A Consumer-Driven Health Care Cost Control Agenda for Massachusetts: 17 Legislative Proposals

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EXECUTIVE SUMMARY

Health Care For All has drafted comprehensive legislation to control health care costs in Massachusetts. The bill, introduced by Senator Mark Montigny and Representative James Marzilli, encompasses 17 provisions that attack the problem of growing health care costs from a consumer perspective. We reject proposals that seek to reduce costs by imposing greater expenses on patients, such as high deductible “consumer-directed” plans, higher co-payments or co-insurance. Rather, we support fundamental reforms in financial incentives and care management that both improve quality and reduce costs.

We see the ideas in this paper and the legislation as the start of a new cost control conversation, not the conclusion. We invite discussion and feedback on our suggestions and encourage others to enter this conversation.

These are our proposals:

A. Promote Real Transparency across the System – No Transparency, No Fundamental Change

1. Require the Division of Insurance to hold a public hearing on health insurance rate increases when premium increases exceed seven percent. The hearing will force insurers to publicly justify their rate increases and allow state officials to reject unreasonable rate hikes.

2. Establish common quality and payment measures for MassHealth, the Connector, the Group Insurance Commission and other public payors. A common metric will reduce administrative costs by eliminating conflicting and contradictory requirements imposed by multiple payors.

B. Use State Programs to Create the Right Financial Incentives for High-Value Health Delivery – Providing the Right Care at the Right Time and at the Right Place

3. Reduce or eliminate payments to hospitals for potentially preventable hospital readmissions. Changing hospital financial incentives will press hospitals to take actions to improve quality and prevent readmissions.

4. Reduce or eliminate payments to hospitals for potentially preventable hospital complications. Hospitals have techniques to reduce complications such as infections, but financial incentives must be altered to encourage hospitals to aggressively pursue these steps.

5. Establish a single fixed payment for outpatient procedures. A set prospective payment will reduce the current financial incentive to provide unnecessary and redundant services to patients.

6. Pay a single annual fee to providers to care for diabetics and other patients with chronic illness. A single payment will allow the provider to coordinate care and focus on improving quality and preventing complications.

7. Establish a coordinated long-term care payment methodology that applies to all settings. Comprehensive payment reform will reward efficient, clinically proper care in the most appropriate setting, without undue incentives to choose a particular setting.

C. Empower Consumers to Take Personal Responsibility – Consumers Can Lower Costs More Effectively Than Can Increasing Copayments and Deductibles

8. Empower and train patients with significant chronic illnesses to manage their care and to improve their wellness. Patient self-management programs have been proven effective in increasing wellness and reducing costs.
D. Expand Effective Care Management Systems for the Most Challenging and High Cost Populations – Coordinated Care for Seniors and the Disabled Will Improve Quality and Lower Costs

9. Expand the Senior Care Options program to enroll more seniors and begin a similar program to cover disabled residents with both MassHealth and Medicare coverage. The programs provide coordinated and accountable care that improve quality and reduce costs.

E. Improve the Managerial Efficiency of Health Care Delivery – Move Health Care into the Electronic Age

10. Improve patient flow management to reduce emergency department overcrowding. Hospitals can reduce emergency room waiting time and diversions by smoothing the schedules for elective surgery.

11. Adopt advanced health information technology and electronic health records in MassHealth and Connector programs. The Commonwealth can lead the way in using technology to improve quality and reduce costs.

F. Promote Cost-Effective Use of Appropriate Prescription Drugs – The Right Drug, at the Right Price, without Pushy Salespeople

12. Use evidence-based, unbiased information to evaluate the effectiveness of drugs and to shape a common preferred drug formulary for state programs. The common drug list will form the basis of a purchasing consortium to negotiate discounts from pharmaceutical manufacturers and will use central purchasing and volume contracting to control costs.

13. Provide educational programs, such as academic “counter detailing” for physicians, pharmacists and others authorized to prescribe and dispense prescription drugs. By educating prescribers about generics and low-cost alternatives, Massachusetts can counter the pharmaceutical industry’s explosive marketing.

14. Ban the sale of individual prescriber information to the pharmaceutical industry. Drug manufacturers use this information to tailor marketing pitches to individual doctors.

15. Ban gifts and other inducements given to prescribers by prescription drug manufacturers, and require disclosure of drug marketing expenses. Industry financial incentives and aggressive marketing distort prescribing decisions and increase costs.

16. Eliminate copayments and coinsurance for chronic and preventive health care, such as immunizations, prenatal care or annual exams. Eliminating patient barriers to preventive care and sustaining treatments for chronic illnesses will lower long-term costs and improve health quality.

G. Rescue Primary Care – the Foundation of Cost-Effective Health Care

17. Establish a state special commission to develop a statewide plan to rescue and revive primary care. The crisis in primary care requires a comprehensive examination of options to increase the availability of primary care practitioners, including recruitment, payment incentives, and licensing policy.
INTRODUCTION

Massachusetts is now implementing a major health reform law (Chapter 58 of the Acts of 2006) to expand access to affordable health insurance for hundreds of thousands of uninsured and underinsured residents. During the lengthy policy formulation process leading to passage of the law, some criticized the process – and result – for not focusing on controlling rising health care costs.

Health Care For All rejected this critique for two reasons. First, the coverage needs of one-half million uninsured Massachusetts residents should not have to wait for societal consensus on how to control costs. Second, no such consensus existed then or now, while agreement on access expansion mechanisms was evident. We concur with the urgency to control rising costs, and believe that the 2007-08 session of the Massachusetts legislature is the appropriate and feasible time for such a discussion and process.

The launch of the 2007-08 legislative session and the inauguration of a new governor suggest the time to start this conversation is now. Attaining better control of rising health care costs is important for all consumers in Massachusetts, whether they obtain coverage through public or private sources. Effective cost control is essential to ensure the success of Massachusetts health reform. Continuing annual health insurance premium increases of ten percent or more will undermine the financing formula on which the law is based. Failure to achieve effective cost control undermines economic stability and growth as well as progress on other important societal needs such as education, environmental protection, and more.

As a voice and advocate for Massachusetts consumers, Health Care For All is clear what kinds of cost control we are against. We oppose cost control strategies which rely on shifting costs to consumers, through higher deductibles, co-payments, co-insurance, health savings accounts, consumer “driven” or “directed” health plans, or defined contribution plans. We oppose strategies which presume consumers are the problem and which seek to reduce health care spending by making health insurance and medical services unaffordable for all but the most affluent.

We accept a role for consumers in controlling costs. We accept this in a “shared responsibility” framework which also holds accountable providers, employers, insurers, and government. In 2001, health economist James Robinson wrote that the “era of the consumer” had arrived because of the abandonment of responsibility by these other sectors. As we advance new policy ideas to trigger a dynamic conversation on cost control, we begin by recognizing the fundamental need for all parties to accept responsibility to implement real and workable solutions.

In this report we provide a road map to improve value. We focus our attention on five areas of health care spending, where cost control initiatives can yield substantial gains:

1. Ambulatory visits;
2. Hospital stays and peri-hospital stays (30 days before and after a hospital stay);
3. Year-long episodes of illness;
4. Long-term care; and
5. Prescription drugs

A key to success is transparency for all – consumers need the ability to look under the hood in a transparent way to understand the cost and quality of each type of health care encounter and service rendered. This is a bottom line precondition if consumers are to work collaboratively to accept our share of responsibility to improve quality and stabilize costs. Without genuine transparency, there is no possibility to stabilize costs and improve quality.

The ideas in this paper have been translated into legislation. “An Act Controlling Health Care Costs and Improving Quality” was introduced by Senator Mark Montigny as S. 1238 and by Representative James Marzilli as H. 2197. A section-by-section summary is appended to this paper.
We present the ideas in this paper and the legislation as the start of a new cost control conversation, not the conclusion. We invite discussion and feedback on our suggestions and encourage others to enter this conversation.

This paper has been researched and written by a team including Norbert Goldfield, Marcia Hams, John McDonough, Michael Miller, and Brian Rosman.

We divide our proposals among seven fundamental strategies. Underneath each strategy we provide specific recommendations and legislative proposals on how to accomplish each strategy. We must emphasize that transparency for every aspect of our health care system is an overall strategy that is key to accomplishing any of the other suggested strategies. While we applaud what the state has done to date with web-based information, we believe that expanded transparency is integral to our ultimate goal of improving the value (quality divided by payment) of our health care system.

Our suggested strategies are:

A. Promote Real Transparency across the System – No Transparency, No Fundamental Change

B. Use State Programs to Create the Right Financial Incentives for High-Value Health Delivery – Providing the Right Care at the Right Time and at the Right Place

C. Empower Consumers to Take Personal Responsibility – Consumers Can Lower Costs More Effectively Than Can Increasing Copayments and Deductibles

D. Expand Effective Care Management Systems for the Most Challenging and High Cost Populations – Coordinated Care for Seniors and the Disabled will Improve Quality and Lower Costs

E. Improve the Managerial Efficiency of Health Care Delivery – Move Health Care into the Electronic Age

F. Promote Cost-Effective Use of Appropriate Prescription Drugs – The Right Drug, at the Right Price, without Pushy Salespeople

G. Rescue Primary Care – the Foundation of Cost-Effective Health Care

**Organization of this Paper**

Describing any one of our policy ideas could easily fill a document much larger than this entire paper. That would defeat our purpose, which is to generate a broad conversation to identify feasible and implementable cost control ideas appropriate for Massachusetts. With that purpose in mind, we have developed a structure to explain each of our policy proposals as follows:

- a. What is the problem?
- b. What is our proposal?
- c. What is the potential benefit?

We claim no monopoly on good ideas. This paper contains ideas we have developed and encountered in our various policy and program activities. Our ideas promote change by encouraging new behavior and activity on the part of providers, insurers, government, business, and consumers.
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A. Promote Real Transparency Across the Health Care System

Calls for greater transparency in the health care system have become common and familiar. In fact, the real possibility exists that an information overload will replace an information drought. We propose several forms of transparency that we believe will provide meaningful benefit for consumers and the health system.

1. Require the Division of Insurance to hold public hearings on health insurance rate increases when premium increases exceed seven percent.

What is the problem?
Health insurance premiums in the small group and non-group (individual) markets have increased by double-digit rates for the past seven consecutive years. These unsustainable increases destabilize budgets for families, employers, and government at all levels. Runaway cost growth also threatens the financial stability of Chapter 58, the new Massachusetts health reform law. Thus far, broad calls for greater health system “transparency” have not extended to health insurance companies. For businesses and individuals in the newly merged (as of July 2007) small/non-group health insurance market, there is little accountability or information.

Yet state government has few opportunities to investigate why insurers continue to increase costs. Without open, transparent information, consumers and government are unable to assess the propriety of the cost increases imposed by health insurers in the Commonwealth.

What is our idea?
We need sunshine, transparency and accountability for health insurers writing policies in the newly merged small/non-group insurance market.

The legislation (section 8) proposes public hearings on health insurance rate increases for any insurer whose annual premium growth exceeds seven percent. The hearings will allow the insurer to justify the proposed rate increase and allow the public to respond to the requested rate increase.

The Commissioner of Insurance would be empowered to obtain all relevant information used by health insurers to calculate their rates. Following the hearing, the Commissioner could reject the proposed rate increase if the benefits provided are unreasonable in relation to the rate charged, or if the premiums are excessive or inadequate.

What is the potential benefit?
Health insurers have been vocal advocates for greater provider transparency, a call which we endorse. Insurers would benefit from transparency as well, instilling greater public/employer confidence in the process by which rates in the most vulnerable market are determined.

This process would also spur greater public dialogue and conversation about the causes of rising health insurance premiums.
2. Establish common quality and payment metrics for MassHealth, the Connector Authority, the Group Insurance Commission and other public payors.

What is the problem?
Providers spend significant dollars maintaining separate systems for reimbursement and routine administrative operations because of conflicting and contradictory requirements by multiple payors. Cost savings and decreased administrative burdens could be realized by eliminating or reducing multiple payor rules.

What is our idea?
Under the proposed legislation (section 6), MassHealth, the Connector, the Group Insurance Commission (GIC) and other public payors would provide one standard contract for health insurers and one set of metrics (including price/quality metrics) for managed care organizations. This would encourage providers and managed care organizations to compete on the basis of a streamlined process of specifying value.

For example, the payors would require – with respect to hospital payments – hospitals and health plans to use the same methodology to describe hospital case mix. By using the same transparent case mix methodology, payors and providers would be able to judge the appropriateness and adequacy of payment rates while monitoring the quality of these services using the same metrics.

A standard RFP process for managed care organizations and providers would cover all markets and providers and simplify the contract process. This would free providers to concentrate on improving care using common metrics instead of confronting different yardsticks for quality measurement and payment purposes.

The legislation directs EOHHS to create transparent, uniform quality and payment measures among public payors. The common quality and payment metrics may include a standard claims payment data set, standard units of payment, and standard performance measures. This will allow varying payors to use the same relative weights for payment even though payment levels may differ across providers and settings. Providers with different populations (such as MassHealth’s emphasis on prenatal care) could add supplemental measures. However, providers will save costs when they must respond to a standard menu of performance measures (leveraging the severity and risk adjustment potential in the latest payment unit definitions) for transparency, performance measurement, and payment incentives.

What is the potential benefit?
Administrative savings for all participants in the health care delivery/payment process; clarity for consumers; clarity for providers of care on the metrics on which they are measured; and substantial compliance cost and consultant savings.

By using the same transparent case mix methodology, payors and providers would be able to judge the appropriateness and adequacy of payment rates while monitoring the quality of these services.
B. Use State Programs to Create the Right Financial Incentives for High-Value Health Delivery

Too often in health care, it just doesn’t pay to do the right thing the right way. Health care reimbursement is a dense and complicated topic. At the bottom is a simple question: does the payment structure provide incentives to do the right thing or the wrong thing? We have identified several areas in which health care financing practices do not pay in a format that ensures the best care for patients is provided in the best way.

3. Reduce or eliminate payments to hospitals for potentially preventable hospital readmissions.

What is the problem?
Between 7 and 15 percent of all patients discharged from hospitals (excluding obstetrics) are readmitted to a hospital within 30 days. Many of these admissions are preventable if the patient receives optimal care during the initial admission and/or if the patient receives maximal coordination between inpatient and outpatient services. The cost of these readmissions is a large and an unnecessary cost burden on all public and private payers. It is also harmful to patients’ quality of life. Avoidable readmissions are an example of poor quality care.

What is our idea?
The legislation (section 6) proposes changing hospital reimbursement rules to change financial incentives for hospitals and physicians to avoid unnecessary readmissions by providing appropriate and coordinated care.

Under the legislation, EOHHS will initially collect data from hospitals on their potentially preventable readmission rates. Hospitals will be given an opportunity to review the analysis of their rate and raise any concerns with EOHHS. Following the review of the data by each hospital, EOHHS will promulgate regulations directing hospitals and insurers to provide publicly-disclosed data on potentially preventable hospital readmissions. Within a year, the Commonwealth’s consumer health information internet site will report the potentially preventable hospital readmission data and rates for each hospital.

Based on the data received, EOHHS will coordinate the creation of a common, transparent payment methodology among public payors (MassHealth, the Connector, GIC and others) to reduce potentially preventable hospital readmissions. The methodology will reduce or eliminate payment for a portion of potentially preventable hospital readmissions.

A consistent payment system will signal the market that Massachusetts citizens will have their care monitored using common and transparent metrics, allowing providers to use a consistent approach. This signal is strengthened if other private payors adopt this approach as well.

What is the potential benefit?
Decreased readmissions hold potential major savings to all payors. A conservative estimate suggests there are 90 readmissions per 1,000 discharges, excluding obstetrical deliveries. Decreased readmissions will improve quality of care overall and improve patient well-being and satisfaction.
4. Reduce or eliminate payments to hospitals for potentially preventable hospital complications.

What is the problem?
Hospitals are often paid extra if a potentially preventable complication (PPC) such as an infection, congestive heart failure, stroke, cardiac arrest, or blood clot occurs during the hospital stay—even though the added revenue to hospitals does not cover the entire cost for each episode. More importantly, hospitals trying to avoid preventable complications are underpaid. Estimates of the costs associated with just one of these complications, hospital-acquired infections, are in the billions of dollars for payors, employers, consumers—and hospitals.

What is our idea?
Massachusetts should follow the lead of California, Pennsylvania, Florida and other states by collecting information to identify PPCs. Once valid information is obtained, public payors should alter their payment methods to reduce or eliminate payments for PPCs. The approach mirrors the proposal regarding potentially preventable hospital readmissions.

The legislation (section 6) calls for EOHHS to initially collect data from hospitals on their PPC rates. Hospitals will be given an opportunity to review their rate and raise concerns. Following the review of the data by each hospital, EOHHS will promulgate regulations directing hospitals and insurers to provide public data on PPCs. Within a year, the Commonwealth’s consumer health information internet site will report the potentially preventable complication data and rates for each hospital.

Based on the data received, EOHHS will coordinate the creation of a common, transparent payment methodology among public payors (MassHealth, the Connector, GIC and others) to reduce PPCs. The methodology will reduce or eliminate payment for a portion of potentially preventable hospital readmissions.

What is the potential benefit?
The financial incentive to decrease complications will result in savings for payors, consumers and hospitals. Additional benefits include improved quality of care for hospitalized patients and better payments to hospitals that work to decrease complications.

Public payers should alter their payment methods to reduce or eliminate payments for potentially preventable hospital complications.
5. Establish a single fixed payment for outpatient procedures.

What is the problem?
Hospital outpatient and ambulatory surgery center visits are skyrocketing with significantly higher associated costs. Existing financial incentives often encourage all providers to provide greater and greater volumes of services.

What is our idea?
Payors should reimburse outpatient providers with one payment for all services for each visit. MassHealth’s PAPE (payment amount per episode) system, which provides a fixed payment for outpatient procedures, could serve as the starting point for the system. Over time, this payment approach can be expanded to reimburse for follow-up visits as well, such as is now done in New York and Iowa.

The legislative provision (section 6) directs EOHHS to coordinate the creation of a common, transparent prospective payment methodology among public payors (MassHealth, the Connector, GIC and others) for outpatient procedures, including ambulatory surgical procedures. This same methodology can be used to monitor many aspects of quality for these ambulatory visits – for both underservice and overservice.

What is the potential benefit or payoff?
Paying prospectively for outpatient and ambulatory surgical procedures eliminates the current incentive to provide redundant or unnecessary services to patients. This change will create significant cost savings for all payors and consumers, as well as improve care quality.

This information collected can also be used to track quality of services for these outpatient procedures (e.g., emergency room visits after an outpatient procedure).

Paying prospectively for outpatient procedures eliminates the current incentive to provide redundant or unnecessary services to patients.
6. Pay a single annual fee to providers to care for diabetics and other patients with chronic illness.

What is the problem?
Costs associated with chronic illnesses such as diabetes and hypertension consume the largest share of health care expenses. The number of individuals with these and other chronic illnesses continues to rise. Many of these individuals find their chronic illness difficult to control and many develop costly complications which impact their quality of life. These chronic illnesses are becoming increasingly responsive to newer treatment approaches, yet poor coordination of services interferes with the availability of these treatments. For all adults, diabetes diagnoses accounted for nearly nine percent of hospitalizations, 12 percent of nursing home admissions, and 10 percent of deaths from 1988 to 1994.

What is our idea?
Payment methods should encourage coordinated care for all individuals with significant chronic illness. Coordination would be encouraged via a reimbursement system that would pay for all care for a year-long episode of, for example, diabetes.

The legislation (section 6) provides for EOHHS to implement transparent, evidence-based payment rates for an annual episode of care among public payors for patients with chronic illnesses. Health plans would contract with a private entity such as a provider or care management system. These entities would focus on improving the health of patients with chronic illness for a fixed price adjusted for severity of illness.

The rate methodologies would provide an annual severity-adjusted payment to a care coordination entity that will provide all clinically appropriate care for the year. The proposal calls for the rate methodologies to encourage clinically integrated care. The methodology will include a comprehensive evaluation process that assesses clinical quality and patient satisfaction.

All details of the payment system and care evaluation will be transparent to patients and providers. A portion of the payments would be contingent upon meeting clinical quality goals and patient satisfaction standards. This program would emphasize implementation of consumer empowerment as key to better management of the individuals’ chronic illness.

What is the potential benefit?
If payors carefully and transparently monitor these programs for quality and cost, there would be increased satisfaction for consumers, increased coordination of services for those with significant chronic illnesses, and decreased overall costs for the health care system.

Payment methods should encourage coordinated care for all individuals with significant chronic illness.
7. Establish a coordinated long-term care payment methodology that applies to all settings.

What is the problem?
Costs for long-term care services are increasing. Medicaid is the primary payor of long-term care services. Today, these services provided in different settings are paid using different classification systems. The payment structures do not allow for an open comparison of the cost/quality of services provided in different settings. A significant portion of long-term care starts with post-acute care, a time-limited period immediately following an acute hospitalization. Payment is often divided between Medicare and Medicaid, and Medicaid policies do not always mesh with Medicare, resulting in higher overall expenses. Typically, though not necessarily, post-acute care is applied to the elderly, that group of individuals often in need of additional services once discharged from the hospital. These services may be provided in any (or all) of the following settings:

- Home (including group home etc)
- Rehabilitation Hospital
- Nursing Care Facility
- Acute and Chronic Long Term Care Hospitals
- Partial hospitalization or day programs for services such as mental health care.

Recently Massachusetts passed legislation that will expand access to the interchange between these services. The challenge is how to best understand the cost and quality of these services.

What is our idea?
The bill (section 9) establishes a long-term care payment coordination task force to develop a common comprehensive and transparent long-term care payment methodology that rewards efficient, clinically proper care in the most appropriate setting. The system would remove undue incentives to choose a particular setting, and focus on providing high value that best meets patient and family needs. The task force, which includes state agencies concerned with long-term care policy, will consult with experts in the field of long-term care, long-term care providers, consumer health organizations, and organizations representing the elderly, the disabled and racial and ethnic minority groups.

What is the potential benefit?
The common payment methodology will encourage patients to receive cost-effective care in the most appropriate settings. Cost-savings will accrue to taxpayers and families, and the mechanism used for prospective payment of long term care services can also be used to track aspects of the quality of services for these important services.
C. Empower Consumers and Patients to Take Personal Responsibility

Even though we oppose mindless cost shifting to consumers, we don't leave consumers off the hook. Fully half of the cost of medical care in the United States is related to unhealthy behaviors including diet, smoking, drinking and lack of exercise. Consumers have to be part of the health care cost solution -- they need smart and effective ways to engage. We believe it is important to engage the consumers who are most at risk, those with chronic disease.

8. Empower and train patients with significant chronic illnesses to manage their care and to improve their wellness.

What is the problem?
Care for individuals with significant and multiple chronic illnesses is the most significant driver of health care costs. Their care is often fragmented, with multiple providers each focusing on their individual specialty’s concerns. Too little attention is paid to educating and training consumers to take effective steps to manage and improve their health and well being. While physicians and other providers play a key role, patients with chronic illness can be taught effective self-management strategies. A variety of patient-empowerment tools, including internet-based programs, have been developed and tested as effective and cost saving.

What is our idea?
The legislation (section 1) establishes a chronic disease self-management program in DPH. The program will provide patients and their families with education to increase skills and confidence and empower patients to manage chronic conditions as active partners in their own care. DPH is authorized to provide pilot demonstration grants to non-profit community organizations to implement a variety of chronic disease self-management approaches. These programs include: Enhance Wellness (Seattle, WA), Active for Life (Austin, TX), a Matter of Balance (Boston, MA), How’s Your Health (Hanover, NH), and the Stanford Chronic Disease Management Program (Palo Alto, CA). Based on evaluation of results, DPH should select one or several models and implement a statewide strategy to undertake broad and effective training of target populations to use the tools.

What is the potential benefit?
Chronically ill patients make daily decisions and engage in behaviors with positive and negative consequences. Effective control requires patient self-management. Self-management means more than telling patients what to do. Rather, it means acknowledging patients’ central role and fostering responsibility. The proven programs provide basic information, support, and strategies for living with chronic illness. Using collaboration, providers and patients define problems, set priorities, establish goals, create treatment plans and solve problems.

These programs have been shown to improve patient quality of life and lower health costs. Other nations -- Canada, United Kingdom, Australia -- have adopted these tools as national strategies to improve quality and lower costs for the most needy and expensive populations in our society. The World Health Organization has empanelled a committee on social determinants of health that is specifying an action agenda to reduce social inequalities of health via patient empowerment.

A chronic disease self-management program will empower patients to manage chronic conditions as active partners in their own care.
D. Expand Effective Care Management Systems for the Most Challenging Populations

Sometimes the most effective strategies are right in front of you. Take the challenge of managing care for “dual eligibles:” elderly and disabled people enrolled in both Medicare and Medicaid. They are the most expensive populations in both programs. Massachusetts already has an effective approach in place for this group, but that approach has not been enabled to grow to its potential for improving care and controlling costs.

9. Expand the Senior Care Options program to enroll more seniors and begin a similar program to cover disabled residents with both MassHealth and Medicare coverage.

What is the problem?
Individuals who are “dually eligible” for Medicare and Medicaid represent among the most expensive and challenging populations in the US health care system. For Medicaid alone, dual eligibles represent 14 percent of enrollees and 52 percent of total spending in Massachusetts (compared to 40 percent nationally). They include senior citizens, including seniors institutionalized in nursing homes. Some 76,000 people with disabilities under age 65 are also enrolled in both programs. Care for these groups is fragmented, inadequate, and inefficient. The result is poor quality of care at exorbitant and unnecessary expense. New models are providing coordinated care to these populations to enhance quality of care and quality of living at significant savings.

Massachusetts already has organizations providing coordinated and accountable care to seniors through the Senior Care Options (SCO) program. SCO enrollment in Massachusetts is around 6,800 out of a potential population of 120,000.

What is our idea?
The legislation (section 10) directs EOHHS to maximize enrollment of eligible persons in the MassHealth Senior Care Options program and develop a plan to offer similar coverage to Medicaid and Medicare-eligible disabled persons under age 65. MassHealth needs to facilitate the removal of clinical, administrative and financial barriers to expanding the SCO programs to a much greater number of dually eligible seniors and disabled persons under age 65. Essential to this strategy is a fair payment mechanism for those under 65, modeled on the payments for seniors. One option is to explore passive enrollment strategies that would allow faster ways to bring this experiment to scale.

What is the potential benefit?
The Commonwealth Care Alliance, a non-profit consumer-governed care management organization associated with Health Care For All, currently manages care for 2,000 dual eligibles. In its first two years of operation, CCA experienced a miniscule disenrollment rate. It has achieved impressive levels of patient satisfaction. The program has produced significant savings for both MassHealth and Medicare. A smart and effective care management system together with transparency/improvement of payment rate calculation is the bright future of care for these most needy and costly populations.
E. Improve the Managerial Efficiency of Health Care Delivery

Back in 2001, the Institute of Medicine defined a “quality” health care system as including six distinct dimensions: patient centered, timely, safe, equitable, effective, and efficient. Using limited resources and using them well is an aspect of quality as well as economic care. Here, we identify three proposals to create a more efficient delivery system.


What is the problem?
Hospital emergency department (ED) overcrowding leads hospitals to close admissions and move to diversion status, jeopardizing care for patients in need of emergency services and adding unnecessary costs. Research shows that a significant factor in ED overcrowding involves ineffective patient flow management, caused by inefficient scheduling of elective surgical procedures. Hospitals across the nation have demonstrated that reorganization of surgical scheduling can lead to meaningful decreases in ED diversion status, significant savings for hospitals, improvement in intensive care unit care, and improvements in nurse staffing and morale. Locally, Boston Medical Center is the only Massachusetts acute hospital that has employed this approach, with positive results and real savings. No other Massachusetts acute care hospital has taken on this approach.

What is our idea?
Smoothing the elective surgical schedule can avoid peaks and valleys that stress a hospital near capacity. The result is less frequent diversions from EDs. Research by Dr. Eugene Litvak, PhD, director of the Program for the Management of Variability in Health Care Delivery and Professor of Health Care and Operations Management at Boston University, has demonstrated the value of this approach.

The legislation (section 2) directs DPH to establish emergency room patient flow management standards. Hospitals will evaluate their surgery scheduling process to determine if changes would reduce overcrowding in the emergency department. Hospitals must take recommended steps to significantly reduce emergency department overcrowding and waiting times.

Under our MassHealth waiver, up to 10% of our federal waiver funds can be used for infrastructure or other non-direct service costs. Some of these funds could be used to implement this provision.

What is the potential benefit?
Substantial financial savings to hospitals and payors can be achieved. Based upon real results achieved at Boston Medical Center, this intervention can result in reductions in the frequency of hospital emergency departments diversion status, lessening the potential harm to patients in need of emergency care. Improving ED patient flow will also improve operation and performance in intensive care units, providing more efficient nurse staffing and increasing morale.

What is the problem?

Advances in health information technology (HIT) could dramatically improve quality and control costs. In Massachusetts, efforts such as the MA eHealth Collaborative are supporting community-wide implementation of electronic health records. MassHealth and the Connector – the largest purchasers of health care for low income and vulnerable populations – need to take a lead in this transformation.

HIT is a tool to improve health system efficiency and effectiveness as the Commonwealth struggles with rising Medicaid costs and increased enrollment. EOHHS and the Connector can support HIT adoption for vulnerable populations, improving their programs. It is essential that the Commonwealth participates as a lead stakeholder in the movement toward higher-quality, effective, and efficient health care through the use of advanced HIT.

What is our idea?

The legislation (section 11) directs EOHHS and the Connector to make MassHealth and Commonwealth Care leaders in the use of advanced health information technology and electronic health records. The agencies will prepare a plan developed in consultation with the Massachusetts eHealth Collaborative (MAeHC), the Massachusetts Health Data Consortium, MassPRO, consumer health organizations, consumer privacy organizations, providers, and others concerned about health information technology and electronic health records.

If enacted, the provision would provide a roadmap for MassHealth and Commonwealth Care to champion integrated IT transformation as a quality and efficiency improvement tool, and allow EOHHS to focus on addressing specific state security and privacy laws. The plan would prioritize EOHHS support for MassHealth’s modernization of its information systems in accordance with the federal Medicaid Information Technology Architecture initiative, active participation in HIT initiatives such as MAeHC, and work with commercial plans to develop statewide health information exchange standards.

MassHealth and the Connector can support broader HIT adoption and use by clinicians and providers by leveraging existing mechanisms and coordinating with commercial plans to promote and provide incentives for HIT adoption and use. Their support for research and dissemination of best practices for the integration of behavioral health and other “high-risk” population data with information technology initiatives will improve quality system-wide.

What is the potential benefit?

Research demonstrates the positive impacts of HIT on low-income populations and programs. Because of higher level of disease burden, Medicaid patients’ utilization rates of health services are high. These high rates, use of multiple sites of care, and churning in and out of eligibility result in increased risk of medication errors and inappropriate care. Potential improvements from advanced HIT include: improving information at the point of care; improving chronic and preventive care; reducing medication errors; coordinating and integrating care; improving access to clinical information; quality monitoring; and program improvement.

HIT can also improve efficiency and effectiveness for MassHealth and Commonwealth Care. Medicaid can improve administrative effectiveness to address complex economic and programmatic challenges, including: better administrative data; introduction of clinical data health information exchange; better automation of the prior approval process; improving quality measurement and reporting; improving detection of fraud, abuse, and inappropriate care; reducing medication costs through information provided at the point of care; and coordination with public health efforts.
F. Encourage Using the Right Prescription Drugs in the Right Way

While the spike in prescription drug spending increases has moderated from the first half of this decade, the growth in drug spending remains a significant part of the health care cost control problem, and opportunities for improvement in this area remain.

12. Use evidence-based, unbiased information to evaluate the effectiveness of drugs and to shape a common preferred drug formulary for state programs.

What is the problem?
Policy makers need evidence-based, systematic reviews of prescription drug research to determine which drugs are most effective and which drugs are therapeutically equivalent. This information can be used to design cost-effective preferred drug lists (PDLs) and formularies based on quality, which can provide leverage for programs, plans and insurers to negotiate with manufacturers for rebates and discounted prices. MassHealth already uses a preferred drug list with prior authorization, which has decreased costs by increasing use of generics and therapeutically equivalent lower cost drugs. The Group Insurance Commission (GIC) has similar strategies to lower costs in its plans for state employees. MassHealth determines its preferred drug list based on research conducted by its own Pharmacy and Therapeutics Committee. MassHealth managed care plans and the GIC use pharmacy benefit managers to determine their formularies. A statewide coordinated PDL could provide increased leverage and savings.

What is our idea?
The proposed legislative provision (section 5) directs EOHHS to coordinate an evidence-based pharmaceutical purchasing and prescribing program for all state health programs. A broad-based task force will advise EOHHS on the program. EOHHS will establish a preferred drug list that may be used by MassHealth, the Connector, GIC, the Departments of Mental Health, Mental Retardation and Corrections, and other state agencies. The most efficient evidence based review methods would be used to design the PDL.

These agencies may join a pharmaceuticals purchasing consortium based on the preferred drug list. Private payors would be invited to join and contribute to this system. The consortium will negotiate discounts from pharmaceutical manufacturers, and use central purchasing and volume contracting to control costs. Also, Massachusetts may join with other states in a combined purchasing pool.

Technical and clinical support for the program would come from the Oregon Health and Science University Drug Effectiveness Review Project (DERP). DERP is now used by 13 states to provide independent, evidence based systematic reviews for public programs. Panel members cannot have ties to the industry; participating states determine what drugs are reviewed. The State of Washington is utilizing DERP in its design of a uniform PDL for all its public programs and has entered into a consortium and purchasing pool with Oregon, which will use the Washington PDL.

What is the potential benefit?
Significant cost savings are possible. Combined purchasing would increase state leverage in bargaining with pharmaceutical firms. Expanding an evidence-based and uniform PDL could improve quality and reduce costs to all state-funded programs including Prescription Advantage and programs in other agencies. Ending duplicate determinations by each program about which drugs to purchase would reduce administrative costs for programs. Subscribing to established drug effectiveness research programs such as DERP would allow Massachusetts programs and academic institutions to use their clinical expertise to extend rather than duplicate existing DERP reviews.

Combined purchasing would increase state leverage in bargaining with pharmaceutical firms.
13. Provide educational programs, such as academic “counter detailing” for physicians, pharmacists, and others authorized to prescribe and dispense prescription drugs.

What is the problem?
Despite the use of preferred drug lists (PDLs) and formularies in public programs and private health plans, physician prescribing patterns are highly responsive to $12 billion spent annually on physician marketing by the pharmaceutical industry. While Massachusetts and most other states have generic substitution laws applying to all prescriptions, average use of generics is still only 56 percent, well below the potential 70 percent rate. Because public insurance programs and private plans must maintain enough flexibility in their rules to allow physicians to exercise clinical judgment to meet patient needs, the pharmaceutical industry continually attempts to influence their decisions. Physician education is an important tool to balance these marketing practices.

What is our idea?
The legislation (section 1) establishes an academic detailing program in DPH to provide evidence-based, balanced information to physicians and other prescribers. The program will outreach to physicians and other health care practitioners who participate in MassHealth, the Prescription Advantage program, Commonwealth Care, and other public health care programs in the commonwealth, to academic medical centers, and to other prescribers. Contracted physicians, pharmacists and nurses would conduct face-to-face visits, utilizing evidence-based materials and borrowing methods from behavioral science, educational theory, and the drug companies themselves. The program – similar to one designed by Dr. Jerry Avorn, MD at Harvard Medical School and Brigham & Women’s Hospital for the state of Pennsylvania – will provide information to providers in MassHealth, Commonwealth Care, and other state-funded programs. Private health plans and payors may also pay a fee to subscribe to the program.

What is the potential benefit?
In addition to saving costs, this program has been demonstrated to increase the quality of prescribing, as well as to reduce complications from inappropriate medications. This program enhances communication between public programs and prescribers and reduces pharmaceutical influence.
14. Ban the sale of individual prescriber information to the pharmaceutical industry.

What is the problem?
Pharmaceutical companies purchase data on physician prescribing from companies such as IMS Health, which purchases this data from pharmacies, combines it with physician lists purchased from the American Medical Association, and produces provider profiles for use by drug representatives. This information then allows pharmaceutical company salespersons to micro-market to physicians based on their individual prescribing habits. The industry then monitors physician responses to specific sales pitches and tailors highly effective follow-up marketing.

What is our idea?
Following the action taken by New Hampshire in 2006, the legislation (section 3) prohibits the sale or transfer of individually-identified prescription information, unless the information is being used as part of a patient’s care. A violation of the section can be prosecuted under the Consumer Protection Act. In New Hampshire, the legislation was supported by the New Hampshire Medical Society, whose members saw the industry practice as a violation of their privacy.

What is the potential benefit?
The provision imposes a barrier on the aggressive pharmaceutical marketing campaigns that increase costs. Other outcomes include increased quality of prescribing, reduced complications from inappropriate medications, and reduced industry influence on prescribing decisions.
15. Ban gifts and other inducements given to prescribers by prescription drug manufacturers, and require disclosure of drug marketing expenses.

What is the problem?
In 2005, pharmaceutical companies spent $12 billion nationally in marketing to physicians (some $13,000/physician), including provision of free samples. Much of the funds are spent providing meals and other gifts to physicians. Voluntary codes from the Pharmaceutical Research and Manufacturer’s Association and the American Medical Association, as well as federal guidelines, have shifted some of the focus of industry marketing but have not stemmed the tide of industry largesse.

An AMA editorial set out the fundamental problem: “Gift-giving inevitably raises concerns about conflict of interest. Even merely the appearance of improper behavior should be avoided. …[A]ny interaction between a physician and industry should be based on what will benefit the patient. Hospitality such as gourmet meals (or even “dine and dash” take-out food), luxury gifts, tickets to sporting events and shows – and certainly cash or gift certificates – are inherently inconsistent with that aim.”

In addition to gifts, drug companies pay doctors inflated consulting fees that are not related to the work performed. The New York Times reported that a lawsuit involving the device maker Medtronic revealed that one prominent Wisconsin surgeon received $400,000 for a consulting contract that required him to work just eight days.

States are stepping in and establishing limits on pharmaceutical marketing practices. Minnesota passed a law establishing a $50 limit on all marketing expenses to prescribers. Vermont law requires public reporting of marketing expenses to prescribers.

What is our idea?
The legislation (section 4) prohibits pharmaceutical and medical device companies from giving gifts to health care practitioners or facilities. Exceptions are allowed for educational seminars and materials, reasonable honoraria, and consulting regarding clinical trials. The section also requires pharmaceutical firms to publicly report their significant marketing expenses in Massachusetts, including the Massachusetts share of expenses for TV, radio, magazine and other national advertising. DPH will annually prepare a report analyzing spending for drug marketing.

What is the potential benefit?
Reduced marketing to physicians will cut industry influence on prescribing decisions, leading to increased quality of prescribing, reduced complications from inappropriate medications, and reduced costs.
16. Eliminate copayments and coinsurance for chronic and preventive health care, such as immunizations, prenatal care or annual exams.

What is the Problem?
Patients with chronic illness represent roughly three quarters of all health care spending. Proper treatment depends on drug therapies. Yet imposing cost sharing for these treatments reduces compliance, increasing use of much more expensive services such as hospitalizations and nursing home care. A New England Journal of Medicine editorial concluded that,

“attempts to save money through the redesign of insurance plans — involving caps on benefits and increases in out-of-pocket spending for prescription drugs — result in the delivery of poor care to chronically ill patients…. We should be reducing the barriers to treatment and encouraging patients to take appropriate medications for the recommended duration, rather than increasing these barriers by limiting benefits. As the findings of Hsu et al. highlight, the use of cost sharing and limits on prescription-drug benefits to control spending is counterproductive both medically and in the immediate attempt to limit spending.”

This has been amply documented in research and literature. A recent study shows that increased drug copayments of more than $10 in three managed care plans throughout the United States resulted in a 20% reduction in the use of effective and life-sustaining medications for diabetes. Sullivan and Hom cited the example of employers who have lowered the total cost of managing chronic illnesses like diabetes and asthma by making it less expensive for their employees to obtain the drugs that address these conditions. Major employers are beginning to recognize this, and more are eliminating copayments for preventive and chronic medications.

What is our idea?
The proposed bill (section 7) prohibits health insurers from charging copayments or coinsurance for preventive health care. Preventive care includes immunizations; periodic health exams for adults and children; prenatal maternity care; well child care, including vision and auditory screening; voluntary family planning; nutrition counseling; and health education. Preventive health care also includes supplies, equipment, medication and specialist-provided treatments and services for persons with chronic illnesses or disabilities, such as insulin for diabetes, hypertensive medications, and hypercholestelemic medications.

What is the potential benefit?
Waiving copayments and other cost sharing will result in increased use of chronic therapies and preventive care, improving overall health and reduce acute episodes of illness. The result will be decreased costs associated with emergency rooms and hospitalizations.
G. Rescue Primary Care

We have an upside-down health care delivery system. In most nations, medical specialists take a back seat to primary care. In the United States, primary care is the poor step-sister to the more remunerative and recognized medical specialties. This is a deep, systemic problem, and we do not pretend to have a substantive solution. We recommend a process solution.

17. Establish a state special commission to develop a statewide plan to rescue and revive primary care.

What is the problem?
Across the nation and across Massachusetts, the practice of primary care is in crisis. Many parts of the Commonwealth are experiencing an acute shortage of primary care physicians, nurse practitioners, and other primary care providers. This shortage is resulting in increased costs as patients seek out more expensive sites for primary care services and delay obtaining necessary medical care because of obstacles in seeing providers.

What is our idea?
Fixing a problem of this magnitude is beyond the scope of our work in this paper, and yet this problem is accelerating at an urgent pace. The legislation (section 12) proposes establishing a broad-based and representative special legislative commission to develop a comprehensive set of recommendations to reinvigorate primary care in Massachusetts.

The commission will include state agencies, physicians, other providers and community groups. The commission will review the availability of primary care services; identify regions of the state with impaired access to primary care; examine the impact of lack of access to primary care on health status, including racial, ethnic, gender, income and other disparities; estimate the additional costs to the health care system due to the lack of availability of primary care; recommend methods to recruit and increase the availability of primary care practitioners; recommend changes in licensing and reimbursement rates to strengthen primary care; and make other findings and recommendations. The commission will hold public hearings and report its findings to policymakers and the public.

What is the potential benefit?
A broad-based and representative commission could identify effective leverage points to improve the ability of primary care providers to thrive in Massachusetts.
REFERENCES

PROPOSAL 1: Public accountability for excessive insurance rate increases


PROPOSAL 2: Common quality and payment metrics


PROPOSAL 3: Potentially Preventable Hospital Readmissions


PROPOSAL 4: Potentially Preventable Hospital Complications


PROPOSAL 5: Prospective Payment for Outpatient Procedures


PROPOSAL 6: Chronic Care episode of care payment rates


PROPOSAL 7: Long-Term Care Rates

1. Types of Housing Options for Seniors in Massachusetts. http://www.massaging.org/content/consumers/types.htm

PROPOSAL 8: Patient Self-Management


PROPOSAL 9: Expand programs for dually-eligible


PROPOSAL 10: Improve Emergency Department Flow


PROPOSAL 11: Advance Information Technology


PROPOSAL 12: Uniform Preferred Drug List


PROPOSAL 13: Counter detailing


PROPOSAL 14: Ban Sale of Prescription Information


PROPOSAL 15: Ban Drug Company Gifts to Prescribers


PROPOSAL 16: No copayments for preventive and chronic care


PROPOSAL 17: Rescue Primary Care


APPENDIX

AN ACT CONTROLLING HEALTH CARE COSTS AND IMPROVING QUALITY (House 2197 / Senate 1238)

Section-By-Section Summary

SECTION 1 adds two new programs in the Department of Public Health (DPH). The first provision establishes a chronic disease self-management program in DPH. The program will provide patients and their families with education to increase skills and confidence and empower patients to manage chronic conditions as active partners in their own care. DPH is authorized to provide pilot demonstration grants to non-profit community organizations to implement a variety of chronic disease self-management approaches. Based on the pilot projects, DPH will set up a comprehensive statewide program.

The second provision sets up an “academic detailing program,” an evidence-based outreach and education program designed to provide information and education on the therapeutic and cost-effective utilization of prescription drugs to physicians, pharmacists, and other prescribers. The program will counteract commercial drug marketing by providing accurate information on generics and alternative therapies. The program will provide information to providers in MassHealth, Commonwealth Care and other state-funded programs. Private groups may also pay a fee to subscribe to the program.

SECTION 2 directs DPH to establish emergency room patient flow management standards. Hospitals will evaluate their surgery scheduling process to determine if changes would reduce overcrowding in the emergency department. Hospitals must take recommended steps to significantly reduce emergency department overcrowding or waiting times.

SECTION 3 prohibits the sale or transfer of individually-identified prescription information, unless the information is being used as part of a patient’s care.

SECTION 4 regulates prescription drug marketing. A provision prohibits pharmaceutical and medical device companies from giving gifts to health care practitioners or facilities. Exceptions are allowed for educational seminars and materials, reasonable honoraria, and consulting regarding clinical trials. The section also requires pharmaceutical firms to publicly report their significant marketing expenses in Massachusetts, including the Massachusetts share of expenses for TV, radio, magazine and other national advertising. DPH will annually prepare a report analyzing spending for drug marketing.

SECTION 5 directs the Executive Office of Health and Human Services (EOHHS) to coordinate an evidence-based pharmaceutical purchasing and prescribing program for all state health programs. MassHealth will establish a preferred drug list coordinated with the Health Insurance Connector, the Group Insurance Commission, the Departments of Mental Health, Mental Retardation and Corrections, and other state agencies. These agencies may join a pharmaceuticals purchasing consortium based on the preferred drug list. The consortium will negotiate discounts from pharmaceutical manufacturers, and use central purchasing and volume contracting to control costs. Also, Massachusetts may join with other states in a combined purchasing pool.

SECTION 6 adds a chapter to the General Laws authorizing EOHHS to reduce health costs in five areas. The provisions apply to “public payors,” which include MassHealth, the Connector, the Group Insurance Commission, and other state health programs.

The first provision creates a transparent, uniform quality and payment measures among public payors. The common quality and payment metrics may include a standard claims payment data set, standard units of payment, and standard performance measures.
Under the second provision, EOHHS will collect data from hospitals and insurers on potentially preventable hospital readmissions. A potentially preventable hospital readmission is a patient's readmission to a hospital within 30 days of a discharge due to a condition that indicates the readmission was potentially preventable during the initial hospital stay. After the initial data is reviewed, subsequent data will be publicly available on an internet site. EOHHS will coordinate the creation of a common, transparent payment methodology among public payors to reduce or eliminate payment for potentially preventable hospital readmissions.

The third provision directs EOHHS to collect data from hospitals and insurers on potentially preventable hospital complications. A potentially preventable hospital complication is a potentially preventable harmful event or negative outcome that occurs to a patient while in a hospital that results from the process of care and treatment and not from any underlying disease. After the initial data is reviewed, subsequent data will be publicly available on an internet site. EOHHS will coordinate the creation of a common, transparent payment methodology among public payors to reduce or eliminate payment for potentially preventable hospital complications.

The fourth provision requires EOHHS to create a common, transparent prospective payment methodology among public payors for outpatient procedures. The methodology will provide a single prospective payment for all services provided in an outpatient visit in a hospital or ambulatory surgery center.

The fifth provision establishes evidence-based episodes of care payment rates among public payors for patients with chronic illnesses. The payments will encourage clinically integrated care based on evidence-based guidelines that reflect high-quality, cost-effective care. The annual payment to a care coordination entity, adjusted for the severity of illness, will cover all clinically appropriate care for the year. A portion of the payments will be contingent upon meeting clinical quality goals and patient satisfaction standards.

SECTION 7 prohibits health insurers from charging copayments or coinsurance for preventive health care. Preventive care includes immunizations, periodic health exams for adults and children, prenatal maternity care, well child care, including vision and auditory screening, voluntary family planning, nutrition counseling, and health education. Preventive health care also includes supplies, equipment, medication and specialist-provided treatments and services for persons with chronic illnesses or disabilities.

SECTION 8 authorizes the Commissioner of Insurance to reject health insurance premium levels for individuals and small businesses if the benefits provided are unreasonable in relation to the rate charged, or if the rates are deemed excessive. Any request for a premium increase of more than 7% will be subject to a public hearing. At the hearing, the insurer will provide information on the reasons for the proposed increase in rates, and members of the public may testify.

SECTION 9 establishes a long-term care payment coordination task force to develop a common comprehensive and transparent long-term care payment methodology that rewards efficient, clinically proper care in the most appropriate setting, without undue incentives to choose a particular setting, and that provides high value that best meets patient and family needs. The task force, which includes state agencies concerned with long-term care policy, will consult with experts in the field of long-term care, long-term care providers, consumer health organizations, and organizations representing the elderly, the disabled and racial and ethnic minority groups.

SECTION 10 directs EOHHS to maximize enrollment of eligible persons in the MassHealth Senior Care Options program and develop a plan to offer similar coverage to Medicaid and Medicare-eligible disabled persons under age 65.
SECTION 11 directs EOHHS and the Connector to make MassHealth and Commonwealth Care leaders in the use of advanced health information technology and electronic health records. The agencies will prepare a plan developed in consultation with the Massachusetts e-Health Collaborative, the Massachusetts Health Data Consortium, MassPRO, consumer health organizations, consumer privacy organizations, providers and others concerned about health information technology and electronic health records.

SECTION 12 establishes a special commission to strengthen primary care. The commission will include state agencies, physicians, other providers and community groups. The commission will review the availability of primary care services, identify regions of the state with impaired access to primary care, examine the impact of lack of access to primary care on health status, including racial, ethnic, gender, income and other disparities, estimate the additional costs to the health care system due to the lack of availability of primary care, recommend methods to recruit and increase the availability of primary care practitioners, recommend changes in licensing and reimbursement rates to strengthen primary care, and make other findings and recommendations. The commission will hold public hearings and report its findings by December 31, 2007.