tions recommended to promote wide use and effectiveness. It describes the rationale behind creating standards for patient centeredness, for prioritizing topics for research, for choosing a study design (including the first edition of the translation table for pairing research questions and appropriate methods), and for designing, conducting, and reporting patient-centered outcomes research. It also highlights gaps in the evidence to be addressed by the PCORI's program of methodologic research. The PCORI will incorporate these standards and recommendations into its funding process and encourage their adoption by the scientific community.

The report focuses on connecting research results to patients' health care needs and making the findings generally accessible. Its standards list is a milestone but not a destination. Transforming this foundational document into meaningful essential guidance for the broad health care community will require a systematic, iterative process of public commenting, public engagement, and revision. Over the coming years, input will be regularly solicited from the community. The Methodology Committee will systematically update and expand the scope of the standards to cover the full spectrum of patient-centered outcomes research questions and approaches and expand the translation tables to include more examples, methodologic issues, and approaches. The committee will work with the public to develop further reports, standards, and translation tables so as to produce better research methodology and better application of existing methods to aid all stakeholders — researchers planning investigations, policymakers weighing the value of health care interventions, and patients, clinicians, and caregivers facing health care decisions.

The legislative mandate to generate a methods report, methodologic standards, and a translation table as guidance for a national research initiative is visionary. It tells us that for research to be meaningful, its methodologic foundation must be scientifically sound and patient-centered — and that all stakeholders should be able to gauge the research's quality and usefulness for decision making. It tells us that if medical research is to realize the promise of improving health, the methods matter.

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Tackling Rising Health Care Costs in Massachusetts

John Z. Ayanian, M.D., M.P.P., and Philip J. Van der Wees, Ph.D.

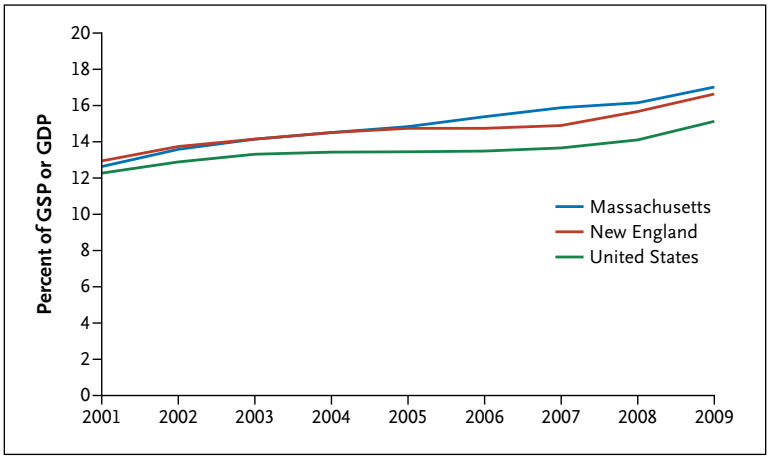
The federal system of the United States gives states substantial latitude and authority to regulate their economic affairs. With health care having grown from 13.8% of the national economy in 2000 to 17.9% in 2010, state governments have developed a major stake in ensuring that relentless growth in health care spending is controlled more effectively. In Massachusetts, for example, the costs of Medicaid for low-income residents and private health insurance for state employees account for approximately 40% of the state budget. Rising insurance premiums are also dampening wages in the private sector. A recently enacted Massachusetts law that seeks to control health care spending may therefore provide useful policy lessons for other states and the federal government.

Massachusetts is already a well-known venue for health care reform, with state leaders seeking to address two paramount challenges in the health care system.

The first — and arguably easier — task has been to achieve near-universal insurance coverage. In 2006, Governor Mitt Romney and the legislature enacted a landmark law that expanded Medicaid eligibility for low-income residents, provided subsidies to make insurance more affordable for those with moderate incomes, and created a health insurance exchange to help individuals with moderate or higher incomes and small businesses to purchase private insurance. The law included financial penalties for individuals who can afford coverage but do not obtain it and for medium and large employers that do not offer insurance. As the proportion of nonelderly Americans without health insurance rose nationally from 17.1% in 2006 to 18.4% in 2010, Massachusetts countered this trend, as its proportion of uninsured residents decreased from 10.9% to 6.3%.[1] In 2010, central elements of this Massachusetts law were incorporated in the federal Affordable Care Act.

The second, greater policy challenge is to control rising health care costs so that gains in coverage remain sustainable. From 1998 through 2009, Massachusetts had the highest personal health care spending per capita of any state.[2] Since 2001, personal health care spending as a percentage of the economy has also risen more rapidly in Massachusetts and other New England states than in the United States overall (see graph).

Momentum for addressing this issue in Massachusetts has emerged from recent evaluations of factors contributing to rising costs. In 2009, the state's Health Care Quality and Cost Council produced a "Roadmap to Cost Containment." In 2010, the state attorney general documented wide variations in prices for health care services. Governor Deval Patrick proposed legislation to control health care costs in 2011, and the state Senate and House of Representatives each developed its own bill in 2012. As the legislative session ended on July 31, the House and Senate resolved the differences between their bills and approved a new law that Governor Patrick signed on August 6.[3]



Personal Health Care Spending Per Capita as a Percentage of Gross State Product (GSP) in Massachusetts and Other New England States (Connecticut, Maine, New Hampshire, Rhode Island, and Vermont) and of Gross Domestic Product (GDP) in the United States, 2001–2009.

Based on data from the Office of the Actuary of the Centers for Medicaid and Medicare Services, the U.S. Bureau of Economic Analysis, and the U.S. Census Bureau. Personal health care expenditures are defined by state of residence, and expenditures on administration, public health, and construction are excluded.

Key elements of this law include limiting the growth of health care spending to growth in Massachusetts' economy as measured by the gross state product (GSP), shifting from fee-for-service care to global payment models, supporting the formation of accountable care organizations and patient-centered medical homes to improve quality and control costs, and promoting greater transparency through expanded public reporting of health care providers' quality and cost data (see table). A health policy commission will be established to oversee the annual target for cost growth and to assess the market power of large provider groups. The attorney general will have increased authority to investigate potential anticompetitive practices of health care organizations.

Relative to other states, Massachusetts has several distinct advantages as it strives to tackle rising health care costs. First, high rates of insurance coverage have lessened the burden of uncompensated care for most providers, reducing their need to recoup these costs through higher charges for privately insured patients. Second, health care organizations and insurers have already begun adopting new payment models that use global budgets and include financial incentives for improving quality and controlling costs. For example, Massachusetts is the site of 5 of the 32

Key Components of the New Massachusetts Law to Constrain Health Care Costs

- Sets targets for limiting annual increases in health care spending to the rate of growth in the gross state product (GSP) for 2013–2017, 0.5 percentage point less than the GSP growth rate for 2018–2022, and the GSP growth rate again for 2023 and beyond
- Requires Medicaid, state employee health plans, and other state-funded programs to adopt alternative payment models (including shared savings programs, global payments, and bundled payments) to replace traditional fee-for-service payments
- Promotes establishment and certification of accountable care organizations and patient-centered medical homes to improve coordination of care and access to preventive and primary care services, and authorizes contracting preferences for these organizations in state health insurance programs
- Establishes health policy commission as independent public entity to oversee cost-growth targets and monitor new delivery and payment models authorized in the law
- Creates special commission to report on variations in provider prices
- Requires providers that exceed the cost-growth benchmark to file and implement a performance-improvement plan, with potential penalty up to $500,000 for failure to comply
- Enhances transparency through expanded public reporting of quality of care and prices using a standard set of measures for common health care services on a public website
- Addresses medical malpractice with a 182-day cooling-off period before patients can file a lawsuit, and makes providers' apologies to patients inadmissible in malpractice proceedings
- Establishes $135 million fund to support financially distressed hospitals
- Establishes Massachusetts eHealth Institute with $30 million fund to accelerate adoption of interoperable electronic health records
- Authorizes $60 million over 4 years for wellness and preventive health programs and an annual tax credit up to $10,000 for businesses that create workplace wellness programs
- Covers expected costs of new law ($225 million) through one-time surcharges on health insurers ($165 million) and large hospitals ($60 million)

initial participants in the Pioneer Accountable Care Organization program launched by Medicare in early 2012 to provide more coordinated care. The state's largest private health insurer, Blue Cross Blue Shield, has implemented performance-based "alternative quality contracts" with 11 health care organizations that include negotiated global budgets and pay-for-performance incentives to achieve quality goals.[4] Approximately 650,000 Blue Cross members — representing 10% of the state population — are currently covered under these contracts.

Third, Massachusetts is one of the first states to create a statewide all-payer claims database to monitor and report on variations in payments and the volume of services across health care organizations. This database will be an important resource for public reporting of health care costs mandated by the new law. Finally, since 2011, the state has required all health insurers to offer tiered products with lower premiums than nontiered plans and higher cost sharing for patients treated by higher-cost providers. These tiered products now cover more than 10% of privately insured residents.

Massachusetts also has some features that may constrain state efforts to limit the growth of health care spending. Physicians and patients in Massachusetts are more accustomed than their counterparts in many lower-cost states to using expensive hospital services,[5] in part because teaching hospitals play a prominent role in Massachusetts and the care they provide is often more expensive than that provided by smaller community hospitals. Large health care organizations, such as Partners HealthCare, established by the state's two largest teaching hospitals, may continue to have substantial market power to attract patients and garner higher prices.

Although the governor and legislature have determined that state action is needed to accelerate the implementation of new models of health care delivery and payment in order to constrain spending growth, some stakeholders have questioned whether state intervention may undermine the market forces that have begun to address this problem. Other observers are concerned that the law does not contain sufficient penalties to enforce specified limits on cost growth. The willingness of patients to choose lower-cost health plans and providers remains uncertain, including whether they will use new public reports on the quality and costs of care to inform their health care decisions. Physicians will undoubtedly be asked to play a more explicit role in balancing quality and costs to achieve greater value in health care, and their clinical decisions will face greater scrutiny from insurers and pa-

tients and from their own medical groups and hospitals.

As with Massachusetts' expansion of health insurance in 2006, this new state law to control rising health care costs will be closely watched by other states and the federal government. Legislative leaders project that the law will save as much as $200 billion in health care spending over the next 15 years. Whether this projection will be realized remains to be seen, but a crucial cornerstone of the new law is its framework for the state government, insurers, and health care providers to share responsibility for containing costs. Massachusetts will be a testing ground to determine the political viability and economic impact of transitioning from the long-standing dominance of fee-for-service care to a statewide focus on new payment models, with expanded public reporting of costs and quality and more explicit limits on the growth of health care spending.

A crucial cornerstone of the new law is its framework for the state government, insurers, and health care providers to share responsibility for containing costs.

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