



5 POINT PLAN

FOR REAL REFORM OF THE MASSACHUSETTS HEALTH CARE SYSTEM

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OVERVIEW

Health Care is a vital component of the Massachusetts economy. More people are employed in health care – one in seven – than in manufacturing or financial services. Our health care sector includes traditional health care providers as well as the biotechnology, pharmaceutical, and medical device industries. The excellence of our health care sector is evidenced by its capture of 9.8% (\$1.9 billion in 2002) of all National Institutes for Health (NIH) grants nationally, the highest in the nation. (Source: Health Care Leadership Forum) A sector of our economy that is so vital to the economic health of our Commonwealth and to the physical and mental health of all Massachusetts residents deserves a leadership position in the administration of state government.

Currently, health care activities of state government are grouped within the Executive Office of Health and Human Services. However, even with the most recent re-organization it is so large as to be difficult to manage. There is no comprehensive statewide health policy to guide the expenditures, investments, and allocation of state resources in health care. When budget cuts have had to be made there is no guide to suggest what should constitute an appropriate health care system below which we must not go. The current administration has promised to develop a reform plan to deliver universal health care, but has so far missed three suggested goals for announcing the plan. The number of uninsured continues to grow in Massachusetts even though we have a lower rate than the nation as a whole. The cost of health insurance for business and for employees continues to rise toward unaffordable levels. There is no strong statewide system connecting local boards of health and regional health entities. There is no clear understanding in the administration of which official – the secretary of health and human services or the commissioner of public health – should declare a public health emergency, yet the commissioner has the statutory responsibility. Capacity for acute hospital beds is near crisis levels with most acute care hospitals functioning at 85-90% capacity 90% of the year. There is no comprehensive plan for long term care although our elder population is growing and will double in the next decade. The health care workforce is experiencing serious shortages of nurses and a variety of health specialties. Professional medical liability reform that raises health costs, reduces available professionals, and fails to protect the majority of patients injured by the health system has, to date, been unachievable. The state activities in the area of mental health appear woefully inadequate. The list could well go on.

Fortunately, after years of advocacy by countless individuals and organizations in and out of the health care system, it appears that state government leaders are ready and willing to raise health care reform to the highest priority in the coming legislative term. Senate President Robert E. Travaglini initiated the call for health care reform in his address to the Blue Cross Health Summit, and Speaker Salvatore DiMasi has added his endorsement to the effort to craft a solution. Governor Mitt Romney has set forth an outline of what could be done to improve access to care at an affordable price.

Given the importance of health care to the Commonwealth and its people, I believe that state government needs to provide leadership in the health care field that is not distracted by the vast array of issues and concerns in the human services sector. A system that places both

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health care and human services together in a state such as Massachusetts does not adequately address the needs and priorities of either sector. Having served as Senate Chair of the Committee on Health Care for the past six years, I suggest that real reform of health care requires the establishment of an executive office of health and mental hygiene charged with the development and updating of a comprehensive state health policy. The executive office needs to be empowered to address the public health system of the state, the health care workforce issues, and the need for containing health care costs through an emphasis on quality and safety rather than simply budget reduction and cost shifting. The state needs to be in the forefront of bringing health care into the 21st century with strong state government leadership advocating significant investment and use of technology for both administrative and clinical areas and revolutionizing the delivery of safe, high quality health care to all residents of the Commonwealth.

Five major bills will be filed to respond to the issues addressed above. They include: 1) the creation of a new Secretary of Health and Mental Hygiene with the charge to develop a comprehensive state health policy framework for physical and mental health; 2) a plan to increase access to safe, high quality affordable health care for all Massachusetts residents; 3) a plan to address the nursing shortage in Massachusetts by requiring publication of hospital staffing patterns and measurement of patient care outcomes, but does not establish mandatory nurse staffing ratios; 4) a major reform of professional medical liability malpractice law to reduce defensive medicine and its high costs, stem the tide of physicians leaving their practice or the state because of exorbitant malpractice insurance rates, and expand the number of injured patients whose complaints are addressed; and 5) an investment in health care technology to reduce costs and waste, as well as improve patient and provider safety.

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POINT 1 REFORMING THE ADMINISTRATION OF HEALTH CARE

Summary

The legislation establishes a new Secretary of Health and Mental Hygiene and an Executive Office of Health and Mental Hygiene (creating a separate Executive Office of Human Services). The new executive office will be responsible for the administration of the departments of public health, mental health, the nursing collaborative, the managed care oversight board, the Betsy Lehman Center for Patient Safety, and the Massachusetts Health Care Cost Containment Council that replaces the Division of Health Care Finance and Policy. It specifically establishes the Health Care Cost Containment Council as a quasi-independent agency to focus on improving health quality. The Secretary is expected to serve as the focal point of state government leadership in improving access to health care – both physical and mental health, improving patient safety and health quality outcomes, promoting the development of an adequate health care workforce to serve the needs of the Massachusetts residents, and addressing the concerns about rising cost of health care and health insurance. Of special note is the requirement for the Secretary to take the lead in developing and implementing a comprehensive health care policy for Massachusetts and to regularly review and update the priorities and objectives of the policy. Another important focus that would improve quality and cut health care costs that would benefit from the leadership of a Secretary of Health and Mental Hygiene is the area of prevention – supporting efforts to help the people of Massachusetts become or remain healthy through healthier lifestyles and earlier detection of illness that would save lives and dollars. The current structure that provides a Secretary of Health AND Human Services is much too large to be effectively managed by even the most dedicated public servants and, consequently, the degree of attention that can be paid to leadership in health care is far less than is needed for developing a world class system of health care in the 21st Century.

Sections 1-3. Creates two distinct cabinet level positions – Health and Mental Hygiene and Human Services.

Divides the office of health and human services into an executive office of human services and an executive office of health and mental hygiene.

Section 4. Establishes the reconfigured Executive Office of Human Services.

The office will include: (1) the department of elder affairs under the direction of a secretary of elder affairs, who shall be appointed by the governor; (2) the division of medical assistance; (3) the office of children, youth and family services, which shall include the department of social services, the department of transitional assistance, the department of youth services, the office of child care services, the child abuse prevention board and the office for refugees and immigrants; (4) the office of disabilities and community services, which shall include the department of mental retardation, the Massachusetts rehabilitation

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commission, the Massachusetts commission for the blind, the Massachusetts commission for the deaf and hard of hearing and the Soldiers' Home in Massachusetts and the Soldiers' Home in Holyoke; and (5) the department of veterans' services under the direction of the secretary of veterans' services, who shall be appointed by the governor.

Section 5. Establishes the new Executive Office of Health and Mental Hygiene

The office will include: 1) the office of health services, which shall include the department of public health, the department of mental health, and the Betsy Lehman center for patient safety and medical error reduction; (2) the managed care oversight board; (3) the health facilities appeals board, (4) the Massachusetts nursing collaborative, and (5) the health care cost containment council, which shall be located within, but not subject to the control of the executive office.

The section also establishes a Health Policy Coordinating Council and framework for a comprehensive state health policy.

Section 6. Public Health Council

Creates an independent Public Health Council comprised of key leaders in state health care appointed by their respective organizations. The Public Health Council members are all appointees of the governor. The intent is to allow the council to be more independent in its actions related to public health.

Section 7. Massachusetts Nursing Collaborative

Establishes in statute an existing collaboration of academic and clinical partners working to address the nursing shortage and to promote the enhancement of the profession of nursing.

Section 8. Transfer of Employees

Provides protection for state employees of the various agencies so that they lose nothing in the transition and reorganization process. It also transfers the function of the Division of Health Care Finance and Policy to the Secretary's office.

Section 9. Transfer of Health Related Boards to Public Health

Completes a reorganization begun two years ago when several health related boards of registration were moved from the office of consumer affairs and business regulation to public health. This change, together with the earlier change would place the following boards within Public Health: the board of registration in medicine; the board of registration in nursing; the board of registration in pharmacy; the board of registration of physician assistants; the board of registration of perfusionists; the board of registration of nursing home administrators; the board of registration in dentistry; the board of registration of respiratory therapists; board of registration of allied health professions; board of registration in podiatry; board of registration in optometry; board of registration of chiropractors; board of registration of health officers; board of registration for speech language pathology and

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audiology; board of registration of dispensing opticians; and the board of registration of psychologists.

Section 10. Health Care Cost Containment Council

The purpose of the council to promote the public interest by encouraging the development of competitive health care services, in which health care costs are contained and to assure that all citizens have reasonable access to quality health care. It is further the intent of the council to facilitate the continuing provision of quality, cost-effective health services throughout the Commonwealth by providing data and information to the purchasers and consumers of health care on both cost and quality of health care services, and to assure access to health care services. Nothing in this act shall prohibit a purchaser from obtaining from its third-party insurer, carrier or administrator, nor relieve said third-party insurer, carrier or administrator from the obligation of providing, on terms consistent with past practices, data previously provided to a purchaser pursuant to any existing or future arrangement, agreement or understanding. It is modeled after the Pennsylvania Health Care Cost Containment Council which has been operating for nearly 20 years focusing on quality outcome measures to improve health care and make sure that purchasers get value for their investment.

Section 11. Transition

Mandates cooperation by Human Services in the process of reconfiguring the agencies.

Section 12. Effective Date

Makes the act effective immediately, but provides that transition be completed by July 1, 2006.

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POINT 2
HEALTH CARE ACCESS & AFFORDABILITY

Developed in cooperation with Health Care for All

Section by Section Summary

Sections 1-4. Create an Office of Health Access and an Assistant Secretary for Health Access within the Executive Office of Health and Human Services. The Assistant Secretary supervises the Office of Medicaid, Division of Health Care Finance and Policy (DHCFP) and the access programs established by the bill.

Section 5. Authorizes MassHealth to cover all adults up to 200% of the federal poverty line, and removes the requirement in current law that only adults who are parents may be covered.

Sections 6-8. Authorize MassHealth to expand eligibility for children up to 300% of the federal poverty level.

Section 9. Directs the Secretary of Executive Office of Health and Human Services to seek a federal waiver to receive maximum federal reimbursements for all programs authorized by the bill.

Section 10. Restores cuts made to MassHealth benefits, such as adult dental care and eyeglasses, and requires MassHealth to cover smoking cessation and all hospital stays. The section also prevents MassHealth from imposing a more restrictive disability standard than that used by the federal government.

Section 11. Restores MassHealth coverage to legal immigrant adults.

Section 12. Repeals the requirement that carriers offering health plans to small businesses provide non-group coverage.

Section 13. Allows individuals to purchase small group insurance

Sections 14 and 15. Repeal the existing small group and nongroup reinsurance programs.

Section 16. Adds a new chapter 118H to the General Laws, titled Health Access and Affordability.

Section 1 of chapter 118H directs the Assistant Secretary for Health Access to certify as qualified all individual and small group health plans that provide reasonably adequate minimum standards of coverage. Only purchasers of qualified plans are eligible for subsidies under other provisions of the chapter.

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Section 2 of chapter 118H creates a sliding-scale subsidy program for workers with incomes between 200% and 400% of the federal poverty level who enroll in a qualified individual/small group plan or employer-provided coverage.

Section 3 of chapter 118H establishes an automatic health insurance assignment process for employees without access to employer-based health coverage. The assistant secretary will assign these employees into qualified health plans. The employees can accept, request a transfer to a different plan, or not participate in the coverage.

Section 4 of chapter 118H establishes a reinsurance program to lower premiums for individuals and small businesses. The reinsurance will cover 90% of medical expenses within the reinsurance corridor.

Section 5 of chapter 118H establishes a health access assessment for each employer subject to unemployment insurance. The assessment is calculated as a percent of payroll, which will be determined by the assistant secretary for health access. The assistant secretary will also set up a low-wage worker deduction to exclude some payroll from the assessment, and other reasonable exclusions.

Employers will receive a credit against their assessment for employee health insurance expenses. The assistant secretary is directed to set the assessment rate and low-wage worker deduction so that small, low-wage firms will not face a substantial burden in paying the assessment. Firms providing health benefits to their employees will not pay any assessment. Assessments paid will go to the Health Access and Affordability Fund.

Sections 17-19. Modify the insurance partnership program by increasing firm size to 75, increasing eligibility up to 250% of the federal poverty level, and increasing payments to participating firms by 50%.

Section 20. Directs the Office of Medicaid to streamline enrollment and participation in the Insurance Partnership program.

Section 21. Revises the method used to set MassHealth provider payment rates. The sections require MassHealth to adopt the Medicare payment systems, starting in fiscal year 2008. Rates are to be increased by the inflation level plus 10% until the Medicare rate levels are reached. Physician payments may reflect more than procedure for a single visit. Rates must also be sufficient to allow providers to cover the cost of providing health care to their employees. An advisory board will oversee and review changes and updates to MassHealth rates.

Section 22. Provides that the Division of Health Care Finance and Policy annually review and report on rates paid to MassHealth providers. It also directs the division to prepare an annual report on the extent to which private insurance coverage prices are higher than they would be otherwise due to inadequate payment by the Commonwealth.

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Section 23. Establishes a Health Quality and Cost Council. The Council will develop goals to lower health care costs and improve quality of care. The recommendations are designed to promote high-quality, safe, effective, timely, efficient, equitable, and patient-centered health care. In addition, the Council will establish an advisory committee with members representing a broad cross-section of the health care industry.

Section 24. Establishes a community health worker outreach program. This program will create an outreach plan that identifies barriers to health care, particularly in ethnic and racial minority communities, and develop strategies to reduce these barriers and improve public health.

Section 25. Amends the Public Health Council statute to make the Council more independent. Appointments will reflect public health, medical education, providers, nurses, physicians, and consumers

Sections 26-28. Replace the Children's and Senior's Health Care Assistance Fund created in 1996 with a new Health Access and Affordability Fund. All revenue to support the current MassHealth waiver and programs created by the bill will be appropriated from the new Fund.

Sections 29-31. Increase the cigarette tax by 50 cents per pack, and direct the revenue to the Health Access and Affordability Fund.

Frequently Asked Questions

Part 1. The Coalition

Who are the members of the Coalition?

The coalition is growing every day. As of December 1, 2004, it has 22 members:

- American Cancer Society
- Boston Center for Independent Living
- Boston Medical Center
- Cambridge Health Alliance
- Coalition for Social Justice
- Families USA
- Health Care For All
- Home and Health Care Association of Massachusetts
- Massachusetts Academy of Family Physicians
- Massachusetts AFL-CIO
- Massachusetts Business Leaders for Quality Health Care
- Massachusetts Council of Community Hospitals
- MIRA Coalition
- Massachusetts Health Council
- Massachusetts Hospital Association
- Massachusetts League of Community Health Centers
- Massachusetts Medical Society
- Neighbor to Neighbor
- SEIU 615
- SEIU 2020
- UMass Memorial Healthcare
- Western Mass Health Access Coalition

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Part 2: The Basic Concept

What are the main goals of the coalition's proposal?

The bill makes substantial improvements in Massachusetts health care in three interrelated areas:

- expanded access to health care coverage
- reduce growth rate in health care costs
- improve quality of health care

The bill builds on the current Massachusetts health care system, and requires minimal disruption of existing arrangements. Passage of the bill would lead to affordable access to quality coverage for most residents of the Commonwealth. It approaches universal coverage, but we do not claim everyone would get covered.

According to the researchers working with the Blue Cross Blue Shield Foundation Roadmap Project, the benefits of covering the uninsured would exceed the cost by a ratio of 3 to 1.

These are our principles:

- MassHealth coverage must expand to cover more low-income people
- Employers have a responsibility to contribute to the health care needs of their employees
- Through intelligent targeting of assistance to small businesses and individuals, government can make health coverage affordable
- Hospitals, doctors and other providers deserve fair payments from the state
- The state can play a key role in coordinating and encouraging quality improvements

The problems of access, quality and cost are interlinked. The uninsured are a factor in the high cost of our system. Lack of quality raises costs, too. High costs contribute to the weakening coverage by the private sector. This bill takes a systemic view of these concerns.

Why cover the uninsured?

The BCBS Roadmap project research by the Urban Institute summarized the economic impact of covering the uninsured:

Expanding coverage to the uninsured in Massachusetts would result in economic and social benefits due to improved health of \$1.2 billion to \$1.7 billion. These benefits are based on estimates of the effect of the lack of health insurance on health, including lower mortality and morbidity and lower wages and productivity.

These estimates of economic and social benefits, i.e., the value of better health, including the higher wages and productivity that the newly insured would experience if fully insured, exceed the incremental cost of expanding coverage by a ratio of about 3:1. The many other

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benefits that would come from universal coverage are difficult to quantify. They include reduced financial uncertainty and depletion of assets such as bankruptcy; improved workplace productivity and higher tax payments; improvement in the quality and availability of personal health services, particularly emergency room care; reduced pressure on the public health system; and lower costs of other public programs such as Medicare and state and federal disability programs.

Others make arguments from *social justice* perspectives.

What is the health impact of being uninsured?

From the Kaiser Foundation's *The Uninsured: A Primer*: "There is a strong relationship between health insurance coverage and access to medical services. Health insurance makes a substantial difference in the amount and kind of health care people are able to afford, as well as where they obtain care. Research has repeatedly shown that the lack of insurance ultimately compromises persons' health because they are less likely to receive preventive care, are more likely to be hospitalized for avoidable health problems, and are more likely to be diagnosed in the late-stages of disease. Having insurance improves health overall and could reduce mortality rates for the uninsured by 10 to 15%."

Part 3: The Problem

How many uninsured people live in Massachusetts?

The best source is the DHCFP survey. They do a comprehensive survey of insurance status every two years. Their latest survey was done in 2004, but only the basic results have been released (the administration has used the detailed results in developing its plan).

Here are the results:

Number of uninsured:	2004	454,000
Previous years' uninsured:	2002	418,000
	2000	365,000
Percent of population uninsured:	2004	7.4% (adults – 10.6%)
	2002	6.7% (adults – 9.2%)
	2000	5.9% (adults – 8.0%)

Another source of data is the Current Population Survey, done by the Census Bureau. This report, which cannot be directly compared to the DHCFP survey, shows 650,000 uninsured.

How fast are health care costs growing?

Health care is becoming increasingly unaffordable for many in Massachusetts. The DHCFP 2003 employer survey found premiums increased by 39% from 2000 to 2003. Employers responded by reducing their contributions (dropped 6% on average from 2001 to 2003). Employee contributions increased on average by 53% from 2001 to 2003, and copayments increased 50%.

Of companies that don't offer coverage, 94% said it was because the premiums were too high.

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What is currently being done by state government to improve health quality?

Massachusetts providers deliver high quality care. Our health plans and providers are generally rated highly. Yet state government has done little to lead the system to pursue innovative quality improvement strategies. The Department of Public Health has several programs, and the Group Insurance Commission and MassHealth are exploring using the reimbursement system to encourage quality. There no coordinated, public, state leadership on health quality and costs. In other parts of the country, (for example, the Pittsburgh Regional Healthcare Initiative) strong leadership has resulted in a healthcare system that is accountable to the public for making quality improvements.

Part 4: The Bill

What is the cost of the bill?

The Blue Cross Roadmap project estimates the incremental cost of covering all the uninsured at between \$374 and \$539 million. Not all of this cost will be borne by taxpayers. A substantial portion of this cost will come from federal funds and employers who do not now cover their workers. We expect this proposal to cover most, but not all, of the uninsured. Covering the uninsured will benefit the economy by some \$1.2 – \$1.7 billion, increasing prosperity and tax receipts. Other provisions, such as reinsurance and rate reform, will cost additional funds. There are substantial savings to Massachusetts businesses and the health care system.

Because of these and other factors, we will not be able to project a total cost for the legislation until the spring of 2005. For example, the state's uninsurance statistics for 2004 have not yet been released. Estimating the cost requires a detailed analysis of the interplay of the various inter-related components of the proposal. The Blue Cross Foundation's Roadmap is performing this level of analysis that will provide the necessary information. Their analysis will be ready by the spring of 2005.

The coalition is committed to paying fully for the initiatives in the legislation with new and identifiable revenues. We do not support expanding health care in ways that crowd out spending for education and other programs.

Provisions of the Bill

Who administers the programs in the bill?

A new Assistant Secretary for Health Access will be responsible for overseeing all of the various access programs set up by this legislation. Additionally, he or she will supervise the Office of Medicaid, the Division of Health Care Finance and Policy (DHCFP).

How does MassHealth expand?

MassHealth will expand to cover all low income adults (19-64) under 200% of the federal poverty line (less than \$38,000 for a family of four). Currently MassHealth covers only parents up to 133% of poverty (up to 200% if employer coverage is available).

MassHealth will also cover all children under 19 years old in households making less than 300% of the federal poverty level (\$56,000 for a family of four).

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The Commonwealth will seek federal matching funds for the newly covered people under MassHealth. A worker with access to employer coverage will be required to enroll in his or her firm's plan. MassHealth will pay part of the employee's premium. This is current law.

MassHealth will also cover services cut in 2002, such as dental care and eyeglasses. MassHealth will also cover smoking cessation programs. Additionally, it will also cover legal immigrants who were cut in 2003.

What is the cost of the MassHealth expansion?

Governor Romney estimates that 106,000 people of the 460,000 uninsured are currently eligible but not enrolled in MassHealth (the DHCFP previously said the number was 70,000). The cost for covering these people is already accounted for in the budget, according to the Governor.

The 2002 DHCFP survey found that 30% of the uninsured were below 200% of the poverty line. Applying this percentage to the 2004 total number of uninsured leads to 138,000 uninsured below 200% fpl. Subtracting the 105,000 already eligible leads to an additional 33,000 people covered by the MassHealth expansion for adults.

Assuming no other changes in coverage, the cost of fully covering this population would be about \$104 million per year. Half of the cost would be reimbursed by the federal government. However, a substantial percentage would be newly eligible for employer-provided coverage, because of the employer responsibility provisions. Additionally, many already-insured people below 200% would join MassHealth. Under the bill, these people would be required to remain in their employers' plan. MassHealth would subsidize only part of the employee's share of the premium, again with 50% federal reimbursement.

Because of the complex interaction of the employer responsibility provisions and the MassHealth expansion, we are not yet able to estimate the total cost to the state of this expansion. We expect the Roadmap analysis to provide much of the cost data.

What support is provided for middle income families and small businesses?

Middle income subsidy: Middle income families (\$25,000 - \$50,000 for a family of 2) will receive subsidies from the state to help them pay for health insurance. The subsidies will be on a sliding scale, phasing out at the top end of the scale.

This prevents assistance from ending abruptly as income rises above the Medicaid level. The cost of this provision depends on the amount of the subsidies, and the number of eligible people. We do not have the data that allows us to estimate a cost for this provision.

Reinsurance: Under the reinsurance program, the Commonwealth will pay part of the catastrophic claims for small businesses and individuals. This program is modeled on the Healthy New York program that has lowered premiums by about 30% in New York. In that program, the state pays 90% of claims between \$5,000 and 75,000. In 2003, New York spent about \$12 million for the reinsurance program that covered around 60,000 people. Enrollment has continued to grow and now exceeds 100,000 people.

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By absorbing the expense of high-cost cases, health plans can lower premiums and pass on the savings to small employers and individuals. The bill gives authority to the Assistant Secretary to set the reinsurance levels. The cost will depend on how the reinsurance program is set up.

Automatic assignment: Companies that do not cover their workers are required to provide demographic information to the state, which then facilitates the enrollment of these workers into a coverage plan. The program is voluntary for the worker, but would make it easier for uninsured workers to get into coverage.

How does the employer responsibility provision work?

Large employers who do not provide health insurance need to be held responsible for their employees' health care. Under the bill, all employers will pay an assessment, set as a percentage of their payroll. There will be a "standard deduction," (in the bill, called the low-wage worker deduction) exempting from the assessment a set amount of payroll for the first few employees. Companies will also be able to take a credit against the assessment for their health care costs. Below is a model for illustrative purposes. However, we must stress that the level of the tax and the exemption is not yet set. The bill allows the administrators to set the levels. The directive in the bill is as follows:

"The assistant secretary shall set the assessment rate and low-wage worker deduction so that small, low-wage firms will not face a substantial burden in paying the assessment, as determined by the assistant secretary. The assessment rate shall be set so that firms providing reasonably substantial health benefits to their employees will not pay any net assessment."

Here's the example, based on round numbers for illustration purposes

The Jones Company has 25 employees. The wage levels vary, but the total payroll is \$750,000 a year (based on an average wage of \$30,000).

For illustration purposes, suppose the "standard deduction" allows employers to deduct the first \$15,000 of payroll for their first 10 workers from the amount subject to assessment. This would let Jones Company deduct \$150,000 (10 x 15,000) from their payroll. Thus their assessment would be based on only \$600,000 of their payroll (750,000 – 150,000).

For illustration purposes, if the assessment rate is set at 5% of payroll, the company would owe 5% of \$600,000, or \$30,000.

But if the company provided health care benefits to 15 of their employees, and spent on average \$3000 per worker, they would receive a credit of \$45,000 (15 x 3000). They would owe nothing, since the credit of \$45,000 is larger than the assessment owed of \$30,000. If they did not cover their workers, they would owe the \$30,000.

Why this model? Unlike the 1988 Universal Coverage bill, which required a set per-worker assessment from most employers, this percent-of-payroll assessment increases as ability to pay increases. Large firms with highly-paid workers would face a

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substantial incentive to provide coverage, while small, low-wage firms would be exempt.

What changes are made to the Insurance Partnership program?

The Insurance Partnership program provides subsidies to low-income workers with employer-based coverage, and helps their employers afford the coverage. The bill simplifies enrollment procedures, and expands the eligibility and benefits. Small businesses with as many as 75 employees (up from 50) can get reimbursed as much as \$1,500 (up from \$1,000) per eligible employee. Eligibility for employees is increased from 200% of poverty to 250% of poverty.

What are the bill's provisions for provider reimbursement reforms?

Currently, MassHealth routinely pays providers far below the cost of care. Depending on the service, payments range from 60% to 80% of cost, or less. This underpayment discourages physicians and other providers from accepting MassHealth patients, and leads to cost-shifting, where providers are forced to raise rates charged to private patients to make up for underpayments from MassHealth.

The bill proposes moving to a system where MassHealth pays providers using the federal government's Medicare fee schedule. In addition to more closely approximating cost (Medicare is still somewhat below cost for many services), using Medicare will reduce the administrative burden on physicians, hospitals and other providers who will not have to use unique codes and billing forms for MassHealth. Instead they will use the Medicare methods which are standard among health care providers.

What is the role of the Quality and Cost Council in the bill?

Under the bill, an independent, 5-person board, chaired by the Governor, will set quality improvement standards as well as the cost reduction goals. Appointments will be made by the Gov, AG, Auditor, Senate President, and Speaker. Persons appointed must be independent of health industry and be chosen for their expertise.

With input from an advisory panel and the public, the board will set annual quality improvement targets. Recommendations for improvements will be issued annually to key stakeholders, the Legislative and Executive Branches, and various state agencies for action and/or enactment. In addition, the board will issue an annual report on how well prior year targets are being met.

What is the Community Health Worker Program in the bill?

The community health worker outreach program will create an outreach plan that identifies barriers to health care, particularly in minority and underserved communities, and develop strategies to reduce these barriers and improve public health.

What changes does the bill make to the Public Health Council?

The Public Health Council exercises oversight authority over DPH. The bill makes the council more independent, by providing for representation of provider and public health interests. Currently, Public Health Council members are all appointees of the governor. The intent is to allow the council to be more independent in its actions related to public health.

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How is the bill funded?

A new Health Access and Affordability Fund will be established, which will support all of the programs established by this legislation. Funds would come from existing funds going to the uninsured, federal matching funds, assessments and premiums, and new state revenues. The bill enacts a tobacco tax increase; however, additional funding may be needed. We are committed to paying for the full cost of the final legislation. The bill will not require cutbacks in education or other programs.

Why increase the cigarette tax?

The cigarette tax is increased by \$0.50 per pack. Our current tax is \$1.51/pack. This puts us 6th highest in the country, behind Rhode Island (\$2.46), New Jersey (\$2.40), Michigan (\$2.00) Montana (\$1.70), Alaska (\$1.60), and tied with Connecticut and a penny ahead of New York (\$1.50). A \$1.50 New York City tax puts the combined tax there at \$3.00/pack; while in Chicago the combined rate is \$2.14 per pack.

Our tax was last raised in 2002, and experts agree it should be increased periodically to keep up with inflation. A 50-cent tax increase would raise over \$100 million (which could be matched by federal Medicaid funds), would lead to 23,000 fewer teen smokers, saving 7,300 kids from premature death. The long-term health savings would be \$400 million.

Polling in Massachusetts and other states has demonstrated that the public strongly supports cigarette tax increases.

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**POINT 3
PROMOTING SAFE PATIENT CARE
& SUPPORTING THE NURSING PROFESSION**

Developed in cooperation with Health Care Leadership Forum

Summary

This bill will provide a process to bolster the supply of nurses and nurse faculty through incentives for students and matching grants for hospitals. It also creates a public accountability process for developing staffing patterns for patient care. The bill further provides a process to evaluate and report on measures to improve the quality of patient care and ensure transparency in hospital nurse staffing. Rather than the Safe Nurse Staffing Ratio Plan that impose a one-size-fits-all mandated nurse staffing ratio with punitive fines for failure to achieve the ration, the concept of this bill is to provide for increasing the pool of available nurses through incentives and to measure each hospitals efforts to provide sufficient staff to produce good quality outcomes using national developed nurse-sensitive measures. The concern with the mandated staffing ratio concept is that it increases demand for nurses, at a time when there is a growing nurse shortage, without directly addressing an increase in supply of nurses. The unintended consequences are that larger, better funded health care facilities might be able to attract and retain sufficient RN's to achieve the ratios, at the expense of struggling community hospitals, community and neighborhood health centers, school nurses, and skilled nursing facilities, leaving them with the need to close facilities thereby leaving large areas of the state with inadequate access to care. Other consequences of the mandated ratio bill would be to increase pressure to import foreign nurses and to expand use of nursing pools. The Safe Patient Care Plan has the support of the Health Care Leadership Forum composed of major industry health purchaser groups and hospital provider groups, the American Nurses Association, the Massachusetts Association of Registered Nurses, the Massachusetts Organization of Nurse Executives, and the Massachusetts Hospital Association.

Section 1. Analysis of Workforce and Faculty Resources

Directs the Secretary of Administration and Finance to review the efficacy of current workforce development programs and recommend the redesign of state initiatives to ensure a coordinated focus on enhancing the development of the health care workforce. Report is due April 15, 2006. It also directs the Board of Higher Education to analyze the nurse faculty shortage in both publicly funded and private schools of nursing. The Board will compile information necessary to understand the full scope of the shortage and make recommendations to enhance the nurse faculty pipeline. The report is due on April 15, 2006 and will be compiled in collaboration with the Department of Labor and Workforce Development, the Board of Registration in Nursing, and the Massachusetts Center for Nursing, Inc.

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Section 2: Promoting Health Care Professions

Directs the Executive Office of Economic Development to develop a statewide plan to promote health care professions to the general public, including young adults and adult career changers.

Section 3. Enhancing the Availability of Nursing Workforce Data

Creates a repository for all nursing workforce data collected by the Commonwealth. This section requires all state agencies that collect data, conduct surveys or gather information related to the practice of nursing, the supply of nursing workforce, the supply of nursing faculty or any other nursing workforce issue, to regularly submit such data to the Massachusetts Center for Nursing, Inc. (MCN). MCN is a unique collective of nursing organizations working together to shape a healthy future for the profession of nursing and for the people of Massachusetts through collaboration and innovation.

Section 4. Establishing the Clara Barton Nursing Excellence Programs

Creates the Clara Barton Nursing Excellence Trust Fund and appropriates \$30 million to fund the Clara Barton Nursing Excellence Programs. These programs include: a student loan repayment program and a faculty position payment program; an expert nursing corps to provide mentoring services to incoming or novice nurses; a grant program for higher education and health care institutions to foster partnerships that promote the recruitment and retention of nurses; a scholarship program to encourage outstanding students to pursue nursing as a profession; and, a matching grant program to provide a dollar-for-dollar match for any hospital that commits resources or personnel to nurse education programs.

Section 5. Addressing the Nursing Faculty Shortage in Public Institutes of Higher Education

Facilitates the expedited hiring of nurse faculty at publicly funded schools of nursing. An early retirement incentive program instituted by the state has exacerbated an existing shortage of nursing faculty. This section gives priority to the rehiring of nurse faculty positions by deeming them to be of a critical and essential nature.

Section 6. Accountability for Nurse Staffing

Requires that all hospitals licensed by the Department of Public Health file and post a nurse staffing plan that addresses patient nursing needs by identifying the appropriate number and mix of staff for each hospital, specific to each shift in the hospital inpatient units, special care units, and emergency departments by day of week. The nurse staffing plan will address patient nursing needs in each hospital and set forth a mechanism to obtain input from all members of the patient care team. Each plan will identify relevant factors, such as: the number of patients in a unit, the intensity of care required; skill and experience of various care givers including registered nurses, licensed practical nurses, ancillary personnel, and other members of the patient care team consistent with the level of authority and responsibility delegated under state licensure; admission, discharge, and transfers;

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geography of a unit; and the availability of technological support. This section also requires that the nurse staffing plan shall be reviewed and updated when necessary to reflect significant variations in services, approved by the hospital board, describe how it meets applicable JCAHO nurse staffing standards, and be filed with DPH on an annual basis. Hospitals will be subject to penalties for failure to submit the plan and are subject to random audits by DPH to ensure that the plan meets the various criteria outlined in the section.

Section 7. Evaluation of Patient Care Using Nurse-Sensitive Performance Measures

Requires hospitals , through their quality improvement programs, to institute a process to collect, monitor, and evaluate patient care through the statewide use of three evidence-based nurse-sensitive performance measures. The measures will be selected by the Betsy Lehman Center from the National Quality Forum nurse-sensitive performance measures, and will include patient care hours per patient day. The Center will develop the annual reporting process and will publicly report both hospital-specific performance measure data and aggregated industry trends and best practices developed from the annual reports.

Section 8. Commission to Review the Analysis of the Institute of Medicine Findings

Establishes a broad-based commission within the Executive Office of Health and Human Services to analyze the Institute of Medicine's 2003 report "Keeping Patients Safe: Transforming the Work Environment of Nurses". The commission shall study key findings of the report and make recommendations for implementation of the findings based on existing state regulations, workforce shortages, and the current financing of hospital care in Massachusetts. The Commission will be jointly chaired by the Chairmen of the Joint Committee on Health Care and will issue a report within six months of the effective date of the act.

Section 9. Application of this Act

Establishes the effective dates of this legislation.

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**POINT 4
REFORMING THE MEDICAL
MALPRACTICE LIABILITY SYSTEM**

Summary

Physicians are increasingly concerned with the rapidly escalating costs of Professional Medical Liability or Malpractice Insurance System in Massachusetts, and across the country. While Massachusetts malpractice cases have not been unusually excessive and most cases are ultimately decided for the physician, the fear of being sued is increasing premiums and that is resulting in some physicians – especially those in high risk specialties such as obstetrics and neurosurgery – to leave their practices. This results in a reduction in access to care. At the same time, the fear of being sued leaves many doctors practicing defensive medicine ordering expensive tests to demonstrate their good faith effort to do everything to help the patient. This increases the cost of health care. Because doctors and hospitals are worried about lawsuits, even when they do everything well, they are reluctant to reveal information that could be extremely helpful in improving patient care and promoting best practices to reduce errors system errors. The current malpractice system, therefore, results in reducing access and creating health workforce shortages, increasing cost of care, and failing to improve safety, while not adequately addressing the needs of the majority of patients who are actually injured – albeit unintentionally for the most part – by the health care system. The proposed plan does not limit damages or compensatory judgments that could be awarded to patients who may be seriously injured, but is intended to help anyone injured by the health care system as well as to promote the improvement of a safer system for the benefit of all patients who may need care.

Section 1. Joint and Several Liability

The rule of joint and several liability allows an injured party to obtain all of the monetary award they may receive from a lawsuit from any one of the defendants regardless of their proportion of liability. For instance, if a patient suffers an injury during surgery and 3 people involved in the surgery are sued—the surgeon, the anesthesiologist and a surgical nurse—and the each of them is found to have contributed to the patient’s injury, proportionally at 10 percent at fault, 20 percent at fault and 70 percent at fault, the plaintiff can recover the full amount of the award from the party found to be only 10 percent at fault. Plaintiffs do this when one of the defendants has “deeper pockets” than the others.

This bill will eliminate the rule of joint and several liability for “health care practitioners.” Under this bill, individual defendants will only be required to pay the amount of damages for which they are proportionally liable. Therefore, if a defendant is determined by a jury to be 10 percent at fault, they can only be made to pay 10 percent of the damages award.

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Section 2. Collateral Source

The collateral source rule allows defendants to reduce the amount they must pay to an injured plaintiff by deducting from that amount the value of any other source of compensation the plaintiff has received or will receive. Massachusetts has a limited collateral source rule now but it applies to only payments the plaintiff has already received. This bill will allow the court to consider any future sources of payment or compensation. Allowing the full use of the collateral source rule will reduce large damage awards while not putting the injured plaintiff in any worse position.

Section 3. Expert Witness

This section and section 4 make changes to the rules governing the qualifications and testimony of expert witnesses. Section 3 applies to expert witnesses offering testimony at the Medical Malpractice Tribunal. This section enhances the qualifications for those experts testifying at the tribunal to require that they are (1) licensed by the medical board, (2) are board certified in the appropriate specialty and (3) actively practice in the same specialty. This section will ensure that experts testifying at the Tribunal are well-qualified to give an opinion and that they are not merely “roving medical experts” employed by plaintiff’s attorneys to get cases past the Tribunal stage.

Section 4. Expert Witness

This section adds the same requirements as section 3 for experts testifying at the trial stage of the proceeding.

Section 5. Accountability for Nurse Staffing

One major factor in medical errors and patient safety is the level of nursing staff available in hospitals. This section requires hospitals to develop a nurse staffing plan that takes into account the important variables in staffing determinations, submit it to the department of public health and incur fines if such plan is not filed correctly. This section will reduce health care costs by improving patient outcomes and thus the number of lawsuits.

Section 6. Evaluation of Nursing Care Quality

Hospitals shall submit an annual report to the Betsy Lehman Center for Patient Safety and Medical Error Reduction as to performance measures for nurse staffing and quality improvement.

Section 7. Limitation on High Risk Surgeries

Repeated studies have shown that certain surgeries and procedures are more prone to error and harmful outcomes when performed in hospitals that have less experience with them. By better monitoring where such surgeries are performed and requiring that such surgeries take place in settings where experience is sufficient to improve patient outcomes, we can reduce the number of errors and therefore the cost of these errors to the health care system. This

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section will set up a system for monitoring high risk surgeries (those that are prone to error from inexperience). By reducing the number of errors we will reduce the number of lawsuits and help keep medical malpractice rates down.

Section 8. Protection against Liability for Physician Apology to Patient

In cases where a mistake has been made, acknowledgement of the error and apology by the physician can prevent costly litigation and help speed resolution of the case. Physicians are wary of apologizing, however, because an apology can be deemed an admission of liability in administrative and judicial proceedings. This section will prevent a physician apology from being used against them in any such proceedings.

Section 9. Medical Malpractice Reinsurance Fund

This section will establish a Medical Malpractice Reinsurance Fund. This state backed fund will help reduce medical malpractice premiums by allowing insurers to obtain "reinsurance" for very large judgments against them. Reinsurance is a way to reduce the cost of malpractice premiums by reducing the risk insurers are exposed to of the very largest malpractice judgments.

Section 10. Patient Education

This section changes the definition of "postoperative complication" to include loss of function or aesthetics. This change, in conjunction with the following section, will help improve patient satisfaction with their medical care and help improve patient outcomes by requiring surgeons to better inform patients of potential postoperative complications and take steps to reduce their occurrence.

Section 11. Patient Education II

This section, in conjunction with the above section, requires health care facilities to put in place a procedure to reduce postoperative complications.

Section 12. Medical Professional Liability Insurance Rate Reduction

This section will authorize the division of insurance to approve rate adjustments by medical malpractice insurers. This is necessary to ensure that with the comprehensive slate of liability reforms contained in this bill, malpractice insurers return their decrease in costs to the health care professionals in the form of lower rates.

Section 13. Mediation

This section requires that the medical malpractice tribunal refer cases that may be appropriate for it, to mediation. Mediation is the least expensive and most amicable way to resolve civil matters and its use will save the system time and money.

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POINT 5

PROVIDING FOR INVESTMENT IN THE ACQUISITION, UPGRADING, DEVELOPMENT & IMPLEMENTATION OF TECHNOLOGY TO IMPROVE THE MANAGEMENT & DELIVERY OF HEALTH CARE IN THE COMMONWEALTH

Summary

“There are advanced technologies which can dramatically lower health care costs and improve quality. The technologies are proven. The associated benefits are known. But there are barriers in the system that impedes their implementation (such as initial start up costs to acquire the technology.) We can change that,” explains Mitchell Adams, Executive Director, Massachusetts Technology Collaborative. Massachusetts is home to a life sciences “Super Cluster” consisting of an extraordinary aggregation of the world’s leading institutions and companies in biomedical research and education, health care delivery, medical devices, biotechnology, pharmaceuticals, and information technology. It is the envy of the world, and an essential element in our region’s future economic vitality.

At the same time, the quality of our health care system suffers as a result of medical errors, fragmented care and inadequate systems. Widely cited estimates from the Institute of Medicine report, To Err is Human, indicate that the cost of medical errors in terms of human life is substantial. Other studies have shown that the financial cost is huge. The total costs associated with these events – including all health care costs, disability, lost productivity and income – could reach \$29 billion. There exist advanced technologies which can dramatically lower health care costs and improve quality. While capital expenditures for equipment and training are required, the cost savings associated with implementing these technologies going forward can be much greater, such that substantial net financial benefits are possible. These technologies cross a spectrum of disciplines including biotechnology, medical devices and information technology.

Seven advanced technologies have already been identified that have demonstrated substantial net financial benefits amounting to a savings of \$2.5 billion annually, and improved quality of care and health outcomes. They were selected from among a wide array of technologies for their demonstrated ability to simultaneously reduce costs and improve quality. They represent only a sample of all of the technologies that could benefit health care in Massachusetts. They are electronic communication between patients and their physicians, e-prescribing, ambulatory computerized physician order entry of medications or tests, out patient computerized physician order entry of medications or tests, regional data sharing, electronic ICU applications, and disease management.

Section 1. Authorizes State Grants or Loans for Health Care Technology

Provide for grants and zero or low-interest loans to state and local agencies of government, institutions of higher education, health care providers, health care organizations, health plans and insurance entities, health consumer organizations, not-for-profit health

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information technology corporations and other organizations in health care technology, including but not limited to equipment, access charges, training and applied research.

Section 2. Uses of the Grants or Loans for Technology

Any such grants, zero or low-interest loans made pursuant to this act, shall be made available through the Massachusetts Technology Collaborative, or through not-for-profit health information technology corporations. The grants/loans would be used for (1) monitoring or implementing patient safety, medical error reduction systems; (2) facilitating direct consumer enrollment in state sponsored health programs including, but not limited to MassHealth, CHIP and the Prescription Advantage Program; (3) developing programs to electronically receive and process provider claims for Medicaid and other state health programs; (4) providing consumer information directly and through health information centers located in public libraries, schools, senior centers and neighborhood health centers relative to prevention and health education; (5) providing telemedicine and e-health services to specific consumers primarily to reduce the reliance on emergency room services or to improve contact with the health system, including, but not limited to internet consultation with physicians and other providers, homecare participants and assisted living or nursing home residents, and to promote underserved populations; (6) providing appropriate access to patient records data, including but not limited to, the development of a credit card sized personal patient medical records; (7) providing health education including but not limited to training and education courses as well as information to the public or health professional, and to provide information about careers in health care; and (8) providing grants to not-for-profit health technology information corporations to be matched with any federal funds designated for the purpose of establishing a health information revolving loan fund for distribution as loans to eligible applicants for healthcare information technology improvements.

Section 3. Funding for Technology

Authorizes technology capital outlay bonds or appropriations as well as providing for any available federal or foundation grants to provide support for the program.

Section 4. Medicaid Rate Incentive for Technology

Establishes a program to provide a one percent increase in Medicaid rates for health care providers to acquire and maintain technology that helps to better manage administrative functions or patient care that could result in cost reduction or slower pace of growth in cost of health care for Medicaid recipients.

Section 5. Borrowing Authorization

Standard borrowing authorization language.

Section 6. Provides oversight by executive and legislative branches and reporting

Standard language for oversight of the program.

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ADDITIONAL LEGISLATION FOR THE 2005-2006 SESSION

Many people of good will in both political parties are stepping forward with suggestions for improving the Massachusetts Health Care System. Legislation that will be filed on December 1, 2004 will cover other very important reforms that should also be considered as we develop a consensus for major health care reform in Massachusetts. Among the list of issues, that is in no way all inclusive of the needs to address, legislative proposals will be filed to seek to address:

- ✓ **Improving Long Term Care** – promoting greater opportunities for care in the home, new proposals for financing long term care, and improvement to care delivered in skilled nursing facilities.
- ✓ **Reducing Drug Costs** – promoting safe access to drugs through Canada, programs for bulk purchasing of medications, mandating reduction of drug costs, promoting more thoughtful use of drugs, preventing unethical practices by pharmaceutical companies or providers.
- ✓ **Treating and Preventing Obesity** – promoting healthier school lunches and snacks, promoting requirements for physical education in schools, promoting healthier lifestyles.
- ✓ **Improving Oral Health** – increasing access to dentists for MassHealth clients, requiring fluoridation on a state wide scale, promoting early oral health for newborns and pregnant women.
- ✓ **Promoting Patient Safety** – limiting the hours worked by medical interns and residents, requiring credentialing of certain allied health specialties, expanding disciplinary options for health professionals including treatment of those with mental and physical illness or personality issues, developing performance standards for physicians and other professionals.
- ✓ **Strengthening Prevention** – improving screening for various forms of cancer, promoting restoration of tobacco control programs.
- ✓ **Health Emergencies & Bio-terrorism** – updating public health emergency law to deal with 21st Century public health challenges, creating a biological agent registry.
- ✓ **Reducing Transmission of Disease** – providing for decriminalization of needle possession to promote use of clean needles and encourage addicts to seek treatment.
- ✓ **Improving Correctional Health** – promoting programs in the correctional system to minimize recidivism and transfer of disease to those on the outside.
- ✓ **Reducing Health Disparities** – providing incentives, training, protocols to improve health care access and care for women and minorities.

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- ✓ **Expanding Consumer Options for Patients** – modernizing optometric care, promoting collaboration between physicians and pharmacists.
- ✓ **Improving Public Health Care Facilities** – improving the financial support for the public health hospitals and the Soldier’s Homes.
- ✓ **Improving End of Life Care** – providing pediatric palliative care options for terminally ill children and expanding hospice opportunities and coverage.
- ✓ **Financing the Health Care Safety Net** – reforming the Uncompensated Care Pool, providing oversight by the State Auditor of safety net programs, improving Medicaid reimbursement rates for all providers, providing health insurance for direct care staff.
- ✓ **Improving School Health** – expanding the access to school nursing services and expanding the number of school-based health centers.
- ✓ **Improving Mental Health Services** – gaining greater access to mental health services for Medicaid recipients, training for best use of medications for adolescents with mental illness, providing adequate resources for behavioral health facilities, creating more acute, and intermediate level adolescent psychiatric facilities.