Chapter 58 Implementation Report
Update No. 4

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

December 12, 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:

Pursuant to section 132 of Chapter 58, I am pleased to provide the General Court with the fourth update on Chapter 58 implementation progress. As calendar year 2006 comes to a close, the Commonwealth can feel proud of its accomplishments on health care reform. MassHealth restored benefits to adults, expanded eligibility for children, raised enrollment caps for programs such as Essential and helped launch the new Commonwealth Care program with the new Commonwealth Health Insurance Connector Authority. The Commonwealth Care Program is successfully up and running with 30,271 people determined eligible and 14,384 enrolled as of November 29, 2006. The program will be ready to start Phase II with enrollment of eligible people with incomes between 100 and 300 percent of the federal poverty level on January 1, 2006.

The Commonwealth Health Insurance Connector Authority is growing and doing an impressive amount of work enrolling Commonwealth residents in Commonwealth Care. The Authority is currently developing its commercial program, Commonwealth Choice, scheduled to launch in the spring of 2007. The Authority is also aggressively adding staff to carry out the tasks of overseeing and ensuring the quality of its new programs.

As 2007 approaches, the Executive Office of Health and Human Services and the Commonwealth Health Insurance Connector Authority are developing information campaigns to reach out to small businesses and uninsured residents about health insurance products available in the Commonwealth. Connector staff is meeting with Chambers of Commerce and small business leaders across the state. The Connector has also issued a Request for Proposals for advertising and marketing assistance to reach uninsured individuals and populations who will be affected by Massachusetts' new health insurance mandate which will be effective July 1, 2007.

As the Connector does its work, the boards and councils created by Chapter 58 are underway and carrying out their missions. The Health Care Quality and Cost Council, whose goal is to bring price and quality information on health care to consumers and providers, is making excellent progress against the goals set forth for the Council in the law. Subcommittees are focused on developing communications strategies and determining what indicators will be most effective in educating consumers about the need to understand the cost of their health care.

In closing, the Executive Office of Health and Human Services appreciates the General Court's passage of Chapter 324, the health care reform technical corrections law. Inside this report there are listed additional technical corrections that should be addressed in the

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

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: MassHealth Update

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

Insurance Partnership Expansion and Changes
On October 1, 2006, MassHealth successfully implemented an increase in the income limits for eligibility in the Insurance Partnership (IP) from 200% to 300% of the federal poverty level (FPL). As of November 30, 2006, 867 additional people have received health insurance coverage through the expanded Insurance Partnership program.

Enrollment Information for Children's Expansion up to 300% FPL
As of November 30, 2006, MassHealth enrolled approximately 13,000 new members and/or converted Children's Medical Security Plan members as a result of the expansion of MassHealth Family Assistance coverage to children up to age 18 in households with incomes over 200% and up to 300% of the FPL.

MassHealth Essential Update
As of November 30, 2006, 53,141 individuals were enrolled in MassHealth Essential. With an enrollment cap of 60,000 MassHealth Essential still has room to enroll additional eligible people into the program. MassHealth does not anticipate having to reinstate a waiting list.

Pay-for-Performance
Under Chapter 58, MassHealth must begin a pay-for-performance program for hospitals beginning on October 1, 2007. An interagency workgroup has been working to develop a pay-for-performance model for hospitals and physicians. The workgroup has met with other payers in the Commonwealth to understand existing pay-for-performance initiatives. As provider involvement and input is critical to the success of pay-for-performance initiatives, the workgroup will begin meeting with hospital and physician representatives in January and February of 2007. MassHealth staff will also consult with the Quality and Cost Council and the MassHealth Payment Advisory Board before implementing the initiative.

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 specific 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. MassHealth and DPH agreed that the wellness program should be consistent with established state and national standards. The program should also be designed in a way so

as to minimize the administrative burden to both MassHealth and its providers by using existing data systems to track member wellness behaviors. 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 Office of Medicaid, DPH, Executive Office of Elder Affairs, and Department of Mental Health representatives. Both committees are advised by a member advisory group and an external stakeholder advisory group comprised of subject matter experts, provider groups, advocates and other MassHealth stakeholders. Five clinical domain work teams have been established and a MassHealth Assistant Medical Director is assigned to each team.

Considerable progress has been made in the collaboration between MassHealth and DPH 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 through December 2006 (90% complete)
- Implementation planning: January through June 2007 (on schedule)
- Program Implementation and subsequent evaluation: July 2007 and ongoing (on schedule)

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 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 or the Commonwealth Care program. MassHealth selected grantees in November. 24 Model A grants were awarded. Model A is for traditional community-based outreach, enrollment and re-determination services. Grantees must develop effective community-based strategies for reaching and enrolling eligible individuals into MassHealth programs or the Commonwealth Care program. 7 grantees have been selected for Model B grant awards for integrated outreach and marketing campaigns. These grantees must develop and conduct comprehensive broad-scale media or grassroots campaigns targeting individuals potentially eligible for either program. Model B grantee contracts are currently under negotiation.

Section 2: Connector Authority Update

The mission of the Commonwealth Health Insurance Connector Authority (Connector) is to promote health care coverage across the Commonwealth. There are a number of critical and complex goals which must be met in order for the Connector's mission to be achieved. The Connector has developed a detailed operating plan that specifically outlines what needs to be accomplished in order to make health care reform successful. This operating plan maps out the Connector's objectives, key strategies, critical projects, and budget for the next six months.

The following are the Connector's objectives for the next six months:

A. **Commonwealth Care**: *Achieve stability and begin attracting members*
   1. Cover all qualified uninsured people whose incomes are below 300 percent of the federal poverty level (FPL)
   2. Facilitate informed choice of health plans by delivering quality, consistent, and measurable customer service to members
   3. Develop Commonwealth Care into a financially-viable, self-sustaining program

B. **Commercial Products**: *Launch fully on May 1st*
   1. Cover a large share of uninsured people whose incomes are above 300% FPL
   2. Stimulate the development of affordable, quality health plans, including select networks
   3. Facilitate informed choice of health plans
   4. Minimize unintended disruption to the existing small-group insurance market
   5. Achieve financial stability & low administrative costs for commercial functions

C. **Health Care Reform**: *Help communicate new responsibilities by July 1st*
   1. Inform employers about their responsibilities under Chapter 58, especially Section 125 plans and fair-share provisions
   2. Inform individuals about their responsibilities under Chapter 58, especially the individual mandate

D. **Operations**: *Establish infrastructure to allow Connector to function independently and stabilize operations*
   1. Develop customer support and problem resolution process
   2. Develop Connector's standard operating procedures to ensure consistency
   3. Meet current staffing target (40 FTEs) by April 30, 2007
   4. Develop and implement Connector financial reporting process and reviews
   5. Complete office move by January 2007 with minimal disruption to basic operations

Commonwealth Care

Commonwealth Care Phase I: Eligibility determinations and enrollment numbers continue to meet the Connector's ambitious targets. As of November 29th there were 30,271 people determined eligible and 14,384 enrolled in a Commonwealth Care health

plan. Approximately 18,000 were determined eligible from the Uncompensated Care Pool in November alone.

Commonwealth Care Phase II: On January 1, 2007, Commonwealth Care will expand to cover those earning up to 300% of the federal poverty level. Substantial premium assistance will be available for them, so that an enrollee will pay as little as $18 per month (those earning 101 – 150 percent of the federal poverty level) up to $106 per month (251 – 300 percent of FPL) for coverage that costs about $330.

Commonwealth Care Information Sessions: Connector staff will be conducting a series of informational sessions across the Commonwealth to help inform providers and the public about this next phase. Frequently Asked Questions on Commonwealth Care will continue to be updated on the Connector website (www.mass.gov/connector) in response to questions generated by these public sessions.

Maximus Call Center: The Commonwealth Care call center continues to help guide potential members through the eligibility and enrollment process. Maximus will be hiring more customer service representatives in response to the growing complexity of member needs as Phase II of Commonwealth Care approaches.

Commercial Program – Commonwealth Choice

Beginning in the Spring of 2007, the Connector will develop and oversee the offering of commercial health insurance products to individuals not eligible for the Commonwealth Care program. The Connector will certify those health insurance products that offer good value to consumers with a Seal of Approval. This seal will signal that the approved plan meets minimum creditable coverage standards. The commercial product offerings will be called Commonwealth Choice.

Connector Board Policy Committee: The Connector Board Policy Sub-committee has been meeting to discuss issues related to commercial program development such as plan design features, minimum creditable coverage, the young adults plan, and matters related to choice. The Committee reported to the full Connector Board (Board) on November 30th. The full Board accepted the recommendations of the Policy Committee as to the proposed RFR for commercial products to be offered through the Connector with the following conditions: the lowest level of products called for in the RFR will not necessarily be minimum creditable coverage*; carriers submit low-level plans that either include drug coverage or exclude drug coverage; the RFR will ask carriers to submit low-level plans that will cost an average of $320; and, that once minimum creditable coverage is set by the Board, carriers will be allowed to change their low level plan products to conform to the minimum creditable coverage standard.

Upcoming Projects: Connector staff issued an RFR to carriers for commercial products during the first week in December. Proposals will be due on January 12, 2007 with staff recommendations going to the Board for approval on March 8, 2007. Open enrollment

* The Board will adopt regulations that define minimum creditable coverage early in 2007.

for these commercial products will begin on May 1, 2007. An RFR for a Subconnector has been issued with proposals due by January 8, 2007. Chapter 58 suggests the Connector consider subcontracting out to existing firms for many of the administrative functions of a health insurance distribution channel. Interviews with finalists will be conducted January 18-19, 2007. Subconnector recommendations will go to the board for review and approval on February 8, 2007.

Health Care Reform

Outreach to the Business Community: The Connector will play a leadership role in communicating the details of health care reform to businesses and individuals across the Commonwealth. The goal of this aggressive outreach campaign will be to inform the business community about how health care reform will affect employers, especially the setting up of Section 125 plans and fair-share employer contributions. Outreach to the business community will focus primarily on small businesses. Staff is currently conducting meetings with small business leaders and Chambers of Commerce across the state.

Advertising & Marketing RFP: The Connector has issued an RFP for advertising and marketing assistance in designing and implementing a comprehensive advertising and marketing campaign aimed at reaching uninsured individuals and populations who will be impacted by Massachusetts' new health insurance mandate. The purpose of this campaign is to educate these populations on the availability of affordable health insurance offered through the Commonwealth Connector.

Web Strategy RFQ: The Connector issued an RFQ for assistance in setting an overall strategic direction for the Connector's web based services as well as assistance in the development of those services. The Connector hopes to expand its current website (www.mass.gov/connector) into an on-line customer service center that can serve as a portal into the many services offered by the Connector. The development of a more comprehensive website is central to the Connector's strategy of making health insurance options attractive and facilitating health plan choice in an interactive, cost-effective manner. The Connector hopes to execute a contract with the chosen vendor by mid-December.

Other Health Care Reform Projects: Upcoming projects at the Connector include developing a mandate waiver and appeals process, and creating a public information line to handle the large quantity of questions the Connector receives daily.

Operations

Projects: There are many important ongoing projects at the Connector. Work continues on the Connector budget and the plan of operations. Also, the Connector is working to reach its staffing goal of 40 FTEs by April 2007 and is developing its standard operating procedures. The Connector is set to complete its move to 100 City Hall Plaza in January 2007.

Section 3: Technical Corrections

The General Court in late October passed a technical corrections bill 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 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 lowering the number of individuals who remain uninsured.

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

In order to obtain approval for any 1115 Waiver, the Commonwealth must demonstrate that a proposed program will not cost any more than a traditional Medicaid program. This provision, referred to as Budget Neutrality, requires that the state regularly report costs that are included in the Budget Neutrality calculation to the Centers for Medicare and Medicaid Services (CMS). If the state exceeds the Budget Neutrality Cap set by CMS, CMS may refuse to reimburse for certain expenditures.

Section 30 of Chapter 58 created the Health Safety Net Office (HSNO) within the Office of Medicaid and charged the HSNO with managing the Health Safety Net Trust Fund (HSNTF), which reimburses providers for uncompensated care. Currently, uncompensated care payments (made from the Uncompensated Care Pool prior to FY08) are not included in the budget neutrality calculation. However, as the HSNO was created under the state Office of Medicaid, any costs incurred by the office, including payments made from the HSNTF, "count" toward the Budget Neutrality Cap.

In order to exclude the payments made from the HSNO from the Budget Neutrality Cap calculation, the Office must be created under the Division of Health Care Finance and Policy (HCFP). Without such a technical correction, the uncompensated care payments that the HSNO will begin making in SFY08 will be included in the calculation to determine if the state has exceeded its budget neutrality cap. As such, the state is at risk to exceed the cap and risk losing significant federal revenue.

Synching of Free Rider Surcharge and Section 125 Plan Offering

Chapter 324 of the Acts of 2006 amended two statutory provisions regarding the Free Rider Surcharge. Section 22 of Chapter 324 changed the definition of a "Non-providing Employer" subject to the Free Rider Surcharge by exempting "an employer that complies with chapter 151F." Chapter 324 changed the effective date of chapter 151F from January 1, 2007 to July 1, 2007. Chapter 324 also changed the effective date of the Free Rider Surcharge from October 1, 2006 to January 1, 2007. Since the Free Rider Surcharge is intended to be an enforcement mechanism for MGL chapter 151F, the

effective dates of these provisions should be consistent, and the effective date of the Free Rider Surcharge should be changed to July 1, 2007.

Uncompensated Care Pool Regulations
The Administration continues to advocate that the Division of Health Care Finance and Policy be able to make technical revisions to the UCP regulations to limit pool eligibility to individuals not eligible for MassHealth or Commonwealth Care. This provision is consistent with the goal of ensuring the success of the Commonwealth Care program by enrolling all individuals eligible into this program and decreasing the draw against the UCP.

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 fully federally 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. Without a separate appropriation to allow for the collection of the Fair Share Assessment, the Division is unable to begin the arduous task it faces in establishing new collection systems for this purpose. The need for appropriated dollars for the start up of this system is immediate. DUA estimates that if funds are not made available by January 15, 2007, that there will not be adequate time to ensure that the new collection system is operational by October 1, 2007. A budget proposal and detailed spending plan for the start up of this new requirement will be forwarded to appropriate members of the legislature under separate cover.

- Second, in order to encourage and maintain employer compliance with the filing and payment requirements of the collection 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 collection 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 impose penalties on delinquent employers will be seriously hampered. Additionally, the proposed amendment will authorize DUA to take other necessary action relative to implementing 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 UCP, Health Insurance Responsibility Disclosure form, Free Rider surcharge, the fair share employer contribution requirements, and the responsibilities of EOHHS' Health Safety Net Office.

- The agencies with which DOR can share data should, but under this provision do not, include EOHHS, even though the purposes of such data sharing includes the administration and enforcement of 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.

Department of Revenue

- Section 14 of Chapter 324 of the Acts of 2006 amends M.G.L. c. 62E, § 12, which authorizes DOR to share wage reporting, 14-day new hire and bank match information with authorized users. The amendment adds language that allows DOR to share this information with the Division of Unemployment Assistance, the Division of Insurance, and the Division of Health Care Finance and Policy for specific health care related purposes. However, the amendment removed existing language that permits DOR to share this information with other state agencies for research and statistical purposes, and with DUA and the Department of Education in accordance with their official duties. The Legislature has indicated that the statutory deletion was unintended. An amendment would add this language back to the statute.

- Section 6 of Chapter 324 eliminates the requirement that the Division of Insurance (DOI) create an insurance database and replaces it with language that allows DOI, 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.

- Section 11 of chapter 324 requires insurers, self-insured employers and the Office of Medicaid to send an annual notice to each insured, which would include the policy number, the coverage period, and a representation whether or not the policy in question is "creditable" coverage. Issuers of these notices would also be required to submit a report to DOR once a year. The statute also prohibits the use of SSN's. An amendment would allow for the use of SSN's for MassHealth purposes only. This section also allows DOR to share the reports from insurance carriers with certain state agencies for health care related purposes. An amendment would allow DOR to share the 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 the Department of Revenue to share quarterly wage reports to verify income for the Commonwealth Care Health Insurance Program. A technical amendment would clarify the information to be contained in data exchange agreements between DOR and the Connector. The statute currently allows for the Department to check wage reporting data only. A technical amendment would authorize the Department to also examine tax return information for purpose of verifying eligibility.

- 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 post 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.

Section 4: Individual Mandate Preparations

Since June, the Division of Insurance (DOI) and the Department of Revenue (DOR) have worked closely with the insurance industry and business groups to identify a method for documenting compliance with the individual mandate. Chapter 58 originally contemplated that DOI would create an insurance database from insurer-provided monthly reports. Based on feedback from the insurance community, DOI and DOR developed an alternative to the insurance database, which was included in the recently passed health care technical corrections bill. Specifically, Chapter 324 requires insurers to issue an annual notice to their insured, called the MA 1099-HC (for health care), which would include the policy number, the coverage period, and a representation whether or not the policy in question is "creditable" coverage. Issuers of MA 1099 HC's would also be required to submit the same information to DOR once a year, so that it could be matched with the health insurance information reported on the tax returns. DOR is currently working with the insurance community to develop procedures and standards to implement this new process.

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

Health Safety Net Trust Fund

Chapter 58 requires that, effective October 1, 2007, payments from the Health Safety Net Trust Fund be made on a claims basis using Medicare pricing principles, as modified to reflect the appropriation. The Executive Office of Health and Human Services (EOHHS) will shortly release a Request for Responses (RFR) seeking a vendor to process and adjudicate the claims for the Health Safety Net Trust Fund. In addition, staff from the Division of Health Care Finance and Policy have begun discussions with hospitals to ensure a smooth transition to the claims adjudication model.

Essential Community Provider Grants

$38 million in total grants were awarded to providers on September 14, 2006. EOHHS has asked grantees to file reports with EOHHS by April 1, 2007 detailing the use of the grant proceeds.

Section 6: Boards, Councils, Commissions and Reports

Health Care Quality and Cost Council
The Health Care Quality and Cost Council continues to make progress toward achieving its goal of greater access to price and quality information for consumers and providers. The four subcommittees established continue to meet at least monthly, as does the Council, to set goals and discuss the milestones necessary to accomplish those goals.

The Council has established its Advisory Committee, as defined by Chapter 58, and will hold the first joint meeting of the full Council and the Advisory Committee on December 14th. The first joint meeting will focus largely on how the Council will interact with the Advisory Committee and what structure makes sense for the Advisory Committee going forward. As the law contemplates, the Council plans to solicit feedback from the Committee on proposed subcommittee charters and goals at this first meeting.

The Council voted recently to establish and post the position of Executive Director, as well as other support staff positions. Staff from the Executive Office of Health and Human Services are working with the Human Resources Division to get the positions filled to ensure full support for the Council's work.

The upcoming December meeting of the Council will focus on identifying a select number of key indicators to measure in the first phase of the roll-out of price and quality information. All subcommittees will present budget proposals for the remainder of fiscal year 2007 which will be contemplated by the board and after a vote, sent to the Secretary for Administration and Finance for consideration.

MassHealth Payment Policy Advisory Board
The MassHealth Payment Advisory Board held its first meeting on October 27, 2006. Members of the Board include Tristram Blake, Deborah Enos, An Hee Foley, Elizabeth Funk, Patricia Kelleher, Joseph Kirkpatrick, Robert LeBow, Amy Lischko, David Matteodo, Robert Moran, Scott Plumb, Mark E. Reynolds, Robert Seifert, Elissa Sherman, David Torchiana and Beth Waldman. At the October 27th meeting, the Medicaid Director Beth Waldman presented an overview of the current MassHealth provider payment process and principles. The Board agreed to meet on a monthly basis.

Commission to Study the Reduction or Elimination of the Contribution to the Uncompensated Care Pool
The Commission to Study the Reduction or Elimination of the Contribution to the Uncompensated Care Pool held its initial meeting on November 13th. Members present were the Chair, Timothy R. Murphy, Commissioner Amy Lischko of the Division of Health Care Finance and Policy, Senator Richard Moore, Senator Stephen Buoniconti, Christie Hager of Speaker DiMasi's office, Nancy Turnbull of the Blue Cross Blue Shield Foundation and Diane Bissonnette Moes of Donoghue, Barret & Singal.

Steve McCabe, Assistant Commissioner of the Division of Health Care Finance and Policy, presented the history of the Uncompensated Care Pool funding and uses over the past 5 years. Members discussed the data presented by Assistant Commissioner McCabe before coming to the conclusion that it is not feasible to reduce or eliminate the contribution to the Uncompensated Care Pool for the fiscal year 2007. Members discussed a desire to meet quarterly, using the venue as a forum to discuss the uncompensated care pool's status as the number of uninsured in the Commonwealth, and hence the cost of unreimbursed care, decline.

Section 7: Public Health Implementation

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

Prostate Cancer (Men's Health Partnership) (4513-1112) - $1,000,000
The Men's Health Partnership has finalized plans for targeted outreach efforts and expanded outreach and care coordination is in place at each vendor site to enhance follow-through for screening and treatment.

Stroke Education (4513-1121) - $200,000
The following activities are in process: stroke education materials have been translated into Spanish, and follow-up with hospitals is in process to determine needs in hospitals for patient education and outreach. The number of Public Service Answering Points (PSAPs) with software to ensure that response to stroke and other emergencies are appropriate and consistent is in process.

Breast Cancer (Women's Health Network) (4570-1500) - $4,000,000
Women's Health Network eliminated the wait list and has expanded screening services. Work continues on the informational technology system, which will provide further data regarding the women using services, outcome and integration with MassHealth.

Diabetes (4516-0264) - $350,000
Health education/communication and community health interventions have been expanded 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, receive blood testing to screen for diabetes and determine the need for follow-up. Appropriate information about risk reduction is being distributed to individuals who are identified with pre-diabetes or considered to be high-risk, but do not yet have diabetes or pre-diabetes. In accordance with recommendations from the American Diabetes Association, screening would only be undertaken in settings where a health care infrastructure is in place to ensure adequate access to health care and follow-up.

Ovarian Cancer (4513-1122) - $200,000
The Ovarian Cancer Education Initiative will consist of two components for each area: screening and treatment. An external vendor contract is in place which will adapt the Ovarian Cancer National Alliance media campaign, "Until there is a Test, Awareness is Best," for MA women. Women 50 years and older are at the highest risk and will, therefore, be the targeted population. The second component marketing the Speakers' Bureau developed by National Ovarian Cancer Coalition (NOCC) through a Gillette Foundation grant has been finalized. The NOCC has trained 14 ovarian cancer survivors representing all the high-risk groups including women 50 years and older, women with a history of breast and colorectal cancer, Ashkenazi Jewish and other minority women to use the Gillette sponsored educational CD presentation on ovarian cancer education.

Both components will emphasize the importance of women discussing their personal risk of getting ovarian cancer with their physician.

The plan to provide all women diagnosed with ovarian cancer with access to a cancer information specialist so that they can share in the decision making about their treatment options is in process. Also in process is the development of the materials to educate newly diagnosed ovarian cancer survivors about the importance of clinical trials as a vital option in expanding the quality and longevity of their lives. Both of these components will be implemented at the forty-eight Commission on Cancer approved facilities in Massachusetts.

Osteoporosis Prevention (4513-1111) - $100,000
The Osteoporosis program is continuing the process to include integration of strength training and balance program into the ACCENT program- a nutrition/physical activity initiative for elders that operates out of Councils on Aging (COA). Small grants are in the process being offered and awarded to COAs to implement the enhanced program. The program will explore opportunities for distribution of bone health materials to 18-24 year old women through the Massachusetts Health Promotion Clearinghouse and update the Osteoporosis Directory.

Multiple Sclerosis (4513-1115) - $250,000
These funds are earmarked for the Central New England Chapter of the National Multiple Sclerosis Society to support its Multiple Sclerosis Home Living Independently Navigating Key Services (HomeLINKS) program. A contract is in place and services have been expanded.

Renal Disease (4513-1116) - $100,000
These funds are earmarked for the National Kidney Foundation of MA, RI, NH and VT (Foundation). This contract is in the process of being amended.

Tobacco Control (4590-0300) - $4,000,000
The Tobacco Control program has completed the review of proposals to expand culturally sensitive smoking cessation programs in community health centers and to develop pregnancy smoking cessation pilot projects in hospitals. The mini-grants to youth groups have been expanded from 40 to 80. In addition, local programs with boards of health and other community agencies to partner with schools, health care providers and community agencies have been expanded. These programs will enforce smoke-free schools, educate local retailers about not selling tobacco to minors, and educate children and youth about the dangers of tobacco. All programs will be targeted to communities with smoking prevalence higher than the state average and must utilize strategies with proven effectiveness.

Pediatric Palliative Care (4570-1503) - $800,000

The Pediatric Palliative Care Program has established draft standards of care, program standards, and funding criteria. Contracts are in the process of being awarded to provide a statewide network of programs to begin operation in January, 2007. Children under 19 years old will be eligible for the program if they are:

- Diagnosed with life-limiting illness, such as cancer, AIDS, and other advanced illnesses; however, no life expectancy requirement may be imposed; and,
- Not covered by a third party payer for the services provided.

The services provided by the program will include pain and symptom management, case management and assessment, social services, counseling, bereavement services, volunteer support services and respite services.

Suicide Prevention (4513-1026) - $750,000

Suicide prevention services through existing community-based programs have been expanded to gatekeeper training for elders and elder caregivers, screening for depression for men of middle age, survivor support services and post-prevention services after the occurrence of a suicide. Existing initiatives are in the process of being expanded for professional education, gatekeeper training, environmental strategies to reduce lethal means, the development of regional coalitions, reducing stigma, increasing awareness, improving linkages between mental health and substance abuse services and coalition development activities. Current surveillance of suicide and self-inflicted injuries have been enhanced to better understand the risk factors and circumstances associated with these injuries in Massachusetts' residents and to develop and disseminate data reports. An evaluation component will be added to suicide prevention efforts.

Teen Pregnancy Prevention (4530-9000) - $1,000,000

Two new programs have been established in Taunton and Attleboro. Citizens for Citizens, Inc. will be funded to replicate the "Focus on Kids" program in Taunton and Community Care Services, Inc. will be funded to replicate the "Making Proud Choices" program in Attleboro.

Work continues on the expansion of programs to enhance healthy decision making, develop parent activities/workshops, trainings for youth service providers and provide technical assistance are underway.

Community Health Workers

A draft survey for DPH providers regarding use of community health workers has been developed and is being reviewed by key DPH staff.

Section 8: Merger of Non-group and Small Group Health Insurance Markets

Study on the Merger of the Nongroup and Small Group Markets

The Special Commission to study the impact of merging the nongroup and small group insurance markets has been working with a contractor, Gorman Actuarial, to produce a report on the availability of products and premiums charged to individuals and small group participants as well as to analyze further the potential impact of reinsurance on the newly merged market. The contractor has worked with the major insurance carriers and intermediaries in the Commonwealth to produce the data necessary for the study. The commission has been routinely meeting with Gorman Actuarial to review the assumptions and modeling for use in the study. The firm is scheduled to complete its review and submit a final report to the Commission in December 2006. The Special Commission intends to forward a report to the legislature by the end of December 2006.

Small Group and Nongroup Regulations

The Division of Insurance has drafted revisions to the regulations for the small group and the nongroup plans and has distributed the drafts to the insurance industry for comment. In addition, the Division is holding a series of meetings with representatives for the insurance carriers, intermediaries and employers in the Commonwealth to discuss the draft revisions. The Division intends to promulgate the regulations after the report is issued by the Special Commission.