Chapter 58 Implementation Report
Update No. 2

Governor Mitt Romney
Lieutenant Governor Kerry Healey
Secretary of Health and Human Services Timothy Murphy

August 14, 2006

Speaker Salvatore F. DiMasi, Massachusetts House of Representatives
President Robert E. Travaglini, 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
Chairwoman Therese Murray, Senate Committee on Ways and Means

Dear Senators and Representatives:

Healthcare reform is taking hold in the Commonwealth. The federal government has approved amendments to our Medicaid waiver. The Commonwealth Health Insurance Connector Authority is up and running. The Division of Health Care Finance and Policy has proposed important regulations and made improvements to the Commonwealth's healthcare cost and quality website. The Office of Medicaid has implemented changes to eligibility and benefit levels that will improve healthcare for many MassHealth members. Medicaid rates for physicians have been increased and the Office of Medicaid is about to propose improved hospital rates. The various councils, commissions and boards have been appointed with inaugural meetings slated for later this summer. By all accounts, the Commonwealth is building a strong foundation to make Chapter 58 of the Acts of 2006 a long-term success.

These are early days, however, with challenging policy choices and difficult implementation decisions just beginning. In order to better prepare for these challenges, I urge the General Court to pass legislation that corrects certain inadequacies of the current law. Specifically, the timing of changes to the Commonwealth's health insurance markets contemplated by Chapter 58 is problematic. Prompt attention to this and other matters is appreciated.

Similar to the first sixty days of implementation, the last sixty days have been consequential. The following report provides specific details of state government's actions to implement Chapter 58 during this period. Given your busy schedules, I would highlight the following items for your review:

Federal Approval: Amendments to the Section 1115 Waiver

Through your support and effort, the Executive Office of Health and Human Services was able to negotiate successfully amendments to MassHealth's 1115 Demonstration Project Waiver (Section 1115 Waiver). This approval was a necessary "first step" for major aspects of the healthcare reform plan to move forward.

Pursuant to the amended Section 1115 Waiver and other federal approvals, over the past six weeks the Office of Medicaid has implemented the following:

- MassHealth Family Assistance, via a Title XXI State Children's Health Insurance Program state plan amendment, was expanded to children up to 300% of the federal poverty level;
- The enrollment cap for MassHealth Essential was increased from 44,000 to 60,000, and approximately 10,000 individuals on the MassHealth Essential wait list were enrolled in the program;
- Several optional MassHealth benefits that were eliminated from coverage for adults during difficult state budgets in FY 2002 and FY 2003 were restored, and dental benefits are now a covered service in MassHealth Essential. In addition, MassHealth benefits now include a smoking cessation benefit through a two-year pilot program; and
- All payment methodologies and sources of non-federal funds for payments made out of the Safety Net Care Pool are approved for FY 2006 and FY 2007.

Commonwealth Health Insurance Connector Authority

The nascent Commonwealth Health Insurance Connector Authority is gaining traction with its Board members and management team working diligently to meet the aggressive schedule set by Chapter 58. The "Connector", through numerous public board meetings and public hearings, is exploring new terrain by defining the core concepts of affordability, benefit structures, cost sharing, and personal responsibility. This report contains significant excerpts of the Authority's business and operation plan detailing both its short-term and long-term objectives.

The Connector is particularly focused on the launching of the Commonwealth Care Health Insurance Program (C-CHIP), which provides premium assistance to eligible individuals for the purchase of private health insurance. With October 1st fast approaching, Executive Director Jon Kingsdale is making prudent recommendations regarding the initial roll out of the C-CHIP, which are detailed in this report.

Proposed Employer Regulations

After conducting three informational hearings across the state, the Division of Health Care Finance and Policy proposed three consequential regulations regarding the role of employers in the new Massachusetts healthcare system on June 30th. The Employer Fair Share Contribution, Employer Surcharge for State-Funded Health Costs (also known as

Free Rider), and Health Insurance Responsibility Disclosure form proposed regulations strike the proper balance of encouraging employers and their employees to participate in employer-based health insurance without jeopardizing the Commonwealth's competitive position. The Division of Health Care Finance and Policy will complete its public hearings this week and finalize its regulations in early September.

Medicaid Rates

The Office of Medicaid has begun the process of increasing reimbursement rates for physicians and hospitals pursuant to Chapter 58. In July, physician rates were increased by $13.5 million with particular attention to improving obstetrical service rates. In the coming weeks, the Office of Medicaid will propose rate increases of $76.5 million for hospital services beginning on October 1, 2006.

Pursuant to section 132 of the Act, I am pleased to provide the General Court with this second update on implementation plan for Chapter 58.

Sincerely,

Timothy R. Murphy,
Secretary

Cc: Senator Brian P. Lees
Representative Bradley H. Jones
Representative Ronald Mariano
Representative Robert S. Hargraves

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Section 1: Waiver Amendment and Final Federal Approval

On July 26, 2006, the Centers for Medicare and Medicaid Services (CMS) approved amendments to the Commonwealth's 1115 Demonstration Project Waiver (Section 1115 Waiver) in order to implement various provisions of Chapter 58 of the Acts of 2006 (Chapter 58). Since early May, the senior staff at the Executive Office of Health and Human Services (EOHHS) worked diligently with senior CMS staff in both the Baltimore and Boston offices to reach agreement on the amended Section 1115 Waiver terms and conditions. The collaborative process facilitated productive negotiations, an expedited CMS review of the amendment proposal, and, ultimately, timely approval of the amendment by CMS. Officials from the federal Office of Management and Budget and the U.S. Department of Health and Human Services General Counsel's Office participated in the discussions as necessary to ensure that budgetary, financing and legal concerns were satisfactorily addressed prior to approval.

As noted in the June 12th implementation report, CMS was most concerned that the Section 1115 Waiver, as amended to incorporate the changes included in Chapter 58, would be budget neutrality to the federal government over an 11-year period ending June 30, 2008. In addition, CMS meticulously reviewed the financing structure, payment methodologies, reimbursement levels, and sources of non-federal dollars for all payments made from the Safety Net Care Pool, particularly reimbursements made to Boston Medical Center, Cambridge Health Alliance, and UMass Memorial Health Care.

CMS review and approval were explicitly based upon a principle of transition; one of redirecting federal and state funds over time from subsidizing institutions and free care to providing premium assistance for the purchase of private health insurance by eligible individuals. In addition, CMS required significantly more transparency, accountability and documentation regarding the financing structure for the Section 1115 Waiver than it had in prior years. CMS also indicated that it is considering a shift in reimbursement policy by implementing a cost-based payment methodology, particularly for governmentally-operated health care providers, rather than reimbursement based on charges or other inflated cost measures.

Other highlights of the approved Section 1115 Waiver include:

- Effective, July 1, 2006, MassHealth Family Assistance, via a Title XXI State Children's Health Insurance Program (SCHIP) state plan amendment, was expanded to children up to 300% of the federal poverty level (FPL);

- Effective July 27, 2006, the enrollment cap for MassHealth Essential was increased from 44,000 to 60,000, and all individuals on the MassHealth Essential wait list were enrolled in the program;

- Effective March 9, 2006, the enrollment cap for MassHealth Family Assistance for HIV-positive adults was increased from 770 to 1,300;

- Effective October 1, 2006, the Insurance Partnership (IP) program will be expanded to individuals up to 300% of the FPL. Additionally, a six-month wait period will be implemented on that date to guard against the dropping of private market health insurance (so-called private market health insurance crowd-out), and the IP employee subsidies will need to be aligned with the individual subsidies provided under the Commonwealth Care Health Insurance Program (C-CHIP). As of July 1, 2007, self-employed individuals in the IP will only be able to receive an employee subsidy through the program and not also an employer subsidy;

- Effective July 1, 2006, several optional MassHealth benefits that were eliminated from coverage for adults during difficult state budgets in 2002 and 2003 were restored, and dental benefits are now a covered service in MassHealth Essential. In addition, MassHealth benefits now include a smoking cessation benefit through a two-year pilot program. A Title XIX state plan amendment to reflect these new covered benefits will be submitted to CMS by September 30, 2006. Under federal Medicaid rules, states must submit a state plan amendment for a proposed change to the Medicaid state plan during the quarter in which the change will become effective; and

- Effective July 1, 2005, all payment methodologies and sources of non-federal funds for payments made out of the Safety Net Care Pool are approved for state fiscal years (SFY) 2006 and 2007. Payment methodologies for SFY 2008, including new Uncompensated Care Pool (UCP) methodologies, will need to be submitted to and approved by CMS.

CMS did, however, place some conditions on its approval of the amendment.

- CMS required that Section 8 of Chapter 58, which created the Medical Assistance Trust Fund, be amended to move any references to or authorization for intergovernmental transfers (IGTs) and any mechanism for recycling federal Medicaid funds;

- After significant work with the state, CMS explicitly quantified the projected Section 1115 Waiver budget neutrality cushion as $82 million over the 11-year waiver period for the period ending June 30, 2008. If the state spends in excess of this cushion over the next two years, the state can choose to fund the amount in excess of budget neutrality at full state cost or take corrective actions to scale back projected spending on the program. Consistent with CMS's policy of supporting individuals, the Section 1115 Waiver details a corrective action plan that would eliminate hospital supplemental payments prior to cutting optional or expansion populations from the Section 1115 Waiver;

- All Demonstration populations are subject to the federal Deficit Reduction Act of 2005's citizenship requirements, including the C-CHIP program;

- Managed care organizations participating in the C-CHIP program must be licensed by the Commonwealth's Division of Insurance (DOI) by July 1, 2007; and

- CMS must review and approve the final C-CHIP structure, including eligibility, enrollment, benefit, and premiums, as well as the UCP reform in 2008.

Section 2: Connector Authority Update

Pursuant to Chapter 58, in early August the Commonwealth Health Insurance Connector Authority's (Connector) management presented its Board with a business and operations plan. The following are major excerpts from the submitted business and operations plan:

Program Designs

The Connector is primarily responsible for implementing C-CHIP and facilitating the purchase of non-state subsidized affordable health insurance products for individuals, small businesses and part-time employees. Given C-CHIP's mandated implementation date of October 1, 2006, the Connector has thus far focused primarily on the program design for C-CHIP. A separate plan of operations will be developed for non-state subsidized affordable health insurance products by release of the next implementation report due to the legislature in October.

Commonwealth Care Health Insurance Program (C-CHIP)

Procurement Process: As an independent authority, the Connector is not subject to state procurement rules. Moreover, the four Medicaid managed care organizations (MMCOs) with which the Connector can contract for C-CHIP as of October 1, 2006, are already specified in statute. The Connector will employ standard practices of fair and prudent procurement, such as issuing a written Request For Proposals (RFP) to all eligible bidders at the same time, requesting responses under the same conditions from all bidders, answering all questions in writing and making such answers available to all eligible bidders and treating proprietary data confidentially until bids and contracts are finalized.

An RFP will be issued to the four MMCOs by the Connector, based on emergency regulations currently in effect and those that it is anticipated will be approved by the Board on August 17, 2006. The MMCOs will be asked to submit proposals within two weeks, incorporating the model contract terms and benefits guidelines set forth in the RFP, addressing the criteria set forth in emergency regulations and informational bulletins to date, and proposing premiums based on actuarially sound methodologies.

The Connector will meet with each MMCO, conduct confidential negotiations, and endeavor to finalize contract terms in time for review by the Board at its mid-September meeting. This process will generate the enrollment options for C-CHIP in each service area. The Connector will use the same 38 geographic service areas as MassHealth currently uses to contract with the MMCOs, and apply an access network adequacy standard comparable to that employed by the DOI.

Plan Benefits: The benefits and cost-sharing in C-CHIP for enrollees who earn 100% or less than the federal poverty level ("FPL") is largely specified in statute. Each MMCO will be requested to submit a bid for the one package of covered services and cost-sharing specified in accordance with Chapter 58 for those eligible individuals earning 100% or less of FPL.

For enrollees earning more than 100% of FPL, deductibles are not allowed by statute, but beyond this prohibition, Chapter 58 is largely silent. The Connector staff has held discussions with the MMCOs about what they consider to be reasonable benefits and cost-sharing for this population.

For the following reasons, Connector staff recommends that, at least for the start of C-CHIP, each of the MMCOs be required to offer to eligibles earning over 100% of FPL, a lower-premium plan option with maximum cost-sharing and a core set of covered services, as determined by the Board:

1. To reduce confusion at the start of this program and to help enrollees choose among plans based on a limited set of key differences—network, medical and disease management programs, and price;
2. To reduce adverse risk selection against the more generous plans;
3. To reduce premium costs, while protecting enrollees from unaffordable levels of cost-sharing; and
4. To allow the Connector to compare pricing among the MMCOs for a standard benefit package, and to use competitive bidding to help determine reasonable premiums.

For the following reasons, Connector staff recommends that, at least at the start of C-CHIP, each MMCO be allowed and required to offer to eligible enrollees earning over 100% of FPL a higher-premium option with less enrollee cost-sharing and additional benefits, as each of the plans decides:

1. To provide more choice for enrollees; and
2. To allow market differentiation, innovation and creativity among the competing MMCOs.

Per the emergency regulations, benefits will be patterned after commercially available health insurance products. However, C-CHIP plans are not required to meet state benefit mandates, so MMCOs may choose to develop products without the inclusion of every state mandated benefit.

Bid Structure and Contracting: To simplify the bidding process and rate negotiation with the MMCOs, and to allow comparison among them, the Connector will ask each of the MMCOs to justify and submit for review, premium bids as follows: one proposal for a "standard" age/sex population of enrollees earning 100% or less of FPL; and one bid separately for those earning over 100% of FPL, using the standardized lower-premium benefits and cost-sharing design set forth by the Connector.

To encourage MMCOs to enroll and serve a broad mix of beneficiaries, the actual capitation or premium rates paid to each MMCO will be adjusted for the mix of membership that actually enrolls. This will be accomplished by indexing rates for differences in age, sex and geographic location of the enrolled members and for the actuarial value of the MMCO's higher-premium option against the final premium rate agreement between the Connector and the MMCO for the base populations and benefit

packages. The per enrollee premium paid to each MMCO will be adjusted quarterly, to reflect the most recent actual enrollment by age, sex, geography and benefit option.

Actuarially sound premium rates proposals will be required to set forth and justify the MMCO's assumptions about expected utilization of services by enrollees. Each MMCO will be required to use provider payment rates which, on average and in aggregate, do not exceed the actual provider payment rates for comparable services then in effect at that MMCO for its MassHealth members.

Given the uncertainties about initial membership enrollment in the first year of C-CHIP, and the utilization patterns of such enrollees, Connector staff recommends that the Connector negotiate reinsurance and/or stop loss arrangements with the MMCOs in order to protect the financial integrity of the program and the solvency of its contracting MMCOs.

Enrollee Choice and Contribution: For eligible enrollees earning 100% or less of FPL, each MMCO will offer one plan design. In a few service areas where only one MMCO may be under contract, eligible enrollees will have this single option; where several MMCOs are under contract, there will be a choice of plans, though not of benefits or cost-sharing. These enrollees will pay nothing toward plan premium.

For eligible enrollees earning 100% or less of FPL, staff recommends that at some point during C-CHIP's first year, the Connector begin to automatically assign eligible individuals into a MMCO plan. To assure continuity of coverage and minimize confusion, Connector staff further recommends that newly eligible enrollees coming off MassHealth, who have been in an MMCO under MassHealth, be automatically assigned to the same MMCO. To minimize the cost of the program, and to reward MMCOs for bidding competitively, Connector staff recommends that all other eligible individuals who are automatically assigned be assigned to the lowest premium MMCO available in the enrollee's service area.

For eligible individuals earning over 100% of FPL, each MMCO will bid two plan designs. Depending on how many MMCOs contract in a particular service area, an enrollee will have a choice of between two and eight plans. Each enrollee earning over 100% of FPL will be required by the Board to make a premium contribution to supplement payment assistance from the Commonwealth. At the time of choosing to enroll in plans, eligible individuals will receive a description of the available plans and the enrollee contribution required for each plan.

Per emergency regulations currently in effect, enrollees are expected to contribute more toward higher-priced plans than to lower-priced plans. The intent is to encourage a market dynamic whereby: (1) enrollees pay more for richer plans, (2) enrollees save the premium dollars associated with lower premium plans, and (3) more cost-effective plans are rewarded with more enrollment. The Board will determine the enrollee contribution formula. Two formulae for calculating such incremental contributions have been suggested, and will be presented to the Board for a decision.

To encourage continuity of care, control administrative costs, and reduce adverse risk-selection for more generous plan designs, enrollees will make a plan choice for a twelve-month enrollment term. As in the commercial group insurance market, enrollees will not be allowed to switch plans mid-year, except for special circumstances.

Eligibility Determination and Enrollment Process: In accordance with Massachusetts General Laws Chapter 176Q, the Connector is working with MassHealth to develop an eligibility determination process by adapting MassHealth's MA-21 eligibility system logic and using the Virtual Gateway portal for an on-line C-CHIP application. The Connector is also exploring using the same organization with which MassHealth contracts for enrollment processing, premium collection, and related elements of customer service.

As the requirements for these functions are considerably less challenging for eligible individuals earning 100% or less of FPL than for those who will be making premium contributions, the systems modifications are being dual-tracked. The Connector and MassHealth staffs are working furiously to meet the October 1st deadline by adjusting current systems, facilitating informed choice among available MMCOs, and for processing enrollment in time to be ready to begin to enroll eligible individuals earning 100% or less of FPL. This population represents approximately 70,000 individuals currently using the UCP, or 40% of total UCP usage.

The Connector does not anticipate being ready to enroll eligible individuals earning over 100% of FPL on October 1st, and is in the process of determining a feasible start date (possibly January 1, 2007) for this population. They represent some 100,000 individuals using the UCP.

Funds Flow: The Connector will remit total premium payments to the MMCOs on behalf of their C-CHIP enrollees. As indicated above, premium payments to each MMCO will reflect the number of member months of enrollment for the quarter, at an assumed demographic and geographic mix of enrollees. Payments will be adjusted quarterly for the actual mix of enrollees.

For enrollees earning 100% or less of FPL, the premium payment from the Commonwealth Care Trust Fund will represent total premium. For enrollees earning over 100% of FPL, the Connector will also collect enrollee premium contributions as determined by the Board. Actual MMCO coverage will begin on the first of the month following completion of the enrollment application. For enrollees earning over 100% of FPL, the application will not be considered complete until the Connector processes the enrollee's payment for his/her contribution toward the first month's premium.

Connector Organizational Structure

Short Term (3-6 months)

The Executive Director, the Deputy Director and the Chief Financial Officer have been hired. The existing management team is currently interviewing candidates to complete

its senior management team. During the start-up phase, summer and fall of 2006, the Connector will need to supplement the work of the in-house staff with a combination of resources provided by EOHHS, other state agencies and contracted professional services.

State Government Resources

With the decision to use MassHealth's eligibility and enrollment systems for the C-CHIP comes the benefit of being able to work closely with many of the existing program and operations staff from MassHealth to implement the C-CHIP program. The Connector continues to explore ways to formalize this relationship as a partnership, and will continue to work with some MassHealth staff to help the Connector successfully meet the October 1st C-CHIP implementation date.

In addition to pooling resources with MassHealth, the Connector is also borrowing some initial administrative resources to help launch the Connector, including some EOHHS staff members who will be helping with space planning, information technology, and project management issues. Also, The Connector will be consulting with the Executive Office of Administration and Finance's General Counsel office and EOHHS attorneys for assistance with legal issues.

Contracted Resources

The Connector will work with existing state resources to the fullest extent possible, but recognizes that there will be limits to their availability. As such, the Connector will continue its relationship with Mintz Levin as outside counsel for advice on selected legal matters and with health care management and actuarial consultants as needed. The Chief Financial Officer is reviewing auditing firms for recommendation to the Board.

Longer Term (6+ months)

As the Connector's policies take shape over the next several months, and as the functions for which the Connector is responsible are clarified, staff will make a series of "build vs. buy" decisions. At this point, it is anticipated that many functions will be outsourced or executed via interagency service agreements (ISAs) with state agencies. Thus, new staff will likely oversee outsourced functions and interagency relationships, rather than performing them directly. It is expected that several of these managers will hire 2-3 people over the course of the fiscal year to oversee key functions in their areas. The Connector's size, based on current planning, is therefore not expected to be greater than 50 employees.

Communications & Outreach

The Connector is seeking to hire a Director of Communications and Public Affairs who will be skilled at developing a communications strategy, managing press and legislative relations, and working with existing organizations to do outreach to low-income populations. The communications strategy will need to include ways to provide widespread publicity about the health insurance mandate, among other things.

In the interim, the Connector is exploring several options for doing outreach to people who will qualify for the C-CHIP program in the months immediately before and after the October 1st implementation date. The Connector will work with MassHealth to administer up to $3 million in grant funds to community-based organizations to do some of this outreach. The Connector will also explore working with the Health Access Networks (HANs).

Working with the Outreach Committee of the Board, the Connector staff will develop a comprehensive strategy for marketing the Connector's programs. Once C-CHIP is completely operational and tested, the Connector will consider launching a systematic, community-based, promotion of the C-CHIP options, tied to health fairs, enrollment kit mailings and other outreach designed to push eligibles to voluntarily enroll. Promotional efforts aimed at voluntary enrollment will be followed by an automatic-assignment process for eligible individuals who have not voluntarily enrolled, at least for those eligible individuals for whom C-CHIP is free.

The Connector also anticipate using a public relations firm for guidance on broadly publicizing the health insurance mandate during 2007 and the use of the Connector for affordable health insurance products for non-state subsidized individuals, small businesses and part-time employees.

Finally, the Connector plans to establish a website as soon as possible. The Connector will work with the Commonwealth's information technology staff to do this in two phases: the first phase will be to establish a basic web presence for the Connector with a static site which will include general information on the health care reform law, the Connector, and "frequently asked questions." It will also include links to the Virtual Gateway and the customer service center for the C-CHIP program. The second phase will be to develop a far more sophisticated site, with interactive components including decision support tools for individuals and small businesses approaching the Connector to find the best health insurance option for them.

Operations

Information Systems

As discussed above, the Connector will be partnering with EOHHS and MassHealth to implement the C-CHIP program on October 1, 2006. The Connector will be using the Virtual Gateway for collecting applications and MA-21 for determining eligibility and enrolling people into C-CHIP. The Connector is currently evaluating the need for modifications to MassHealth's systems, given some of the unique characteristics of the C-CHIP program.

The Connector will need to have a system for applications and enrollment for individuals seeking health insurance who do not qualify for C-CHIP, and who are mandated to have health insurance by July 1, 2007. The Connector has seen an initial presentation of software that similar health network organizations are using in Connecticut and California. Connector management will need to determine whether to "make or buy"

these functions, and to assess the complexities of interfacing with MassHealth's systems, given the expected fluidity of the eligible population, many of whom will be moving between subsidized and unsubsidized health insurance programs.

The Connector's management will also need to determine an internet "host" for the Connector's website and email system. In the short run, the Connector is using the Commonwealth's systems for these things.

Finally, we are in the process of purchasing several personal computers, laptops, and a printer, which will all be networked locally, as well as leasing a copier to get the office going.

Applications and Enrollment

As discussed above, the Connector will primarily use the Virtual Gateway to collect applications for the C-CHIP program. We are working closely with EOHHS and MassHealth staff to have this in place by October 1, 2006. We will explore making the Virtual Gateway more accessible to community-based outreach sites.

The Connector plans to contract with a vendor to handle the member enrollment process for the MMCOs. The vendor will interface with the MassHealth information systems to process the enrollments.

Customer Service

As mentioned above, the Connector is planning to contract with an outside organization for customer service functions. For the C-CHIP program, the Connector will explore a contract with Maximus, MassHealth's customer service organization for members and providers. We have not yet determined our customer service approach for the commercial program.

Permanent Space

The Connector is starting to work with Bob Burgess, Director of Facilities for EOHHS, and his team to identify permanent space in downtown Boston, close to the State House. Management will be looking for Class B office space for up to 40 people, including a few conference rooms. The Connector will favor office space that offers an opportunity to add space if necessary in a few years. In addition, management anticipates a three- to five-year lease.

The Connector plans to use current state facilities for public hearings and board meetings.

Development of Authority Policies and Procedures

We have initiated a contract with Martha Walsh, former Deputy Commissioner of Administration and Finance for the Department of Revenue (DOR), to help the Connector develop an initial set of administrative policies and procedures, primarily in

the human resources area, but also including some procurement and space leasing guidelines. She will be benchmarking other state authorities of similar size and scope. Her deliverables include recommendations on position levels, job descriptions and pay ranges; an outline of recommended personnel policies and employee benefits; an outline of recommended procurement and leased space policies; and a recommendation of how to administer employee benefits.

Accounting & Finance

Structure of Bank Accounts

Based on input from the State Comptroller, State Treasurer, an independent accounting firm and various state agencies' chief financial officers, the Connector plans on managing its funds as follows:

i. Open an operating bank account with a sufficient balance, based on cash flow projections, to satisfy liabilities generated from daily operations. Examples of expenses to be paid from this account include Payroll and Benefits, Supplies, Contract Employees and accounting, consulting and actuarial services.

ii. The balance of the funds not required will be deposited in the Massachusetts Municipal Depository Trust ("MMDT"). This is a Fidelity Investments managed fund, endorsed by the State Treasurer, which allows state agencies, municipalities, school districts and authorities, to invest in a low-risk mutual fund.

iii. To maximize interest income, as cash needs are identified, we will transfer funds from the MMDT to the operating account

iv. In order to maintain a separation of Connector operating funds from various funds flow transactions resulting from Connector managed programs or products, management will evaluate the use of opening various accounts for specific purposes. For example, relative to C-CHIP, management anticipates opening an account for the purpose of depositing enrollee contributions. Based on the current funds flow model of C-CHIP, these funds will be subsequently paid to the Commonwealth Care Trust Fund.

Hire Accounting/Audit Firm

Based on a recommendation from the State Comptroller, the Connector anticipates hiring a Boston-based firm to initially assist in the procurement and set-up of an accounting system.

In addition, based on the cost effectiveness of outsourcing the payroll process, management is performing due diligence for vendor selection to process Connector payroll. The Connector's accounting firm will also assist in this process.

After an accounting and payroll system has been implemented, which is targeted for mid-August, the Connector will work with the accounting firm to establish Connector accounting policies and procedures, as well as the development of internal controls for all accounting and finance functions.

Appeals Function

The Connector is charged with several distinct appeals functions:

1. Eligibility for C-CHIP
   The Connector is currently exploring doing this in conjunction with MassHealth's Board of Hearings, perhaps contracting with them to perform the hearings.

2. Availability of an Affordable Health Plan
   The Connector Board has established a subcommittee that has just started to define "affordable" premium levels for the individual mandate to purchase health plans. These will be determined by the board on December 1, 2006, at which point the Connector will begin to develop a corresponding appeals process.

3. Enforcement of Individual Mandate by DOR
   Since this provision of Chapter 58 will not be implemented until later in 2007, the Connector has not yet developed a plan of operations for this appeals process. The Connector will be meeting with DOR during August 2006 to begin the work on this.

Section 3: Regulatory Progress Update

The Division of Health Care Finance and Policy (DHCFP) has begun the process of promulgating regulations for the Employer Fair Share Contribution, Employer Surcharge for State-Funded Health Costs (also known as Free Rider), and Health Insurance Responsibility Disclosure (HIRD) form provisions of Chapter 58 of the Acts of 2006.

On June 20th and 21st DHCFP conducted three consultative sessions in order to provide an opportunity for parties affected by the Fair Share and Free Rider provisions to present their ideas and concerns. The consultative sessions were held in Boston, Springfield and on Cape Cod. During these sessions, DHCFP heard primarily from business leaders and business associations, but also from insurance providers, health care reform interest groups, and unions. The input DHCFP received helped inform the policies embodied in the regulations that were proposed on June 30th.

On June 30th, DHCFP also proposed the HIRD form regulation. The HIRD form will aid in the implementation and enforcement of both the Employer Fair Share Contribution and the Employer Surcharge for State Funded Health Costs provisions. Each Massachusetts employer will be required to file information about the health insurance status of its employees, including whether each employee was offered employer-sponsored insurance, whether the employer offered to arrange for the purchase of health insurance and whether the employee accepted or declined such insurance or accepted or declined such an arrangement. A public hearing on the proposed regulation is scheduled for August 15, 2006. DHCFP intends to adopt the regulations prior to October 1, 2006.

On August 8, 2006, DHCFP held public hearings on the proposed regulations governing the Employer Fair Share Contribution and the Employer Surcharge for State Funded Health Care Costs, two provisions of Chapter 58 that support the overall goal of providing access to health insurance for all residents. A number of Massachusetts employers and business representatives testified, as well as members of the advocacy community. DHCFP will take all comments into consideration in developing the final rules, which may be adopted no earlier than August 29, 2006.

The proposed Employer Fair Share Contribution, Employer Surcharge for State-Funded Health Costs, and the Health Insurance Responsibility Disclosure regulations are available for review at www.mass.gov/dhcfp.

Section 4: MassHealth Coverage and Operations Update

As noted in Section 1, MassHealth successfully implemented several MassHealth coverage changes that were mandated by Chapter 58 and approved by CMS in the amendments to the Section 1115 Waiver. These include changes in covered benefits and in eligibility for the program for certain populations.

The following benefits, consistent with normal protocols regarding medical necessity, were restored for adults beginning July 1, 2006:

- Dental services, including to MassHealth Essential members
- Eye glasses benefits
- Chiropractic benefits
- Prosthetic benefits
- Orthotic benefits
- Level 3B detoxification benefits
- Smoking cessation benefits (as part of a two year pilot program)

In June 2006, all MassHealth members newly qualified for the benefits listed above received a notice from MassHealth describing the scope of the restored or new benefits (see attached MassHealth member notice). Providers were also notified of the changes to covered benefits (see attached All Provider Bulletin No. 155), and MassHealth staff worked closely with its network management organization to mitigate any potential access issues for members who might not be able to find a provider.

With respect to the newly created Wellness Program for MassHealth members, a workgroup, which has been meeting for several months, has been tasked with designing and implementing the program. Due to the complexities of designing a wellness program and the short timeframe for implementation provided in Chapter 58, this benefit is not currently available.

On July 27, 2006, approximately 10,000 individuals determined eligible for the MassHealth Essential benefit but who had been placed on a wait list for the program due to the then 44,000 person enrollment cap were enrolled in the program. In addition, as required, MassHealth has maintained the state-funded MassHealth Essential benefit for roughly 3,000 senior and disabled aliens with special status.

On July 1, 2006, MassHealth expanded income eligibility for the MassHealth Family Assistance program, through a State Children's Health Insurance Program (SCHIP) state plan amendment, to children without access to employer sponsored health insurance from 200% of the FPL to 300% of the FPL. To facilitate immediate enrollment of approximately 9,000 newly eligible children who had been enrolled in the state-funded Children's Medical Security Plan (CMSP), the state sent advance notices and individualized notices to these children informing them of their eligibility for the more comprehensive Family Assistance benefit package. To prevent families of eligible

children from dropping other coverage to enroll in the publicly-funded program, a six-month wait period was implemented.

Other approved changes to MassHealth, including the expansion of and changes to the IP program, will occur in October and are currently being designed by MassHealth staff. Finally, to the extent that MassHealth Operations and Systems units are assisting the Connector with the design and implementation of C-CHIP, the activities are coordinated by the Connector and are described in Section 2.

The Office of Medicaid will provide enrollment and utilization information in forthcoming updates as the changes implemented in the prior four weeks take hold.

With respect to MassHealth program integrity efforts, phase one of the three-phase MassHealth provider re-credentialing project is well underway. A vendor is in place to begin to work on the task and a workgroup has been established to identify the target population of one-third of MassHealth providers who will receive a full review and re-credentialing.

Section 5: Technical Corrections

The General Court is currently considering certain technical correction amendments to Chapter 58 that primarily focus on reconciling timing issues and clarifying effective dates. The House of Representatives passed H. 5240 on July 27, 2006 and the Senate is currently considering the bill. The Administration believes a major omission from H. 5240 is the ability to make technical revisions to the UCP regulations to limit pool eligibility to individuals ineligible for MassHealth **and** C-CHIP. The C-CHIP program cannot succeed if individuals are given the choice of receiving services and paying a premium through C-CHIP or receiving services at no cost through the UCP.

Section 6: Individual Mandate Preparations

Since June 12, state officials have met with insurance carriers and other interested parties regarding implementation of the individual mandate. Specifically, Chapter 58 requires the state to ascertain the insured status of an individual during the calendar year. Further, Chapter 58 envisions the creation of a health insurance coverage database with commercial insurers and government programs providing information, including social security numbers, to the DOI on the insured status of its members.

Based on feedback from insurers and business groups, the DOR and the DOI have determined that the provision of social security numbers is unnecessary and are recommending the elimination of this provision in Chapter 58. The DOR and the DOI are exploring various alternatives to ensure successful confirmation of taxpayer responses to the health coverage question on their income tax returns. Current thinking includes a new form, called the 1099-HC (for health care), which would be mailed from insurers and other payers to insured individuals indicating the number of months of creditable coverage the person had in the prior calendar year, which in turn would be noted by the individual on his or her tax return.

Section 7: Medicaid Rate Increases

Chapter 58 provided for substantial rate increases to physicians and acute hospitals, totaling $270 million over three years. In 2007, MassHealth rates to acute hospitals and physicians must increase by $90 million, with not less than 15% of this amount allocated to physician rates.

On July 6, 2006, the DHCFP adopted an emergency regulation to increase physician rates by $13.5 million, or 15% of $90 million. The new physician rates provide an overall increase of 5.8% to MassHealth physician spending in the Primary Care Clinician (PCC) and the Fee-for-Service (FFS) programs, with a 6% increase for obstetrical services. On average, MassHealth physician rates equal approximately 80% of current Medicare rates, with the enhanced services (e.g., obstetrics, colonoscopy screening, mammography) at or above the Medicare comparable rates. The increases fall into broad categories as follows: Surgery, $3.5 million (5.38% increase); Medicine, $8.5 million (6.11% increase) and Radiology, $1.5 million (5.44% increase).

The Office of Medicaid will shortly release its Acute Hospital Request for Applications (RFA), the contract between MassHealth and the hospitals for the PCC and FFS programs. This proposal will increase rates by approximately $77 million. In accordance with the "hold-harmless" provisions of the SFY 2007 state budget, no hospital's rates will be below the rates paid in the prior hospital rate year.

Section 8: Uncompensated Care Pool Update

Chapter 58 included provisions that largely maintained the UCP in its current form both in funding and policy for pool fiscal year (PFY) 2007. Chapter 58 funded the UCP at $610 million for PFY 2007, including $550 million to reimburse acute hospitals, $56 million to reimburse Community Health Centers (CHCs) and $4 million for demonstration projects and administration.

Although the funding provisions provided guidelines for calculating the PFY 2007 payments, including the current protections for the two state-designated disproportionate share hospital (DSH) hospitals with the highest relative volume of low income patient care costs and the next fourteen DSH hospitals with the highest relative volume of low income patient care costs, the other elements of the payment calculations were not specified. The DHCFP will specify by regulation, the base period and the appropriate adjustments for the prospective payment calculation.

The DHCFP has met with stakeholders to discuss general principles of the base period adjustments and plans to propose regulation governing the prospective payment provisions and reimbursements for the UCP payment regulation on or around August 18, 2006.

Section 9: Boards, Councils, Commissions and Reports

As noted in the June 12 report, Chapter 58 creates various boards, councils, commissions and advisory committees. Several of the entities have been established and members appointed.

Health Care Cost Quality Council

Purpose: The Council's charge is to set quality improvement and cost containment goals for the Commonwealth. The Council will collect cost and quality data from health care providers, pharmacies, payers, and insurers that will be maintained on a website for consumers and purchasers so that there is greater transparency and accountability on the part of providers and insurers to inform better decision-making. Secretary Murphy has sent correspondence to the Council members to schedule the first meeting for August 23 (see attached invitation). An advisory committee to the Council has not yet been appointed.

Members:

- Timothy Murphy, Secretary of EOHHS (Chair)
- Joseph DeNucci, Auditor
- Gregory Sullivan, Inspector General
- Thomas Reilly, Attorney General
- Julie Bowler, Commissioner of DOI
- Dolores Mitchell, Executive Director of the Group Insurance Commission
- Dr. Ken LaBresh, Health Care Quality Improvement Organization Representative (MassPro), (appointed by the Governor)
- James Conway, Institute for Health Care Improvement, Dana Farber Cancer Institute, (appointed by the Governor)
- Christopher Delorey, President, Telamon Insurance and Financial Network, Mass Association of Health Underwriters, (appointed by the Governor)
- Robert Seifert, Mass Medicaid Policy Institute, (appointed by the Governor)
- Dr. Thomas Lee, Partners, Expert in Health Policy, (appointed by the Governor)
- Charles Baker, Harvard Pilgrim Health Care, Non-Governmental purchaser of insurance, (appointed by the Governor)
- National Association of Insurance and Financial Advisors, Governor's Office awaiting information from this group in order to make appointment

MassHealth Payment Policy Advisory Board

Purpose: The Advisory Board's charge is to collect and analyze MassHealth and Division of Health Care Finance and Policy data to evaluate provider rates and recommend rates and rate methodologies that provide "fair compensation for Masshealth services and promote high-quality, safe, effective, timely, efficient…care."

Members:

- Timothy Murphy, Secretary of EOHHS (Chair)
- Amy Lischko, Commissioner of DHCFP
- Appointment of House Speaker (not yet appointed)
- Dr. David Torchiana, Partners, (appointment by the Senate President)
- Joe Kirkpatrick, VP, Massachusetts Hospital Association
- Dr. Robert Lebow, Massachusetts Medical Society
- Scott Plumb, VP, Massachusetts Extended Care Federation
- Elissa Sherman, President, Massachusetts Aging Services Association
- Patricia Kelleher, Executive Director, Home Care Alliance of Massachusetts
- Tristram Blake, Executive Director, South End Community Health Center, Mass League of CHCs
- Betty Funk, President and CEO, Mental Health and Substance Abuse Corporation
- Bob Seifert, Medicaid Policy Institute
- David Matteodo, Massachusetts Association of Behavioral Health Systems
- An Hee Foley, CFO, Planned Parenthood of Massachusetts
- Deborah Enos, NHP, Medicaid Managed Care Organization, (appointment by the Governor)
- Bob Moran, UMass, expert in payment methodologies from a foundation or academia, (appointment by the Governor)

Section 10: Implementation Budget Update

The General Court appropriated $10 million in Chapter 58 to facilitate the implementation of healthcare reform by state agencies. The Administration's inter-agency healthcare reform implementation management committee solicited requests from applicable state agencies regarding their expected funding needs in Fiscal Year 2007 for the healthcare reform implementation. The Executive Office for Administration and Finance, a member of the inter-agency management committee, evaluated the requests and made the following funding decisions and allocations:

Resource Allocation Plan

Total Requested	$15,218,678
Total Available	$10,000,000
Variance	($5,218,678)
Percent Decrease Necessary	34.72%

	Total Requested	**Hold for Discussion***	**Total Remaining**	**FY07 Approved (65% of Requests Not on Hold)**
DOR	$1,888,660	$1,532,020	$356,640	$233,350
DOI	$1,023,000	-	$1,023,000	$669,349
HCF	$3,084,399	$1,573,024	$1,511,375	$988,893
EHS/Health Care Quality and Cost Council	$9,222,619	$905,973	$8,316,646	$5,441,581
Totals	**$15,218,678**	**$4,011,017**	**$11,207,661**	**$7,333,173**

*Holds include $1.5M for DOR mailing, $1.6M at HCF for Fair Share implementation and possible assessment increase, and $906K at EHS for premium billing system upgrades and the cost of the Health Care Quality and Cost Council.

Quarter 1 – Allocation Plan

	FY07 Approved Spending	Q1 Allocation*
DOR		
Approved Request Object Classes A-E	-	-
Approved Request Other Object Classes	$233,350	$233,350
Total Q1 Allocation		**$233,350**
DOI		
Approved Request Object Classes A-E		
Approved Request Other Object Classes	$669,349	$669,349
Total Q1 Allocation		**$669,349**
HCF		
Approved Request Object Classes A-E	$135,767	$33,942
Approved Request Other Object Classes	$853,125	$853,125
Total Q1 Allocation		**$887,067**
EHS		
Approved Request Object Classes A-E	$1,862,871	$465,718
Approved Request Other Object Classes	$3,578,710	$3,578,710
Total Q1 Allocation		**$4,044,428**
Total Q1 Allocation		**$5,834,193**

*Q1 Allocation is 25% of object classes A-E and 100% of all other object classes

Section 11: Public Health Implementation

There are no significant updates regarding the public health related provisions of Chapter 58. All of the program investments mandated by Chapter 58 were incorporated as DPH line item appropriations in the SFY 2007 budget.