special Commission on the Health Care Payment System included provider and health plan representatives, other health care experts, state agency administrators, and legislators. The Special Commission presented a report with its findings and recommendations to the state legislature in July 2009. It unanimously recommended a global payment system that encourages comprehensive patient care with significant incentives for high-quality care. See [www.mass.gov/dhcfp/paymentcommission](http://www.mass.gov/dhcfp/paymentcommission).

In October 2009, HCQCC approved the Roadmap to Cost Containment (the Roadmap), a plan with long- and short-term strategies to redesign the Massachusetts care delivery system with the appropriate structure, incentives, and regulatory tools to promote changes. HCQCC drew on the Special Commission's report, but sought to emphasize payment reform as just one component of a larger delivery system reform. The Roadmap outlines eleven strategies including innovations in payment and insurance design, adopting HIT, engaging consumers, and increasing transparency.

The HCQCC Roadmap envisions payment reform as a way to promote chronic disease management, care coordination, and integration of behavioral health services. In the short term, the Roadmap recommends increasing the use of medical homes, implementing pay-for-performance and bundled payment programs, and reducing payments for avoidable hospitalizations and preventable readmissions. The Roadmap's longer-term vision is a statewide global payment system that would include widespread, appropriate use of ACOs, and rate regulation where necessary. Both the Special Commission report to the legislature and the Roadmap recommend a statewide transition to global payment, involving all payers.

While the state legislature considers its options, Massachusetts plans to implement targeted payment reform strategies to reduce preventable readmissions, improve coordination in care transitions, and reduce emergency department use. In addition, Massachusetts officials hope to implement some of the payment reform demonstrations and pilots authorized through the Affordable Care Act.

### **Consumer Engagement**

Consumer engagement is a key component of both the Roadmap and Special Commission recommendations. The Special Commission's plan includes a consumer education component, in which state partners (like trade associations), not-for-profit quality improvement organizations, and IT partners would mount public education initiatives for both patients and employers. In addition, the Roadmap recommends engaging consumers through public education campaigns with partners such as the Partnership for Healthcare Excellence. The Roadmap also calls for targeted consumer engagement through medical home and shared decision-making initiatives.

Massachusetts engages consumers on other fronts as well. HCQCC includes consumers on its advisory council. The Roadmap includes plans to engage consumers in order to reduce emergency department usage, hospital readmission rates, and to reduce demand for low-value care. Moreover, HCQCC convened an Expert Panel on End of Life Care. The panel released a draft of its recommendations in February 2010. The recommendations include next steps for implementing a patient-centered end of life delivery system, based on best practices.<sup>28</sup>

### **Provider Engagement**

HCQCC has strong provider representation among its membership. The Roadmap and the Special Commission recommendations recognize that providers will require extensive support in the transition to a reformed delivery system. The Roadmap includes plans to promote learning among providers and institutions, to support providers in transitioning to ACOs and in the effective use of HIT, and to train providers with patient safety programs. The Special Commission recommendations include training for providers in best practices for governance and contracting, patient-centered care management, health information technology, data analysis, and medical home primary care practice redesign.

### **Health Reform**

As Massachusetts moves forward with its state health reform efforts, state policymakers are paying close attention to federal health reform implementation. Massachusetts state officials hope to work with the federal government so that lessons Massachusetts learns

before the Affordable Care Act pilots begin will be used to inform the design of the pilots.

In the Roadmap, HCQCC recommends that, with the advent of health reform, Massachusetts should continue efforts to work with CMS on implementing medical homes, coordinating care for dual-eligibles and ensuring Medicare participation in payment reform efforts.<sup>29</sup>

---

## **MINNESOTA**

### **Overview**

Minnesota passed a landmark state health reform bill, S.F. 3780, in 2008. The bill seeks to fulfill the “Triple Aim” (established by the Institute for Healthcare Improvement): to improve the health of the population; improve the patient experience; and improve the affordability of health care. In addition to establishing and funding a Statewide Health Improvement Program (SHIP), enhancements related to coverage for the low-income and uninsured, and steps to increase consumer engagement in all aspects of the system, the law included various provisions to collect and report data to achieve price and quality transparency and provisions to support care redesign and payment reform.

### **Data Collection and Standardization**

As part of a 2007 administrative simplification bill, Minnesota will require the use of interoperable electronic health records by 2015. After passing the 2008 reform bill, Minnesota started developing the Minnesota Statewide Standardized Quality Reporting and Measurement System (<http://www.health.state.mn.us/healthreform/measurement/adoptedrule.html>). System measures are based on existing indicators, with an emphasis on outcomes rather than process. The state sought to select measures that would not place a large administrative burden on providers. Clinics and hospitals were required to begin reporting on the measures in January 2010. In addition, Minnesota developed the Provider Peer Grouping, a composite measure that compares providers on overall value (including quality and cost); data collection began in July 2009. Finally, Minnesota developed standard quality reporting measures for its baskets of care bundled payment initiative (see Payment Reform).

### **Public Reporting**

Minnesota began publicly reporting statewide quality measure data in mid-November 2010 (data is available at



<http://www.health.state.mn.us/healthreform/measurement/report/index.html>). Public reports from the Provider Peer Grouping system will be released in 2011.

### **Payment Reform**

Minnesota is designing a bundled payment program as part of state health reform: the state developed seven “baskets of care,” a collection of services that would be paid for separately under a fee-for-service system but that providers usually combine in delivering a full diagnostic or treatment procedure to a patient. Minnesota is discussing whether to build on the baskets of care program in order to participate in a Medicare bundled payment pilot authorized through the Affordable Care Act. Minnesota’s state health reform also called for a statewide health care home approach, which will be used as a foundation for ACOs; the state hopes to participate in national health reform ACO pilots as well.

### **Consumer Engagement**

As part of the 2008 health reform legislation, Minnesota convened a work group “to develop strategies for engaging consumers in understanding the importance of health care cost and quality, specifically as it relates to health care outcomes, consumer out-of-pocket costs, and variations in health care cost and quality across providers.”<sup>30</sup> The work group, which comprised consumer groups, health plans, and other health care and communications experts, held a series of meetings and focus groups with consumers regarding health care homes, baskets of care, the Provider Peer Grouping system, palliative care, and general quality and cost issues.

The work group released its report, “Strategies to Engage Consumers about Health Care Cost and Quality” in January 2010. The report includes findings from the focus groups, and lays out eight five-year goals, along with recommendations for achieving the goals, such as using Personal Health Records, developing a Web portal for consumers with cost and quality information, and building on the SHIP public health initiative to strengthen community partnerships and to develop communities where making healthy choices is easy.<sup>31</sup>

### **Provider Engagement**

A provider advisory group was active in the development of the Provider Peer Grouping system. Minnesota hopes to use Provider Peer Grouping data to help engage providers in value-improvement strategies; this will be particularly important for providers participating in ACOs. Across all of Minnesota’s initiatives, providers are involved in the work groups making critical decisions.

## **Health Reform**

Some Minnesota state officials predict that the state's current initiatives, such as primary care redesign through medical homes and standardized quality reporting, will put the state in a good position to build on and leverage components of federal health reform.

---

## **OREGON**

### **Overview**

Oregon's state health reform legislation, House Bill 2009, was signed into law in June 2009. The new law was developed on the recommendations of the Oregon Health Fund Board. It creates the Oregon Health Authority, an entity (with broad authority) intended to streamline the state's health care functions; information is available at <http://www.oregon.gov/OHA/>. The Oregon Health Authority's Policy Board (OHPB), comprising seven members appointed by the governor and confirmed by the senate, is charged with setting the state quality improvement agenda and coordinating with outside groups also working in quality improvement. As one of its first actions, OHPB directed its Health Incentives and Outcomes committee to make recommendations about using statewide health care quality standards in support of a high performing health system. The new delivery system envisioned in the 2009 bill is built on the patient-centered primary care home model (PCPCH); the legislation created a PCPCH committee to develop a PCPCH program. In addition, the Health Authority is looking across the lines of coverage overseen by the state to incorporate those quality standards uniformly when contracting for purchasing services for its Medicaid, CHIP, State Employees, Oregon Educators, Oregon Hi-Risk Pool, and premium subsidy enrollees.

Oregon's public-private partnership continues as an informal arrangement, coordinating and implementing quality improvement initiatives statewide. The partners include the Oregon Patient Safety Commission, a semi-independent state agency, and the Oregon Health Care Quality Corporation (Quality Corp), a nonprofit 501(c)(3) organization. Representatives from the partner organizations sit on some of OHPB's committees and subcommittees, and the state is represented on the governance of the Commission and Quality Corp.

### **Data Collection and Standardization**

OHPB's Health Incentives and Outcomes Committee is developing a statewide quality scorecard, with a special focus on metrics that can be used for both improving population health and for implementing payment reform. As AF4Q grantee, Quality Corp has used grant funds to develop an almost statewide voluntary quality metric reporting program.

The program builds on Quality Corp's Chronic Disease Data Clearinghouse pilot, which collected outpatient primary care measures (<http://q-corp.org/publications/archives>). Oregon has added new elements to its hospital data sets, including race and ethnicity data and ambulatory surgical data. In February 2010, the PCPCH committee released the standardized measures on which participants in Oregon's medical homes pilot will be required to report.

Oregon's state health reform legislation directs the Health Authority to implement an all-payer all-claims database. The database, expected to be operational by late 2010, will coordinate closely with the Quality Corp voluntary quality reporting program to present a full picture of health care value with both cost and quality data.

### **Public Reporting**

The two-year Chronic Disease Data Clearinghouse pilot has since evolved into the Partner for Quality Care initiative, which maintains a portal of publicly available quality reporting information at <http://www.partnerforqualitycare.org/>. Reporting began in 2010 and will be updated annually. This augments reports that Oregon has produced for several years on inpatient hospital quality measures. Recently, Oregon has begun "crosswalking" several of those measures with cost data obtained in partnership with the Insurance Division of the Dept of Consumer and Business Services; data is available at: <http://www.oregon.gov/OHPPR/HQ/>, and at <http://www.oregon.gov/OHPPR/RSCH/comparehospitalcosts.shtml>).

### **Payment Reform**

OHPB's Health Incentives and Outcomes Committee is charged with developing recommendations for transparent payment methodologies that provide incentives for cost-effective, patient-centered care and reduce variations in cost and quality of care. Their recommendations will be used by the OHPB Public Health Benefits Purchasers Committee (which includes state employers, school districts, cities, and counties) as it works to share best practices in public purchasing power. The purchasers committee will implement quality reporting requirements and payment incentives in future contracting cycles.

Oregon hopes to include Medicare, along with Medicaid and private plans, in future payment reform efforts that might be supported by Affordable Care Act funds. There is strong interest by the new Health Authority to explore ACOs and advance the medical home model. Oregon has developed its own framework for the medical home; in

February 2010, the PCPCH committee released a consensus approach to define and measure a patient-centered primary care home.

### **Consumer Engagement**

Quality Corp has focused on the needs of the consumer in its AF4Q reporting effort. All of the board's committees and meetings are open to the public and committee membership includes a wide spectrum of stakeholders including consumer advocates. Recommendations are vetted with community partners as they are being developed and refined. Broader consumer engagement in partnership with Quality Corp and the Patient Safety Commission is planned.

### **Provider Engagement**

Providers are involved in the Health Authority, OHPB, Quality Corp, and the Patient Safety Commission at multiple levels. Organizations such as the Oregon Medical Association and the Oregon Nurses Association serve on OHPB's committees.

Quality Corp developed a provider portal for its quality reporting that allows clinics to see individualized provider performance to use for on-site quality improvement. In the care coordination pilot, their data is also being augmented with more frequent data feeds in order to assist a public-private multipayer care coordination pilot that is just beginning in 14 clinics across Oregon. The quality data, which will soon include cost data, will help both providers and payers understand the impact of enhanced care coordination for a small cohort of the high-utilizing/high-cost patients in these settings.

### **Health Reform**

Oregon's state health reform plan is in close alignment with federal reform. For instance, the Affordable Care Act provisions addressing health care acquired infections will provide increased direction and support for Oregon's current work in patient safety. OHPB's Health Incentives and Outcomes Committee will draw on new national quality metrics in the creation of its state quality scorecard and in its public purchasing initiative. Public purchasers will use the federal emphasis on prevention and wellness to promote population health, and will use comparative effectiveness research in public purchasing decisions.

Some Oregon state officials are particularly interested in the national health reform provisions that require quality reporting to be linked to HIT, especially given ARRA's incentives for HIT adoption. The state's quality work is aligning with the new meaningful-use requirements and officials believe the requirements are another tool to

incentivize improving the quality of care. However, Health Authority staff are concerned that small practices in rural areas will be unable to keep up with both HIT implementation and reporting requirements, especially when required reporting will include quality and efficiency metrics in addition to claims data. Oregon is working with its regional extension center grantee, its Office of Rural Health, and provider organizations to help rural practices adopt and use HIT to improve patient care.

Finally, Oregon anticipates severe state budget cuts at least through 2013, which may hinder reform efforts; staff hopes to secure adequate federal health reform funding to keep reform plans on track.

---

## **PENNSYLVANIA**

### **Overview**

The Pennsylvania Chronic Care Management, Reimbursement and Cost Containment Commission was established through executive order by Governor Ed Rendell in May 2007. The 37-member commission represents a broad cross-section of health care-related fields, employers, unions, and consumers, and represents all geographic areas of the state. In addition, the secretaries of health, public welfare and insurance, as well as the director of the Governor's Office of Health Care Reform (GOHCR), serve as ex-officio members. The commission developed a strategic plan, focusing on a combined chronic care and patient centered medical home model, starting with diabetes and pediatric asthmatic patients.

Based on the plan, Pennsylvania established the Chronic Care Initiative and began implementing the initiative in May 2008. The centerpiece of the Chronic Care Initiative is regional learning collaboratives, which support providers in the rollout of a medical home/chronic care model. The state runs seven regional learning collaboratives in which 800 primary care practitioners participate. Chronic Care Initiative practices make a three-year commitment to participate in the learning collaboratives. Three of the collaboratives were rolled out starting in spring 2009, and the three most recent rolled out in fall 2009; two more are planned for fall 2010. Pennsylvania's GOHCR is responsible for convening the learning collaboratives, as well as for funding the collaboratives and data collection and aggregation. The Commonwealth Fund is funding an independent evaluation of the Chronic Care Initiative (See <http://www.rxforpa.com/chroniccare.html>).

### **Data Collection and Standardization**

Practices participating in Pennsylvania's learning collaboratives agree to report monthly on pre-specified quality measures to guide their quality improvement strategies. The state is working to develop a common reporting structure to be used in the medical home practices. The learning collaboratives use patient registries that show evidence-based care guidelines for a variety of chronic conditions; practices report data monthly on the percentage of patients that meet these guidelines. Pennsylvania will incorporate the national measures resulting from the Affordable Care Act into the learning collaborative efforts. All practices agree to achieve at least NCQA Level 1 certification as a patient-centered medical home.

### **Public Reporting**

Pennsylvania is working to develop plans within its learning collaborative to make the quality measure data available to the public.

### **Payment Reform**

Pennsylvania's Chronic Care Initiative continues as a multipayer partnership using four payment models and with participation from all large payers (commercial, Medicaid, and Medicare Advantage) except Medicare fee-for-service. Chronic Care Initiative practices and payers make a three-year commitment to participate in regionally organized learning collaboratives that are implementing patient-centered medical home and chronic care models. The three most recent learning collaboratives are funded by small state start up grants only.

### **Consumer Engagement**

Pennsylvania incorporates consumer self-management into all of its learning collaboratives, by having providers work with patients to establish treatment goals. One learning collaborative is operating a shared decision-making pilot for patients with preference-sensitive conditions, using Health Dialog decision aids. Pennsylvania state officials anticipate that the Affordable Care Act will allow for wider dissemination of tools for patient self-management and shared decision-making.

### **Provider Engagement**

Supporting providers through learning collaboratives is a key focus of Pennsylvania's reform efforts. In their first year, each collaborative's participants are provided with practice coaches assigned by the state's Improving Performance in Practice program, to assist with provider office redesign and link practices to community resources.

## **Health Reform**

Pennsylvania state officials are hopeful that federal health reform will result in payers becoming more open to proven payment methodologies that improve quality and reduce costs.

---

## **RHODE ISLAND**

### **Overview**

Since 2006, Rhode Island has passed numerous health reform bills geared toward expanding health care access and improving the health of the state's population. Many of the bills have bolstered the responsibilities of Rhode Island's executive branch agencies. Rhode Island's recent delivery system reforms, which include a medical home initiative and other payment and quality reporting initiatives, have come about primarily through actions of executive branch agencies, as described below.

### **Data Collection and Standardization**

Rhode Island's state agencies have robust authority to require performance reporting of health professionals and institutions. The state uses only national, consensus-developed measures, relying mostly on NQF measures, and coordinates with national reporting requirements where possible. The Department of Health currently requires institutions (hospitals, nursing homes) to report on structure, process, and outcome measures, as well as satisfaction measures. Rhode Island has established seven key efficiency measures to be measured with consistent metrics across public and private payers, regulators, providers, and programs. The measures focus on preventable hospitalizations, rehospitalizations, and avoidable emergency department visits. National (NQF, AHRQ) measurement definitions and software are being applied to the current hospital discharge database.

The state is expanding its reporting capacity by developing an all-payer claims database (statutory authority provided in 2008) and is collecting emergency department and rehospitalization data, to be reported back to providers. In 2011, the database will be fully available to produce reports at a more detailed level, such as by primary care practice.

Rhode Island is experimenting with innovative uses of EHRs in performance reporting. Practices participating in the CSI medical home initiative are required to use EHRs for performance reporting, and data collected is used to evaluate the effect of the medical home model. In CSI, smoking cessation advice and depression screening are

measured using EHRs to gauge the impact of a medical home on patient behavior and outcomes. Besides CSI sites, an increasing number of practices and community health centers in Rhode Island use EHRs for performance reporting. Rhode Island officials are looking for ways to encourage all providers to report through EHRs. The state continues to work with the non-profit Rhode Island Quality Institute, primarily on HIT adoption and use. The institute received a Beacon grant, which it will use to stimulate data aggregation and performance measures around chronic disease management, efficiency and costs, and population health.

### **Public Reporting**

Rhode Island hopes to use transparency to drive quality improvement, payment reform, and cost control. In this vein, OHIC released a [report](#) in January 2010 on the wide variation in payment rates to hospitals.<sup>32</sup> Rhode Island collects and publicly reports hospital acquired infection data for every hospital under the authority of state statute.

### **Payment Reform**

Much of Rhode Island's payment reform activity has taken place through the Office of the Health Insurance Commissioner (OHIC). The state legislature established the OHIC in 2004, giving it broad authority for "improving the health care system's quality, accessibility and affordability" as one of its four core objectives.<sup>33</sup> In 2006, OHIC convened a medical home initiative, the Chronic Care Sustainability Initiative (CSI). CSI includes payment to medical home practices by Medicaid and all three major private insurers in the state; officials hope to include Medicare patients soon. CSI sites include solo practices, group practices, and some community health centers, initially covering 25,000 lives, but doubling in scope during summer 2010 to cover 50,000 lives, 5 percent of the state's population. The program will be rolled into Rhode Island's new Beacon grant to scale up further. Evaluation results have become available during the last six to 12 months, showing significant improvement on performance measures, especially for diabetes, and decreases in ER visits and hospitalization. Blue Cross & Blue Shield of Rhode Island participates in CSI, but also operates a separate medical home program with additional practices.

OHIC has also established affordability standards for Health Plans, mandating that plans increase their medical spending on primary care. OHIC recently released a requirement that health plans double the percentage of their medical spending that goes to primary care within the next five years. At the outset, 5 percent of spending went to primary care; OHIC will require plans to increase this by 1 percent in each of the next five years. OHIC has used its insurance rate review authority to control the inflation of



health insurance rates. Most recently OHIC has required insurance plans to re-examine their contracts with hospitals, with the requirement for plans to structure contracts to realign payment methods to reward quality improvement and efficiency and promote transparency.

In addition, Medicaid has expanded its use of performance-based managed care contracts with health plans to include all enrolled families, children with special needs, and adults with disabilities. In the future Rhode Island hopes to implement further payment reforms using national health care reform opportunities and building on successful programs and initiatives already under way.

### **Consumer Engagement**

OHIC posts at its Web site all proposed rate factors for all lines of commercial insurance for oral and written public comment. The rate factors are also presented to the Health Insurance Advisory Council, comprising both consumers and providers, for analysis and public comment. This publicly accessible rate review process assists OHIC in holding insurers accountable for goals that may conflict, including financial solvency, consumer protections and increasing affordability, quality, and accessibility of the health care system. As an improvement to this process, with new federal funding for rate review available under the Affordable Care Act, OHIC is planning to engage a consumer organization to achieve greater attendance at public meetings and encourage more informed public communications regarding rate factors.

### **Provider Engagement**

Rhode Island's providers have been heavily involved in delivery system reform efforts. The Primary Care Physicians Advisory Committee (PCPAC), representing a diverse array of primary care practices, advised OHIC on its new primary care spending requirements for insurers. PCPAC is currently examining the relationship between hospitals and practices under the medical home model. PCPAC has worked with the Department of Health to find alternative methods of influencing delivery system changes through regulatory authority.

A provider coalition advises the Chronic Care Sustainability Initiative. In addition, CSI uses coaching and sharing between practices to support participating providers. Through CSI, Rhode Island learned to allow providers to develop their own plans for meeting goals, rather than dictating the steps providers must take to improve performance. This, and having money or accountability measures already tied to

improvements has worked best to move providers to action. Rhode Island has convened a large work group of providers to advise the state on implementing national health reform.

### **Health Reform**

Since June 2010, over 150 Rhode Islanders have been meeting as the Healthy RI Task Force, a broad-based citizen coalition convened by Lieutenant Governor Elizabeth Roberts, to examine the opportunities and challenges presented by the Affordable Care Act. The task force organized into seven issue-specific work groups and made the recommendations in each of the key areas in which there are state-level policy decisions to be made. Recommendations emerged as commonly held by most or all of the work groups and from deliberations of the Task Force as a whole.<sup>34</sup>

Rhode Island officials see national reform as an enormous opportunity if used wisely. National reform initiatives could support transformative change but such change will hinge on strong political backing and community support. Rhode Island officials view exchange design and drawing private insurance into Medicaid and Medicare innovation projects as important opportunities for delivery system reform. To this end, one of Rhode Island's main goals in implementing reform is ensuring that state agencies work together to align efforts so that the entire state pursues a unified vision.

Rhode Island officials are very interested in applying for an ACO project with Affordable Care Act funding. If ACO incentives are designed well, providers may recognize that advocating for prevention and population health policies has a good return on investment. Policies that support disease prevention and population health strategies, such as posting calorie counts, are more effective than education and outreach campaigns alone.

Rhode Island state officials consider payment reform one of many exciting delivery system opportunities in the Affordable Care Act; another is the provisions encouraging uptake of medical homes and care coordination for chronic care in Medicare. Rhode Island will have an opportunity to partner with providers on implementing these provisions that are not so focused on payment realignment.

Finally, Rhode Island officials are excited that national health reform advances efforts to tie EHRs into performance reporting. The officials see EHRs as a potentially disruptive technology that can move the delivery system to a preventive, population-based management focus rather than a disease-based system. Rhode Island's executive agencies hope to work with the Rhode Island Quality Institute, which has been focused

on HIT in the state, to implement meaningful EHR use in a way that truly transforms the delivery system.

---

## **VERMONT**

### **Overview**

Vermont has been fortunate to have governors and a legislature who are committed to reform across parties. This has allowed the state to pursue its health reform agenda even as other priorities divert attention elsewhere. In 2006, Vermont's legislature passed the Blueprint for Health (Blueprint), a vision, plan, and partnership designed to improve Vermont's health care system and the health of the state's population. Since 2006, the Blueprint has grown from a chronic care initiative into a statewide delivery system reform effort.

One principal Blueprint initiative has been advancing data aggregation and dissemination to drive data-driven decision-making at the clinical and statewide level. Another cornerstone of the Blueprint is the Blueprint Integrated Pilot Program (BIPP), in which community health teams, teams of various health professionals that coordinate care and educate patients and providers, support the implementation of medical homes, with a financial realignment component supported by Medicaid and the state's private insurers. The initial pilot was targeted to include 14 practices, 44 physicians, and 6,000 covered lives.<sup>35</sup> Legislation passed in 2007 and 2008 strengthened the involvement of private insurers. In May 2010, Vermont's legislature passed a health reform bill that included provisions to expand BIPP statewide.<sup>36</sup> The state hopes to use the various federal funds available in ARRA and the Affordable Care Act to support scaling up BIPP. Blueprint works closely with the private, non-profit Vermont Program for Quality in Health Care (VPQHC).

### **Data Collection and Standardization**

Vermont's evaluation infrastructure is based on various levels of data, with each level aggregated in its own database. First, the centralized clinical registry compiles common elements from EHRs used by providers statewide; the goal of the registry is to use the same data that is collected in everyday clinical practice to drive evaluation and improvement. Once BIPP is expanded, there will be a statewide, electronically reported, clinical data registry. Second, the multipayer database is an aggregated central repository for claims data from all commercial payers and Medicaid; Vermont hopes to include Medicare data as well. Next, Vermont conducts statewide chart reviews, along with NCQA scoring. The University of Vermont has a contract with the state to serve as an

independent and objective NCQA scorer, but Vermont hopes to do away with chart reviews and NCQA scoring once the centralized clinical registry is fully functioning and comprehensive. Finally, the state maintains a number of statewide public health registries to track patterns of prevalence and utilization, and to use for health system planning; Vermont wants to develop its public health registries to be interoperable with its other health care data systems.

### **Public Reporting**

Currently, each of Vermont's five levels of data collection has a dedicated reporting infrastructure. Later this year, Vermont will release its first Web-based performance reporting dashboard. The dashboard will provide dynamic, live reporting on clinical processes and outcomes, using data from the centralized clinical registry. Users will be able to select any level (from state to organization to site to individual provider) to view comparative effectiveness and benchmark reporting. Different levels of identification or de-identification will be available to different users. In the future, Vermont hopes to include claims data from the multipayer database in the dashboard as well.

### **Payment Reform**

Vermont's BIPP includes a per-person per-month financial incentive for providers, based on NCQA scores, on top of fee-for-service payment. Medicaid and Vermont's three commercial payers participate, and the state covers the cost of the Medicare share.<sup>37</sup> Additionally, the cost of the BIPP community health teams is shared by the payers. The payment reform will expand statewide when BIPP scales up. Vermont's May 2010 legislation also commissions a study that will examine different models of global payment reform and their applicability to Vermont.

### **Consumer Engagement**

Vermont engages consumers at the local level, with providers and service areas producing materials and educating their own patient populations. Blueprint holds patient education sessions called Healthy Living Workshops for patients with chronic diseases.<sup>38</sup> In addition, Vermont has a shared decision-making demonstration project that uses community health teams to train providers and patients to improve care self-management and decision-making. As BIPP expands statewide, Vermont hopes to implement a broader consumer communications plan, which is still in development stages.

## **Provider Engagement**

In addition to serving on the Blueprint central committee, each hospital service area has provider-driven planning work groups. The planning work groups coordinate the community health teams.

Vermont also has two demonstration projects that support providers: shared learning collaboratives and teams of facilitators and coaches that use data to work with practices and plan ongoing quality improvement. Both projects will rely on Vermont's new data dashboard to inform discussions with providers. Blueprint is funding VPQHC, its private partner, to facilitate the shared learning collaboratives. The VPQHC collaboratives work with FQHCs and practices to prepare them for becoming medical homes and for eventual NCQA scoring.<sup>39</sup>

## **Health Reform**

Key Vermont players see health reform as a way to strongly support the work already underway as part of the Blueprint. Many of the new funding opportunities in health reform tie into Blueprint initiatives, so Vermont's Blueprint team hopes to use the influx of new funds to expand projects and drive a more comprehensive and widespread reform than would have been possible with state funds alone. For instance, receiving Medicare funds for the advanced primary care BIPP sites would mean that the state would no longer pay the quality incentive costs for Medicare patients, freeing funds for other purposes. Some Vermont state officials see the Affordable Care Act as a way to flesh out state activities, especially with regard to data systems, in that the Affordable Care Act will give states new ways to integrate their data and make data systems more dynamic. They see ongoing project evaluation as key to transformative change and hope to develop a system in which projects can be modified mid-course, in response to data. Officials hope that the Affordable Care Act allows the state's current reform initiatives lead to truly transformative reform.

---

## **WASHINGTON**

### **Overview**

Washington's 2007 state health reform legislation, the Healthy Washington Initiative, called for payment reform, a shared-decision making project, and the establishment of the Washington State Quality Forum, within the state's health agency, the Health Care Authority. The legislation was based on the recommendations of the Washington State Blue Ribbon Commission on Health Care Costs and Access, which was convened by Governor Chris Gregoire. Though the Quality Forum was a victim of the state's recent

budget deficits, Washington's quality improvement work continues. The state works closely with the Puget Sound Health Alliance, a nonprofit regional partnership of consumers, doctors, hospitals, employers, unions, and health plans, which serves a five-county region that includes Seattle (<http://www.pugetsoundhealthalliance.org/>). Governor Gregoire aligned her health reform proposal with the Alliance's prior efforts.

### **Data Collection and Standardization**

Washington continues to work with the Puget Sound Health Alliance to coordinate reporting efforts in the Alliance's service region. The state is also discussing an all-payer claims database with legislators.

### **Public Reporting**

The Puget Sound Health Alliance's Community Checkup Web site (<http://www.wacommunitycheckup.org/>) allows consumers to access the performance reporting data collected by the Puget Sound alliance. In October 2009, the alliance added health plan data to Community Checkup, giving consumers a level of information beyond the existing provider-level data.<sup>40</sup>

### **Payment Reform**

Washington began its medical homes pilot in spring 2009, with 33 practices; the pilot has a special focus on diabetes patients, and includes the entire patient panel for one provider in each practice. Washington's multipayer reimbursement pilot entered planning stages in June 2009. Four work groups were convened on practice transformation, aligning incentives, consumer engagement, and measurement/evaluation. As a result, Washington developed plans to implement two pilot models by early 2011: one model does not provide any additional revenue to practices but will allow providers to share savings, and the other will give providers funds up front that will be reduced if providers do not reach target outcomes of avoidable emergency room and hospital utilization. Eight health plans, including two Medicaid managed care plans, have agreed to participate, and Washington is applying to include Medicare as well. Finally, legislation in 2010 mandated that the state convene two ACO pilots; Washington will select a lead organization for the pilots by January, 2011.

### **Consumer Engagement**

Washington became the first state to establish a shared decision making/patient decision aids demonstration project, through legislation passed in 2007. Washington convened a multi-stakeholder shared decision-making collaborative, and developed plans for two patient decision aid pilot projects; one pilot began in January 2009 and the other in

January 2010. Washington plans to evaluate the effect of both pilots on utilization and costs, and to evaluate the return on investment of the patient decision aids.<sup>41</sup>

In addition, state officials see public reporting on the Internet as an important opportunity for consumer engagement. The state is looking for ways to present the newly available information to consumers, so that they begin to trust sources of health care information beyond their physician's opinions. Washington officials view those Affordable Care Act provisions that seek to expand the availability of internet reporting to consumers as an enormous opportunity for states to engage and empower and harness them as allies.

### **Provider Engagement**

An important part of Washington's state reform efforts was discussions with provider organizations that informed the state on which reforms could garner support and interest from the provider community. Washington received an Improving Practice in Performance grant, which allowed it to join with the Washington Academy of Family Physicians to develop the patient-centered medical home learning collaborative in which providers participating in the medical home pilot can convene to share experiences and receive technical assistance. In addition, quality improvement coaches visit the medical homes pilot sites. The Washington State Hospital Association was also one of three state's selected to participate in IHI's State Action for Avoidable Rehospitalizations (STAAR) initiative. This initiative is coordinated with the payment reform initiative to share the goal of avoiding unnecessary hospital admissions.

### **Health Reform**

Washington officials hope to incorporate federal health reform into the existing state quality improvement efforts rather than changing direction. Further, key Washington state officials view all components of health reform more as opportunities to drive delivery system reform than as simple coverage expansion initiatives. In its federal reform implementation process, the state is carefully considering how to structure their exchange and public programs so that they drive quality and efficiency. Washington believes that delivery system reforms that increase quality and efficiency are key to the long-term sustainability of the Affordable Care Act's coverage components. Furthermore, Washington officials see a need for both the state and the federal government to maintain flexibility in implementation, so that reform can meet the varying regional needs within the state.

In April 2010, Governor Gregoire used an executive order to establish the Health Care Cabinet to oversee federal health reform implementation. Among the cabinet's charges are maintaining key partnerships such as that with the Puget Sound Health Alliance; developing a plan to consolidate duties, functions, and powers with respect to public purchasing of health care; and "assuring on-going information sharing and coordination of efforts with the Office of Insurance commissioner so that delivery system improvements are coordinated with insurance reforms."<sup>42</sup> Washington officials are particularly interested in using Affordable Care Act funding to drive delivery system innovation through models like ACOs.



## APPENDIX B. KEY CONTACTS/INFORMANTS

### Colorado

Phil Kalin  
*Executive Director*  
Center for Improving Value in Health Care  
[pkalin@civhc.org](mailto:pkalin@civhc.org)

### Kansas

Andrew Allison  
*Executive Director*  
Kansas Health Policy Authority  
[andrew.allison@khpa.ks.gov](mailto:andrew.allison@khpa.ks.gov)

Hareesh Mavoori  
*Director of Data Policy and Evaluation*  
Kansas Health Policy Authority  
[Hareesh.Mavoori@khpa.ks.gov](mailto:Hareesh.Mavoori@khpa.ks.gov)

### Maine

Josh Cutler  
*Director*  
Maine Quality Forum  
[josh.cutler@maine.gov](mailto:josh.cutler@maine.gov)

Karynlee Harrington  
*Executive Director*  
Dirigo Health Agency  
[Karynlee.Harrington@maine.gov](mailto:Karynlee.Harrington@maine.gov)

### Massachusetts

David Morales  
*Commissioner*  
Executive Office of Health and Human  
Services,  
Division of Health Care Finance and Policy  
[david.morales@state.ma.us](mailto:david.morales@state.ma.us)

Seena Carrington  
*Chief of Staff and Chief Operating Officer*  
Executive Office of Health and Human  
Services, Division of Health Care Finance  
and Policy  
[seena.carrington@state.ma.us](mailto:seena.carrington@state.ma.us)

David Martin  
Director of Health Care Policy and Strategies  
Executive Office of Health and Human  
Services  
[David.Martin@state.ma.us](mailto:David.Martin@state.ma.us)

Jessica Moschella  
*Administrative Director*  
Health Care Quality and Cost Council  
[jessica.moschella@state.ma.us](mailto:jessica.moschella@state.ma.us)

### Minnesota

Carol Backstrom  
*Assistant to the Commissioner*  
Minnesota Department of Health  
[Carol.Backstrom@state.mn.us](mailto:Carol.Backstrom@state.mn.us)

### Oregon

Jeanene Smith  
*Deputy Administrator*  
Office for Oregon Health Policy Research  
[Jeanene.smith@state.or.us](mailto:Jeanene.smith@state.or.us)

### Pennsylvania

Ann Torregrossa  
*Director*  
Governor's Office of Health Care Reform  
[atorregros@state.pa.us](mailto:atorregros@state.pa.us)

### Rhode Island

David Gifford  
*Director*  
Department of Health  
[David.Gifford@health.ri.gov](mailto:David.Gifford@health.ri.gov)

Tricia Leddy  
*Senior Policy Advisor*  
Department of Health  
[tricia.leddy@health.ri.gov](mailto:tricia.leddy@health.ri.gov)

### Vermont

Craig Jones  
*Director*  
Vermont Blueprint for Health  
[craig.jones@state.vt.us](mailto:craig.jones@state.vt.us)

Lisa Dulskey Watkins  
Vermont Blueprint for Health  
*Assistant Director*  
[lwatkin@vdh.state.vt.us](mailto:lwatkin@vdh.state.vt.us)

**Washington**

Richard Onizuka  
*Health Policy Director*  
Washington Health Care Authority  
*Richard.Onizuka@hca.wa.gov*

Jonathan Seib  
Executive Policy Advisor for Health Care  
Reform  
Governor's Executive Policy Office  
*Jonathan.Seib@gov.wa.gov*

## NOTES

<sup>1</sup> K. Davis, C. Schoen, and K. Stremikis, *Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally, 2010 Update* (New York: The Commonwealth Fund, June 2010).

<sup>2</sup> D. McCarthy, S. K. How, C. Schoen, J. C. Cantor, and D. Belloff, *Aiming Higher: Results from a State Scorecard on Health System Performance, 2009* (New York: The Commonwealth Fund, Oct. 2009).

<sup>3</sup> K. Davis, S. Guterman, S. R. Collins et al., *Starting on the Path to a High Performance Health System: Analysis of Health System Reform Provisions of Reform Bills in the House of Representatives and Senate* (New York: The Commonwealth Fund, Dec. 2009).

<sup>4</sup> D. Justice, C. Hess, and A. Weil on behalf of NASHP Members, *State Policymakers' Priorities for Improving the Health System* (Portland, Maine: National Academy for State Health Policy, Nov. 2009).

<sup>5</sup> J. Rosenthal and C. Hanlon, *State Partnerships to Improve Quality: Models and Practices from Leading States Report* (Portland, Maine: National Academy for State Health Policy, June 2009).

<sup>6</sup> Ibid.

<sup>7</sup> We used the framework as in the paper for our research, but made some slight modifications given updated thinking from our analysis.

<sup>8</sup> The 2009 NASHP report entitled *State Partnerships to Improve Quality: Models and Practices from Leading States Report*, available at: <http://nashp.org/sites/default/files/Quality%20Improvements%20FINAL.pdf>.

<sup>9</sup> Rosenthal and Hanlon, *State Partnerships to Improve Quality*, 2009.

<sup>10</sup> Ibid.

<sup>11</sup> The Governor's Office of Health Policy and Finance with The Advisory Council on Health Systems Development. *2010–12 Maine State Health Plan: Making Us Better, Improving Health and Lowering Cost*, available at: <http://www.maine.gov/healthreform/health-plan.shtml>.

<sup>12</sup> State of Washington Office of the Governor, *Executive Order 10-01 Implementing Health Reform the Washington Way*, available at: [www.governor.wa.gov/execorders/eo\\_10-01.pdf](http://www.governor.wa.gov/execorders/eo_10-01.pdf).

<sup>13</sup> Minnesota has not yet developed an enforcement mechanism for this requirement.

<sup>14</sup> D. Love, W. Custer, and P. Miller, *All-Payer Claims Databases: State Initiatives to Improve Health Care Transparency* (New York: The Commonwealth Fund, Sept. 2010).

<sup>15</sup> National Academy for State Health Policy, *State Policymakers' Priorities for Successful Implementation of Health Reform*, available at: <http://nashp.org/node/2050>, accessed Aug. 26, 2010.

<sup>16</sup> The Beacon Community Cooperative Agreement Program will provide funding to communities to build and strengthen their health information technology infrastructure and exchange capabilities. More information is available at: <http://www.grants.gov/search/synopsis.do?sessionId=zDBPM9pdwpRtshvxx50BBjV7SsgcNJs5qS1J121m4T14pJ2n3CtZ!1682760543>.

<sup>17</sup> Davis, Schoen, and Stremikis, *Mirror, Mirror on the Wall*, 2010.

<sup>18</sup> Expert Panel on End of Life Care, "Update to Quality and Safety Committee on DRAFT Recommendations" PowerPoint presentation, Expert Panel on End of Life Care, Boston, Feb. 3,

2010, available at:

[http://www.mass.gov/Ihqcc/docs/meetings/2010\\_02\\_03\\_expert\\_panel\\_on\\_EOL\\_update.ppt](http://www.mass.gov/Ihqcc/docs/meetings/2010_02_03_expert_panel_on_EOL_update.ppt), accessed Aug. 13, 2010.

<sup>19</sup> H. Pelletier, *How States Are Working with Physicians to Improve the Quality of Children's Health Care* (Portland, Maine: National Academy for State Health Policy, April 2006).

<sup>20</sup> State profiles reflect progress since June 2009 profiles. J. Rosenthal and C. Hanlon, *State Partnerships to Improve Quality: Models and Practices from Leading States Report* (Portland, Maine: National Academy for State Health Policy, June 2009), available at: <http://nashp.org/sites/default/files/Quality%20Improvements%20FINAL.pdf>, accessed Aug. 11, 2010.

<sup>21</sup> Rosenthal and Hanlon, *State Partnerships to Improve Quality*, 2009.

<sup>22</sup> Kansas Health Policy Authority, *Kansas Health Indicators* (Topeka, Kan.: Kansas Health Policy Authority, March 26, 2009), accessed Aug. 13, 2010, available at: [http://www.khpa.ks.gov/data\\_consortium/data\\_consortium\\_health\\_indicators/DataConsortiumHealthIndicators.pdf](http://www.khpa.ks.gov/data_consortium/data_consortium_health_indicators/DataConsortiumHealthIndicators.pdf).

<sup>23</sup> Kansas SB 81-2008 *An Act Enacting the Health Care Reform Act of 2008* (available at: <http://www.kslegislature.org/bills/2008/81.pdf>).

<sup>24</sup> While CIGNA, Maine's fourth commercial payer, is not participating in the medical home pilot, it is currently pursuing its own medical home initiative.

<sup>25</sup> The Shared Decision-making Study Group for the Dirigo Health Agency's Maine Quality Forum, *Interim Report: The Practice and Impact of Shared Decision-making* (Augusta, Maine: Maine Quality Forum, May 2010).

<sup>26</sup> The Governor's Office of Health Policy and Finance with The Advisory Council on Health Systems Development. *2010-12 Maine State Health Plan* (Augusta, Maine: Governor's Office of Health Policy and Finance, July 2010), available at <http://www.maine.gov/tools/whatsnew/attach.php?id=105356&an=1>, accessed Aug. 13, 2010.

<sup>27</sup> 2010–12 Maine State Health Plan, p.73.

<sup>28</sup> Expert Panel on End of Life Care. *Update to Quality and Safety Committee on DRAFT Recommendations* (Boston: Expert Panel on End of Life Care, Feb. 3, 2010), available at [http://www.mass.gov/Ihqcc/docs/meetings/2010\\_02\\_03\\_expert\\_panel\\_on\\_EOL\\_update.ppt](http://www.mass.gov/Ihqcc/docs/meetings/2010_02_03_expert_panel_on_EOL_update.ppt), accessed on Aug. 13, 2010.

<sup>29</sup> Health Care Quality and Cost Council, *Roadmap to Cost Containment Final Report* (Boston: Massachusetts Health Care Quality and Cost Council, Oct. 21, 2009).

<sup>30</sup> Minnesota Department of Health, *Strategies to Engage Consumers about Health Care Cost and Quality* (St. Paul, Minn.: Minnesota Department of Health, Jan. 2010), available at: <http://www.health.state.mn.us/healthreform/consumer/ConsumerEngagementReport.pdf>, accessed on Aug. 13, 2010.

<sup>31</sup> Ibid.

<sup>32</sup> See [http://www.ohic.ri.gov/documents/Insurers/Reports/2010\\_Hospital\\_Payment\\_Report/2010\\_Variations\\_in\\_Hospital\\_Pmt\\_Rates.pdf](http://www.ohic.ri.gov/documents/Insurers/Reports/2010_Hospital_Payment_Report/2010_Variations_in_Hospital_Pmt_Rates.pdf).

<sup>33</sup> Office of the Health Insurance Commissioner, *About Us* (Providence, R.I.: Office of the Health Insurance Commissioner), available at: <http://www.ohic.ri.gov/AboutUs.php>, accessed on Aug. 13, 2010.

<sup>34</sup> The Healthy RI Task Force Report is available online at:  
<http://www.ltgov.ri.gov/taskforce/Healthy%20RI%20Task%20Force%20Report%2009.23.10.pdf>.

<sup>35</sup> More information about the Blueprint Integrated Pilot Program is available at  
<http://www.pcpcc.net/con10t/vermont-blueprint-integrated-pilot-program>.

<sup>36</sup> Vermont S. 88, 2010, *An Act Relating to Health Care Financing and Universal Access to Health Care in Vermont*, available at:  
<http://www.leg.state.vt.us/database/status/summary.cfm?Bill=S.0088&Session=2010>.

<sup>37</sup> Vermont Department of Health, *Blueprint for Health 2009 Annual Report* (Burlington, Vt.: Vermont Department of Health, Jan. 2010), available at:  
[http://healthvermont.gov/prevent/blueprint/documents/Blueprint\\_AnnualReport\\_2009\\_0110rev.pdf](http://healthvermont.gov/prevent/blueprint/documents/Blueprint_AnnualReport_2009_0110rev.pdf), accessed on Aug. 13, 2010.

<sup>38</sup> Ibid.

<sup>39</sup> Ibid.

<sup>40</sup> Washington State Health Care Authority, “Puget Sound Health Alliance Adds Health Plans to Community Checkup Report,” Press release (Olympia, Wash.: Washington State Health Care Authority, Oct. 23, 2009), available at: [http://www.hca.wa.gov/press\\_release/puget-sound-health-alliance-adds-health-plans.html](http://www.hca.wa.gov/press_release/puget-sound-health-alliance-adds-health-plans.html), accessed on Aug. 13, 2010.

<sup>41</sup> R. Onizuka, “Engaging Consumers In Health Care in Washington State” (presentation, Washington State Health Care Authority, Olympia, Wash., Feb 8, 2010), available at: [http://www.academyhealth.org/files/nhpc/2010/NHPC2010\\_Onizuka.pdf](http://www.academyhealth.org/files/nhpc/2010/NHPC2010_Onizuka.pdf), accessed on Aug. 13, 2010.

<sup>42</sup> Washington State Office of the Governor, “Gov. Gregoire Takes Immediate Steps to Implement Healthcare Reform in Washington State,” Press release (Olympia, Wash.: Office of the Governor, April 1, 2010), available at: <http://www.governor.wa.gov/news/news-view.asp?pressRelease=1469&newsType=1>, accessed on Aug. 13, 2010.