CREATING THE FRAMEWORK FOR HIGH PERFORMING HEALTH CARE ORGANIZATIONS

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Hearings of Massachusetts Division of Health Care Finance and Policy on Health Care Costs Trends

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Thank you Commissioner Morales for the opportunity to participate in these hearings of the Division of Health Care Finance and Policy "on health care costs, provider and insurer costs, and strategies to mitigate these cost trends". I am Executive Vice President for Programs of The Commonwealth Fund, a national grant-making foundation based in New York City

In 2005, The Commonwealth Fund's Board of Directors approved our developing a Commission on a High Performance Health System and charging it with "recommending policies and practices that would move the United States toward a higher-performing health care system that achieves better access, improved quality, and greater efficiency, and focuses particularly on the most vulnerable due to income, minority status, health, or age." There currently are 17 members of the Commission. The chairman since its inception is James J. Mongan, former Chief Executive Officer of Partners Health Care; and there are two other current members of the Commission from Massachusetts – Maureen Bisognano, the Chief Operating Officer of the Institute for Healthcare Improvement, and Michael Chernew, professor of health economics at Harvard Medical School. For the first

four years, Cleve Killingsworth, then Chairman and CEO of Mass Blue Cross Blue Shield, was also a Commissioner.

Early on, the Commission established that the objective of health care and a high performance health system is to help everyone, to the extent possible, lead long, healthy, and productive lives.[1] It stated that a high performance health system accomplishes this by providing: access to care for all; high quality care; efficient use of resources; and relentless system and workforce innovation and improvement.

The Commission evaluated the performance of the U.S. through national and state scorecards.[2] The scorecards document that in each dimension (as shown in Exhibit 1), average performance is only about two-thirds of achievable benchmarks. There also is wide variation across the country. As seen in Exhibit 2, in the most recent state scorecard published last October, Massachusetts' overall performance was very high - 7th out of the 50 states and District of Columbia. Like almost all other states, Massachusetts' performance did vary by dimension. Not surprisingly, given the Commonwealth's landmark health care reform law and its implementation, Massachusetts ranked first in the country on "access to care". It was 5th on "prevention and treatment", 6th on "healthy lives", 7th on "equity", and 33rd on "avoidable hospital use and costs".[3] Although it is fitting that the principal subject of these hearings is related to cost, and cost is higher throughout the United States than in other countries, Massachusetts ranks near the middle of states in per capita health spending as a percent of Gross State Product (GSP)[4] and better than average in employer premiums as a percentage of median household income for persons under age 65.[5]

In November 2007, as the country was beginning to prepare for the last presidential election, the Commission on a High Performance Health System published a report that laid out an "Ambitious Agenda" for the next president.[6] It defined a set of 5 strategies for achieving a high performance health system in the U.S. (as shown in Exhibit 2A): The first is to extend affordable health insurance to all; the second is

to align financial incentives to enhance value and achieve savings; the third is to organize the health care system around the patient to ensure that care is accessible and coordinated; the fourth is to reach current benchmarks and continually raise performance for high-quality, efficient care – in short, to ensure increasing accountability for quality and cost; and the fifth is to develop accountable leadership and strong public/private collaborations throughout the health system. In Massachusetts, you have extended health insurance and have the lowest rates of uninsured in the country. The challenge now is to make it sustainably affordable. I believe that will require attention to all of the other four strategies. Since, they are inter-related, it also will require addressing them together and not in isolation from each other.

I would love to be able to give you a listing of high performance delivery system organizations in the United States and Massachusetts – ones that have demonstrated excellent access, high quality/equitable care that achieves excellent clinical and patient experience outcomes, and costs that are low and trending down year over year. But, I do not have a list of organizations that meet all those criteria. The U.S. lacks an agreed upon set of performance criteria for health care organizations that can be used to assess even their quality and cost across all the populations they serve.

The measures we have, cover just a part of the picture. For instance, last summer, the Institute for Healthcare Improvement and the Brookings Institution convened representatives of 20 of the more than 300 Hospital Referral Regions or HRRs from around the country. They chose 20 HRRs that have been shown by investigators at Dartmouth Medical School to have some of the lowest costs for comparable outcomes in the country. The choice of those communities as exemplars of high performance has since been criticized as representing examination of only limited outcomes and only Medicare cost data. Although it is undeniably important for Medicare, the single largest payer for health care in the United States, to know who performs best for its beneficiaries and how they do it, I believe that a *major national and state priority* should be *obtaining agreement on a standard set of quality and cost*

***measures that can be collected across all populations and all payers*.** **To develop so-called "Accountable Care Organizations" and recognize their achievements, it is essential to reach general agreement on how their performance will be measured.**

Although there is a lot we do not know about performance, let me start with what we do know: First, as Exhibits 3 and 4 illustrate, we know that organization of care is a necessary condition for higher quality and cost performance; but it is not a sufficient condition. Second, we also know that integration of care within health care settings and across settings – i.e., across transitions in care - is important for achieving higher quality and efficiency of care. A key element for achieving integration and coordination is "information continuity". "Information continuity" is the ability to provide a continuous flow of data and synthesized information across all the individual people and units that are involved in a patient's care. It doesn't happen often. Third, we know that our current lack of integration and organization of care reflects at least two things: One, as shown in Exhibits 5 and 6, has been the slow adoption of health information technology in the U.S. vs. other developed countries. This is beginning to be addressed at the national level thanks to the appointment of a strong National Coordinator for Health Information Technology, Dr. David Blumenthal, and about $30 billion of funds specifically for health information technology in the American Recovery and Reinvestment Act of 2009 (or "stimulus bill). Another key factor fostering lack of organization and integration of care is the current payment incentive structure for health care. It is, predominantly fee-for-service, which encourages higher volume of services and fragmentation. Current payment incentives, including DRGs, also do not foster care that meets the highest quality and safety standards. There is no financial incentive for hospitals to reduce emergency room visits, hospitalizations, complications such as central line associated blood-stream infections, or re-hospitalizations. Nonetheless, some hospitals are participating in efforts in each of these areas. Indeed, a group of hospitals in Massachusetts is participating in an effort to reduce re-hospitalizations that we are funding. But, many hospital CEOs

are able to sleep comfortably at night without addressing these issues, and many feel there is no "business case" and they "cannot afford" to address them.

Exhibit 7 shows the relationship between the two major types of payment reform and the organization of the delivery system.[7] The two major types of payment reforms, bundling and pay-for-performance, have different objectives. The principal objective of bundling is to stimulate more efficient use of resources, whereas the principal objective of pay-for-performance is to assure better quality of care and achieve better outcomes. Bundling ranges in complexity from the simple use of diagnosis-related groups (DRGs) by Medicare, which aggregates the hospital services provided in a single admission, to full global payment (or capitation), which aggregates payment for a single patient over a period of time such as a year. Pay-for-performance ranges from payments based on simple process measures to more sophisticated measures of coordination and risk-adjusted outcomes measures. And, delivery system organization ranges from small practices or single hospitals, to networks of independently-practicing physicians, physician-hospital organizations, multi-specialty group practices, and fully integrated physician/hospital delivery systems. It is much more feasible to achieve higher performance – more effective and efficient care - in the more organized forms of delivery system.

There are many ways that organizations can achieve better health outcomes for their patients at lower costs and these are detailed in a report by McCarthy et al, that is referenced in the printed testimony.[8]

The challenge is to drive health care delivery from its current mostly fragmented, un-wired state into the organizational structures that are capable of achieving the desired health and cost outcomes, and then to assure that those organizations achieve the desired health and cost outcomes. You are undoubtedly familiar with Mass. Blue Cross Blue Shield's alternative quality contract program, which is one model for encouraging organization and performance. Another is being employed by Blue Cross Blue Shield of Michigan. Its Physician Group Incentive Program

(PGIP) is a pay-for-performance program that rewards both quality and cost and involves about 6,500 physicians. The payments are made only to groups of physicians such as physician organizations, and electronic data collection and sharing is a requirement of participation. In an effort to create program "ownership", it is physicians who structure the initiatives for the insurer.[9]

One concern about stimulating the development of large health care delivery organizations is reflected in the recent preliminary report of Attorney General Coakley on health care cost trends and cost drivers in this state[10] and a similar report from the Office of the Health Insurance Commissioner of Rhode Island.[11] Both of these reports provide evidence that market leverage is a dominant driver of current payment, an issue that needs to be dealt with and that will require strong and talented leadership at the national, state, and local levels. It will involve addressing head-on very complicated issues of health care design and financing. Speaking personally, I believe that at a minimum, we are going to have to achieve price and performance transparency; and possibly we will need all-payer prices or rate-setting. Only 2 states, Maryland and West Virginia currently have all-payer hospital rate-setting.[12] In the early 1990s it was thought that "managed care" would be more effective at controlling hospital costs and health care spending than regulation. Yet, during the period 1975-1991 when Massachusetts had its program, the increase in hospital costs here averaged 20 percent below the U.S. as a whole. Since discontinuing the program, Massachusetts' increases in hospital costs have been slightly above the national average.

It is worth remembering that there are many ways to bend the cost curve (Exhibit 8).[13] They relate not just to payment reform and regulation but to diverse efforts such as generating better evidence and deploying it to achieve evidence-based medicine and informed decisions by patients, and increased efforts to control obesity, tobacco and substance use.

To change the existing cost trends is going to require a full-court press. This simply cannot occur without strong and competent leadership at the national and state levels. Government's levers should be exercised in the context of goals for performance of the health system. We currently have no national health care goals,[14] and I am unaware of explicit state goals.

In setting goals, it is highly unlikely that a state or the nation, can fully satisfy all of the disparate interests within it. For the sake of discussion, I will assume that one goal will be to bend the cost curve, and one of the strategies will be to develop more robust primary care, which has been sine qua non in almost every country that has better outcomes and lower costs than we do. Yet how will you do this in Massachusetts? This state has an excellent highly specialized and sub-specialized physician workforce. Even though, in primary-care-oriented health systems, specialists and sub-specialists are still essential to provision of excellent care, one needs relatively fewer of them than we have today.[15]

Another example of a strategy to bend the cost-curve and provide higher quality care would be to develop a group of locally organized after-hours services across the state to reduce the use of emergency rooms and decrease hospital admissions. The Netherlands and Denmark both have required and developed such programs. In both countries, they are physician-organization and have achieved excellent results.[16]

Yet another state strategy might be to encourage substitution of competent, but less expensive labor, for more expensive labor. This is likely to require a change in various state scope-of-practice laws and regulations. It is predictable that proposing such changes is going to pit various groups of professionals and workers against each other and the state – e.g., physicians and nurses; opthalmologists and optometrists; nurses and nursing assistants.

Thus, in order to set goals, and develop and implement strategies to achieve them, it will be critically important for government to convene the key stakeholders whose participation is essential to achieving the goals, recognize that the various stakeholders have conflicting interests, and seek to come up with the fairest solutions consistent with the goals.

Finally, and certainly not least, it is extremely important to engage the public or patients. They must be convinced that whatever is done will yield as good or better care and more affordable care than they otherwise would have. The national reform debate has shown that this is an uphill battle. The public may be beginning to realize that the U.S. health system could perform better, but most individuals who have insurance coverage and access to health care believe that their own care is at least satisfactory if not excellent; and they fear change. The major issue for individuals has been the costs of care - both contributions for coverage and out-of-pocket costs. Yet, efforts to reduce health care costs are greeted suspiciously by the public and individuals as efforts to stint on needed health care services. The public must understand just what is being done and why, and ideally the public should be integrally involved in the process. The central principle of patient-centered care, "Nothing about me without me" should also be a central principle of efforts to reform the health system and improve its performance.

Thank you.

[1] The Commonwealth Fund Commission on a High Performance Health System, Framework for a High Performance Health System for the United States, The Commonwealth Fund, August 2006. Accessible at: http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2006/Aug/Framework%2

0for%20a%20High%20Performance%20Health%20System%20for%20the%20United%20States/Commission_framework_high_performance_943%20pdf.pdf

[2] National scorecards were issued in 2006 and 2008:
The Commonwealth Fund Commission on a High Performance Health System, Why Not the Best? Results from a National Scorecard on U.S. Health System Performance, The Commonwealth Fund, September 2006; and
The Commonwealth Fund Commission on a High Performance Health System, Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008, The Commonwealth Fund, July 2008

State scorecards were issued in 2007 and 2009:
J. C. Cantor, C. Schoen, D. Belloff, S. K. H. How, and D. McCarthy, Aiming Higher: Results from a State Scorecard on Health System Performance, The Commonwealth Fund Commission on a High Performance Health System, June 2007; and
D. McCarthy, S. K. H. How, C. Schoen, J. C. Cantor, D. Belloff, Aiming Higher Results from a State Scorecard on Health System Performance, 2009, The Commonwealth Fund, October 2009.

The reports and accompanying documents including chartpacks can be accessed at:
www.comonwealthfund.org

[3] D. McCarthy, S. K. H. How, C. Schoen, J. C. Cantor, D. Belloff, Aiming Higher Results from a State Scorecard on Health System Performance, 2009, The Commonwealth Fund, October 2009. Accessible at:
http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2009/Oct/1326_McCarthy_aiming_higher_state_scorecard_2009_full_report_FINAL_v2.pdf

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http://www.mass.gov/Eeohhs2/docs/dhcfp/r/cost_trends_files/part1_system_in_context.pdf

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http://www.commonwealthfund.org/~/media/Files/Publications/Data%20Brief/2009/Aug/1313_Schoen_paying_the_price_db_v3_resorted_tables.pdf

[6] Commission on a High Performance Health System, A High Performance Health System for the United States: An Ambitious Agenda for the Next President, The Commonwealth Fund, November 2007. Available at:
http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2007/Nov/A%20High%20Performance%20Health%20System%20for%20the%20United%20States%20%20An%20Ambitious%20Agenda%20for%20the%20Next%20President/Ambitious_Agenda_1075%20pdf.pdf

[7] A. Shih, K. Davis, S. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy, Organizing the U.S. Health Care Delivery System for High Performance, The Commonwealth Fund, August 2008. Available at:
http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2008/Aug/Organizing%20the%20U%20S%20%20Health%20Care%20Delivery%20System%20for%20High%20Performance/Shih_organizingushltcaredeliverysys_1155%20pdf.pdf

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http://www.commonwealthfund.org/~/media/Files/Publications/Case%20Study/2009/Jul/1288_McCarthy_Overview_report_final.pdf

[9] See: http://www.bcbsm.com/provider/value_partnerships/index.shtml and http://www.valuepartnerships.com/programs/phys03.shtml

[10] Office of Attorney General Martha Coakley. Investigation of health care cost trends and cost drivers: Pursuant to G.L. c. 118G, § 6½(b) January 29, 2101. Available at: http://www.mass.gov/Cago/docs/healthcare/Investigation_HCCT&CD.pdf

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[14] For an example of long term goals and shorter-term target indicators for achieving them, see: K. Davis and S. Schoenbaum, National Leadership to Achieve a Performance-Driven Health System, The Commonwealth Fund Blog, July 2009. Available at: http://www.commonwealthfund.org/~/media/Files/Publications/Blog/Davis_Schoenbaum_Blog_July_09.pdf

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