Chapter 58 Implementation Report
Update No. 6

Governor Deval L. Patrick

Lieutenant Governor Timothy P. Murray

Secretary of Health and Human Services JudyAnn Bigby, M.D.

April 12, 2007

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
One Ashburton Place, Room 1109
Boston, MA 02108

Tel.: 617-573-1600
Fax: 617-573-1890
www.mass.gov/eohhs

DEVAL L. PATRICK
Governor

TIMOTHY P. MURRAY
Lieutenant Governor

JUDYANN BIGBY, M.D.
Secretary

April 12, 2007

Speaker Salvatore F. DiMasi, Massachusetts House of Representatives
President Therese Murray, Massachusetts Senate
Chairwoman Patricia A. Walrath, Joint Committee on Health Care Financing
Chairman Richard T. Moore, Joint Committee on Health Care Financing
Chairman Robert A. DeLeo, House Committee on Ways and Means
Chairman Steven C. Panagiotakos, Senate Committee on Ways and Means

Dear Senators and Representatives:

Pursuant to section 132 of Chapter 58, I am pleased to provide the General Court with the sixth update on Chapter 58 implementation progress on the one year anniversary of its signing. One year ago today, this legislation was signed into law and since then we have made significant progress towards expanding access to health insurance for many residents of the Commonwealth. The Connector has provided residents and small businesses with affordable, high quality health plans. The Commonwealth provides comprehensive, subsidized health insurance for low and moderate income residents. There is increased access to public health programs and expanded enrollment in MassHealth for the Commonwealth's neediest citizens. In short, we have come a long way to building the infrastructure to achieve the goal of providing access to affordable health care for all residents of Massachusetts. We should all be proud.

As of March 2007 the MassHealth program successfully implemented changes resulting in the enrollment of an additional 3,071 people in health plans through the Insurance Partnership program and 13,000 new and/or converted Children's Medical Security Plan members in MassHealth Family Assistance. Additionally, MassHealth has enrolled over 11,000 individuals in the expanded Essential program for the long-term unemployed. Throughout the last year, overall enrollment in MassHealth has grown by 48,000 members due to eligibility expansions and ongoing outreach and enrollment efforts. As of April 1, 2007 the Massachusetts Health Insurance Connector Authority successfully enrolled

nearly 63,000 people in subsidized health insurance programs. Of those individuals, almost 53,000 enrollees are people with incomes at or below 100% of the federal poverty level and about 10,000 are individuals with incomes between 101 and 300% of the federal poverty level (FPL) or between $10,210 and $30,630 annual income for an individual. To date, between MassHealth expansions and Commonwealth Care programs, approximately 11 0,000 individuals have benefited from new access to affordable health insurance plans and many more will have that opportunity over the coming months.

Within the next few months, the Commonwealth will achieve significant milestones in the implementation of Chapter 58. On May 1st, the Connector will begin enrolling individuals in Commonwealth Choice, the Connector's commercial health insurance program. Through extensive cooperation between the many stakeholders including the Executive branch, the Connector Authority, the Legislature, health plans, consumers, business leaders, and advocacy groups, the Commonwealth Choice products have been established with premium prices which will ensure access to comprehensive health insurance plans with a choice of benefits. Bold efforts to publicize both the Commonwealth Care and Commonwealth Choice insurance plans will continue in advance of the July 1, 2007 implementation date of the requirement for residents to comply with the individual mandate. It remains crucial for the various stakeholders to continue to work together to address questions of affordability and implementation of the employer regulations. We must recognize the delicate balance between encouraging universal participation and the need to ensure that people have the opportunity to make a claim about whether they can afford insurance. Today the Connector Board will issue draft regulations that begin that discussion.

On March 20 draft regulations on Minimum Creditable Coverage (MCC) were approved by the Connector Board. There will be public hearings across the state in May before these draft regulations are finalized. MCC benefits include preventive and primary care, emergency services, hospitalization benefits, ambulatory patient services, mental health services, and prescription drug coverage. There are no annual or per sickness maximums, no indemnity fee schedule of benefits, and specific caps on deductibles and out-of-pocket spending. MCC requirements will be phased in starting July 1, 2007; full MCC requirements will become effective January 1, 2009.

Promotion and publicity efforts continue throughout the Commonwealth because of the strong collaborations between many agencies and stakeholders. The Connector has worked to educate employers in conjunction with Associated Industries of MA (AIM) in all parts of the Commonwealth. Over 1000 business owners and individuals have attended the forums and benefited from the Employer Handbook designed to explain the employer provisions of Chapter 58. Outreach partners in conjunction with the Connector and MassHealth, have developed materials targeting uninsured individuals which are being distributed

through large consumer businesses such as CVS pharmacies and Shaw's supermarkets throughout the Commonwealth. The Connector's Public Information Unit remains very active in responding to questions on all aspects of health reform and aiding individuals in understanding the new opportunities available to them under Chapter 58. We will continue to keep the Legislature updated as additional communications strategies develop. The Legislature has been instrumental in addressing technical changes to ensure its successful implementation. Several remaining issues are described on pages 1 1-15.

If you would like any further information on the activities summarized in this report, do not hesitate to contact me or my staff.

Sincerely,

JudyAnn Bigby, M.D.
Secretary

Cc: Senator Richard R. Tisei
Representative Bradley H. Jones
Representative Ronald Mariano
Representative Robert S. Hargraves

Table of Contents

Section 1: MassHealth Update

The Office of Medicaid reports the following progress on Chapter 58 initiatives:

Insurance Partnership Expansion
On October 1, 2006, MassHealth successfully implemented an increase in the income limit for eligibility in the Insurance Partnership from 200% to 300% of the federal poverty level (FPL). As of March 2007, the Insurance Partnership has added 3,071 covered lives through expansion of the program.

Children's Expansion up to 300% FPL
On July 1, 2006, MassHealth implemented expansion of MassHealth Family Assistance coverage to children in households with incomes greater than 200% up to 300% of the FPL. As of February 2007, there were 46,200 children enrolled in Family Assistance, up from 31,000 in June 2006. More than 13,000 of those children are new members and/or converted Children's Medical Security Plan members enrolled as a result of the income expansion.

MassHealth Essential Update
Effective July 1, 2006 the enrollment cap for MassHealth Essential was increased from 44,000 to 60,000. This allowed MassHealth to enroll more than 12,000 applicants who were on a waiting list at that time. As of February 2007, Essential enrollment was at 53,103. Given the amount of additional enrollment room for the program, MassHealth does not anticipate having to reinstate ment of the waiting list for MassHealth Essential.

Wellness Program
Section 54 of Chapter 58 requires that MassHealth collaborate with the Massachusetts Department of Public Health (DPH) to implement a wellness program for MassHealth members. It specifies five clinical domains: diabetes and cancer screening for early detection, stroke education, smoking cessation, and teen pregnancy prevention. The law mandates co-payment and premium reduction for members who meet wellness goals. However, since members do not pay significant co-payments or premiums, alternative incentives are being investigated.

A project structure has been established that includes a joint MassHealth/DPH Project Team, which reports to a Steering Committee chaired by the MassHealth Medical Director. The Steering Committee includes the Office of Medicaid, DPH, Executive Office of Elder Affairs, and Department of Mental Health representatives. Both committees receive guidance from an external stakeholder advisory group.

The Wellness Program has completed research and data analysis to set a baseline for accurate tracking of MassHealth members' wellness behaviors. This work is essential for effective measurement and evaluation of the success of the Wellness project.

In February the Wellness Program project management team proposed a two-phase implementation process to the Office of Medicaid leadership to permit the development of a flexible and sustainable incentive program and to ensure that MassHealth members and providers support and buy-in to the idea of wellness. The first phase will begin in June of 2007 and will focus on promoting and educating MassHealth members about the concept of wellness and healthy lifestyle activities. This education would be coordinated with the MassHealth providers. Phase one would not include incentives, nor would the possibility of incentives for participating in wellness activities be discussed with members. The Wellness Program incentive would be implemented in phase two, following research about the best way to track wellness activities and provide incentives to MassHealth members. Implementing the Wellness program incentive system requires surveying the marketplace which will be accomplished with a formal Request for Information (RFI) to vendors throughout the state.

MassHealth has made progress in planning the logistics of the RFI process with all necessary internal stakeholders. MassHealth has met as scheduled with the external advisory group to discuss incentive options for members. The project team is planning the phase one promotion campaign and developing materials about the Wellness program for members and providers.

Overall, considerable progress has been made in designing the wellness program and the method by which to evaluate and report on its effectiveness. The project is on the following implementation time track:

- Creation of overall program structure: May through August 2006 (complete)
- Research and program design: September 2006 through February 2007 (complete)
- Implementation planning: January through June 2007 (on schedule)
- Program Implementation and subsequent evaluation: July 2007 and ongoing (on schedule)

As previously reported, the co-payment/premium reduction requirement in the law has proven problematic. Most MassHealth members pay no premiums, and those who do generally pay negligible amounts. Consequently, MassHealth and DPH have concluded that such an incentive structure would have little impact on member compliance, and are currently exploring alternative member incentives. The Office of Medicaid and Wellness Project Leaders met with legislative staff in late December 2006 to discuss the change in the direction of the project from the original mandate and have received support to pursue alternative member incentives. The Office of Medicaid will recommend changes to the legislation to

implement a different benefit for members that participate successfully in the Wellness Program.

Outreach Grants

MassHealth and the Commonwealth Health Insurance Connector Authority (Connector) released a Request for Response (RFR) on September 9 to solicit grant proposals from community and consumer-focused public and private non-profit organizations for activities directed at reaching and enrolling eligible Commonwealth residents in MassHealth programs and the Commonwealth Care program. Grantees were selected in November.

Twenty-four "Model A" grants, for traditional community-based outreach, enrollment and re-determination services, were awarded. Grantees must develop effective community-based strategies for reaching and enrolling eligible individuals into MassHealth programs or the Commonwealth Care program. Seven grantees were selected to fulfill "Model B" requirements which focus on integrated outreach and marketing campaigns. Model B grantees must develop and conduct comprehensive broad-scale media or grassroots campaigns targeting individuals potentially eligible for either program.

Both Model A and Model B contracts have been executed and grant awards distributed. Model A and Model B organizations continue to submit outreach materials to the state for accuracy review. These materials are reviewed by EOHHS and Connector staff. Model A organizations are heavily involved in day-to-day outreach and enrollment activities on the local level. Many creative outreach strategies are being pursued to reach those difficult to reach populations. As a direct result of this outreach, recent enrollment data for January and February reflects over 10,800 applications have been filed, with over 4,700 approved for MassHealth, and over 2,100 approved for Commonwealth Care.

Model B organizations are involved in collaborative efforts to produce widely-distributed materials for outreach. These include public service announcements for radio and television, video broadcasts for use in patient waiting rooms, and a website that will be used to make approved outreach materials, including materials developed by Model A organizations, available to other outreach and community organizations state-wide.

Section 2 Connector Authority Update

The Connector Authority has made significant progress in implementing many of the important initiatives contained in the landmark health care reform legislation signed one year ago.

Commonwealth Care
Commonwealth Care was launched successfully on October 1, 2006 for individuals whose income is below the federal poverty level. On January 1, 2007 Commonwealth Care was expanded to include those individuals who earn between 101% and 300% of the federal poverty level or between $10,210 and $30,630 annual income for an individual. These newly eligible enrollees qualify for Plan Types II, III, or IV depending on income, and are required to pay a portion of their premiums. As of April 1, 2007 almost 63,000 people have enrolled in Commonwealth Care, approximately 53,000 in Plan Type 1 for those earning up to 100% of FPL or up to $10,210 for an individual, and over 10,000 of whom are in Plan Types II, III, and IV and have incomes between 101% and 300% FPL. Individuals can enroll through the call center, the Commonwealth Care website, by mail, or with the assistance of many community organizations, hospitals, and community health centers.

Commonwealth Care has expanded efforts to outreach to eligible populations. Businesses such as CVS pharmacies and Shaw's supermarkets have begun distributing flyers about Commonwealth Care to their customers. Locally-based organizations who received outreach grants continue to work in their communities conducting enrollment assistance and creating and distributing outreach materials for MassHealth and Commonwealth Care.

Commonwealth Choice
The Connector continues to work within the extremely tight timeframes required to launch Commonwealth Choice and is on schedule for May 1st enrollment. Extensive coordination amongst the Connector, the sub-connector, health insurance carriers, and other interested parties is required to meet the May 1st start date for enrollment.

<u>Seal of Approval</u>
During the March 8th meeting the Connector Board awarded the Connector Seal of Approval to seven insurance carriers. Following market research, including focus group testing, the Connector confirmed that consumers want a simple choice of health plans at a few different benefit levels. The Seal of Approval plans will be offered at three different levels which vary by price and cost sharing, but all three levels will offer comprehensive coverage, including inpatient and outpatient medical care, emergency care, mental health and substance abuse services, rehabilitation services, hospice, and vision care. The Connector is currently working with the health plans to finalize contracts for board approval on April 12th.

Sub-Connector

The Connector has selected Small Business Service Bureau, Inc. (SBSB) to serve as the Sub-Connector for the Commonwealth Choice program. SBSB will handle much of the administrative functions associated with Commonwealth Choice including customer service, enrollment processes, premium billing, and Section 125 program support.

Section 125

The Connector Board adopted Emergency Regulations 956 CMR 4.00 regarding the requirement under M.G.L. c. 151F that employers offer Section 125 plans to their employees to enable employees to use pre-tax dollars to purchase health insurance. A public hearing on these regulations is scheduled for April 27 th.

Minimum Creditable Coverage

On March 20 draft regulations on Minimum Creditable Coverage (MCC) were approved by the Connector Board. There will be public hearings across the state in May before these draft regulations are finalized. MCC benefits include preventive and primary care, emergency services, hospitalization benefits, ambulatory patient services, mental health services, and prescrip tion drug coverage. There are no annual or per sickness maximums, no indemnity fee schedule of benefits, and specific caps on deductibles and out -of-pocket spending. MCC requirements will be phased in starting July 1, 2007; full MCC requirements will become effective January 1, 2009.

Operations

Connector staff approved the framework for the new Connector website being developed by CSC Consulting Inc. The CSC team continues to work with SBSB in order to ensure a smooth integration of systems come May 1 st. The toll free number currently used for the Commonwealth Care call center, 1 -877-MA-ENROLL, will also be used for Commonwealth Choice. Callers will be routed to the appropriate call center. Work is also underway on handbooks for Commonwealth Choice shoppers, brokers, and for those employers interested in setting up Section 125 plans for their employees.

Marketing and Outreach

The Connector has been participating in a series of forums across the state hosted by Associated Industries of Massachusetts (A.I.M.) in conjunction with regional chambers of commerce explaining how health care reform affects local businesses. To date, greater than 1000 individuals have attended these forums and additional forums are scheduled to be held. The Connector has also created the Employer Handbook, an educational tool used to provide information on some of the important healthcare programs and requirements affecting employers. The handbook is available on the Connector website as well as at the public forums. The Connector's Public Information Unit continues to be an enormous resource for handling concerns about all matters of health care reform.

Section 3: Technical Changes

The General Court has passed two separate bills making amendments to Chapter 58 to better align key provisions of the law and to ensure the successful implementation of all aspects of Health Care Reform.

There still remain, however, a number of outstanding issues that should be addressed to allow the Connector, the Division of Unemployment Assistance, the Department of Revenue, the Division of Health Care Finance and Policy and the Office of Medicaid to continue to make progress toward decreasing the number of individuals who remain uninsured.

Budget Neutrality:
Transfer of the Health Safety Net Office to the Division of Healthcare Finance and Policy

A critical element of the Centers for Medicare and Medicaid Services (CMS) approval of the MassHealth 1115 Waiver amendment that supported Health Care Reform was the requirement that the Commonwealth demonstrate that the Waiver will be budget neutral through its current term. In July 2006 a federal budget neutrality calculation was submitted by the Commonwealth and accepted by CMS based on State Fiscal Year (SFY) 2005 actual expenditures and member months, trended for SFY 2006 through SFY 2008. This calculation resulted in an estimated budget neutrality "cushion" of $ 82 million over the 11 years of the Waiver (SFY 98 - SFY 08). It is important to recognize that $82 million is a slim margin over 11 years and $46 billion worth of total expenditures, and is indicative of the serious challenge budget neutrality presents.

Budget neutrality calculations must be updated as actual expenditures become available. MassHealth is closely monitoring actual spending to gauge ongoing compliance with this fundamental waiver requirement.

The budget neutrality calculation approved by CMS in July 2006 did not include expenditures made from the Health Safety Net Trust Fund (HSNTF). The types of provider reimbursements to be made from the HSNTF have in previous years been made though the Division of Health Care Finance and Policy (DHCFP). As such, those expenditures were not included in the 1115 Waiver budget neutrality calculations. The terms and conditions of the 1115 Waiver specifically exclude expenditures made by other agencies (other than the Medicaid agency) from the budget neutrality test.

If the Health Safety Net Office, as manager of the HSNTF, is created in the Office of Medicaid, payments made to providers from the HSTNF must be included as Waiver expenditures. The Waiver will not be budget neutral if HSNTF payments are included. It is, therefore, critical that provider payments made from the

HSNTF be made by the DHCFP, and continue to be excluded from the W aiver budget neutrality calculation. Therefore it is necessary to place the Health Safety Net office to the Division of Health Care Finance and Policy rather than in the Office of Medicaid.

Division of Unemployment Assistance

Chapter 324 of the Acts of 2006 (An Act Relative to Health Care Access) shifted responsibility for collection of the Fair Share Assessment to the Division of Unemployment Assistance. The following issues require legislative action:

- The Division of Unemployment Assistance is a fed erally funded agency, and therefore has no discretion under federal law to expend federally appropriated dollars specified for the collection of unemployment insurance on other activities. DUA recommends that, after the initial start -up year, the ongoing funding of the Division's responsibilities for the assessment be derived from a portion of the fair share assessment monies collected.

- Second, in order to encourage and maintain employer compliance with the filing and payment requirements of the collecti on of the Fair Share Assessment, the Division feels it is imperative that language be included allowing audit & enforcement authority consistent with the authority in the DUA statute relative to Unemployment Insurance, Chapter 151A. Specifically, the law requires DUA to implement penalties against employers who fail to pay the assessment. Since the requirement to pay the assessment falls within G.L.c.149 and not the Unemployment Insurance (UI) statute, DUA is not able to use the expedited and effective co llection tools provided in G.L.c.151A for the collection of delinquent UI taxes. In many of these cases, a notice of intent to proceed with further legal action, citing the statutory authority to do so, was sufficient to obtain compliance with filing, payment and/or payment plan requirements. Without this technical amendment, the division's ability to enforce compliance by delinquent employers will be seriously hampered.

- Third, statutory language must be enacted to authorize DUA to promulgate regulations in order to establish definitions and requirements needed to administer the fair share assessment.

Executive Office of Health and Human Services/ MassHealth

- Section 23 of Chapter 62E of the General Laws, as amended by section 15 of Chapter 324 of the Acts of 2006, authorizes DOR to share wage reporting and financial institution information with specified state entities. The

amendment included in Chapter 324 adds language to permit DOR to share that information with the Division of Unemployment Assistance (DUA), the Department of Insurance, and the Division of Health Care Finance and Policy for purposes of administration and enforcement of the Uncompensated Care Pool (UCP), Health Insurance Responsibility Disclosure form, Free Rider surcharge, the fair share employer contribution requirements, and the responsibilities of EOHHS' Health Safety Net Office.

- Another technical change necessary to Chapter 324 concerns that of the definition of "creditable coverage". As written, the definition included in Chapter 324, and therefore Chapter 58 does not include coverage under Title XXI of the Social Security Act, the State Children's Health Insurance Program (SCHIP). SCHIP, as a comprehensive coverage plan, should be included as providing creditable coverage under Health Care Reform.

- Chapter 58 was enacted with the assumption that certain state Medicaid expenditures would be federally reimbursable. Specific language needs to be incorporated into the law to ensure that certain state Medicaid payment obligations are explicitly conditioned upon the availability of FFP and legislative appropriation. The language will need to identify those sections that calculated the availability of FFP as it relates to state funding of health care reform implementation. Such language would exclude FFP as a requirement for health care reform expenditures that calculated funding at 100% state cost.

Department of Revenue

- Section 6 of chapter 324 allows the Division of Insurance, upon request, to collect insurance information from insurance carriers and the Office of Medicaid. The statute prohibits the use of SSNs, which in many cases is a MassHealth recipient's identification number. Therefore, an amendment would permit the use of SSN's for MassHealth purposes only.

- A similar problem exists in section 11 of chapter 324, which requires insurers, self-insured employers and the Office of Medicaid to send an annual notice to each insured regarding insurance coverage. This section also prohibits the use of SSN's. A similar amendment to the one described above would allow for the use of SSN's for MassHealth purposes only. Issuers of these notices would also be required to submit a report to DOR once a year. The reports must identify the carrier or employer, the covered individual and covered dependents, the insurance policy or similar numbers and the dates of coverage during the year, and other information as required by the commissioner of revenue for the purposes of verifying coverage for the named individuals. Section 11 allows DOR to share these reports with certain state agencies for health care related purposes. A further amendment to this section would allow DOR to also share these reports with

the Executive Office of Health and Human Services to assist in the identification of other insurance coverage to ensure that the Commonwealth is the payor of last resort.

- Chapter 58 calls for DOR to share quarterly wage reports with the Connector to verify income eligibility for participants in the Commonwealth Care Health Insurance Program. A technical amendment would clarify the information to be contained in the data exchange agreements between DOR and the Connector. In addition, the statute currently authorizes DOR to release wage reporting data only. A further amendment would authorize DOR also to release tax return information for purposes of verifying eligibility.

- As described above, the statute allows DOR to share wage reporting information with the Connector for limited purposes – to verify income eligibility. The Connector may also need access to this information for other health care related purposes. An amendment would allow the Connector to access wage reporting and non-financial information contained on withholding returns for purposes of the administration and enforcement of health care reform.

- The individual mandate section currently applies to "every person who files an individual return." A technical amendment would expand the section to apply to every person who files or is "required to file" a tax return.

- Effective Tax Year 2007 only, every person who files a resident tax return must state whether, as of the last day of the taxable year, he or she met the individual mandate requirement. If the person answers "no" or leaves the question blank, the person loses his or her personal exemption (half the exemption is lost if one person answers "no" on a joint return). Technical amendments would clarify and define the penalty for year 1.

- Effective Tax Year 2008, every person who files a resident tax return must indicate on the return whether the individual mandate requirement was met for each of the 12 months of the taxable year. If the person says "no" or leaves the question blank, DOR must assess a penalty equal to half of the amount of premiums an individual would have paid toward an affordable premium. Technical amendments would clarify and define the penalty after year 1.

- Effective October 1, 2007, the Division of Health Care Finance and Policy must promulgate regulations requiring acute hospitals to submit data "that will enable the department of revenue to pursue recoveries from individuals who are ineligible for reimbursed health services and on whose behalf the Health Safety Net Trust Fund has made payments to acute hospitals for emergency bad debt." Technical amendments would establish procedures

regarding the “recovery of payments,” and clarify the information to be contained in data exchange agreements between DOR and DHCFP.

- The Department requires a change to references to nonprofit entities under the definition of employer to tax-exempt organizations consistent with Section 501 of the Internal Revenue Code.

- The Department also requires clarification that the same rules that apply to group health plans maintained by partnerships, and to their partners, also apply to limited liability companies.

- Another clarification to a reference to gross income is necessary to be consistent with Internal Revenue Code references.

- Finally, a clarification is necessary to allow that information exchanged with the Connector for purposes of verifying eligibility for participants in the Commonwealth Care Health Insurance Program must contain social security numbers.

Division of Insurance

- Chapter 58 added section 4R to the M.G.L.c.176G, the requirement for dependent age up to age 26. However, DOI has become aware that Chapter 172 of the Acts of 2006, An Act Relative to HIV and Hepatitis C Prevention, also inserted a new section 4R of M.G.L.c.176G. DOI recommends that the section number be amended in order to avoid confusion.

- Changes made in section 4 of Chapter 450, which amended the Chapter 175 section 110(O), nondiscrimination of premium contribution provision by excluding stand-alone dental services from the requirement inadvertently dropped the provision to allow separate contribution levels under collective bargaining agreements.

  Chapter 58 also added this nondiscrimination provisions to the BCBS and HMO statutes (See C.58 sections 52, 55 & 59) and the collective bargaining language remains in place under these statutes.

Section 4: Individual Mandate Preparations

The individual mandate requires most residents 18 and over to obtain and maintain health insurance by July 1, 2007 or face tax penalties. The Department of Revenue is responsible for enforcing the individual mandate through the state income tax returns. The most challenging issue to date is how to confirm that the health insurance information reported by the taxpayer is accurate.

The Department reports significant progress in this area. Beginning in 2008, insurance carriers and certain employers must send an annual written statement, called the MA 1099-HC (for health care), to every resident for whom coverage was provided in the previous calendar year. Taxpayers will use this statement, similar to other 1099-like statements, to transcribe the information onto the tax return. Issuers of these statements will also send a separate report electronically to the Department for matching purposes. The Department has worked closely with the insurance industry to develop standards and procedures to implement this new process. Earlier this month, the Department entered into a Pilot Phase with five insurance carriers to determine the final specifications and also to begin testing the file transfer procedures.

The Department is also working closely with the Connector to define affordable health insurance and the appeals procedures. The individual mandate only applies if health insurance is deemed affordable by the Connector. The Connector will establish a schedule of affordability (in the form of tables), which will be used by the Department to calculate whether the mandate and applicable penalties apply. Taxpayers for whom the Department has assessed a penalty may appeal to the Connector. The Department and the Connector are developing the appeals procedures.

In addition, the Department is developing the 2007 tax returns to capture the relevant information that must be reported by taxpayers to show proof of insurance.

Lastly, the Department is working with the Connector to mail a postcard in the spring to every taxpayer that will explain the individual mandate requirements.

Section 5: Health Safety Net Trust Fund and Essential Community Provider Grants

Health Safety Net Trust Fund

Chapter 58 requires that, beginning on October 1, 2007, payments from the Health Safety Net Trust Fund are to be made on a claims basis using Medicare pricing principles, as modified to reflect the level of appropriation for the Health Safety Net. Chapter 58 also requires that, by April 1, 2007, the Division of Health Care Finance and Policy, in consultation with the Secretary of Health and Human Services, file a report with the Committees on Ways and Means outlining a "new methodology for equitably allocating free care reimbursements from the Uncompensated Care Trust Fund to hospitals and community health centers beginning in hospital fiscal year 2008". The Division has been conducting analyses and working with a technical advisory group of hospital representatives to develop the payment system that will be in place for October 1, 2007. As this work is ongoing, the Secretary requested a one-month extension of the date to complete the report. The report will provide more specific details of the proposed payment system, but generally the proposed model will achieve the goals outlined in Chapter 58 by incorporating Medicare payment principles, basing payments on actual claims of service, and introducing more robust claims and eligibility edits to ensure appropriate payment for services.

Chapter 58 also requires that Community Health Centers be paid no less than the Medicare Federally Qualified Health Center visit rate plus additional payments for services not included in that rate. This provision also goes into effect on October 1, 2007. The Division has begun analysis to determine the effect of these changes and has convened a Community Health Center technical advisory committee to facilitate the transition to a modified payment system.

In addition, the Division is exploring the feasibility of using the MassHealth Pharmacy On-line Processing System (POPS) for prescription drug claims adjudication in community health center and hospital outpatient pharmacies. It is expected that this move will enable the Health Safety Net Office to achieve efficiencies through use of the pharmacy management tools available under the MassHealth pharmacy program.

Health Safety Net Regulations

The Division of Health Care Finance and Policy, in conjunction with the Office of Medicaid and the Executive Office of Health and Human Services, has begun the process of formulating policy options regarding services and eligibility under the new Health Safety Net regulations. The Division is researching the types of services providers have billed to the Uncompensated Care Pool to inform the decision making process. The Division expects to seek input from interested

parties and stakeholders via consultative sessions about the services to be covered by the Safety Net Care Pool. The Division will also consult with the Board of the Commonwealth Health Insurance Connector, the Director of the Office of Medicaid, and representatives of the Massachusetts Hospital Association, the Massachusetts Council of Community Hospitals, the Alliance of Massachusetts Safety Net Hospitals, and the Massachusetts League of Community Health Centers, as required by Chapter 58. The Division, in conjunction with the Office of Medicaid and the Executive Office of Health and Human Services, expects to propose the Health Safety Net regulation in June or July 2007 for an October 1, 2007 effective date.

Section 6 Boards, Councils, Commissions, and Reports

Health Care Quality and Cost Council

The Health Care Quality and Cost Council has made significant progress on a number of fronts. The Council and its Advisory Committee each meet monthly to consider the work of the subcommittees and measure progress on the requirements set forth in Chapter 58.

Executive Director:

The Council has selected an Executive Director to support the work of the Council.

Communications:

The Communications Subcommittee has drafted and will soon release a Request for Proposals (RFP) from communications consultants to begin formalizing a plan to make price and quality information about health care available and useful to the general public. The audience will be primarily consumers, but the information should be useful to providers, payers, employers, agents and policymakers. The Council is seeking communications assistance from experienced individuals or firms for the purpose of developing a comprehensive communications plan aimed at reaching consumers, media outlets, providers, policy makers and agent/brokers of the Commonwealth, all of whom will stand to benefit from the information the Council produces.

The plan will include steps to inform people about the availability of information on cost and quality; guidelines for presenting information in the most understandable and useful way, based on input from consumers; strategies for disseminating the information via multiple media, including a website; and a means to solicit ongoing feedback from consumers to inform adjustments to the approach.

Cost Subcommittee:

One of the Cost Subcommittee's goals is to establish statewide cost containment goals and work with the quality subcommittee to develop quality improvement goals that are intended to lower or contain the growth in health care costs. In February, the Cost Subcommittee released a Request for Information on proposals from individuals or groups that can identify reasonable goals that are within the control of that individual or group's health care sector. The Subcommittee received 26 responses, primarily from members of the Advisory Committee, with a broad range of recommendations towards lowering or containing the growth in health care costs. The responses were consolidated by members of the Subcommittee and distilled into four specific areas to focus on in the short term which will be further defined with the Council. Those proposed goals are:

1. Improve hospital care quality
2. Promote e-prescribing

3. Analyze and improve use of diagnostic imaging
4. Improve end-of-life care

These recommendations will be reviewed and refined.

Quality Subcommittee:

The Quality Subcommittee has set forth a draft proposal of overarching quality goals for the Commonwealth which the full Council will discuss. The Subcommittee supports leveraging the many quality improvement initiatives and measurements currently going on within the Commonwealth and developing a strategy to centralize the information. The initial proposal for quality goals includes:

1. Improve patient safety and effectiveness of care in hospitals
2. Improve screening and the management of chronic illnesses in the community
3. Eliminate racial and ethnic disparities in health and in access to and utilization of health care
4. Develop and provide useful measurements of health care quality in areas of health care for which current data are inadequate.

Masshealth Payment Policy Advisory Board

The MassHealth Payment Policy Advisory Board held its second meeting on February 20, 2007. At the February meeting, Secretary Bigby addressed the Board and expressed hope that its work will inform the agency and the public about Medicaid rate policy. Acting Medicaid Director Tom Dehner chaired the meeting, which included a presentation about the Open Meetings law from EOHHS General Counsel Kristin Apgar, and a more detailed discussion of the role and responsibility of the Board. The Board accepted a proposal of Division of Health Care Finance and Policy staff about a procedural matter involving how that agency will communicate with Board members about regulatory rate proposals

The Board tasked DHCFP staff with preparing a matrix view of MassHealth rates by provider type and rate methodology, including specific information about certain universally-applied rating factors. The Board also agreed to review a draft summary report to the General Court at its next meeting. At its next meeting the Board will discuss the DHCFP deliverable and an update on pay-for-performance planning pursuant to Chapter 58.

Members of the Board include Tristram Blake, Deborah Enos, An Hee Foley, Elizabeth Funk, Sarah Iselin, Patricia Kelleher, Joseph Kirkpatrick, Robert LeBow, David Matteodo, Robert Moran, Scott Plumb, Mark E. Reynolds, Robert Seifert, Elissa Sherman, David Torchiana and Tom Dehner.

Section 7 Public Health Implementation

The Department of Public Health (DPH), Center for Community Health reports the following progress on implementation of components funded through Chapter 58:

Prostate Cancer (Men's Health Partnership) (4513-1112) - $1,000,000

The Men's Health Partnership has completed translation of education materials into 5 languages and run two rounds of program promotion in news and radio for four weeks each at 10 program sites statewide.

Stroke Education (4513-1121) - $200,000
DPH has developed and disseminated culturally appropriate stroke education materials in English and Spanish. Materials are also being developed for Portuguese speakers.

Breast Cancer (Women's Health Network) (4570-1500) - $4,000,000
In 2006, the program expanded services to approximately 3000 women who would otherwise have been on a wait list for WHN services. In 2007, the program continues to rely on health care reform dollars to supplement federal funding in WHN provision of screening services and facilitate outreach and education services. A major activity of this program has been to assess the impact of health care reform on current clients and develop a new model based on recommendations of the Advisory Committee. Work will continue on the Enterprise Invoice Management/Enterprise Service Management system to replace the current ACES information system.

Diabetes (4516-0264) – $350,000
The Diabetes Prevention and Control Program (DPCP) is initiating several activities to identify and increase the number of individuals with undiagnosed diabetes or pre-diabetes, or who are at risk for these conditions, to undergo a risk assessment and, if appropriate, undergo screening for these conditions. Initiatives to provide community support for healthful behaviors aimed at reducing the risk of developing diabetes, as well as educating providers about the importance of identifying and supporting prevention efforts in high-risk individuals are underway. These activities include: 1) surveillance initiatives of a high-risk population, the Cape Verdean community in southeastern Massachusetts; 2) conducting a Community Survey of all cities and towns in the Commonwealth regarding facilities and opportunities for people to improve their nutrition and increase their physical activity levels; and 3) issuing clinical guidelines for the identification and treatment of children and adults with type II diabetes and women with gestational diabetes, which puts them and their children at a higher risk of developing type II diabetes later in life.

Ovarian Cancer (4513-1122) – $200,000
In 2006, the Ovarian Cancer Awareness Campaign included a coalition comprised of the National Ovarian Cancer Coalition, Inc. (NOCC), The Ovarian Cancer Education and Awareness Network at Massachusetts General Hospital (OCEAN), The Massachusetts General Hospital Cancer Center, and the M. Patricia Cronin Foundation to fight Ovarian Cancer, Inc. (Cronin Foundation). The coalition successfully employed a concerted effort to raise awareness of ovarian cancer throughout Massachusetts. This campaign included media advertising (TV, radio, print, transit), a website, media event a lignment, a cable television show, and government and legislative efforts.

Osteoporosis Prevention (4513-1115) – $250,000
The funds have been used to support and evaluate the ACCENT program which is a nutrition and physical activity initiative for elders that operates out of Councils of Aging. The ACCENT program also develops bone health materials for 18-24 year old women and has created a statewide osteoporosis directory which is currently being printed. DPH is also in the process of implementing mini grants for the ACCENT program which has incorporated a stronger physical activity and strength training component. Up to 20 Councils on Aging will be funded to implement the 12 week sessions of the ACCENT program.

Multiple Sclerosis (4513-1115) – $250,000
Chapter 58 earmarked funds for the Central New England Chapter of the Multiple Sclerosis Society. The contract was amended to undertake the following enhanced data collection and outcome measurement, expansion of B.Fit, a wellness and rehabilitation program, increased outreach for people with MS, increased services for individuals with MS, and provision of short-term care management services during June and July 2005.

Renal Disease (4513-1116) – $100,000
These funds are earmarked for the National Kidney Foundation of MA, RI, NH, and VT. The funds will be used for the same types of services currently provided by the Foundation through an earmark on account 4510-0600. The program will provide nutritional supplements and early intervention services for people with kidney disease as well as those at risk for renal disease.

Tobacco Control (4590-0300) - $4,000,000
Promotion of tobacco cessation and systems changes in 8 health care centers including Community Health Centers, hospitals, and through radio and transit advertisement is in place. Funding to secure additional compliance checks in unfunded areas of the state experiencing high rates of sales to minors has been completed.

Mini-grants to youth groups to promote smoke-free schools and playgrounds have been distributed. As a result, creation of a youth website, promotion of a video contest, and plans for a summit for youth participants are in progress.

Additional funding has also been targeted to reduce exposure to secondhand smoke by increasing inspections to enforce the statewide smoke free workplace law.

Development of retailer education kits, school signs to promote no smoking policies, and materials for healthcare providers and consumers around cessation and the new MassHealth benefits is in progress.

Pediatric Palliative Care (4570-1503) - $800,000
Contacts are in place with 10 licensed hospices to provide pediatric palliative care services to residents of all cities and towns in Massachusetts. Major start-up objectives include informing likely referrals sources of the existence of the program, training staff to address gaps in knowledge and experience given limited pediatric hospice services in the past, setting up procedures for pediatric intakes and services, and providing services to children and families. All providers have had referrals of children for services and are working with families.

Suicide Prevention (4513-1026) $ 750,000
Health Care Reform funding has been used this fiscal year to augment activities of the overall program. Major areas of activity completed include funding of community-based suicide prevention services, education and training for a broad spectrum of community members, professionals and gatekeepers, and funding for surveillance. Funding is in place to support the ongoing activities of the Massachusetts Coalition for Suicide Prevention and the revisions of the Massachusetts State Plan for Suicide Prevention are in process.

Teen Pregnancy Prevention Services (4530-9000) - $1,000,000
Increased funding to15 Community based vendors located throughout the state currently receiving funds to implement science-based teen pregnancy prevention services to implement additional teen pregnancy prevention services to youth, parents/families and providers in communities with high teen birth rates. Three new programs funded through these health reform dollars in Attleboro, Taunton and Southbridge are currently recruiting and /or serving youths. Continued planning for the Connecting for Change! Youth Summit 2007. The goal of the conference is to celebrate and promote a positive image of Massachusetts youth by supporting involvement and adult-youth partnership to improve the health and well-being of youth and their communities.

Community Health Workers
Although no funding was provided for the component, a survey of DPH vendors who do community health outreach to assess utilization and effectiveness of CHW's in increasing access to care is in process. The survey has been pilot-tested and will be adapted shortly to an electronic format. An electronic list of vendors is being complied. The request to complete the survey will be sent out by the commissioner, once the survey has been adapted to e-format and the e-

list complied. We are working with the Heller School to hopefully get an intern to do a lit review in this area.

DPH CHW Advisory Council membership list has been finalized and it is expected that the first meeting will happen in late May or early June.

Betsy Lehman Center for Patient Safety and Medical Error Reduct ion (4000-0140) $500,000

The Betsy Lehman Center for Patient Safety and Medical Error Reduction (Lehman Center), established in Section 16E of Chapter 6A of the General Laws, was given a $500,000 appropriation for Fiscal Year 2007 in Line Item #4000 - 0140 of Chapter 58 of the Acts of 2006. The mission of the Lehman Center is to "serve as a clearinghouse for the development, evaluation and dissemination, including, but not limited to sponsorship of training and education programs, of best practices for patient safety and medical error reduction. The following have been completed.

- 3rd Annual Betsy Lehman Patient Safety Conference Collaboration with the Massachusetts Coalition for the Prevention of Medical Errors for best practices in nursing home medication and ambulatory medication safety; and
- Collaboration with the Massachusetts Coalition for the Prevention of Medical Errors for a model for investigating and reporting medical errors .

Hepatitis C Program

The Hepatitis C Program has piloted medical management programs for people living with HCV infection, expanded integrated HCV counseling, testing and vaccination services to 3 additional sites. Surveillance and evaluation efforts to ensure that data are collected on the extent of the problem and the impact of the initiatives to address it, as well as to increasing capacity of the Hepatitis Laboratory to provide essential testing services in support of the program has also occurred.

State Laboratory Account - (4516-1000)

The $2.418m in healthcare reform supplemental funding awarded to the State Lab account enabled DPH to finance a number of essential services at the State Lab that were in deficiency. These funds were intended to cover the State Lab's occupancy costs that had been severely underfunded for several years, as well as to restore funding to help overcome several years of underfunding of laboratory operations particularly for lab supplies, equipment and essential laboratory and disease control personnel. These funds have provided additional funding to UMMS to address a deficiency in DPH operations cost, funded several positions critical to State Lab operations, and provided funding for critical laboratory operations, including lab supplies and equipment. Critical Laboratory areas included arbovirus and drug laboratory activities.

The critical activities funded through these dollars are ongoing. Costs for laboratory supplies continue to rise, due to increased volume of testing; increased cost of reagents and other supplies as test become more technically sophisticate; and decrease in federal grant funding previously used to offset costs of laboratory supplies. These funds also enabled the State Laboratory, for the first time in several years, to replace broken and outdated equipment critical to laboratory operations.

Infection Control and Prevention Program

The goal of the Infection Prevention and Control Program is to develop a statewide infection prevention and control program in licensed health care facilities. The initial project is focusing on hospitals. An Expert Panel provides overall guidance to a series of Task Groups who develop recommendation on four of the most common infections (ventilator associated, blood stream, surgical site and MRSA) seen in facilities. Two other groups are focusing on data collection and reporting and designing the framework for recommendations. When all of the information is organized, DPH and the Betsy Lehman Center will provide evidence based recommendations on the surveillance, prevention and reporting of specific health-care associated infections.

The Expert Panel is a the midpoint of its work at the time of this report. Task groups have been meeting regularly. Some of them have formulated their initial recommendation for best practices while others are close to formulating their recommendations. The literature review for ranking the evidence based of a recommendation is largely completed. The Expert Panel, which meeting monthly, is set to finalize best practices for some groups based on the quality of evidence. The Public Reporting group has reviewed approaches to communication and education as well as estimates for the cost of implementation. The Program Design group is identifying critical components and key activities of a comprehensive infection prevention and control program. Additional, a RFQ has gone out for consulting resources that will examine centralizing electronic data collection.

As discussions continue and decisions are made, the groups may conduct additional literature reviews to ensure that the most current practices are captured. The Public Reporting and Program Design groups will be finalizing their recommendations as the infection specific groups finalize their best practices. The hospital survey is providing data on current practices, data capabilities and staff education to determine hospitals' capacity to expand and standardize activities. An examination of other states' experiences with this kind of program is also underway.

Section 8 Insurance Market Update

Merger of Nongroup and Small Group Insurance Markets

Small Group and Nongroup Regulations
The Division of Insurance held a public hearing on March 20, 2007 on the revisions to the nongroup health insurance regulations, 211 CMR 41.00, and the small group health insurance regulations, 211 CMR 66.00. No changes were made to 211 CMR 41.00 as a result of the public hearing and minor changes were made to 211 CMR 66.00. The revisions to 211 CMR 66.00 have been sent to the Secretary for Administration and Finance for review and the Division anticipates filing both sets of regulations with the Secretary of State by April 6, 2007.

Young Adult Health Benefit Plan

Young Adult Health Benefit Plan Regulations
The Division of Insurance has continued to work with the Connector to draft regulations for the young adult health benefit plans relying upon the Connector's recommendations for benefit parameters. The Division distributed the draft regulations to the insurance industry and other interested parties for comment and met with them to review the proposed regulations, addressing their concerns and incorporating appropriate recommendations. The Division is consulting with the Connector on the final draft, which will then be placed in final form prior to proceeding with the promulgation process.

Health Carrier Requirements

Nondiscrimination
The Division of Insurance has worked with health carriers in reviewing a draft Bulletin. When complete, the bulletin will clarify the statutory requirement that carriers may only contract to sell health insurance plans to employers that offer the health plan to all full-time employees who live in Massachusetts and only if the employer does not require a greater premium contribution from lower wage employees than they do from higher wage employees. In the course of developing the bulletin, the carriers requested guidance on what constitutes a "full-time employee" since this was not defined in the law. Since this definition could have an impact on economic development if employers take action to reduce employee work hours to avoid meeting the definition of "full-time," this issue is being reviewed with the Administration to ensure that the definition is in line with Administration policies.

Section 9: Updates on Employer Provisions

Several aspects of Chapter 58 related to employers have also seen progress during the past few months.

Division of Health Care Finance and Policy

The Division of Health Care Finance and Policy has made several regulatory changes in response to Chapter 450 of the Acts of 2006, which made technical corrections to some of the employer requirements under Chapter 58 of the Acts of 2006:

In July, the Division proposed three new regulations to implement three statutory requirements of Chapter 58:

114.5 CMR 16.00: Employer Fair Share Contribution
114.5 CMR 17.00: Employer Surcharge for State Funded Health Costs
114.5 CMR 18.00: Health Insurance Responsibility Disclosure (HIRD)

The Division held public hearings in August, 2006 on all three regulations. The Division adopted 114.5 CMR 16.00 in September, but delayed adoption of 114.5 CMR 17.00 and 114.5 CMR 18.00 pending enactment of technical corrections to Chapter 58. Since that time, Chapter 450 of the Acts of 2006 has delayed the effective date of the Employer Surcharge and HIRD requirements.

114.5 CMR 16.00: Employer Fair Share Contribution

The Division adopted 114.5 CMR 16.00: Employer Fair Share Contribution on September 8, 2006. This regulation governs the determination of whether an employer makes a fair and reasonable premium contribution to the health costs of its employees. The Division has determined that Section 16.03 (2) (a) Employee Leasing Companies requires clarification. Under that section, Employee Leasing Companies will be required to perform the fair share contribution tests separately for each Client Company. Although the Employee Leasing Company is responsible for collecting and remitting the Fair Share Contribution on behalf of its Client Companies, the Client Company is responsible for any Fair Share Contribution liability.

The Division of Unemployment Assistance will issue rules, regulations and forms for the collection of the fair share contribution.

114.5 CMR 17.00: Employer Surcharge for State-Funded Health Costs

The Division initially adopted Regulation 114.5 CMR 17.00: Employer Surcharge for State Funded Health Costs on December 22, 2006, with an effective date of January 1, 2007. This regulation implemented the provisions of M.G.L. c. 118G, § 18B. Following enactment of Chapter 450 of the Acts of 2006 on January 3,

2007, the Division repealed this regulation. Chapter 450 changed the effective date of M.G.L. c. 118G, § 18B from January 1, 2007 to July 1, 2007. The Division has begun the regulatory approval process and will shortly issue a new proposed regulation and schedule a public hearing in order to adopt the regulation to be effective July 1, 2007. The revised regulation will reflect the recent legislation clarifying that a "non-providing employer" subject to surcharge is an employer that does not comply with the requirement in M.G.L. c. 151F to offer a Section 125 cafeteria plan in accordance with the rules of the Connector. The new effective date is consistent with the July 1, 2007 effective date of the Section 125 cafeteria plan requirement to be implemented by the Connector.

114.5 CMR 18.00: Health Insurance Responsibility Disclosure

The Division initially adopted 114.5 CMR 18.00: Health Insurance Responsibility Disclosure as an emergency regulation effective January 1, 2007, but the Division has now repealed the regulation. The regulation implemented M.G.L. c. 118G, § 6C, which was previously effective on January 1, 2007. Chapter 450 of the Acts of 2007, which became effective on January 3, 2007, changed the effective date of M.G.L. c. 118G, § 6C from January 1, 2007 to July 1, 2007.

The Division has begun the regulatory approval process and will shortly issue a new proposed regulation and schedule a public hearing for the regulation to be effective July 1, 2007. The proposed regulation will reflect the provisions of Chapter 324 which significantly reduced the amount of information the Division is required to collect from employers. In addition, only employees that have declined to enroll in employer sponsored insurance or to participate in a Section 125 cafeteria plan will be required to sign an Employee HIRD form .

Division of Unemployment Assistance in the Department of Workforce Development

The Division of Unemployment Assistance has made progress on several fronts related to collection of the Employer Fair Share Contribution:

On February 22, 2007, the Division received $3 million in funding to support development and implementation costs associated with carrying out the division's responsibilities under Section 188 of Chapter 149 of the General Laws.

On February 26, DUA issued a Request for Quotation to three software development vendors approved to provide services to Commonwealth agencies under ITS23 (state blanket contract), in accordance with accepted procurement protocols. Proposals were due to DUA on 3/13/07, and the selection of Collaborative Consulting of Burlington, MA was finalized on 3/28/07. Contract negotiations are underway, and it is expected that the vendor will be on board by late April.

Draft regulations outlining certain provisions related to employer liability for, and DUA collection of the FSC were sent to EOHHS' Division of Health Care Finance and Policy and the Connector for comment. The draft regulations were discussed with Secretary Suzanne Bump and DUA's Advisory Council, members of which have been involved in various aspects of the enactment and/or implementation of the Health Care Reform law.

Following all required notifications by April 20, a public hearing will be scheduled for late May. Regulations are expected to take effect by the end of July. Employer filings of the first annual FSC report and initial payment by liable employers will be due by November 15, 2007 for the liability period ending September 30, 2007.