

A Consumer-Driven Healthcare Cost Control Agenda

Health Care For All, Inc, and Community Catalyst

Health Care For All and The Prescription Project

Health Care For All has drafted comprehensive legislation to control healthcare costs in Massachusetts. The bill, introduced by Senator Mark Montigny and Representative James Marzilli, encompasses 16 provisions that attack the problem of growing healthcare 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, or higher copayments or coinsurance. Rather, we support fundamental reforms in financial incentives and care management that both improve quality and reduce costs. We see the ideas in this article 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. **Key words:** *cost control, CQI, disease management, pay for performance*

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

Health Care For All rejected this critique for 2 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 suggest that the 2007–08 session of the Massachusetts legislature is the appropriate and feasible time for such a discussion and process. The inauguration of a new Governor, Deval Patrick, pro-

vides another opportunity for a new initiative to contain rising costs.

Attaining better control of rising healthcare 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 10% 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 that rely on shifting costs to consumers, through higher deductibles, copayments, coinsurance, health savings accounts, consumer-“driven” or “directed” health plans, or defined contribution plans. We oppose strategies that presume that consumers are the problem, and that seek to reduce healthcare 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 that 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 (Robinson, 2004). 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 5 areas of healthcare spending, where cost control initiatives can yield substantial gains:

- ambulatory visits;
- hospital stays and perihospital stays (30 days before and after a hospital stay);
- year-long episodes of illness;
- long-term care; and
- 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 healthcare 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 article 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. We present the ideas in this article 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.

We divide our proposals among 7 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 healthcare 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 healthcare system.

Our suggested strategies are as follows:

- 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 will lower costs more effectively than just 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 healthcare delivery—*Move healthcare into the electronic age*
- f. Promote cost-effective use of appropriate prescription drugs—*Right drug, at the right price, without pushy salespeople*
- g. Rescue primary care—*The Foundation of Cost-Effective Health Care*

ORGANIZATION OF THIS ARTICLE

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

What is the problem?

What is our idea?

How would it work?

What needs to be done first?

What is the potential benefit?

We claim no monopoly on good ideas. This article 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. Our recommendations seek to

- a. create the right incentives for healthcare delivery,
- b. empower consumers and patients to take personal responsibility,
- c. expand effective care management systems for the most challenging populations,
- d. improve the efficiency of healthcare delivery,
- e. promote real transparency across the system,
- f. encourage using the right drugs in the right way, and
- g. rescue primary care.

Promote real transparency across the system

1. Require the Division of Insurance to hold public hearings on health insurance rate increases for every licensed insurer when rate increases exceed 7%. The hearing will force insurers to publicly justify their rate of increases and allow state officials to reject unreasonable rate hikes.
2. Eliminate unnecessary administrative costs by requiring the Group Insurance Commission (GIC) (payment system for state employees among others) and MassHealth (Massachusetts Medicaid program) and other public payers to establish common quality and payment metrics. A common metric will reduce administrative costs by eliminating conflicting and contradictory requirements imposed by multiple payors.

Create the right financial incentives for health delivery

1. Change financial incentives to avoid potentially preventable hospital readmissions. Changing hospital financial incentives will press hospitals to take actions to improve quality and prevent readmissions.
2. Change hospital financial incentives related to potentially preventable complications (PPCs). This information should be released to the public. Hospitals have techniques to reduce complications such as infections, but financial incentives must be altered to encourage hospitals to aggressively pursue these steps.
3. All public and private payers should reimburse providers for outpatient procedures on a prospective payment basis. A set prospective payment will encourage groups to provide these ever-increasing services on a more efficient basis.
4. Improve payment of long-term care services in the appropriate setting. Comprehensive payment reform will reward efficient, clinically proper care in the most appropriate setting, without undue incentives to choose a particular setting, providing high value that best meets patient and family needs.
5. Episode of illness payments and quality monitoring system for diabetic patients and other patients with chronic illness. A single payment, adjusted for the complexity of the patient, will allow the provider to coordinate care and focus on improving quality and preventing complications.

Empower consumers to take personal responsibility

1. Empower and train patients with significant chronic illnesses to manage their care and to improve their wellness. Patient self-management programs have proven effective in increasing wellness and reducing costs.

Expand effective care management systems for the most challenging and high-cost populations

1. Remove barriers to more rapid and significant expansion of Senior Care Options SCOs and Special Needs Plans or SNPs (managed care plans for the disabled and/or frail elderly) to improve quality and lower cost of care for dual eligibles. The programs, as long as they have rules in place to avoid selecting healthier people, provide coordinated and accountable care that improves quality and reduces costs.

Improve the managerial efficiency of healthcare delivery

1. Improve patient flow management to reduce emergency department (ED) overcrowding. Hospitals can reduce emergency department waiting time and diversions by smoothing the schedules for elective surgery.
2. Executive Office of Health and Human Services (EOHHS) and MassHealth should become engaged leaders in the implementation of health information technology (HIT) and electronic health records (EHRs).

Encourage using the right drugs in the right way

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

3. Ban the sale of individual prescriber information to the pharmaceutical industry. Drug manufacturers use this information to tailor marketing pitches to individual doctors.
4. 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.
5. Eliminate patient barriers to access to needed life-sustaining treatments for chronic illnesses—eliminate co-payments for urgently needed medications. Eliminating patient barriers to preventive care and sustaining treatments for chronic illnesses will lower long-term costs and improve health quality.

Rescue primary care

1. 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.

PROMOTE REAL TRANSPARENCY ACROSS THE HEALTHCARE SYSTEM

Calls for greater transparency in the health-care system have become common and familiar (Berwick et al., 2002; Clarke, 2006; McCormick et al., 2002; Wilensky, 2006). 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 system.

Require the Division of Insurance to hold public hearings on health insurance rate increases for every licensed insurer when rate increases exceed 7%

What is the problem?

Health insurance premiums in the small group and nongroup markets have increased by double-digit rates for the past seven consecutive years. These increases destabilize budgets for families, employers, and the government at all levels. These rates of increases also threaten 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 1, 2007) small/nongroup health insurance market, there is little accountability or information.

What is our idea?

We need sunshine, transparency, and accountability for health insurers writing policies in the newly merged small/nongroup insurance market. We propose annual public hearings on health insurance rate increases for any insurer whose premiums in the newly aggregated market exceed 5%. The Commissioner of Insurance would be granted the authority to require reconsideration of rates based on the evidence produced in the hearings.

How would it work?

The Commissioner of Insurance would be empowered to obtain all relevant information used by health insurers to calculate their rates, including subpoena power. The Commissioner would produce public reports based on the information obtained. The Commissioner would be required to conduct a public hearing on aggregate rate increases exceeding 7%. The Commissioner would also be required to accept testimony from the public in making the decision whether to require rate reconsideration.

What needs to be done first?

The Legislature needs to approve legislation directing the Commissioner of Insurance to undertake this new process.

What is the potential benefit?

Health insurers have been vocal advocates for greater provider transparency, a call that 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 be a spur for greater public dialogue and conversation about the causes of rising health insurance premiums.

Eliminate unnecessary administrative costs by requiring the GIC and MassHealth to establish common quality and payment metrics

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 payers. There are cost savings to be realized and decreased administrative burdens that could be eliminated by eliminating or reducing multiple payer rules (Woolhandler, Campbell, & Himmelstein, 2003; Woolhandler, Himmelstein, & Lewontin, 1993).

What is our idea?

GIC and MassHealth should 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 (quality/price).

For example, GIC and MassHealth would require—with respect to hospital payments—hospitals and health plans to use the same methodology to describe hospital case mix. Even though a health plan might still pay

Hospital A more than MassHealth for the same type of the patient, this would be done transparently by using the same case-mix methodology. Payers 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 GIC/MassHealth RFP process for managed care organizations and providers would cover all markets and providers simplifying the contract process together with quality and price transparency. This would free providers to concentrate on improving care using common metrics instead of confronting providers with different yardsticks for quality measurement and payment purposes.

How would it work?

Standardized methods for service definition and counting using the existing claims system will create significant administrative savings: (1) work with a standard claims data set for both payment and transparency; (2) standardize units of payment (cases and visits) and payment methods—initially for the inpatient and then moving to the outpatient; (3) use the same relative weights for payment even though payment levels may differ across providers and settings; and (4) develop 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. Providers and managed care organizations wishing to respond to GIC/MassHealth RFPs would use a simplified RFP process containing the same metrics.

What needs to be done first?

The Legislature should direct MassHealth and the GIC to agree on metrics to be used in standard RFPs for managed care organizations, standardized metrics to be used by managed care with whom GIC and MassHealth contract.

What is the potential benefit?

Administrative savings for all participants in the healthcare delivery/payment process, clarity for consumers, clarity for providers

of care on the metrics on which they are measured, and consultant savings would also occur.

CREATE THE RIGHT INCENTIVES FOR HEALTHCARE DELIVERY

Too often in healthcare, it just does not pay to do the right thing the right way. Healthcare reimbursement is a dense and complicated topic. At the bottom of it is a simple question, does the payment structure provide incentives to do the right thing or the wrong thing. We have identified several ways we believe healthcare financing does not pay in a way that helps ensure the best care for patients done in the best way.

Change financial incentives to avoid potentially preventable hospital readmissions

What is the problem?

Between 7% and 15% of all patients discharged from hospitals (excluding obstetrics) result in readmission to a hospital within 30 days (Halfon et al., 2006; Jovicic et al., 2006; Luthi et al., 2003). Many of these admissions are preventable if the patient received optimal care during the initial admission and/or if the patient received 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 the patient's quality of life. Avoidable readmissions are an example of poor quality.

What is our idea?

We propose changing hospital reimbursement rules to incentivize hospitals and physicians to avoid unnecessary readmissions by providing appropriate and coordinated care.

1. In year 1, the State should provide consolidated reports to all acute care hospitals on their readmission rates.
2. In year 2, the State should undertake public reporting of hospital readmission rates, including rates of potentially preventable readmissions.

3. Also in year 2, all payers of hospital services should change reimbursement rules to provide a financial incentive to hospitals and outpatient settings to decrease preventable hospital readmissions

How would it work?

1. The GIC and MassHealth (and other payers if possible) would merge patient-specific data to allow the tracking of readmission rates.
2. GIC and MassHealth, working with providers and payers, would devise a common financial incentive strategy to incentivize hospitals to decrease preventable readmissions.
3. GIC and MassHealth would facilitate public release of hospital readmission rates.

Merging GIC and MassHealth data would 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 payers adopt this approach in a consistent manner.

What needs to be done first?

The Legislature should direct GIC and MassHealth to undertake this initiative that will involve paying hospitals in a manner that takes into account both the severity of illness of hospitalized patients and the readmission rate.

What is the potential benefit?

There are 2 benefits. Decreased readmissions will improve quality of care overall and improve patient well-being and satisfaction. Decreased readmissions hold potential major savings to all payers. A conservative estimate suggests that there are 90 readmissions per 1000 excluding obstetrical deliveries.

Change hospital financial incentives related to PPCs

This information should be released to the public.

What is the problem?

Hospitals are often paid extra if a PPC occurs during the hospital stay—even though the added revenue to hospitals often does not cover the entire cost for each episode. Some analyses indicate that hospitals lose money when they have patients with PPCs. More importantly, hospitals trying to avoid preventable complications are underpaid. Estimates of the costs associated with just one of these complications (hospital-acquired infections) to payers, employers, consumers—and hospitals—are in the billions of dollars.

What is our idea?

Massachusetts has followed the lead of California, Pennsylvania, Florida, and other states by collecting information to identify PPCs. The New York State Department of Health is currently confidentially releasing information about PPC rates to hospitals. After an initial period of time to improve the validity of the data collection of PPCs, GIC and MassHealth should use this information to provide financial incentives to decrease PPCs (or at a minimum not provide a financial incentive to have more) (Averill et al., 2006; Hughes et al., 2006).

How would it work?

State government would facilitate the collection and dissemination of information from hospitals to identify their rates of PPCs.

1. The GIC and MassHealth (and other payers, if feasible) would require the collection of information necessary to identify PPCs.
2. GIC and MassHealth, working with providers and payers, would devise a common approach to use data to reduce PPCs.
3. GIC and MassHealth would facilitate public release of hospital complication rates.

Joining GIC and MassHealth data would signal the healthcare market that Massachusetts citizens will have their care monitored using similar transparent metrics and allow providers to use a consistent approach.

What needs to be done first?

Starting January 1, the State of Massachusetts is collecting the information needed to identify whether or not a hospital complication occurred. The Legislatures should next direct public and private payers to change hospital reimbursement formulae to pay less for PPCs (eg, infections, congestive heart failure, strokes, cardiac arrest, blood clots) that occur during the hospital stay.

What is the potential benefit?

There are several benefits: improved quality of care for hospitalized patients; hospitals that work to decrease complications will be better paid; a positive incentive to decrease complications will result in savings for payers, consumers, and hospitals.

All public and private payers should reimburse providers for outpatient procedures on a prospective payment basis***What is the problem?***

Hospital outpatient and ambulatory surgery center visits are skyrocketing with significantly higher associated costs. Existing financial incentives only encourage all providers to provide greater and greater volumes of services and do not provide any incentive to control the costs of these services (Averill et al., 1993; Goldfield, 1993).

What is our idea?

We should reimburse outpatient providers with one payment for all services for each visit; over time, this payment approach can be expanded to include reimbursement for follow-up visits as well.

How would it work?

The State should begin the process to establish a prospective payment reimbursement methodology for outpatient procedures.

1. The GIC and MassHealth (and other payers, if feasible) would begin to pay for ambulatory procedures on a prospective basis.

2. Price information should be posted on the Commonwealth's Web site to provide information to consumers on the prices paid for outpatient procedures, as is now being done in Florida.

What needs to be done first?

The Legislature needs to direct public and private payers to develop a prospective payment methodology 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?

There are several benefits. First, paying prospectively for outpatient and ambulatory surgical procedures eliminates the current incentive to provide as many services as possible to all patients. Second, this change will create significant cost savings for all payers and consumers. This will occur because providers will have a financial incentive to negotiate both the quantity of services provided during an outpatient visit and the costs of these individual services. Third, this mechanism can be used to track quality of services for these outpatient procedures (eg, emergency department visits after an outpatient procedure).

Episode of Illness payments and quality monitoring system for diabetic patients 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 healthcare expenses. The numbers 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 that impact their quality of life. These chronic illnesses are becoming increasingly responsive to newer treatment approaches that often result in poor coordination of services. For all adults, diabetes diagnoses accounted for nearly 9% of

hospitalizations, 12% of nursing home admissions, and 10% of deaths from 1988 to 1994 (Roblin et al., 2007).

What is our idea?

Encourage coordinated care for all individuals with significant chronic illness. Coordination would be encouraged via a financial mechanism that would pay for a year-long episode of, for example, diabetes.

How would it work?

1. MassHealth and the GIC would encourage their participating health plans to contract with a private entity (eg, provider, care management system). These entities would focus, for a fixed price adjusted for severity of illness, on improvement of health for patients with chronic illness.
2. Health plans would create work groups with MassHealth/GIC to review existing ways to contract for episodes of illness for significant chronic illnesses. At the end of this process, the work group would create a reimbursement methodology that is transparent consumers, providers, and entities contracting for these episodes of illness payments.
3. Health plans would issue an RFP seeking bidders to contract for year-long episodes of individuals with a chronic illness. The reimbursement would be adjusted for the complexity of the illness, particularly for those situations in which the chronic illness is compounded by mental health disabilities, a critical factor that is absent today and key to long-term success.
4. This program would emphasize implementation of consumer empowerment as key to better management of the individuals' chronic illness.

What needs to be done first?

MassHealth and GIC would need to develop this program and develop a database of individuals with significant chronic illness.

What is the potential benefit or payoff?

If payers carefully and transparently monitor these programs for quality and cost, there would be increased satisfaction for consumers, increased coordination of services for significant chronic illnesses and decreased overall costs for the healthcare system.

Improve payment of long-term care services in the appropriate setting

What is the problem?

Costs for long-term care services are increasing. Mass Medicaid is the primary payer of long-term care services. Today these services provided in different settings (described below) are paid using different classification systems—this does not allow for any comparison of the cost/quality of services provided in different settings (Medpac, 2006, pp. 153–167). A significant portion of long-term care starts with postacute care. Postacute care is defined as the time-limited period immediately following an acute hospitalization. Typically, though not necessarily, postacute 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 healthcare

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?

Require Medicaid to develop a plan to pay nursing homes, acute long-term care facilities, and home healthcare using the same classification system recognizing that fixed costs will be different (Medpac, 2006, pp. 163–165).

How would it work?

Currently, the State of Massachusetts pays for many different types of home care and nursing home services. Recently, the state expanded funding for these services.

What needs to be done first?

All Massachusetts agencies paying for long-term care services need to compile a list of the differing ways of paying for long-term-care health services for seniors and disabled persons in Massachusetts. Incentives that favor one type of long-term-care service over another should be clarified. The different agencies then need to consider ways of developing/adapting a classification system that would be used to pay for all long-term-care services.

What is the potential benefit or payoff?

There are several benefits:

- a. Enrollees will receive cost-effective care in the most appropriate settings.
- b. There will be cost savings for tax payers.
- c. The same 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.

EMPOWER CONSUMERS AND PATIENTS TO TAKE PERSONAL RESPONSIBILITY

Even though we oppose mindless cost shifting to consumers, we do not 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 healthcare cost solution—they need smart and effective ways to engage. We especially believe that it is important to engage the consumers who are most at risk, those with chronic disease.

Empower and train patients with significant chronic illnesses to manage their care and to improve their wellness***What is the problem?***

Research shows that the cost of caring for individuals with significant and multiple chronic illnesses is the most significant driver of healthcare costs (Thorpe, 2006). Care for these individuals is most often uncoordinated. 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 need to be taught effective self-management strategies. A variety of patient-empowerment tools have been developed and tested as effective and cost saving (Lorig et al., 2006; Marmot, 2005; Nolte et al., 2006). Even the use of Internet-based programs has shown positive results (Lorig et al., 2006).

What is our idea?

The Department of Public Health should test patient self-empowerment, self-management programs that have proven effective in increasing wellness. These programs include Enhance Wellness (Seattle, Wash), Active for Life (Austin, Tex), a Matter of Balance (Boston, Mass), How's Your Health (Hanover, NH), and the Stanford Chronic Disease Management Program (Palo Alto, Calif). On the basis of the 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 tools.

How it would work?

Legislation and funding can direct DPH to establish a pilot program to test these models among populations with chronic illness. On the basis of the evaluation, DPH can undertake a statewide campaign to disseminate these tools through providers and community-based organizations to reach tens and hundreds of thousands of residents who could benefit from this program.

What needs to be done first?

Legislation needs to be approved to direct DPH to undertake this program and to provide funding for a demonstration program.

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. It means acknowledging patients' central role and fostering responsibility. Such an approach recognizes that patients and families are part of a wider society and that, for example, adequate housing is key to the likelihood that low-income HIV-positive women take medications regularly. It means using proven programs to 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, and 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 empowerment (World Health Organization, 2007).

**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,” the most expensive populations in both Medicare and Medicaid. Massachusetts already has an approach in place, an approach that has not been enabled to grow to its potential for improving care and controlling costs.

Remove barriers to more rapid and significant expansion of Senior Care Options and Special Needs Plans to improve quality and lower cost of care for dual eligibles

What is the problem?

Individuals who are “dually eligible” for Medicare and Medicaid represent among the most expensive and challenging populations in the US healthcare system. For Medicaid alone, “dual eligibles” represent 14% of enrollees and 40% of total spending. They comprise 17% of Medicare enrollees and 24% of total spending. They include senior citizens, including seniors institutionalized in nursing homes. They also include a significant number of individuals younger than 65 with disabilities. Care for these populations is fragmented, inadequate, and inefficient. The result is poor quality care at exorbitant and unnecessary expense. There are new models to provide coordinated care to these populations to enhance quality of care and quality of living at significant savings (Flanders, 2006; MassHealth Senior Care Options, 2006; Surpin, 2007).

What is our idea?

Massachusetts already has organizations providing coordinated and accountable care to these needy populations through 2 programs: the Senior Care Options (SCO) program for senior duals and the Special Needs Populations (SNP) program for duals younger than 65. SNP enrollment in Massachusetts is just getting started. SCO enrollment in Massachusetts, as of June 2006, totaled about 5000 out of a potential population of 120,000. MassHealth needs to facilitate the removal of clinical, administrative, and financial barriers to expanding the SCO and SNP programs to a much greater number of dually eligible seniors and disabled persons younger than 65. As part of the effort to resuscitate primary care (see below), the state needs to facilitate an increase of primary healthcare professionals, a necessary ingredient for the ultimate success of SCOs and SNPs.

How would it work?

MassHealth needs to create incentives to attract more dual eligibles to join SCO/SNP entities, and explore passive enrollment strategies that would allow faster ways to bring this experiment to scale. MassHealth needs to join the federal government and other states and be a payer for dual eligibles younger than 65 who enroll in SNP plans. Massachusetts needs to establish transparent reporting processes and transparent/improved payment calculation methods relative to these programs to enable clear and effective comparison of varying programs.

What needs to be done first?

MassHealth needs a comprehensive strategy to expand enrollment and to ensure continuing and increasing transparency and quality in SCO/SNP plans. Essential to this strategy is a fair payment mechanism removing the incentive to pick and choose healthier individuals. The Legislature could help by passing a directive to MassHealth to facilitate these changes. While the absolute amount paid to SCO/SNP plans may, in some cases, be adequate, under the current payment mechanism there is considerable incentive to game the system.

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 2000 dual eligibles. In its first 2 years of operation, CCA experienced a disenrollment rate of 0.61%. It has achieved impressive patient satisfaction scores. It results in 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.

IMPROVE THE MANAGERIAL EFFICIENCY OF HEALTHCARE DELIVERY

Back in 2001, the Institute of Medicine defined a "quality" healthcare system as includ-

ing 6 distinct dimensions: patient-centered, timely, safe, equitable, effective, and efficient. Using limited resources right and using them well is an aspect of quality care as well as economic care. Here, we identify 2 proposals to create a more efficient delivery system.

Improve patient flow management to reduce ED overcrowding***What is the problem?***

Hospital 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 findings are from research conducted by Eugene Litvak, PhD, director of the Program for the Management of Variability in Health Care Delivery and professor of healthcare and operations management at Boston University. Every acute hospital in Massachusetts with an ED should undertake an investigation and analysis to explore ways to improve patient flow management to increase efficiency and to lessen ED overcrowding and diversion status.

How it would work?

The Massachusetts Department of Public Health should promulgate regulations requiring each acute care hospital with an ED to

undertake an analysis to assess the benefit of changes in surgical scheduling to the operation of the ED and reductions in diversion status. Every hospital would be required to demonstrate compliance with this new requirement as a condition of licensure.

What needs to be done first?

The Massachusetts Legislature should approve legislation authorizing and directing the MA DPH to undertake this process, with clear timelines for DPH and participating acute care hospitals.

What is the potential benefit?

Based upon real results achieved at Boston Medical Center, this intervention can result in (1) drops in the number of times hospital EDs move to diversion status; (2) financial savings to hospitals; (3) reduction in potential harm to patients in need of emergency care; (4) benefits in improved operation and performance in intensive care units; and (5) improvements in nurse staffing and morale (Litvak et al., 2005; McManus et al., 2003).

EOHHS and MassHealth should become engaged leaders in the implementation of HIT and EHRs

What is the problem?

Advances in HIT hold the promise to improve quality and control costs. In Massachusetts, efforts such as the MA eHealth Collaborative (MAeHC) are supporting community-wide implementation of EHRs. The EOHHS and MassHealth—the largest purchaser of healthcare for low-income and vulnerable populations—may be left behind in this transformation.

What is our idea?

HIT is a tool to improve health system efficiency and effectiveness as the Commonwealth struggles with rising Medicaid costs and increased enrollment. EOHHS can benefit from and support HIT and HIE adoption for vulnerable populations. It is essential that EOHHS participates as a lead stakeholder in the movement toward higher quality, effec-

tive, and efficient healthcare through the use of HIT and HIE.

What needs to happen first?

Research and policy development would support EOHHS involvement in HIT efforts.

- EOHHS leaders needs to champion Medicaid and Commonwealth Care involvement in HIT by prioritizing HIT as a quality improvement tool and addressing specific state security and privacy laws.
- Medicaid can support higher quality for their enrollees and programmatic efficiencies by supporting MMIS modernization in accordance with the MITA initiative, actively participate in HIT initiatives such as MAeHC, and work with commercial plans to develop statewide HIE standards.
- Medicaid can support 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.
- Leverage waiver flexibility to strategically support targeted HIT investments.
- Conduct detailed economic and policy analysis to gain an understanding of the economic and quality benefits of adopting HIT in MassHealth and other EOHHS agencies.

Support research and develop best practices for the integration of behavioral health and other “high-risk” population data with HIE initiatives.

What is the potential benefit?

Research points to these positive impacts of HIT on Medicaid populations and programs are as follows.

Improving quality of care for Medicaid enrollees: Because of higher level of disease burden, Medicaid patients’ utilization rates of health services are high (Garis & Farmer, 2002). 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 HIT include improving

information at the point of care, improving chronic and preventive care, reducing medication errors, coordinating and integrating care, and improving access to clinical information and quality monitoring and program improvement.

Improving efficiency and saving costs for Medicaid agencies: HIT can improve efficiency and effectiveness for MassHealth and Commonwealth Care. Medicaid can improve administrative effectiveness to address complex economic and programmatic challenges, including improving 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 electronic drug list access, generic substitution, and other information provided at the point of care; and coordination with public health efforts.

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 healthcare cost control problem, and opportunities for improvement in this area remain.

Expand the use of evidence-based, unbiased information to evaluate the effectiveness of drugs and to shape PDLs and formularies

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 (Oregon Health and Science University, n.d.). This information can be used to design cost-effective PDLs and formularies based on quality. They can provide leverage for programs, plans, and insurers to negotiate with manufacturers for rebates and discounted

prices. MassHealth already uses a PDL with prior authorization, which has decreased costs by increasing use of generics and therapeutically equivalent lower cost drugs. The GIC has similar strategies to lower costs in its plans for state employees. MassHealth determines its PDL based on research conducted by its own Pharmacy and Therapeutics Committee. MassHealth managed care plans and the GIC use pharmacy benefit managers (PBMs) to determine their formularies.

What is our idea?

All Massachusetts public health insurance programs should adopt a uniform, evidence-based system for their prescription drug benefit programs.

How would it work?

The state would coordinate an evidence-based pharmaceutical purchasing and prescribing program for all state health programs. With advice from a broad-based set of stakeholders, EOHHS would establish a PDL 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 could join a pharmaceutical purchasing consortium based on the PDL. Private payers would be invited to join and contribute to this system. The consortium would 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. If the state utilizes a PBM (such as MedMetrics) to assist in implementation, it must be a nonprofit PBM or fully transparent.*

Technical and clinical support for the program would come from the Oregon Health

*MedMetrics is nonprofit, transparent PBM founded in 2004 and affiliated with UMass Medical School, Commonwealth Medicine division. It currently has contracts with NHP and the State of Vermont.

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.

What needs to be done first?

The Legislature should enact legislation directing EOHHS to (1) set up an evidence-based pharmaceutical purchasing and prescribing program for all state programs, which will establish a PDL and invite participation by all state agencies, and (2) create a pharmaceutical purchasing consortium to negotiate lower prices from manufacturers, which will be available to all agencies that adopt the uniform PDL.

What is the potential benefit or payoff?

1. Expanding an evidence-based and uniform PDL could improve quality and reduce costs to all state-funded programs including Prescription Advantage, and programs in DPH, DMH, DMR, DOC, and DET.
2. Ending duplicate determinations by each program about which drugs to purchase would reduce administrative costs for programs.
3. Subscribing to established drug effectiveness research programs (DERP) would allow Massachusetts programs and academic institutions to use their clinical expertise to extend rather than duplicate existing DERP reviews.*
4. This action would increase state leverage in bargaining with pharmaceutical firms.

Provide educational programs, such as academic “counter detailing” for physicians, pharmacists, and others authorized to prescribe and dispense prescription drugs in the Commonwealth

What is the problem?

Despite the use of PDLs and formularies in public programs and private health plans, physician prescribing patterns are highly responsive to \$12 billion annual spending in physician marketing by the pharmaceutical industry. While most states have generic substitution laws applying to all prescriptions, average use of generics is still only 56%, well below the potential 70% rate. Since 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 can exploit this opening by aggressively attempting to influence physician decision making. Physician education is an important tool to balance these marketing practices.

What is our idea?

An academic detailing program should be implemented to provide evidence-based, balanced information to physicians and all 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.

How would it work?

An academic detailing program—similar to one designed by Jerry Avorn, MD, at Harvard Medical School and Brigham & Women’s Hospital for the state of Pennsylvania—would be available to all physicians who participate in programs sponsoring the initiative (Drea et al., 1991; Siegel et al., 2003). Private plans could contract with the program for their providers.

*DERP is now used by 15 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.

What needs to be done first?

The Legislature should authorize establishment of an academic “counter detailing” program to be managed by the Department of Public Health and will provide evidence-based, balanced information to physicians and other prescribers who participate in public healthcare programs in the Commonwealth, including MassHealth, GIC, Commonwealth Care and the Prescription Advantage Program, as well as other prescribers and private health plans who choose to participate.

What is the potential benefit or payoff?

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.

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 (AMA), 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 (National Legislative Association on Prescription Drug Prices, 2006).

What is our idea?

Follow the action taken by the State of New Hampshire in 2006, banning the sale or use of prescriber or patient identities for pharmaceutical marketing, and making the practice a violation of the state’s Unfair Trade Practice Act. The legislation was supported by the New Hampshire Medical Society, whose mem-

bers saw the industry practice as a violation of their privacy.

How would it work?

A new law would prohibit the sale of data on physician prescribing practices for commercial purposes. Transactions for nonmarketing purposes would be allowed—for example, transactions necessary for dispensing drugs, care management and physician education, utilization review, and healthcare research.

What needs to happen first?

The Legislature needs to pass legislation banning the sale of data on physician prescribing practices with legitimate exceptions.

What is the potential benefit?

1. Increased quality of prescribing, reduced complications from inappropriate medications, reduced costs for both public and private payers
2. Reduced marketing to physicians and reduced industry influence on prescribing decisions

Reduce contact of pharmaceutical representatives with prescribers and ban industry gifts and other inducements to prescribers

In 2005, pharmaceutical companies spent \$12 billion nationally in marketing to physicians (some \$13,000), including provision of free samples. Much of the fund is spent providing meals and other gifts to physicians. Voluntary codes from the Pharmaceutical Research and Manufacturer’s Association (PhRMA) and the AMA, as well as guidelines from the Office of the Inspector General (OIG), have shifted some of the focus of industry marketing but have not stemmed the tide of industry largesse. There is abundant research documenting the impact of pharmaceutical advertising on healthcare professionals (Dana & Loewenstein, 2003).

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 8 days.

What is our idea?

Establish limits on pharmaceutical marketing practices as had been done in other states to address this problem. Minnesota passed a law establishing a \$50 limit on all marketing expenses to prescribers. Vermont law requires public reporting of marketing expenses to prescribers. Our idea is to reduce the ability of the industry to interact inappropriately with individual prescribers.

How would it work?

Prohibit pharmaceutical and medical device companies from giving gifts to health-care practitioners or facilities and allow exceptions for educational seminars and materials, reasonable honoraria, and consulting regarding clinical trials. Require 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.

What needs to happen first?

The Legislature needs to approve a new law prohibiting such gifts and requiring public reporting as described above. DPH would be given the authority to prepare an annual report analyzing spending for drug marketing.

What is the potential benefit?

1. Increased quality of prescribing, reduced complications from inappropriate

medications, reduced costs for both public and private payers

2. Reduced marketing to physicians and reduced industry influence on prescribing decisions

Eliminate patient barriers to access to needed life-sustaining treatments for chronic illnesses—Eliminate copayments for urgently needed medications

What is the problem?

Copayment for medications results in decreased use of medications—some of which are needed for life-sustaining treatment. Copayments for these medications lead to increased use of emergency departments and increased hospitalizations. This has been amply documented in both the research and anecdotal literature/experience (Tambly et al., 2001).

What is our idea?

Eliminate barriers such as copayments for all medications needed for life-sustaining treatment (eg, insulin for diabetes, hypertensive medications, hypercholesterolemic medications).

The private sector has experience with such programs. For example, Pitney Bowes has eliminated copayments for medications and observed, anecdotally, significant improvement in employee health after waiving copayments. 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 contain these conditions. While companies pay a little more up front to subsidize the medicine, they rapidly recoup these costs through fewer hospitalizations and better productivity from the affected employees. “Every single day, companies make decisions about how to invest scarce funds for greater returns,” said Sullivan. “Our goal is to encourage them to apply this same discipline to their investment in health care benefits. They will see bottom line results, their employees will be healthier, and the nation will benefit by lowering the total health care bill we pay.”

How would it work?

MassHealth would need to draw up a list of chronic illnesses, the lack of treatment of which results in hospitalizations.

What would need to be done first?

The Legislature needs to authorize MassHealth to waive copayments for chronic illnesses. MassHealth would need to assemble a committee of experts and consumers to draw up a list of chronic illnesses such as diabetes for which there would be no copayments.

What is the potential payoff or benefit?

The payoff is a win-win for both patients and taxpayers. That is, waiving copayments will result in decreased costs associated with emergency departments and hospitalizations.

RESCUE PRIMARY CARE

We have an upside-down healthcare delivery system. In most nations, medical specialists take a backseat to primary care. In the United States, primary care is the poor stepsister 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.

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 and patients seek out more expensive sites for primary care services, and delay obtaining necessary medical care because of obstacles in seeing providers (American College of Physicians, 2006; Kowalczyk, 2006).

What is our idea?

Fixing a problem of this magnitude is beyond the scope of our work in this article, and yet this problem is accelerating at an urgent pace. We propose establishing a broad-based and representative special legislative commission to develop a comprehensive set of recommendations to reinvigorate primary care in Massachusetts.

How would it work?

A special commission with legislative, executive, health sector, payer, and consumer representation could consult with leaders and consumers statewide and nationally to develop robust and workable recommendations to improve and expand primary care in Massachusetts.

What needs to happen first?

The Legislature needs to authorize the creation and appointment of a special commission on the future of primary care.

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.

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