CENTER for STUDYING HEALTH SYSTEM CHANGE

Community Report

BOSTON, MASS.

NUMBER 11 OF 12 • DECEMBER 2005

In June 2005, a team of researchers visited Boston to study that community's health system, how it is changing and the effects of those changes on consumers. The Center for Studying Health System Change (HSC), as part of the Community Tracking Study, interviewed more than 90 leaders in the health care market. Boston is one of 12 communities tracked by HSC every two years through site visits. Individual community reports are published for each round of site visits. The first four site visits to Boston, in 1996, 1998, 2000 and 2003, provide trend information against which changes are tracked. The Boston market encompasses Middlesex, Bristol, Essex, Norfolk, Plymouth and Suffolk counties.

BLUE CROSS INFLUENCE GROWS IN BOSTON AS STATE REVISITS REFORM DEBATES

The continued ascendance of Blue Cross Blue Shield of Massachusetts is felt in nearly all aspects of Boston's health care market, from provider contract negotiations to state-level policy deliberations. The increasing presence of multi-state employers, often replacing locally based corporations through sales or mergers, has made Blue Cross more attractive because of its national Blue Card network. Blue Cross also has benefited from the still-growing employer interest in preferred provider organization (PPO) products. The relative stability that such a large health plan has brought to the Boston market is reinforced by the similarly strong presence of Partners HealthCare—the market's largest hospital system—and growing cooperation between these two major players.

Major developments in Boston include:

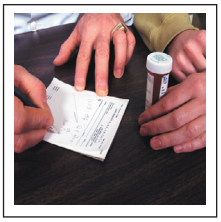
- Continued movement away from capitation payments for hospitals and physicians and expansion of pay-for-performance programs.
- Increasing efforts to strengthen quality improvement initiatives and information technology capacity, building on Boston's long-time leadership in these areas.
- An easing of state budget difficulties that has provided a political window for renewed discussions of health care financing reform, amid concerns that dedicated funding for care for low-income and uninsured people may be curtailed.

Growing Dominance of the Massachusetts Blues

Blue Cross Blue Shield of Massachusetts has enjoyed continuous growth since its financial troubles of the mid-1990s and now holds a commanding position in the Boston health insurance market. This position has allowed the plan to play a leadership role in system-wide initiatives, including supporting a major study of how the state could reach universal coverage and an e-health collaboration.

Blue Cross has added enrollees, reaching nearly 1.5 million in the Boston market by mid-2005, nearly the combined size of its two health maintenance organization (HMO)-based rivals—Tufts Health Plan and Harvard Pilgrim Health Care. Tufts has lost enrollees over the last two years and was the only plan of the three largest health plans in Boston to lose money in 2004, reportedly because of disappointing investments in information technology (IT) and consumer-driven health plans.

Two developments in the Boston market have worked to the benefit of Blue Cross. Nationally, the growth in multi-state and national employers has increased the attractiveness of plans with national health care provider networks, which Blue Cross can offer through the Blue Card network. This



Boston Demographics

Boston	*Metropolitan Areas 200,000+ Population*
Population[1]	
*4,579,137**	
Persons Age 65 or Older[2]	
12.7%	*10%*
Median Family Income[2]	
*$39,182**	*$31,301*
Unemployment Rate[3]	
5.2%	*6.0%*
Persons Living in Poverty[2]	
9%	*13%*
Persons Without Health Insurance[2]	
5%#	*14%*

** Indicates 12-site high*
 # Indicates 12-site low

Sources:
[1] U.S. Census Bureau, County Population Estimates, 2003
[2] HSC Community Tracking Study Household Survey, 2003
[3] Bureau of Labor Statistics, average annual unemployment rate, 2003

trend also reinforces interest in self-funded arrangements, in which Blue Cross is also strong. Second, employers in the Boston area have shown growing interest in PPO products, which have long been a mainstay of Blue Cross' product portfolio. HMO products, however, still dominate the Boston market.

Blue Cross has a seemingly tighter relationship with Partners, the market's hospital system leader, which includes a new five-year contract with financial incentives tied to measures of efficiency and safety. The contract with Partners also commits the two organizations to several collaborations involving quality improvement, including promoting electronic medical records and developing joint disease management and prevention programs. In addition, Partners and Blue Cross are working together to encourage the state to increase Medicaid provider payment rates, which have reportedly added to financial pressures on many hospitals and led to higher prices for private insurers. Yet, this alliance has stirred some concerns in the community that such a high degree of concentration will stifle competition and innovation.

Harvard Pilgrim and Tufts have responded to Blue Cross' ascendancy by forming alliances with national carriers to market integrated packages of local HMO products and national PPO products to multi-state employers. Harvard Pilgrim's affiliation with UnitedHealthcare goes beyond joint marketing and sales to include moving all of the local plan's products to United's administrative and IT platforms. Harvard Pilgrim also has purchased a local third-party administrator to enhance its ability to offer products to self-funded employers. Tufts entered a partnership with Cigna in part to be able to offer coverage to national accounts.

Performance Payment Continues Boston's Focus on Quality

The most significant change among Boston providers, especially physicians, over the past two years is the movement to pay-for-performance programs (P4P). Hospitals and physician groups have entered into contracts with the major health plans that base a portion of payment on quality and cost-containment measures. This payment method either is added to existing fee-for-service arrangements or replaces existing budgeted capitation agreements, and its emergence follows a long-term decline in the use of capitation in Boston. In contrast with other markets using P4P (most notably Orange County, Calif.), few observers were optimistic about P4P's ability to control costs in Boston, as these arrangements generally offer weaker incentives to providers for utilization management. However, P4P has the advantage of being applied to a large population that was never subject to capitation, such as employees of self-funded businesses. Another key aspect of this shift is that it enables hospital systems and their affiliated physicians to be in accord on quality goals and financial incentives, thus supporting the continuation of joint hospital and physician contracting.

The three largest health plans in Boston each have pay-for-performance programs in place for both hospitals and physicians. Blue Cross' P4P systems use measures of cost, efficiency, IT capacity and clinical quality indicators. In 2003, the plan paid $20 million in incentive payments to physician groups. Harvard Pilgrim negotiates incentives tied to targets such as hospital admission rates, patient satisfaction and radiology use. Tufts has built performance measures into its provider contracts, placing about 10 percent of payments at risk for both hospitals and

Health Department Pushes Collaboration to Improve Community's Emergency Preparedness

Emergency preparedness remains a high priority for the Boston Public Health Commission four years after Sept. 11, 2001. As in many communities, the local public health agency has invested considerable resources in strengthening not only its own capacity to respond to disasters and epidemics but the community's capacity as a whole. Reflecting Boston's leadership in health information technology, the commission has created a state-of-the-art syndromic surveillance system that connects every emergency department in the city, as well as some community health centers, with the health department to provide daily information on the chief complaints of patients. Through this system, staff epidemiologists are able to monitor disease trends in real time and to act as the city's early warning system against bioterrorist or other disease outbreaks.

physicians—half based on cost and half on quality. The financial effect of performance-based payment on provider organizations can be significant. For instance, of Partners' reported $90 million in payments under P4P contracts, 10 percent to 15 percent is at risk based on efficiency and quality goals. The hospital system in turn withholds $15,000 to $20,000 annually per primary care physician in its network, which is repaid to them depending on their pattern of use of hospital beds, pharmaceuticals, and radiology services, as well as IT use.

Each health plan has made considerable progress in involving the large practices with employed physicians and large network groups in these systems, but incorporating physicians in solo and small practices has been much more difficult. Some observers suggest that physicians who are not part of large, integrated systems are less aware of or less motivated by P4P incentives and do not have ready access to the capital needed to purchase information systems to track and improve their quality and cost performance.

Boston providers have long focused on quality improvement efforts beyond P4P, and mission-driven efforts to improve quality continue. For the most part, academic medical centers' quality improvement activities are driven by internal goals rather than external reporting organizations. However, quality reporting programs—particularly those spawned by the public sector such as Medicare's Hospital Quality Initiative—have increased attention to, and investment in, this area and have served to validate providers' ongoing quality improvement efforts. With public data reporting, health care organizations also have started to view quality improvement not only as the right thing to do but as a necessary competitive strategy.

Boston has for some time been a leader in IT and interconnectivity in health care, in part, according to some observers, because of the good relationships among the chief information officers of major health care systems and health plans. In addition, providers' focus on quality has led to significant investments in IT infrastructure. Perhaps the largest effort is the Massachusetts e-Health Collaborative, an initiative to improve clinical data sharing. The pilot, funded with $50 million from Blue Cross, is providing electronic medical record (EMR) systems and related support to hospitals and physicians in three Massachusetts

Health System Characteristics

Boston	*Metropolitan Areas 200,000+ Population*
Staffed Hospital Beds per 1,000 Population[1]	
2.2	*3.1*
Physicians per 1,000 Population[2]	
2.8	*1.9*
HMO Penetration (including Medicare/Medicaid)[3]	
37%	*29%*
Medicare-Adjusted Average per Capita Cost (AAPCC) Rate, 2005[4]	
$768	*$718*

Sources:

[1] American Hospital Association, 2002

[2] Area Resource File, 2003 (includes nonfederal, patient care physicians, except radiologists, pathologists and anesthesiologists)

[3] Interstudy Competitive Edge, markets with population greater than 250,000

[4] Centers for Medicare and Medicaid Services. Site-level payment rates refer to Medicare Advantage AAPCC Payment Rates by County (Part A + Part B Aged Rates). National figure is actual payment per capita, based on payments for Medicare Coordinated Care Plans and the number of Coordinated Care Plan enrollees in April 2005.

Health Care Utilization

Boston	*Metropolitan Areas 200,000+ Population*
Adjusted Inpatient Admissions per 1,000 Population[1]	
240	*197*
Persons with Any Emergency Room Visit in Past Year[2]	
20%	*18%*
Persons with Any Doctor Visit in Past Year[2]	
*86%**	*78%*
Persons Who Did Not Get Needed Medical Care During the Last 12 Months[2]	
3.6%	*5.7%*
Privately Insured People in Families with Annual Out-of-Pocket Costs of $500 or More[2]	
33%#	*44%*

** Indicates 12-site high*

 # Indicates 12-site low

Sources:

[1] American Hospital Association, 2002

[2] HSC Community Tracking Study Household Survey, 2003

communities, two of which are in the Boston area. The pilot's effect on cost and quality will be evaluated in two years, with an eye toward adopting EMRs statewide.

The hospital systems are working to connect physicians to their EMRs. Partners is undertaking a major effort to roll out its EMR to network physicians at all of its hospitals. Similarly, CareGroup Healthcare System and its flagship Beth Israel Deaconess Medical Center are focusing on improving EMR use among community physicians. A number of safety net health centers, as well as clinics run by Boston Medical Center, also are using EMRs. And the Boston health department has linked up with providers to electronically collect disease or symptom information daily (see box on page 3).

Hospital Expansions, Payment Pressures Continue

Most of Boston's teaching hospitals are doing better financially than two years ago. But now they face pressure to expand as a result of high occupancy rates as patients continue to migrate from suburban hospitals to those in the city—in contrast to other communities where migration is toward the suburbs—and years of under investment. Partners—with its flagship hospitals Massachusetts General Hospital and Brigham and Women's Hospital—has more resources than any other hospital system in the market, reflecting a trend mentioned by some respondents of the strong hospitals getting stronger. Beth Israel Deaconess is experiencing financial gains—it reported a surplus of more than $30 million last year—after financial troubles in the aftermath of the merger between its two hospitals several years ago. Patient volume at Beth Israel Deaconess also has increased, suggesting the hospital has drawn patients from other downtown hospitals or from community hospitals.

Capacity expansions at academic medical centers are focusing on high-revenue specialty services. Beth Israel Deaconess is beginning to restore closed capacity, reopening inpatient beds, outpatient surgery suites, intensive care units and telemetry, especially in the profitable service lines of oncology, cardiology and neurosurgery. The largest completed expansion within the Partners system is the $200 million, multi-specialty Yawkey Center at Massachusetts General. And Brigham and Women's recently announced plans for a new tower to consolidate and expand cardiovascular services. Boston Medical Center, a major safety net provider in the city, also is expanding its outpatient facility. In addition, community hospitals may soon begin offering additional high-end services, the result of changes to state regulations that had banned non-teaching hospitals from offering some services, such as cardiac catheterization. Under this change, Partners' North Shore Medical Center recently received approval to perform open-heart surgery.

Hospitals also are undertaking competitive strategies to link with affiliated physician groups and community hospitals to expand their referral base. Competition between physicians and hospitals is seen as less intense in Boston than in other markets as most physicians are tightly linked to large health care systems. Beth Israel Deaconess is looking to build relationships with multi-specialty groups and community hospitals, while Partners is branding some of its community hospitals as academic medical centers to market teaching hospital quality care in the suburbs.

Boston's large medical groups and hospitals report increasing difficulties recruiting physicians, though this has not yet affected patients' access to care. Recruitment is taking more time and resources, as prospects face very high housing costs in Boston and reimbursement rates below many other areas of the country. Fewer physicians

remain in the market after completing their education, with particular gaps in neurosurgery, radiology, obstetrics, gastroenterology and anesthesiology. As a result, more physicians are being employed by hospitals, which can subsidize their incomes, and teaching hospitals are poaching physicians from each other.

Indeed, physicians are struggling with payment rate increases that reportedly do not keep up with cost increases, pushing physicians to be more productive and to provide more services to keep their incomes level. Another response has been several mergers or affiliations, often to help bring more ancillary services in house and further offset fixed administrative costs. Harvard Vanguard Medical Associates became the HealthOne Care System, after acquiring several physician groups in the Boston area and expanding its geographic reach.

State Budget Rebound Sparks New Debates over Coverage

The recent turnaround of the state's economy has improved its budget picture and opened the door for renewed discussions of comprehensive health care reform. Despite the loss of some large businesses, the state's unemployment rate in October 2005 was 4.8 percent and was relatively constant over the previous year—down significantly from 5.8 percent in October 2003. The state Legislature passed a fiscal 2006 budget that restored a number of cuts instituted in recent years. Perhaps more significantly, the recent optimism about state revenues has contributed to renewed interest in coverage expansions and broader system reform that could lower what is already among the lowest rates of uninsurance in the country.

Enrollment in MassHealth, the commonwealth's Medicaid program, peaked at 1 million in 2002-2003, but fell to 925,000 after eligibility recertification was shortened from 60 to 30 days and the Legislature cut MassHealth Basic, a program for chronically unemployed adults. But care for people dropped from Medicaid was subsequently paid by the state's free care pool, a limited account funded by insurers, hospitals and the state that reimburses safety net hospitals and community health centers (CHCs) for uncompensated care. As expenditures by the pool soared, the governor reversed the recertification policy and implemented a new program to bring many—but not all—of those who had been dropped back into Medicaid. By June 2005, MassHealth enrollment had rebounded to 985,000.

The high visibility of health reform discussions reflects a long-standing commitment to a "culture of insurance" in this community and a renewed hope to reinvigorate 1988 and 1996 efforts to achieve universal coverage. The principal proposals from the governor, Senate president, House speaker, Blue Cross Blue Shield of Massachusetts Foundation and the advocacy group Health Care for All have many commonalities as well as critical differences. All aim to approach 100 percent coverage through various subsidized insurance mechanisms, including Medicaid expansions, and all would regulate both individual and small group insurance as a single risk pool. Yet, the proposals vary greatly on their reliance on market mechanisms and the methods of financing, especially the role of employers; the House plan to mandate that businesses help to finance coverage is being watched by other states considering similar proposals.

The health reform proposals also reveal the interconnectedness of the existing health care financing mechanisms in Massachusetts. These mechanisms are the product of earlier efforts to ensure access to care and financial stability for safety net providers, particularly as a result of a 1996 Medicaid waiver negotiated with the federal

The recent turnaround of Massachusetts' economy has improved its state budget picture and opened the door for renewed discussions of comprehensive health care reform.

Boston's network of safety net providers has been well supported and has in turn been able to address the diverse and complex health care problems of the uninsured.

government. The waiver allowed the use of certain intergovernmental fund transfers to meet the state's Medicaid match and, thus, to increase the total federal funding available to the state for low-income health care programs. Some of these additional funds have been earmarked payments to safety net hospitals and CHCs. With the waiver's expiration in July 2005—and a federal deadline of January 2006 for a new agreement to be in place—the state has been negotiating new terms with federal officials that put in jeopardy these special sources of funding. In response, focus has turned to efforts to provide health insurance coverage for nearly everyone as an alternative to earmarked safety net funding.

What is at risk in these discussions is a relatively strong safety net system. Boston has two major safety net hospitals—Boston Medical Center (BMC) and Cambridge Health Alliance (CHA)—and 26 community health centers. Between the earmarked funds and the free care pool, this network of providers has been well supported and has in turn been able to address the diverse and complex health care problems of the uninsured. In 1986, the clinics formed their own managed care plan, Neighborhood Health Plan (NHP), which continues to be an important financial mechanism for the CHCs. Both BMC and CHA have large Medicaid managed care plans and also provide a form of managed care to uninsured low-income people at their hospitals and affiliated clinics. Although the safety net providers support the coverage expansions, they also fear that they will still be expected to provide care for remaining uninsured patients—such as undocumented immigrants—without earmarked funds to pay for it.

Also at risk are already tenuous funding streams for mental health programs. Previous state budget cuts affected a host of programs, including support for mental illness and substance abuse treatment and prevention programs. These cuts have led to more restrictive criteria for who is eligible for publicly funded mental health care, leaving community mental health centers with less funding and hospital emergency departments and other providers with growing numbers of mentally ill patients. Some respondents described mental health services for the poor as "appalling" and "horrible," as some access points for inpatient care, detoxification services, and outpatient care have disappeared. These problems are particularly acute for people without any coverage, including the city's large homeless population. Given Boston's reputation as having a strong, responsive, and well-organized system of care for poor people, the dire situation for mental health and substance abuse is striking.

As in many markets, providers in Boston report ongoing financial pressures from Medicaid payment rates that don't keep up with expenses. Medicaid and related state program rates have increased annually by 2 percent or 3 percent in recent years, but hospitals view this as a payment cut given their reported operating cost increases of approximately 6 percent a year. Unlike some other markets, however, private health plans have been willing to discuss adjusting their payment rates to offset lower Medicaid rates and to help hospitals seek payment increases from the state. In the most recent contract negotiations with plans, providers have received increases that outstrip cost trends by several percentage points.

Employers Target Benefit Structure to Seek Savings

Premium increases have slowed in Boston in the past few years, reportedly because of changes in employee health benefits and declining cost trends. Market observers suggested that the 15 percent to 20 percent annual increases

of several years ago have dropped to 10 percent to 15 percent. Private employers have tried to mitigate rapidly rising health care costs by increasing copayments, deductibles and employees' share of premiums. Private firms continue to "kick the tires" on consumer-driven health products like health savings accounts, generally expressing reservations about the ability of these products in their current form to influence health behavior and control costs.

The Group Insurance Commission (GIC) is one of the few organizations in the state that is large enough to attempt to influence health plan activities. The GIC, which provides and administers health insurance to the commonwealth's 267,000 employees, retirees, dependents and survivors, offers a wide range of coverage options and, unlike local governments, does not have to collectively bargain benefits with state workers. Without this constraint, the GIC—whose director is viewed by many as a market leader among purchasers—has been able to look at some aggressive purchasing strategies and launched a clinical performance improvement initiative in 2004. The project is collecting claims data from six health plans to be used to create a large physician profiling database that all participating plans will employ in developing tiered-network products. Both Tufts and Harvard Pilgrim health plans are participating in the initiative, but Blue Cross—which does not serve state employees—is not.

Issues To Track

Boston's health care market is increasingly dominated by two large players—Blue Cross among health plans and Partners among providers. A characteristic of this "bipolar" system is relative calmness of contract negotiations, which has led to somewhat more favorable payment terms for hospitals and physicians. But all is not quiet in Boston, as the major academic medical centers are girding for capacity expansions to take advantage of new patients drawn from community hospitals and to seek an edge in high-end specialty care. Moreover, Blue Cross' main rivals, Tufts and Harvard Pilgrim, have forged alliances with large national insurers, potentially increasing pressure on payment rates to providers and raising new possibilities for competition in specific market segments, such as high-deductible benefit plans.

Key issues to track in Boston include:

- Will the dominance of Blue Cross and Partners aid efforts in Boston to improve quality and increase efficiency or will it stifle innovation?
- Will the Tufts-Cigna and Harvard Pilgrim-United alliances strengthen the market positions of local health plans or result in mergers or buyouts in one or both cases?
- How will the health care reform debates and Medicaid waiver negotiations play out and with what effects on the financial condition of both safety net and mainstream providers and on access for low-income people?
- What impact, if any, will new P4P payment methods have on provider performance, quality and costs in the market?
- Will the Group Insurance Commission's clinical performance initiative improve the effectiveness and efficiency of its contracting networks and will other market players adopt it?

Some respondents described mental health services for the poor as "appalling" and "horrible," as access points for inpatient care, detoxification services, and outpatient care have disappeared.

Boston is one of 12 metropolitan communities tracked through site visits by the Center for Studying Health System Change.

Authors of the Boston Community Report:

Aaron Katz, University of Washington
Melanie Au, MPR
Paul B. Ginsburg, HSC
Robert E. Hurley, Virginia Commonwealth University
Jessica May, HSC
Glen Mays, University of Arkansas for Medical Services
Bradley Strunk, HSC

Community Reports are published by HSC:

President: Paul B. Ginsburg
Vice President: Jon Gabel
Director of Site Visits: Cara S. Lesser
600 Maryland Avenue SW • Suite 550 • Washington, DC 20024-2512
Tel: (202) 484-5261 • Fax: (202) 484-9258

www.hschange.org

HSC, funded principally by The Robert Wood Johnson Foundation, is affiliated with Mathematica Policy Research, Inc.