

# An Interim Report Card on Massachusetts Health Care Reform

## Part 4: Cost-Effective Quality

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*A Pioneer Institute White Paper*

*by Amy M. Lischko and Kristin Manzillo*



**PIONEER INSTITUTE**  
PUBLIC POLICY RESEARCH

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# **An Interim Report Card on Massachusetts Health Care Reform**

## **Part 4: Cost-Effective Quality**

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■ **An Interim Report Card on Massachusetts Health Care Reform:  
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## FOREWORD

In Massachusetts and across the country, the Commonwealth's health care reform has taken on an exaggerated "persona"; for some, it embodies all that is evil about government intrusion into health care markets; for others, it exhibits all the virtues of government action.

The simple fact is that the reform is an experiment. It is likely to succeed on some fronts and fail on others. Given the early stage of our 2006 reform, we are now only starting to gain access to data on outcomes, and the series of years covered is often inadequate to making judgments.

State-level experimentation is needed to test and ultimately to drive the national debate on health care reform. As occurred with welfare reform in the eighties and nineties, robust experimentation allowed federal officials to draw important lessons from the successes and failures of a number of states as they sought a thoughtful national welfare reform bill.

It is undeniably premature to enact a reasoned national-level solution based on Massachusetts' or other state experiments. They have yet to be evaluated. In a field as complicated as health care, where government involvement is already considerable and where states have historically played a defining role, we need a sensible debate based on facts.

That's where the *Interim Report Card* series of reports come in. Our *Report Card* series is the first attempt to provide a comprehensive assessment of the Massachusetts Health Care Reform Act. In January, we released an assessment of the reform's impact on access to care. The second chapter, released in February, covered equitable and sustainable financing and the third chapter, released in March, focused on administrative efficiency. This final chapter assesses cost-effective quality of care.

Pioneer has not yet taken a position on the reform act. We seek first to understand and measure its performance empirically. Only after publication of the *Report Card* series will we begin suggesting fixes and formulating a comprehensive position. The tone and substance of current federal proposals do not remotely resemble the quality of dialogue we need.

*James Stergios*

## INTRODUCTION

On April 12, 2006, Chapter 58 of the Acts of 2006, entitled “An Act Providing Access to Affordable, Quality, Accountable Health Care” was passed, reforming the Massachusetts health care system. The goals of the legislation were to make health insurance affordable to most every resident and establish mechanisms to help control health care inflation.<sup>1</sup>

Key components of the reform included employer and individual requirements, a small Medicaid expansion, the creation of a state-subsidized insurance program and an insurance exchange, and the merging of the non-group and small group insurance markets. Although the Massachusetts reform has expanded insurance coverage to many of the state’s uninsured, the success of other aspects of the reform has yet to be comprehensively evaluated. While much data has been collected on the reform’s impact, not all information has been gathered and evaluated in such a manner to provide an inclusive review of the reform.

As an alternative to analyzing the reform’s impact on isolated issues, in January 2009 the Pioneer Institute proposed a framework for evaluating the reform.<sup>2</sup> The framework focuses on an evaluation of four key areas:

- Reduction of barriers to access
- Equitable financing, based on ability to pay
- Administrative efficiency
- Cost-effective quality.

Specific metrics to evaluate each of the above areas were proposed in order to conduct a comprehensive review of Chapter 58. This quantitative outcomes approach can help highlight what has and has not worked well as a part of the Massachusetts reform, and can help guide policymakers on the latest reform efforts.

This report is the final report in a series of four. Earlier reports in this series evaluated access to health insurance and health care, equitable and sustainable financing, and administrative efficiency.<sup>3</sup> The focus of this report will be on cost-effective quality, and the analysis will be organized by the four “Scorecard Metrics” presented in Figure 1.

No new data collection was performed to conduct this evaluation. Rather, a systematic approach was taken to evaluate available data. Unfortunately, good data are not readily available for all of the proposed scorecard metrics. When this situation occurred, several different pieces of data were synthesized to arrive at a conclusion. A grade was assigned to each of the scorecard metrics as follows:

A = Excellent performance, high level of certainty that the goal has been achieved.

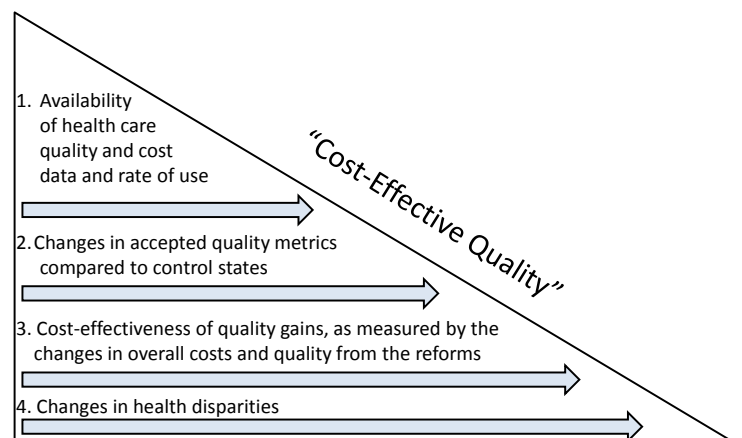
B = Good performance, moderate level of certainty that the goal has been achieved.

C = Mixed results, the available evidence is inconsistent, more research is needed.

D = Poor performance, a high level of certainty that the goal has not been achieved.

I = Current evidence is insufficient to assess whether the goal has been achieved.

**Figure 1: Cost-Effective Quality Metrics**



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### **BACKGROUND**

Prior to the reform, Massachusetts health care costs exceeded national averages and were growing at faster rates than the nation overall. For example, Massachusetts' 2004 per capita health expenditure of \$6,683 was 27% greater than the national average of \$5,283.<sup>4</sup> In addition, health care spending from 2000 to 2004 grew by 7.4% in Massachusetts, compared with 6.9% nationally.<sup>5</sup> However, Massachusetts also scored well on many of the quality indicators when compared to the rest of the nation. Massachusetts was ranked in the top 10 states for 7 out of 15 measures reported by the Agency for Healthcare Research and Quality (AHRQ) in 2006.<sup>6</sup>

Several components of Chapter 58 are identified as pertaining to cost-effective quality as follows:

- **Creation of Health Care Quality and Cost Council:** The Health Care Quality and Cost Council (HCQCC) is a semi-independent agency made up of Governor-appointed subject matter experts and state officials. The Council's mission includes improving health care quality, containing costs, and reducing racial and ethnic disparities. Additionally, the HCQCC is tasked with disseminating quality and cost information to the general public.<sup>7</sup>
- **Funding to establish an infection control program:** The Department of Public Health received funding to establish and implement an infection control program in licensed health care facilities.<sup>8</sup>
- **Creation of a Health Disparities Council:** Under the control of the Executive Office of Health and Human Services, the Health Disparities Council (HDC) aims to eliminate racial and ethnic disparities in health care and health outcomes. The HDC also addresses diversity in the health care workforce. The Council is made up of 34 members, including representatives from state government, health departments,

hospitals and academic medical centers, advocacy groups, and community members.<sup>9</sup>

- **Pay-for-Performance framework for MassHealth reimbursements:** MassHealth hospital reimbursements are subject to a pay-for-performance (P4P) framework. The P4P framework, implemented in October 2007, contains criteria aimed at reducing racial and ethnic health disparities in addition to other initiatives.<sup>10</sup>

### **SCORECARD METRIC 1: AVAILABILITY OF HEALTH CARE QUALITY AND COST DATA AND RATE OF USE**

In its efforts to improve access to quality, affordable, and accountable care, Chapter 58 created specific requirements to make quality and cost information more transparent and readily available to health care consumers. The law established the HCQCC under the leadership of the Secretary of Health and Human Services as a separate entity comprised of state and independent members. Under Chapter 58, insurers and providers are required to provide data to the HCQCC, which is charged with generating reports for policymakers about health care quality and cost trends in addition to providing information to the general public. Scorecard Metric 1 examines the availability of and utilization by consumers of quality and cost information.

The HCQCC's website, "My Health Care Options" (MHCO), was launched in December 2008.<sup>11</sup> MHCO contains quality and cost information for Massachusetts hospitals, including data specific to medical conditions and procedures. Users are given the option to search by provider name, location, medical condition, or procedure, although quality and cost information is only available for a limited number of conditions.

The HCQCC consults a variety of data sources to produce the quality metrics displayed on their website, including: Centers for Medicare and Medicaid Services (CMS), the Leapfrog Group, Massachusetts Department of Public Health's Data Acquisition Center (Mass-DAC), and the Agency for Healthcare Quality and Research (AHRQ).<sup>12</sup> While it is important that the HCQCC aggregates quality data from all available sources, there can sometimes be a substantial lag time between the collection and reporting of the quality data. Much of the quality data available to consumers now, for example, are based on care delivered in 2007. Although difficult, it seems that over time the HCQCC should be able to develop an approach to provide more timely data to consumers.

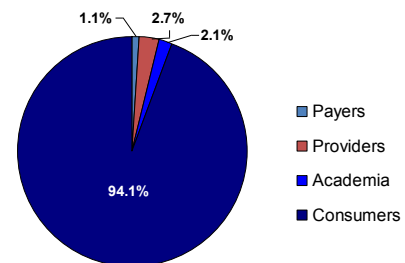
For the reporting of cost data, the HCQCC clearly describes how provider costs are calculated. The HCQCC maintains a database of paid claims for approximately two-thirds of the privately insured population in Massachusetts. This database includes paid claims for all fully-insured plans, the Massachusetts Group Insurance Commission, and self-insured Blue Cross Blue Shield of Massachusetts plans. The claims included in the metrics provided on the website currently were incurred from July 2006 through June 2007, and paid through December 2007. Cost data are therefore very much out of date and not useful to consumers in estimating their actual costs. The information is only marginally helpful in determining the relative cost of services from one hospital to another, as one must assume that each hospital's costs have increased at the same rate since last reported.

Although the statute specified that comparative information be provided to consumers by facility, clinician or physician group practice, thus far only information on hospitals is provided on the MHCO website. It should also be noted that the website was launched more than two years after the passage of the law. Due to state funding constraints, the administration of the HCQCC was moved to the Division of Health Care Finance

and Policy (DHCFP). A comprehensive report, "Measuring Health Care Quality and Cost in Massachusetts" was released in November 2009 comparing hospitals on various quality and cost metrics.<sup>13</sup> This report is not, however, aimed at providing information for consumer use.

In addition to evaluating the data that have been made available to consumers, it is important to assess whether and how people are using the available information. According to data collected by the HCQCC, from May 2009 through December 2009, the MHCO had approximately 18,000 unique visitors.<sup>14</sup> Figure 2 below illustrates that the overwhelming majority of these unique visitors are health care consumers. Close to 50% of all searches on the MHCO were for hospitals in Middlesex and Suffolk counties, as illustrated in Figure 3.

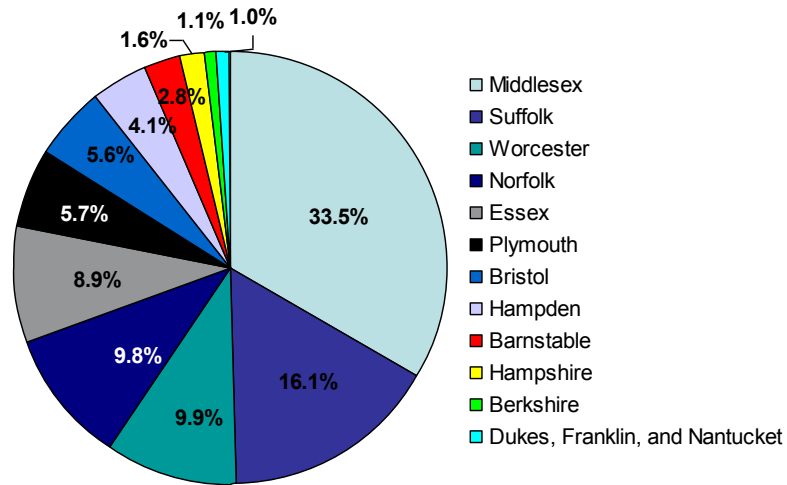
**Figure 2: Distribution of Unique Visitors to My Health Care Options Website**



Source: Health Care Quality and Cost Council, Special Data Request. December 2009. Based on Data collected from 5/9/2009 through 12/6/2009. Excludes State dept hits.

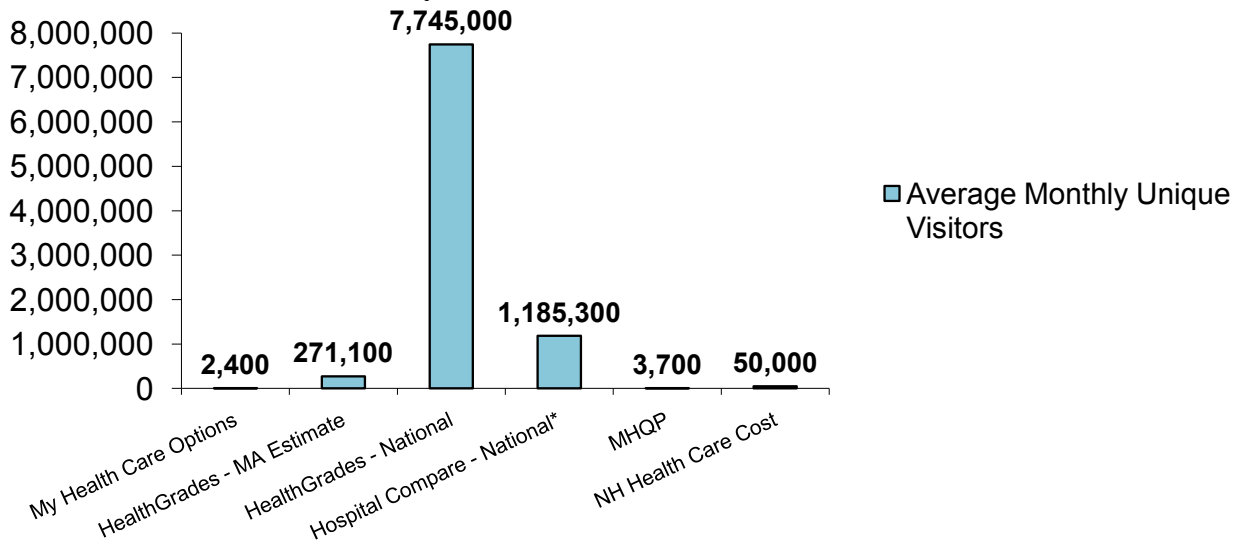
While these numbers are small relative to the population of Massachusetts, it is important to provide some context to determine whether use of the MHCO website is in line with other websites that provide similar information on the quality and costs of health care services. Some comparison websites may be those provided by the Centers for Medicare and Medicaid Services'

**Figure 3: My Health Care Options Website Distribution of Provider Search Queries by Zip Code**



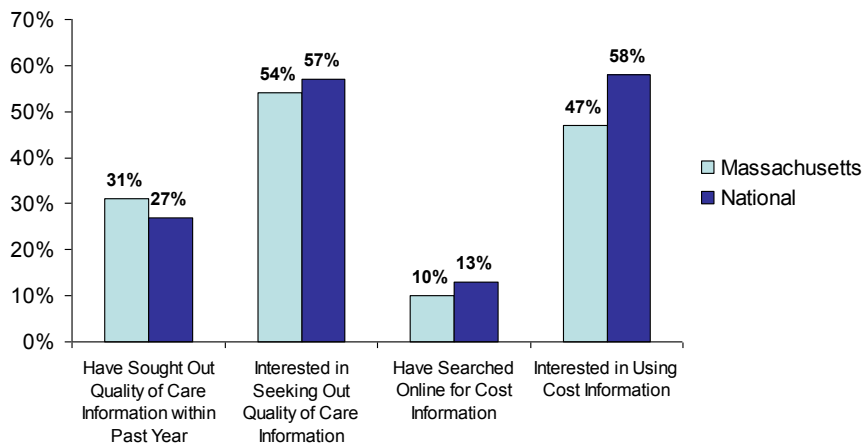
Source: Health Care Quality and Cost Council, Special Data Request. December 2009.  
Based on Data collected from 5/9/2009 through 12/6/2009. Excludes State dept hits.

**Figure 4: Average Monthly Visitors to Health Care Rating Websites, May 2009 – November 2009**



Sources: Massachusetts Health Care Quality and Cost Council, personal data request, December 2009. Excludes unique visitors from URL state.ma.us.; HealthGrades.com, personal data request, December 2009.; CMS, personal data request, December 2009.; Tyler J. Bannen, NH Health Care Cost website, personal data request, March 2010.

**Figure 5: Health Information Resource Utilization, Massachusetts vs. US, 2008**



Source: Health Care Consumerism – Snapshot for Massachusetts; Results from Deloitte’s 2009 Survey of Health Care Consumers

(CMS) Hospital Compare, Healthgrades.com, and The Leapfrog Group, and other state websites such as the Massachusetts Health Quality Partners and the NH Health Care Cost websites. These sites provide either quality or cost information that is targeted primarily to consumers. Figure 4 compares the number of average monthly unique hits to these websites.

MHQP provides quality information regarding clinical performance and patient experience in primary care medical groups in Massachusetts. The data do not include information on costs. The number of hits to MHQP's website are somewhat higher than those found for the MHCO website. Another state website is the NH Health Cost website (<http://www.nhhealthcost.org/>) which only contains information on health care costs. Comparing the number of hits on MHCO with the New Hampshire website is particularly interesting. New Hampshire has about one-fifth the population of Massachusetts but the website boasts approximately 50,000 hits per month. This website, however, is more interactive than the MHCO website, providing consumers with estimates of their actual out-of-pocket health care costs for each provider for a given procedure. Further assessment of these data finds the number of hits per 1000 members of the population is 38 in New Hampshire compared to 0.38 in Massachusetts for the MHCO website. The NH website provides cost data through June 2009 which is much more up-to-date than the MHCO website.

While many Americans, including residents of the Commonwealth, report being interested in using online resources to learn more about the quality and cost of their health care, the majority of people are not currently seeking out this information. Figure 5 highlights this discrepancy between interest and action. However, it is important to note that more Massachusetts residents sought out quality information from online resources in 2008 when compared to the national average.

Because the amount and currency of the data provided on MHCO is not in line with what was proposed in Chapter 58, and because there has been relatively little use of these data this metric is given a grade of D.

**Overall grade for Scorecard Metric 1: D**

## **SCORECARD METRIC 2: CHANGES IN ACCEPTED QUALITY METRICS COMPARED TO CONTROL STATES**

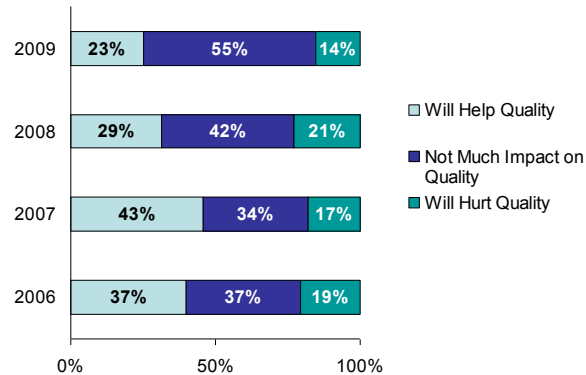
Scorecard Metric 2 examines whether and how specific health care quality metrics have changed in Massachusetts since Chapter 58. This metric also compares changes in Massachusetts with other states over the same time period to better ascertain whether any observed changes were due in part to the reform initiative.

First, self-reported data are assessed using results from an annual consumer survey conducted by The Harvard School of Public Health measuring consumer perceptions regarding what impact, if any, the reform has had on quality of care. When the survey was first conducted, just after the passage of Chapter 58, participants were evenly split as to whether the reform was going to improve quality or not have much impact on it. Each year since 2007, more and more residents have expressed that the reform will not have much impact on quality. In fact, in 2009 the majority of survey participants felt that the reform has had little impact on quality of care, as illustrated in Figure 6.

Historically, quality of health care in Massachusetts has exceeded national averages. Figures 7 and 8 examine quality of care for surgery patients in Massachusetts compared to Minnesota, Utah, and national averages. As far back as 2004, a substantially larger number of Massachusetts surgery patients were given

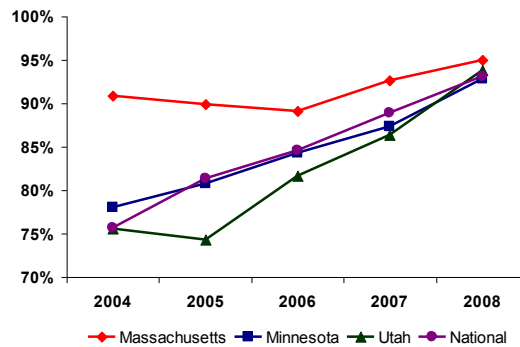
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**Figure 6: Impact of Reform on Health Care Quality as Reported by Massachusetts Residents, 2006 – 2009**

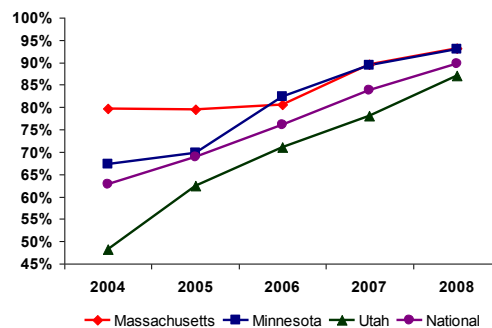


Sources: Harvard School of Public Health/BCBS of Mass. Foundation/ICR The Massachusetts Health Reform Law: Public Opinion and Perception (conducted Sep. 11-18, 2006).  
Kaiser Family Foundation/Harvard School of Public Health/BCBS of Mass. Foundation Massachusetts Health Reform Tracking Survey (conducted May 29-June 10, 2007).  
Harvard School of Public Health/BCBS of Mass. Foundation/ICR Massachusetts Health Reform Survey (conducted June 10-23, 2008).  
Harvard School of Public Health/Boston Globe Massachusetts Health Reform Poll (conducted September 14-16, 2009).

**Figure 7: Surgery Patients Given Antibiotics to Prevent Infection, 2004-2008**

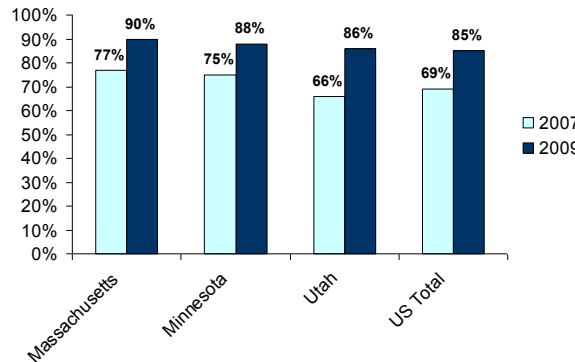


**Figure 8: Surgery Patients with Appropriate Termination of Antibiotics Post-Surgery, 2004 - 2008**



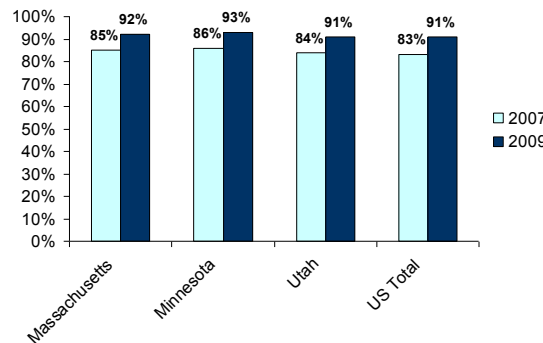
Source: Patient average data provided by CMS. Collected and published by Consumers Union, StopHospitalInfections.org, accessed February 7, 2009

**Figure 9: Percent of Surgical Patients Receiving Appropriate Care to Prevent Complications, 2007 vs. 2009**



Sources: The Commonwealth Fund State Scorecard, 2009.

**Figure 10: Percent of Hospitalized Patients Receiving Recommended Care for Heart Attack, Heart Failure, and Pneumonia, 2007 vs. 2009**



Sources: The Commonwealth Fund State Scorecard, 2009.

antibiotics at the right time, and continued to receive antibiotic treatment, when compared to patients in other states. What is interesting to note, however, is that from 2004 through 2006, improvement in these two quality metrics for surgery patients remained relatively flat, or even decreased, in Massachusetts. It was not until 2007 – the first year under the reform – that these quality metrics did improve. Comparatively, the national average for these two metrics increased at a relatively constant rate from 2004 through 2008.

Other data also indicate that quality of care in Massachusetts has exceeded national averages both before and after reform. The Commonwealth Fund’s State Scorecards, illustrated in Figures 9 and 10, highlight that while quality of care has improved in Massachusetts from 2007 to 2009, it

has not done so at a higher rate than the national average.

Quality of care in Massachusetts has continued to outperform other states and national averages. However, it is difficult to attribute improvements in quality of care to Chapter 58. One feature of the law can be evaluated to determine whether improvements have occurred that can be specifically attributed to Chapter 58.

Chapter 58 provided \$1 million dollars to the Department of Public Health (DPH) for the development of a statewide infection prevention and control program. Massachusetts became the 11th state in the nation to require reporting of central line infection rates. One recent industry report presented selected hospitals’ success at reducing various infection rates,<sup>15</sup> but it was

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acknowledged that not all infections or all hospitals had seen reductions. A Consumer Reports article published recently using data reported by Massachusetts hospitals to The LeapFrog Group regarding central-line infections found significant variation among Massachusetts hospitals, with seven reporting perfect records, and ten others reporting rates that were worse than national averages.<sup>16</sup> Post-reform data on all hospitals will be reported soon by the DPH but unfortunately pre-reform data on infection rates will not be available for comparison. Moving forward, progress on this measure will be based on improvement over time since the passage of reform.

Because timely quality data comparing the Massachusetts health care system before and after reform are not readily available this scorecard metric it is assigned a grade of “I” and should be monitored on a regular basis.

**Overall grade for Scorecard Metric 2: I**

### **SCORECARD METRIC 3: COST-EFFECTIVENESS OF QUALITY GAINS, AS MEASURED BY THE CHANGES IN OVERALL COSTS AND QUALITY FROM THE REFORMS**

Increasing access to insurance coverage, and ultimately health care services, for Massachusetts residents was one of the primary goals of Chapter 58. As Chapter 1 of this series earlier reported, available data indicate that Chapter 58 has provided greater access to health insurance in the Commonwealth.<sup>17</sup> While there is a general consensus that access to health insurance leads to better health outcomes over time, the cost-effectiveness of this increased access is more difficult to measure.

The term ‘cost-effective’ does not equate to monetary savings. Instead, for a treatment or

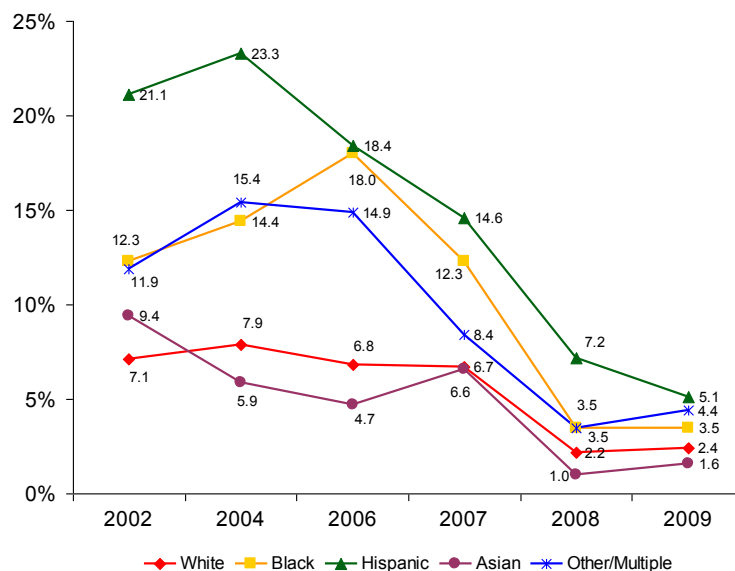
service to be deemed ‘cost-effective’ it must have benefits that are large when compared to the cost.<sup>18</sup> Cost-effectiveness research uses a term called quality-adjusted life year (QALY) to reflect the years of high-quality life a patient gains with a particular intervention. The “cost-effectiveness ratio” compares the price of buying more healthy years with a new treatment compared with a standard treatment and then judges whether the new treatment is good value. Because the “value” of a QALY differs based on where you live, the World Health Organization provides a standard for judging the cost-effectiveness of a particular intervention, which is three times per-person income per QALY gained. Using this standard, in Massachusetts, with a per capita income of \$49,082 in 2008, an intervention would be deemed cost effective if it cost less than approximately \$150,000 for one additional quality adjusted life year.

Cost effectiveness analysis typically requires a clinical study whereby one can compare two groups, one being treated with the standard and another with the new intervention being assessed. A comparison of the additional costs of the new intervention with the added years of quality life is then conducted. This is clearly a difficult task in this situation for a number of reasons.

First, the cost of the intervention – access to insurance – is difficult to estimate. The cost of insurance is not just a one time occurrence like a surgery or treatment. Should the calculation include just the cost of one year’s worth of insurance or the cost over the newly covered person’s lifetime?

Second, there are no good data measuring how many added years of quality life health insurance adds to someone’s life. There are no publicly available data to date specifically on the newly insured with respect to access to care or improvements in health. The only data available on access to care or improvements in health quality relate to the entire Massachusetts population or the lower-income population

Figure 11: Percent of Uninsured Massachusetts Residents, by Race and Ethnicity



Sources: Massachusetts Division of Health Care Finance and Policy, Massachusetts Household Survey on Health Insurance Status 2007  
 Massachusetts Division of Health Care Finance and Policy, Access to Health Care in Massachusetts: Results from the 2008 and 2009  
 Massachusetts Health Insurance Surveys - Detailed Tabulations: 2008 and 2009  
 Massachusetts Division of Health Care Finance and Policy, Access to Health Care in Massachusetts: Results from the 2008 and 2009  
 Massachusetts Health Insurance Surveys - Detailed Tabulations: 2008

cohort. Although researchers have tried to quantify the effect of uninsurance on life expectancy, the results are equivocal. In a recent literature review on this issue researchers found that studies of the effect of Medicare, which is available to most Americans at the age of 65, “paint a surprisingly consistent picture: Medicare increases consumption of medical care and may modestly improve self-reported health but has no effect on mortality, at least in the short run.”<sup>19</sup>

It is for the above reasons that this metric is removed from the scorecard for now. This metric may be revisited if data on changes in life expectancy and disease prevalence of the newly insured become available in the future. However, as noted above, even with the availability of data, it will be difficult to document the cost-effectiveness of health insurance.

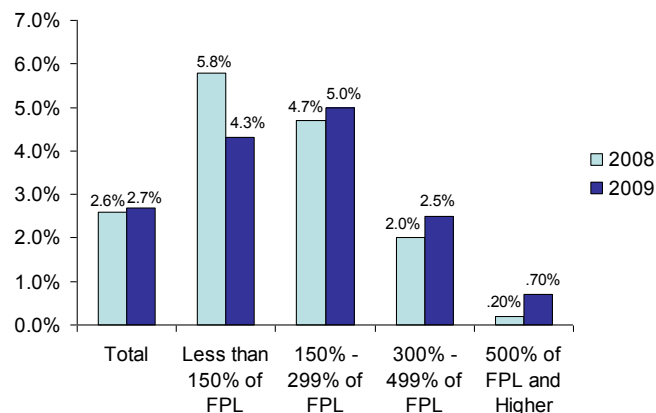
#### SCORECARD METRIC 4: CHANGES IN HEALTH DISPARITIES

Chapter 58 not only aimed to improve quality of care, but it also sought to reduce health care disparities between ethnic and racial groups by creating the Health Disparities Council (HDC). In 2009, the HDC produced a framework for eliminating health disparities.<sup>20</sup> No data are available from the HDC measuring the impact of reform on health disparities, which is disappointing. However, there are some data that can be used to assess whether Chapter 58 has had any impact thus far on reducing health disparities.

Perhaps the most logical place to begin when examining the reform’s impact on health disparities are the characteristics of the uninsured. Figure 11 shows that all ethnic and racial groups have had a reduction in rates of uninsurance from 2002 to 2009. All ethnic and racial groups experienced at least a 70% decline in the number of uninsured from the time when the rate of

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**Figure 12: Percent of Uninsured Massachusetts Residents, by FPL**



Source: Massachusetts Division of Health Care Finance and Policy, Health Care in Massachusetts: Key Indicators, November 2009

uninsurance was at its highest. However, it is interesting to note that for whites, Asians, and other/multiple races and ethnicities, the number of uninsured actually dropped to its lowest rate in 2008, and rose slightly in 2009.

Uninsured Massachusetts residents can also be stratified by federal poverty level (FPL). In 2004, approximately 38% of Massachusetts' uninsured earned incomes that were less than or equal to 200% of FPL, while 62% earned incomes greater than 200% of FPL.<sup>21</sup> As Figure 12 illustrates, Commonwealth residents under 300% of FPL were more likely to be insured in 2009. Additionally, there has been a statistically significant (albeit small) increase in the number of uninsured who are above 500% of FPL from 2008 to 2009. However, the DHCFP reports that increases present in other subgroups are not statistically significant.<sup>22</sup>

In addition to assessing changes in access to insurance, Chapter 58 and the HDC's impact, actual utilization of care by different racial and ethnic groups can also be evaluated pre- and post-reform. Figures 13 through 15 illustrate how personal care provider selection, mammography and colonoscopy screening changed for various racial and ethnic groups pre and post reform.

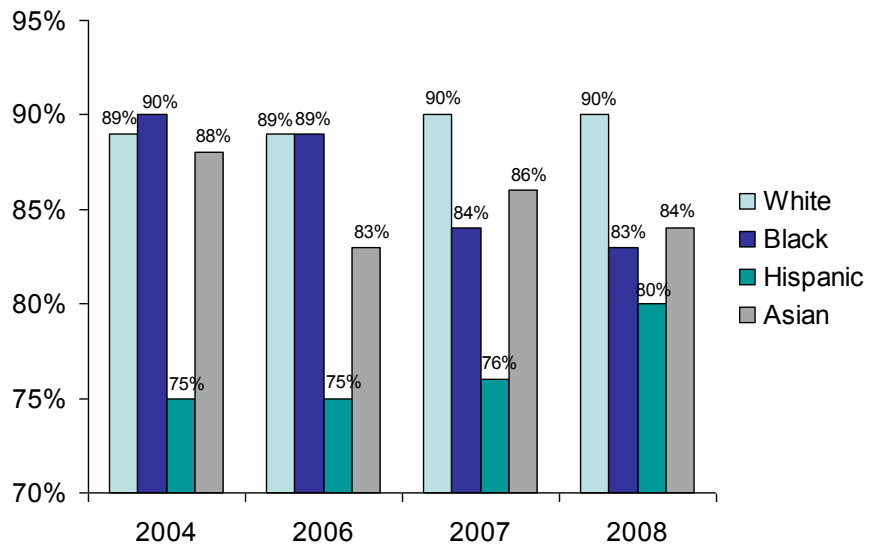
When compared to whites, a significantly lower percentage of blacks, Hispanics, and Asians reported having a personal health care provider

in 2008.<sup>23</sup> Additionally, the percentage of blacks and Asians that have a personal health care provider actually dropped from 2007 to 2008 (Figure 13).

Mammogram rates pre and post reform among the various racial and ethnic groups do not show a clear pattern of improvement. While rates for Hispanic women dropped in 2007 they increased in 2008. Black women reported consistently higher rates post reform (2007 and 2008) from pre-reform (Figure 14). Figure 15 presents colonoscopy rates in adults 50 years of age or older and show better rates for Hispanics post-reform but inconsistent results for blacks.

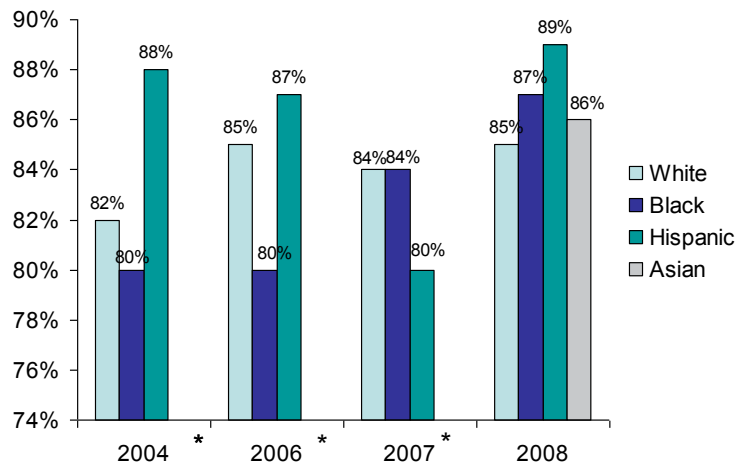
One last area of inquiry for this metric includes an examination of the pay-for-performance initiative under MassHealth. MassHealth included a health disparities measurement strategy in its 2008 rate year contracts with hospitals. The strategy included both structural and inpatient clinical measures. In a summary prepared by the MassHealth Office of Acute and Ambulatory Care, it was reported that of 66 participating hospitals, average performance was only 41% (out of 100%) with seven hospitals scoring above 75%. Of \$4.5M in incentives available to hospitals for performance in this area, only 40% or \$1.8M was distributed due to lackluster performance.

**Figure 13: Percent of Massachusetts Adults Reporting a Personal Health Care Provider, 2004 – 2008, by Race and Ethnicity**



Source: Massachusetts Division of Health Care Finance and Policy, Health Care in Massachusetts: Key Indicators, November 2009

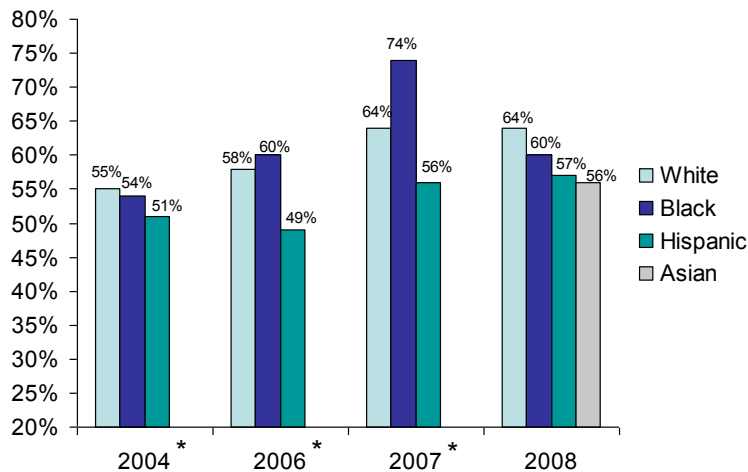
**Figure 14: Percent of Massachusetts Women 40+ Reporting a Mammogram Within the Past 2 Years, 2004 – 2008, by Race and Ethnicity**



\* Insufficient data available for Asian population

Source: Massachusetts Division of Health Care Finance and Policy, Health Care in Massachusetts: Key Indicators, November 2009

**Figure 15: Percent of Massachusetts Adults 50+ Reporting Colonoscopy Within the Past 5 Years, 2004 – 2008, by Race and Ethnicity**



\* Insufficient data available for Asian population

Source: Massachusetts Division of Health Care Finance and Policy, Health Care in Massachusetts: Key Indicators, November 2009

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Because of the improved rates of insurance coverage by ethnicity, and some small improvements in screening rates for certain racial and ethnic groups, this Scorecard Metric achieves a grade of B.

### **Overall Grade for Scorecard Metric 4: B**

## **CONCLUSIONS**

Overall, the framework and scorecard metrics proposed by the Pioneer Institute were useful in summarizing the effects of the Massachusetts Health Care Reform around cost-effective quality. In some cases, additional and more recent data are necessary to form conclusions.

An important component of the law was to provide greater transparency of provider quality and cost data to consumers. The launch of the MHCO website was significantly delayed due to data issues and staffing constraints. However, even with the launch of the website, problems remain. First, only data on hospitals are currently available on the website. Even at that, the hospital data are not comprehensive; many diagnostic categories have only cost or only quality data available and some have neither. Moreover, much of the data currently available are dated putting into question the value of such information to a consumer looking to compare quality and cost performance. The cost data provided on the website provide consumers with some comparison data on the how cost of treatment varies from one hospital to the next but do not approximate true costs to the consumer. The state may want to consider developing a more interactive website similar to the one which exists in New Hampshire. Finally, data on consumer use of the website is not promising. Given the variability of costs and quality across providers in Massachusetts, it is surprising the state has not placed greater emphasis on producing and disseminating information that can be easily used by consumers. This scorecard metric earned a grade of D.

Scorecard Metric 2 aimed to measure changes in accepted quality measures before and after reform. Although this report presented data on various quality metrics pre- and post-reform and compared Massachusetts to other states, this scorecard metric is incomplete. Data are not available from DPH measuring the impact of the statewide infection prevention and control program pre- and post-reform. It is unclear whether the DPH will release any aggregate data from the pre-reform period. Such data would be useful for measuring improvement. Because data are incomplete for this scorecard metric it is assigned a grade of "I" and should be assessed again once data are made available.

Scorecard Metric 3 was removed from this analysis as it was not possible to measure the overall cost effectiveness of the law. If and when more data become available on the impact of insurance on the newly insured, it may be possible to design an analysis that attempts to estimate the cost-effectiveness of the law. Even with good data, this metric will be difficult to assess.

Scorecard Metric 4 received a grade of B. The law was successful at reducing barriers to access to insurance for all populations. However, there is no evidence that the Health Disparities Council has had any effect on reducing health disparities in the state.

Overall, the scorecard for cost-effective quality earns an incomplete grade. It is disappointing that there are not more data available to assess overall quality and to make comparisons before and after implementation of the law, particularly for the newly insured populations. The overall health care system in Massachusetts was of relatively high quality before implementation of the law. However, there are areas where improvements can be made and there is variability across providers and institutions on a number of measures. Although significant funding was added to the system (see Chapter 2) it is not clear that any overall improvements in quality of care are evident.

The following individuals contributed data and/or insights to this report:

- Katherine Barrett and John Waclawik, HCQCC
- Bethany Gilboard, MassTech
- Jayne Hammen and Zabeen Chong, CMS
- Scott Shapiro, Health Grades
- Lisa McGiffirt, Consumers Union
- Paul Keckley and Jennifer Bohn, Deloitte

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***About Pioneer:***

Pioneer Institute is an independent, non-partisan, privately funded research organization that seeks to change the intellectual climate in the Commonwealth by supporting scholarship that challenges the “conventional wisdom” on Massachusetts public policy issues.

**■ An Interim Report Card on Massachusetts Health Care Reform:  
Part 4: Cost-Effective Quality**

**Endnotes**

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