Office of the Inspector General

Commonwealth of Massachusetts

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Status Report on Issues Related to Health Care Reform Implementation Raised by the Joint Committee on Health Care Financing

December 13, 2007

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Introduction

In response to a request by the Joint Committee on Health Care Financing, the Office of the Inspector General has performed research on a number of concerns raised by Committee members regarding the implementation of health care reform and Chapter 58.

This status report is part of an ongoing study to track certain elements of health care reform implementation that are key to the viability and success of the statewide initiative. As more information becomes available, the Inspector General will submit a progress report to the Joint Committee.

For this component of the status report to the Joint Committee, we have interviewed staff members from the Executive Office of Health and Human Services, MassHealth, the Commonwealth Connector, the Division of Health Care Finance and Policy, the Department of Public Health, the Division of Insurance, the Department of Revenue, the Group Insurance Commission, the Massachusetts Hospital Association, the Massachusetts Association of Health Plans, Health Care for All, the Associated Industries of Massachusetts, the Health Care Quality and Cost Council, the Massachusetts League of Community Health Centers and the Massachusetts Business Association.

Areas addressed in this status report include information involving geographic access, enrollment, past enrollment backlogs, accommodations for anticipated volume, and the appeals process involving the Commonwealth Connector's Commonwealth Care insurance products targeted to participants in the state's Uncompensated Care Pool. We reviewed the impact of changes to premium rates for Commonwealth Care that were enacted by the Connector, which resulted in increased enrollment of lower income individuals and families into the subsidized Commonwealth Care plans. As of December 1, 2007, out of the total 158,000 Commonwealth Care enrollees, the Connector reports that nearly 100,000 former pool users are now insured through the Connector's Commonwealth Care programs in one of the four designated Medicaid Managed Care Organizations (MMCOs).

Also included in this review is the status of the statutory provider rate increases from MassHealth to acute hospitals and physicians, including implementation of the MassHealth's Pay for Performance process, which is designed to enhance provider quality and patient safety. Beginning attempts to develop, consolidate and standardize hospital quality measures among the many organizations that collect this data are also reviewed.

The Joint Committee has requested information on the impact of health care reform on the non-group and small-group health insurance market. We have inquired about the status and reasons for rate increases to the small group market which have been in excess of those anticipated during the early days of health care reform. We addressed the use of limited provider networks and other efforts being considered to help reduce health insurance premium increases. Finally, we reviewed key steps which merit consideration and could help manage state funded health care premium increases and other costs, designed to improve the bargaining position for state health care service purchasers.

Issues dealing with developing a methodology for identifying, calculating, and monitoring the number of uninsured, continue to be examined. Similarly, information relative to the number of individuals that will fall into the affordability gap waivers from mandated coverage, and the number of individuals that currently have health insurance that will not meet minimum creditable coverage standards by January, 2009, is still being estimated and reviewed. The Joint Committee's inquiry into the impact of ERISA limitations/exemptions is also still in the investigational stage and will be reported in an upcoming progress report.

Health Care Reform Implementation Issues Currently Reviewed

Issue 1. Commonwealth Care Enrollment Backlogs

There have been reports of backlogs of eligibility and enrollment into Commonwealth Care occurring at the MassHealth Enrollment Centers (MEC) and/or on the MassHealth Recipient Eligibility Verification System (REVS) system over the past few months, as activity in the Connector has increased considerably. What has caused these backlogs, how have they been addressed, and what is the plan to avoid these backlogs from occurring again? How long does it usually take to enroll someone once the application has been received? Are there particular staffing or funding challenges affecting this processing?

Individuals enroll in Commonwealth Care by calling the Connector's customer service center. The Connector's customer service center, which fields the calls and facilitates the enrollment process, is run by Maximus, Inc. (Maximus), a private contractor. Problems related to high call volume or backup in the MassHealth enrollment processing systems can cause delays in the enrollment process. During the summer months and into the fall, the Connector and MassHealth have experienced significant increases in eligibility and enrollment application volume, coupled with system problems and understaffing in the Connector's consumer service center. This caused 1-2 month delays in enrollment and increased abandoned calls (where a caller hangs up before getting to the proper resource) to the call center as high as 22% during one week in September and over 47% in October, when call center volume was very high. Periodically, this increasing volume of calls, which can create higher abandon call rates, delays eligibility determination and enrollment processing.

Our review of the October, 2007 breakdown in customer support call center volume below in Chart 1, indicated that the largest percentage of calls were general customer

service related, followed by enrollment, inquiries about health plans, and then all other subjects. As the November deadline approached, it was reported that more calls tended to be enrollment based.

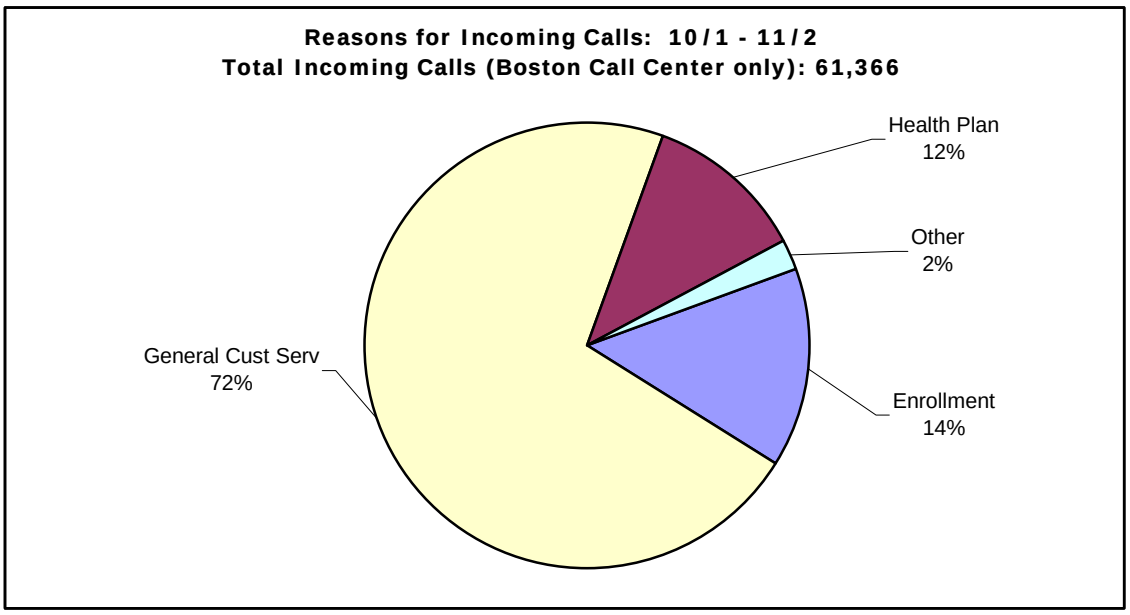


Chart 1
Source: Maximus, Inc.

According to information from the Connector and MassHealth, there are four categories of calls that contribute to the increasing volume of calls received by the customer call center. Dramatic increased volume of any or all of these can cause delays in the flow of enrollment into the Connector insurance programs.

- The first category is the volume of calls that are received for general questions about the insurance plans, generated from the television and radio media and Connector outreach and marketing efforts. These had steadily increased as the original deadline (for enrollment in a health insurance plan by December 31, 2007) of November 15th approached.
- The second level of increased volume is from those individuals who have decided to enroll, whose applications must be assessed for appropriate eligibility and processed by the MassHealth REVS system and the MassHealth Enrollment Centers to determine in which state subsidized program, if any, the individual will be qualified to participate. This factor is also impacted by the volume of all other call activity in the MassHealth MECs servicing the existing MassHealth population as well. There were 25,000 new enrollees in November.
- The third category of increasing calls began in the first part of November, when the Connector scheduled Commonwealth Care's open enrollment period, where currently enrolled individuals are permitted to make changes to their health insurance plans or carrier. This will continue until December 15, 2007.
- And finally, added to the call center volume are more than 45,000 former Uncompensated Care Pool users who recently received notices that they no longer qualify for coverage in the new Health Safety Net and are required to seek eligibility and enroll in one of the Connector health plans or in MassHealth.

Maximus tracks caller topics and reports on call abandonment rates. As seen in the series of charts below provided by Maximus, abandoned calls were up to 1,500-2,200 per week at the beginning of June and, after receding somewhat in later June through August, steadily increased to over 10,000 abandoned calls for the week of October 15th.

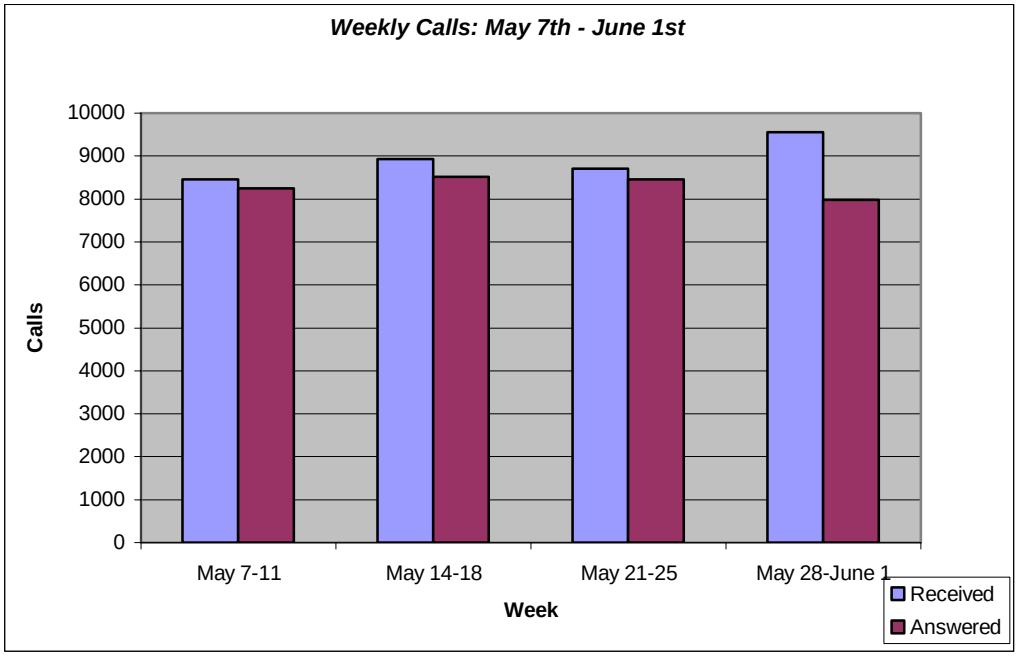


Chart 2
Source: Maximus, Inc. (Received and Answered Calls)

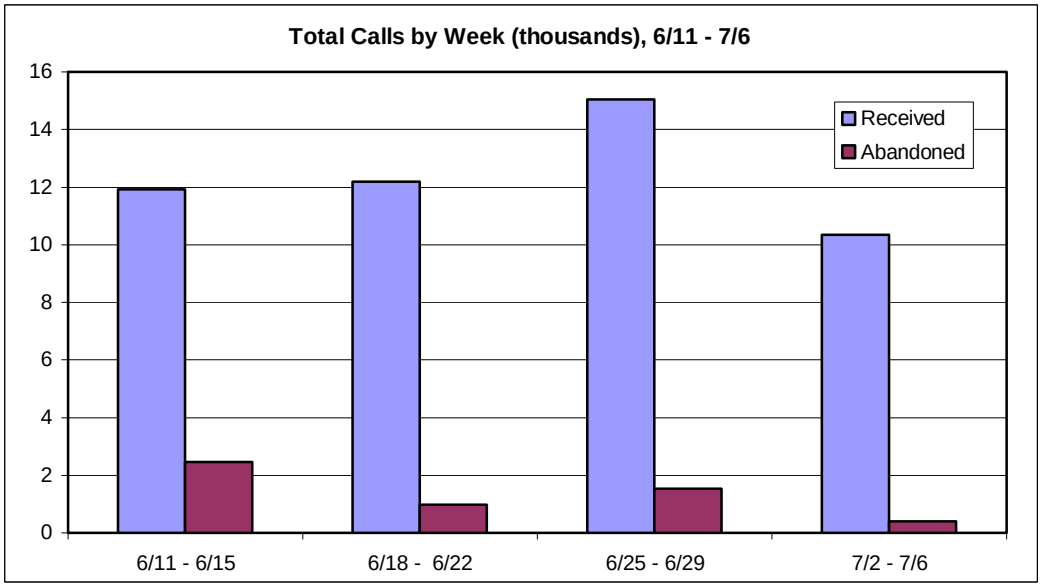


Chart 3
Source: Maximus, Inc (Received and Abandoned Calls)

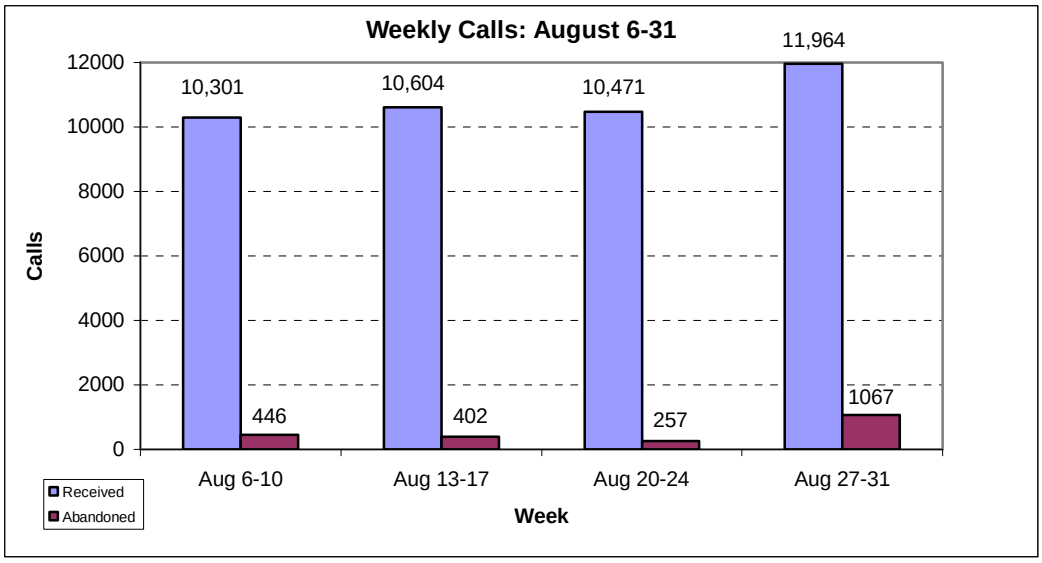


Chart 4
Source: Maximus, Inc. (Received and Abandoned Calls)

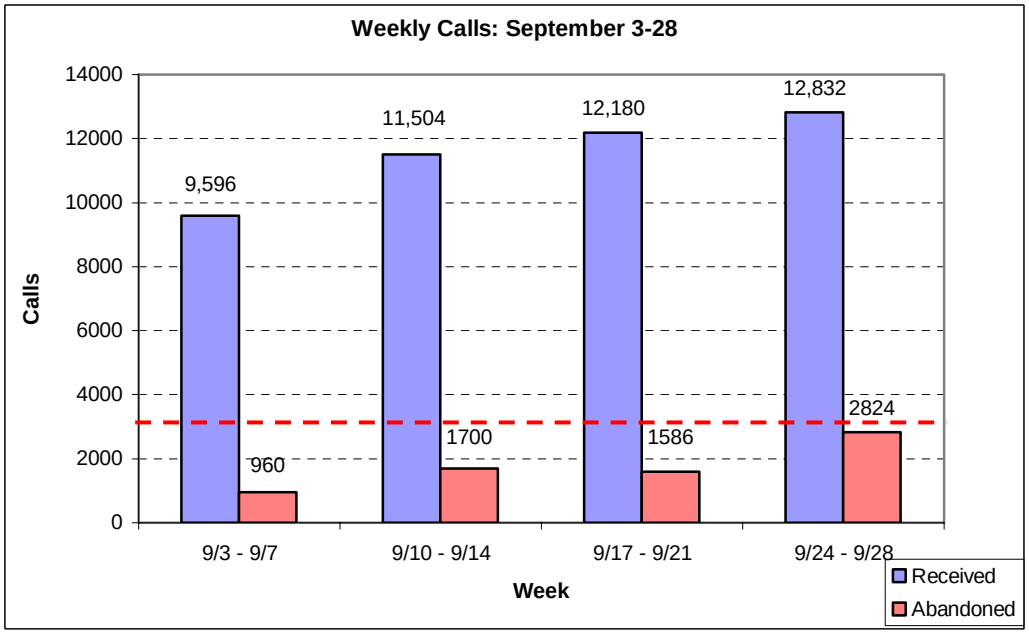


Chart 5
Source: Maximus, Inc. (Received and Abandoned Calls)

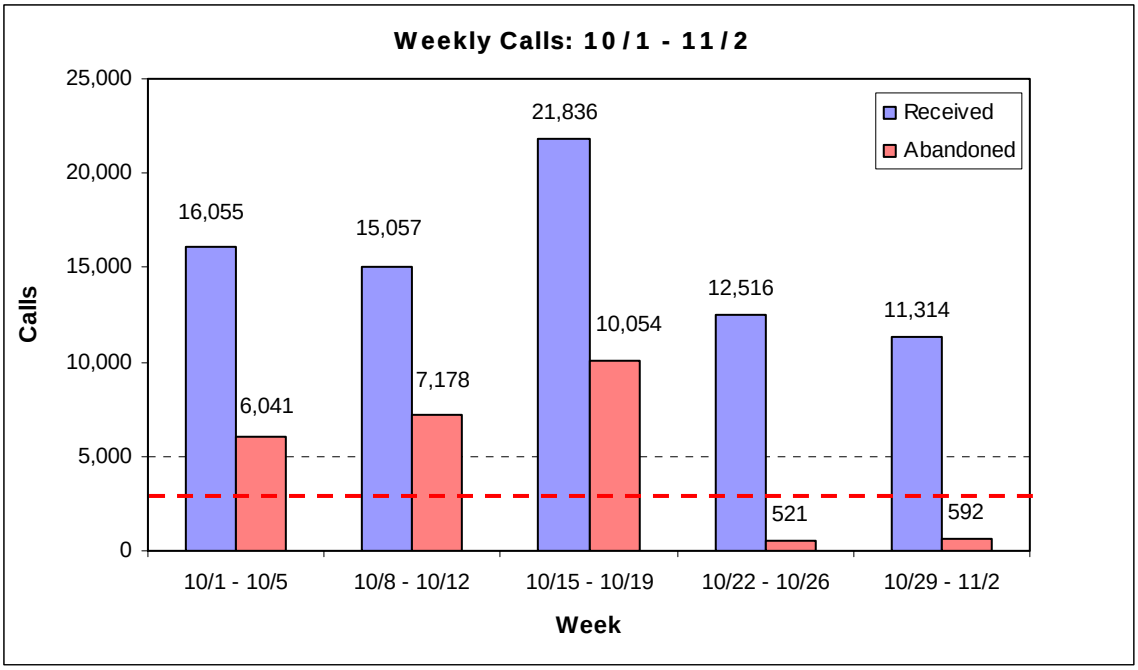


Chart 6
Source: Maximus, Inc. (Received and Abandoned Calls)

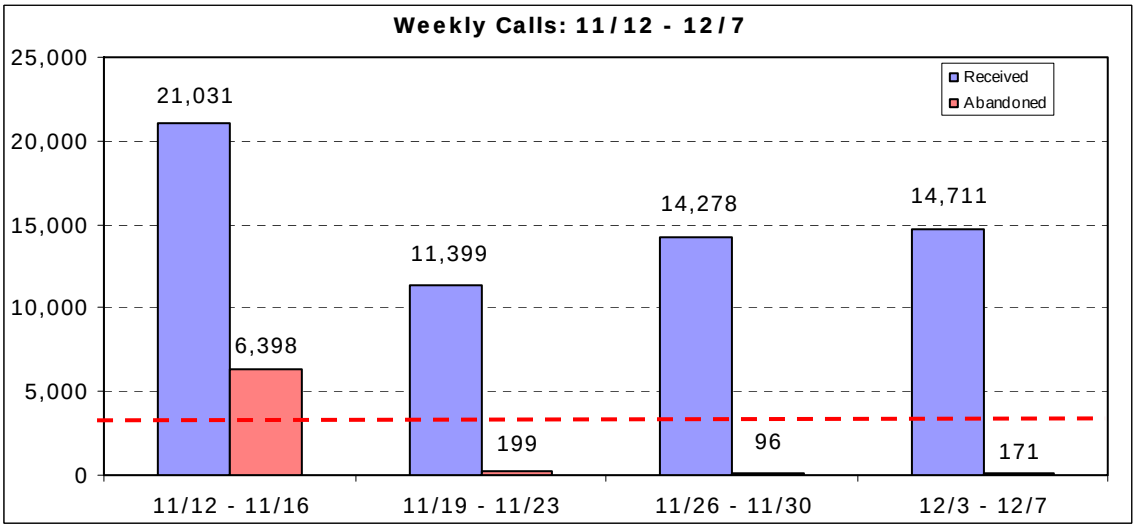


Chart 7
Source: Maximus, Inc. (Received and Abandoned Calls)

As seen above in Charts 6 and 7, calls also increased approaching the original enrollment deadline of November 15th. The Connector decided to extend the deadline for enrollment into the following week to help accommodate the record call volume.

Based on the problematic experience with abandoned calls during the summer months and into the fall, the Connector reported that they took a series of steps to address the issues:

- Staffing was increased in the call center by 30-40% as of October 9, 2007, although the increased capacity took approximately three weeks from that date to be effective. Most of the new staff completed training within the following two weeks and were being supervised by existing staff for one week prior to functioning on their own towards the end of October. Depending on volume, there are now 60-70 customer support staff available in Massachusetts to answer questions and assist with inquiries and enrollment.
- Arrangements were made with Maximus' overflow call center in Georgia to train more experienced staff to assist in heavy volume situations. This expansion was enhanced on October 22nd.
- The call center telephone system was expanded on November 5th to include additional trunk lines to create more capacity to transfer overflow calls to Georgia.
- The Connector also reported that it made changes to its call triaging system, to ensure that callers requesting enrollment are transferred directly to a customer service representative to process their enrollment, and not be delayed with the volume of callers who may have general questions or premium billing issues.

Again referring to Chart 7 above, while call center volume increased dramatically in mid-November, abandonment rates also increased somewhat in early November, but have since subsided. The Connector had set a goal for Maximus of under 5% abandoned calls as acceptable, which has only been achieved during a few weeks over the last six months, and also very recently.

MassHealth reported that it has taken steps to reduce backlog problems processing eligibility determinations at the MECs. In order to remain on schedule with the timely processing of applicants, MassHealth has delegated more staffing resources to these activities, including scheduling overtime for existing staff to meet demands. MassHealth also has indicated that it has improved its technical capability by enhancing the functionality of the Virtual Gateway and encouraging more individuals to use the web-based system. The *MyAccount* page has been created to allow Virtual Gateway users, who help individuals enroll through the Virtual Gateway system, to have direct connection to the eligibility system to track enrollee account status. This also allows users to respond to issues delaying eligibility and enrollment and update the account. The MassHealth call center (also operated by Maximus) has been instructed to route eligibility and enrollment related calls directly to the appropriate customer service representative, to avoid having general helpline call volume delay individuals who are seeking to enroll.

Currently, when MassHealth receives a completed application with all necessary verifications and signatures, officials indicated that the application can be processed in an average of 8-9 days. If the application is received electronically via the Commonwealth's Virtual Gateway System, the turnaround can be within 5 days. With the recent heavy enrollment activity, a slight majority of applications have been processed manually, with around 45% using the Gateway. However, MassHealth indicates that over 85 % of the total applications submitted are incomplete and require follow-up with the applicant for proper documentation and signatures. The application turnaround for these depends on when the necessary documentation is received by the MEC from the applicant.

Issue 2. Commonwealth Care Waiver and Appeal Mechanisms

Related to backlogs in enrollment in Commonwealth Care experienced in the past, what is the status of the waiver/appeal mechanism individuals will need to use to avoid any penalties from the Department of Revenue if they could not be successfully enrolled in a health plan by December 31, 2007, due to system backlog/processing problems, etc.?
Can you predict the volume of individuals who would likely be affected by this sequence of events?

Both the Connector and MassHealth reported that as of November 30, 2007, no recent backlogs in eligibility determination from MassHealth have occurred. Once determined eligible for Commonwealth Care by the MEC, individuals can enroll in one of the four MMCOs and select a primary care physician by phone for immediate processing. The recent major deadline for enrollment in the Commonwealth Care health insurance plans was November 15, 2007. This was the date by which an individual must have been declared eligible for Commonwealth Care, chosen an MMCO plan, and paid the first month's premium to be covered by health insurance by December 1, 2007. As originally designed, any individual that completed the enrollment process after November 15, 2007 would not have secured coverage until January 1, 2008, thus failing to comply with the individual mandate for tax year 2007.

The Connector does not currently anticipate that difficulties with the enrollment process based on backlogs would cause a significant need for waivers to be granted, although late enrollment requests will pose some challenges to the system and the penalty exemption process. (Reported enrollment in Commonwealth Care increased by 25,000 in November). This is a serious policy and financial challenge where the statute indicates that individuals are required to demonstrate that they had effective health insurance coverage as of December 31, 2007. The Connector has not published a policy on this subject as of December 5, 2007. Connector officials report that they are currently coordinating plans with other state agencies to take a very open and flexible approach to enrolling individuals throughout December and accommodating those who have demonstrated an effort to enroll within the deadline prior to December 31, 2007, but for some reason were not able to successfully secure coverage until January 1, 2008.

Connector officials were not able to predict the size of the population that would be affected by the potential of having a penalty imposed on them because of the lack of insurance by December 31, 2007 despite individual efforts to enroll in a plan. On December 5, 2007, the Connector announced that nearly 300,000 individuals have now enrolled in health insurance plans offered by the Connector, MassHealth or by enrollment in the workplace since the health reform law went into effect. Efforts are continuing in December to enroll uninsured individuals.

The concern of the Joint Committee on preparing properly for the anticipated swell of enrollment throughout December is well founded. Depending on the total number of individuals believed to be uninsured at the beginning of health reform, potentially more than 200,000 -300,000 residents of the Commonwealth could still remain uninsured through December and into 2008. The total number of uninsured will most likely not be

known with any precision prior to the processing of the 2007 state tax forms, at which time many of these individuals will realize that they have incurred a penalty for not having health insurance in 2007. Also uncertain, at this time, is the exact number of individuals who have signed up with a Commonwealth Choice type health plan by enrolling directly with health insurance carriers versus with the Connector through the end of 2007.

Since the Connector reports that it is in the process of implementing procedures to certify enrollment (or grant 2007 tax year penalty waivers based on individual efforts to enroll in a health plan by December 31, 2007), the potential number of uninsured may be somewhat reduced for the Commonwealth Care eligible population. This is important because it is anticipated that those individuals who are waiting until the end of the year are most likely younger and/or healthier and would represent a potential positive impact on the Connector's overall medical risk ratio. The Connector released an Administrative Bulletin in dated December 6, 2007 clarifying the process of granting exemptions to the 2007 tax year penalty for the lack of health insurance coverage for certain individuals, which states:

1. Any individual who has obtained health insurance coverage that is effective as of January 1, 2008 in the Commonwealth Care program operated by the Connector will be deemed by the Connector to have insurance adequate to meet the standards of G.L. c. 111M for 2007. Those individuals, therefore, will not be liable to pay a penalty to the Commonwealth of Massachusetts under the individual mandate for the tax year ending December 31, 2007.

2. Any individual who has obtained private health insurance through the Connector's Commonwealth Choice Young Adult Plan that is effective as of January 1, 2008 will be deemed by the Connector to have insurance adequate to meet the standards of G.L. c. 111M for 2007. Those individuals, therefore, will not be liable to pay a penalty to the Commonwealth of Massachusetts under the individual mandate for the tax year ending December 31, 2007.

If an individual appeal to the mandatory enrollment process is necessary, the established appeal process will be utilized. In July, the Department of Revenue (DOR) published the first draft of Schedule HC, Health Care Information, which taxpayers will file with their 2007 income tax return to show either proof of health insurance coverage or that no affordable health insurance was available to them. DOR has since published subsequent drafts after receiving feedback from many sources. Recently updated (November 9, 2007) versions of the draft Schedule HC along with draft instructions and a worksheet are available for review on DOR's website: www.mass.gov/dor/hcinfo. DOR continues to seek feedback from consumer groups, advocates and tax practitioners to ensure that the form is as easily understandable as possible. The Connector and the Department of Revenue (DOR) report all the necessary health insurance mandate appeal forms will be complete by December 15, 2007.

The appeals process involves three steps.

- First, the taxpayer must complete Schedule HC-A, Health Care Appeals, and include it with his or her income tax return. If an individual is due to incur a penalty, but believes that he or she has a hardship or other status that should

preclude any penalty, the individual will need to file the HC-A appeal at the time the tax return is filed.

- Second, following the filing of the appeal, the taxpayer will receive a follow-up letter and form with instructions from DOR on which the taxpayer must state the grounds, and provide significant documentation to substantiate the claim for hardship. This form must be filed within 30 calendar days of receipt of the form. Failure to submit the form and provide sufficient documentation in the required time frame will result in a dismissal of the appeal.
- Third, the Connector will then review the claim and accompanying documentation. The taxpayer may be required to attend a hearing to review his or her case. The Connector will notify the taxpayer directly as to the outcome of the requested appeal. A denial by the Connector may be appealed only to the Superior Court. If the claim is dismissed, or if Connector denies the taxpayer's appeal, he or she will be issued a bill by DOR based on the loss of the personal exemption for tax year 2007, plus interest from the due date of the income tax return, without regard to extensions. Any unpaid bill will constitute a lien on future tax returns.

What efforts need to be made to publicize the availability of this process to individuals and employers?

The Associated Industries of Massachusetts reports that efforts continue in the workplace to alert employees of their responsibilities and options relative to mandated health insurance coverage. Employers reported that they have begun to receive their Health Insurance Responsibility Disclosure forms (HIRD), which will be used for employees to confirm that they have been offered employer sponsored health insurance or Section 125 plans, but have declined to enroll. Employers also noted that there did not appear to be a significant spike in enrollment in employer-sponsored health insurance over the past few months, as some had anticipated, although some recent increases have been noted.

It is not apparent that the appeal process, individually, has been well publicized in the media or within the employment community. However, the Connector reports that it has performed outreach to tax preparers, CPAs, advocates and employers about the Schedule HC, HC-A and 1099 HC forms. The Department of Revenue stated that it has posted all of the relevant required forms, as well as the description of the appeals process, on its website for the public to access. The Massachusetts 2007 state tax return form will also highlight this requirement. After the November 15, 2007 deadline to enroll in health insurance which will become effective by the December 31, 2007 mandate deadline, we had suggested that media communication by the Connector include reference to affordability exemptions and appeal rights to individuals who may have a permissible circumstance to waive compliance with the individual mandate deadline.

We recommend that the Connector emphasize the appeals process and instruct the call center staff to become well informed of the process to be able to effectively communicate it to interested parties. Currently, in MassHealth, a more mature insurer, over 1,500 appeals are heard every month by the Board of Hearings.

What is the current volume and rate of hardship appeals received by the Connector? How has the appeals process been working for individuals and the Connector?

Hardship waivers are sought by individuals enrolled in Commonwealth Care who cannot afford the required premiums or co-pays. Current hardship waiver applications are requested through the Connector call center, which allows applicants to be screened to determine if a payment plan or re-determination would be more appropriate. The individual then submits the hardship waiver application to the Connector, and it is reviewed within a few days of being received. The Massachusetts League of Community Health Centers reported that it has assisted a number of individuals who have filed appeals for financial and provider access issues.

As of December 1, 2007, the hardship waiver process has been utilized by approximately 188 individuals, who have requested six month waivers of premiums and/or co-pays, as well as reductions in premiums and/or co-pay amounts. Of those requests, the Connector has approved around 50%. Of the approximate 90 denials, a total of 15 individuals have scheduled hearings, which are pending before a panel of independent hearing officers established by the Connector. Thus far, only 6 appeals have been heard with no reported outcomes. Also, as of December 1, 2007, 46 certificate of exemptions requests have been filed, which seek exemption from the individual mandate because of financial, religious or other permitted exemptions. Of those, 19 were approved, 27 were denied, with one individual seeking an appeal. The volume of appeals in both of these areas is very likely to increase as the year-end deadline draws near for individuals to enroll in a health insurance plan. Also, most Commonwealth Care members have not had health insurance to date, with little experience paying premiums on a monthly basis. It is quite possible that the Connector process to handle appeals may be dramatically insufficient. As stated earlier, MassHealth has approximately 1,500 appeals filed every month by individuals challenging eligibility denials, being terminated for not paying their participating share, and other issues.

Issue 3. MassHealth Acute Hospital and Physician Rate Increases

Under Section 40 of the Fiscal Year 2008 Budget, which amended section 128 of Chapter 58 of the Acts of 2006, MassHealth was required to pay rate increases of an additional $90 million to acute hospitals and physicians in each of the fiscal years 2007, 2008, and 2009. For Fiscal Year 2007, did MassHealth include inflationary increases as part of the $90 million or was the $90 million on top of any inflationary increases? How was this determined?

The distribution of the $90 million rate increase in FY2007 was split, according to the statute, between the hospitals, receiving $76.5 million, and physicians, receiving $13.5 million. For the hospitals, there are statewide and hospital-specific factors that are taken into account when determining the rates. In FY2007, MassHealth reported that there was an amount attributed to inflation included as part of the hospital $76.5 million rate increase. Further, for FY 2008, there is an additional $10 million included in the rates, bringing the total increase for hospitals to $86.5 million. For the physicians there is no inflationary component included in the rate calculation. The Division of Health Care

Finance and Policy updated the conversion factor and anesthesia per unit rates to reflect this increase.

There has been some debate as to the intent of the legislature regarding how inflation and other enhancements should have been treated in the hospital rate increase. MassHealth indicated that the administration had decided that the planned hospital rate increase was not additional to inflation and other increases. MassHealth thus included inflation and enhancements in the calculation of the FY2007 budget increase of $76.5 million. The Massachusetts Hospital Association (MHA) and others have indicated that the $76.5 million increase should have been in addition to any inflationary factors because this increase was meant to help close the gap between what it costs the hospitals to provide care and what MassHealth pays for that care. It has been estimated by the MHA that about $40 million of the $76.5 million was due to inflation and routine changes in payment methodology. The legislation is silent on the issue of including or not including inflation within the rate increase.

Issue 4. MassHealth Quality Standards and Performance Benchmarks

For Fiscal Year 2008, the statutory language, section 40 of Chapter 61 of the Acts of 2007, states that not more than $20 million of the rate increase for acute hospitals "be contingent on hospital adherence to quality standards and achievement of performance benchmarks" as determined by the Secretary of Health and Human Services. What dollar amount will be contingent on meeting these goals? What quality standards and performance benchmarks will be used?

The pay-for-performance program that MassHealth must implement in FY2008 is governed by Section 128 of Chapter 58 of the Acts of 2006, as well as Section 13B of Chapter 118E of the General Laws. Section 13B links hospital rate increases to quality standards and performance benchmarks. The Executive Office of Health and Human Services (EOHHS) is to develop or adopt benchmarks in a way "to advance a common national framework for quality measurement and reporting." EOHHS should draw on "measures that are approved by the National Quality Forum and adopted by the Hospitals Quality Alliance and other national groups concerned with quality." MassHealth shall consult with the Health Care Quality and Cost Council and the MassHealth Payment Policy Advisory Board while developing these standards and benchmarks. Section 128, which was amended by Section 40 of Chapter 61 of the Acts of 2007 (FY 08 Budget), included the $20 million contingency hospital payment based on quality standards and benchmarks. The legislation states that these performance benchmarks "shall be determined by the Secretary of Health and Human Services without any limitations", but in consultation with hospitals, the Health Care Quality and Cost Council and the MassHealth Payment Advisory Board. Section 128 gives broad latitude to the Secretary in developing these quality standards and benchmarks. Both Section 13B and Section 128 speak to the importance of including benchmarks related to the reduction of racial and ethnic disparities in health care.

In FY2008, MassHealth reports that $20 million of hospital payments will be contingent on meeting performance benchmarks determined by the Secretary of Health and Human Services, following consultation with a number of stakeholders. In cases where

MassHealth has previously collected data in Rate Year 2007, that will serve as the baseline for a performance improvement calculation between RY2007 and RY2008. For new measures, hospitals can earn incentive payments for reporting data which will be used as the baseline for the measure going forward. The minimum quality performance requirement for hospitals to be eligible for incentive payments is to demonstrate full participation in the Leapfrog Hospital Quality and Safety Survey, the Institute for Healthcare Improvement 5 Million Lives Campaign, or the Commitment to a Never Events Protocol. The measures issued by MassHealth to be used include:

Measurement Category and Name	Reporting Status
Maternity and Neonate	
Intrapartum Antibiotic Prophylaxis for Group B Streptococcus	New for RY08
Perioperative Antibiotics for Cesarean Section	New for RY08
Neonatal Intensive Care – Administration of Antenatal Steroids	New for RY08
Community Acquired Pneumonia	
Oxygenation assessment	Reported in RY07
Blood culture performed in ED prior to first antibiotic received in hospital	Reported in RY07
Adult smoking cessation advice/counseling	Reported in RY07
Initial antibiotic received within 4 hrs of hospital arrival	Reported in RY07
Appropriate antibiotic selection for CAP in immunocompetent patients	Reported in RY07
Pediatric Asthma	
Children's Asthma Care – Inpatient Use of Relievers	New in RY08
Children's Asthma Care – Inpatient Use of Corticosteroids	New in RY08
Surgical Infection Prevention	
Prophylactic antibiotic received within 1 hour prior to surgical incision	New in RY08
Appropriate antibiotic selection for surgical prophylaxis	New in RY08
Prophylactic antibiotic discontinued w/in 24 hrs after surgery end time	New in RY08
Health Disparities	
Cultural and Linguistic Appropriate Service Standards (CLAS)	Reported in RY07

Chart 8
Source: MassHealth

There will be three standards used as part of a weighted point system to determine compensation. They are:

Best Practice Benchmark bonus: A benchmark is the best practice standard that must be met to receive benchmark bonus points.

Minimum Threshold bonus: A minimum threshold is the lowest standard of performance that must be met to receive threshold bonus points.

Improvement bonus: An improvement is a desired level of improvement above the threshold that must be achieved in order to receive improvement bonus points.

Who was consulted in the development of these quality standards and performance

benchmarks and what were their recommendations? What was the process for determining the final quality standards and performance benchmarks?

In developing these quality standards and benchmarks, MassHealth reported they had consulted with:

- Health Care Quality and Cost Council
- MassHealth Payment Policy Advisory Board
- MassHealth's Medical Care Advisory Committee
- Health Disparities Roundtable
- The Hospital Quality Steering Committee
- The Group Insurance Commission
- Harvard Pilgrim Health Care
- Blue Cross Blue Shield of MA
- Tufts Health Plan
- The Centers for Medicare and Medicaid Services (CMS)
- Maryland Quality Indicators
- The Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- The Hospital Quality Alliance (HQA)
- The Agency for Healthcare Research and Quality (AHRQ)
- Pennsylvania Medicaid
- Arkansas Medicaid

After these consultations, the quality standards were selected by MassHealth based on recommendations by staff. Selection criteria included relevance for the MassHealth population, administrative ease for collection of data, and the validity and reliability of the measure. Benchmarks are based on prior year reporting of the hospitals to MassHealth for measures that have been previously reported. For measures being collected for the first time this year, the requirement is to report the data, with MassHealth setting benchmarks for next year.

Reportedly, there was general approval of MassHealth's decisions on measures, but there are concerns regarding the implementation of the pay-for-performance system. Hospitals stated that they need enough lead time to implement the new systems. Timelines have been characterized as too narrow, and hospitals have said they have not received technical specifications in time to meet data collection start dates. The Massachusetts Hospital Association indicates that there is a lack of system support for some of these measures. Because of some of the unique measures being collected, vendors who provide information and reporting systems to the hospitals have not yet incorporated these measures into the data gathering/reporting software packages they offer. Also, MassHealth indicated that a hospital preference for the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measures was expressed, and also acknowledged that some measures would not accommodate the MassHealth population demographics.

Are there any efforts underway to consolidate and standardize quality standards/performance benchmarks with other groups performing these functions?

The Executive Office of Health and Human Services reports that efforts are underway to provide uniformity and standardization in pay-for-performance by all state purchasers of

health care. MassHealth has involved the MassHealth Payment Policy Advisory Board, established by Chapter 58, and the Hospital Quality Advisory Board in helping to address the standardization of quality measures. National measures have been used when available and MassHealth reports that it has worked with providers and other public and private payers to collectively establish new measures. Regarding the adoption of national measures, primarily offered by Medicare and some private sector groups, there is a difference in the demographics between the MassHealth population and both the Medicare and commercial population, which may pose a significant challenge in terms of standardization of these national measures. As much as the state agencies involved in health care can attempt to standardize measures, it was suggested by MassHealth and the Massachusetts Hospital Association that the Health Care Quality and Cost Council should take the lead on creating uniformity in quality measures and benchmarks across all payers, both public and private.

Issue 5. Financial Impact of Connector Premium Subsidy Changes

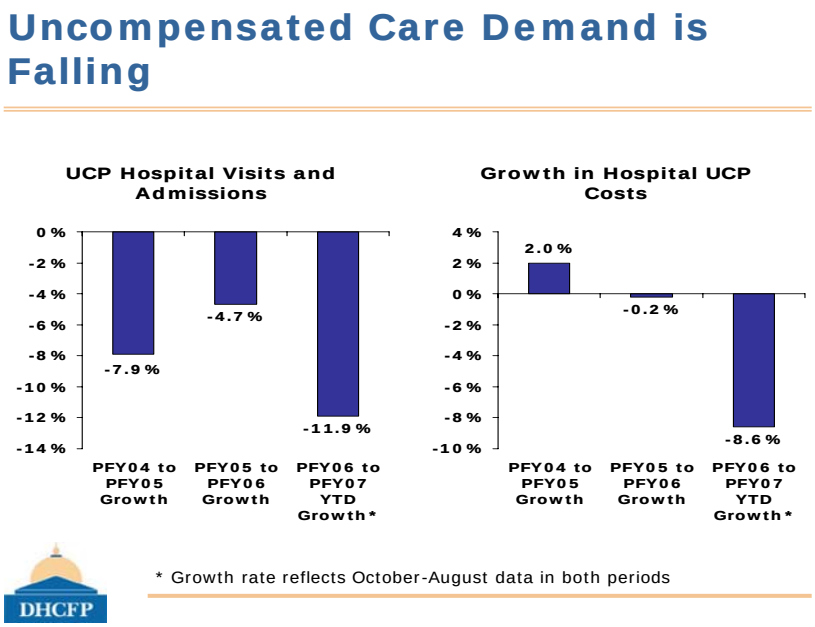
On April 12, 2007 the Connector increased the eligibility for a full premium subsidy from 100% of the Federal Poverty Level (FPL) to 150% of FPL. At the same time the Connector also lowered the premium contributions for the group making between $15,300 and $20,400. What has the fiscal impact of these changes been to date? What is the anticipated fiscal impact going forward?

The total fiscal impact is $14.55 million, broken down as follows:

- At the time the Connector increased eligibility and lowered premiums, it was estimated that the cost to the Commonwealth Care Trust Fund would be $5.2 million in non-collected premium contribution income.
- Currently, enrollees up to 150% of FPL pay nothing, down from $18 per month; and enrollees between 150.1% and 200% FPL pay $35, down from $40 per month. Because of these changes the Connector anticipated that enrollments would grow faster than originally expected, increasing the capitation payments to the MMCOs by an estimated additional $7.4 million.
- In order to maintain consistency between programs, MassHealth eliminated premiums for families with children that were also paying Commonwealth Care premiums. They estimated a loss of an additional $2.7 million in non-collected premium contribution income.
- However, due to fact that enrollees between 100.1% and 150% of FPL would no longer need to be invoiced or have their premium payments collected, the Connector reports that there would be an administrative savings totaling around $750,000.

The Division of Health Care Finance and Policy anticipates that there should be increasing cost reductions to the Health Safety Net in Health Safety Net Year 2008, due to the increased enrollment in Commonwealth Care caused, in part, by the expanded eligibility for Commonwealth Care subsidies and premiums. Of the large group of Uncompensated Care and Medicaid eligible individuals who were determined eligible for Commonwealth Care , as of October 1, 2007, nearly 100,000 have enrolled in a Commonwealth Care plan, according to officials at the Connector. As illustrated in Chart 9 below from the Division of Health Care Finance and Policy (DHCFP), utilization of the

Uncompensated Care Pool in hospital inpatient admissions, outpatient visits and overall hospital costs have been declining over the last three years since the legislature has focused attention on the pool. Most dramatically, volume fell once health reform efforts had begun in the fall of 2006. DHCFP officials are expecting this trend to continue as enrollment continues to increase in Commonwealth Care.



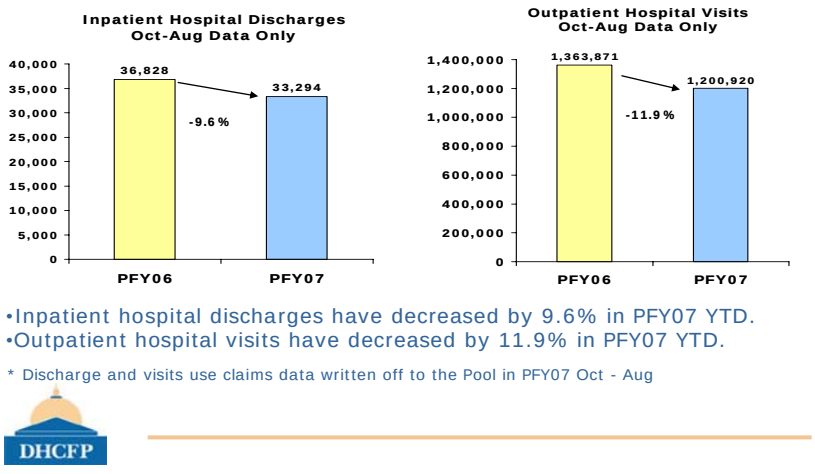


Chart 9
Source: The Division of Health Care Finance and Policy, 2007

How many more people are eligible for a full subsidy due to this change?

At the time the decision was made to eliminate the enrollee contribution for enrollees between 100.1 to 150% of the FPL, the Connector reported that there were approximately 29,000 enrollees in this group.

What effect will these decisions have on the ability of the Health Safety Net Trust Fund to cover hospitals providing free care and emergency bad debt?

The Connector reports that the enrollment rate for individuals entering into Commonwealth Care has been faster than originally expected, due, in part, to the expanded subsidy changes (described above) made by the Connector. Because a greater number of former Uncompensated Care Pool utilizers have been enrolled in Commonwealth Care earlier than expected, Connector staff estimate that there should be reduced utilization of the Health Safety Net Trust Fund and increased availability of budgeted funds in the Health Safety Net Trust Fund for Commonwealth Care premiums. This increased availability of funds has been incorporated into the Health Safety Net Trust Fund's FY2008 funding assumptions by DHCFP, leading to a $162.1 million budget reduction in the Health Safety Net Trust Fund (from $610 million in FY2007 to $447.9 million in FY2008).

Issue 6. Non-Group and Small Group Insurance Merger Impact

As a result of the merger of the non-group and small group risk pools in the health insurance markets, it was anticipated that non-group individual market health insurance rates would decrease significantly and small group health insurance market rates would increase slightly. It has been reported that the small group health insurance market annual premium increases have been rising significantly (10-20%) over the last few months. Can you confirm this original estimate and offer an explanation of why higher rate increases have occurred?

Chapter 58, in section 114, called for the establishment of a special commission to conduct a study of merging the non-group and small group health insurance markets. The study, which included the examination of the impact on health insurance premiums of merging the non-group and small-group health insurance markets, was performed by Gorman Actuarial, LLC, the actuarial firm contracted by the special commission. It concluded, in a report published on December 26, 2006, that the combined rate impact of the merger of the two markets would result in a decrease in non-group health insurance premiums by approximately 15% and an increase in small group premiums by 1% to1.5%, with a wide range beyond that based on the particular carrier. Although not specifically stated in the report, according to the study's authors, these rates were only comparing base rates to base rates and did not include annual trend increases, which were estimated to be close to 11%, or other individual group rating factors.

The non-group market in Massachusetts contains about 60,000 members who are typically rated as higher risk and tend to be older and more regular users of health care services because these individuals have medical conditions that justify seeking expensive individual coverage. When grouped with the 800,000 small group market, that risk is disseminated among a much larger group of younger, healthier individuals; thus the

anticipated major reduction in premiums for the non-group individuals. However, the small group market must now bear the higher risk of a sicker segment of the population and the smaller projected rate increase reflects that increased risk basis. Additionally, since some small groups are very small, one or two major medical claims (heart attack, chemotherapy, high risk newborn, trauma, etc.) could result in large increases in premiums in subsequent years for these small groups.

When reviewing the HMO small group plan rates filed with the Division of Insurance (DOI), the data revealed that recent annual rates increased within a range of 6% to 20% depending on the HMO and specific coverage offered within the plans. For example, the most populated small group plan with prescription coverage from one major insurer increased 11.9% from 10/2005-10/2006, and 8.7% from 10/2006-10/2007. A second major insurer's most populated small group plan with prescription coverage increased 9.9% from 12/ 2005-12/2006, and 20% from 12/2006-12/2007. A third major insurer had increases of 8.3% from 12/2005-12/2006, and 6.5% from 12/2006-12/2007 in their most populated small group plan with prescription coverage. These rates also do not represent additional adjustments due to other risk rating factors for individual employers. DOI felt that it is hard to conclude with certainty what, if any, part of the 2007 rate increases was attributable to the merger of the non-group and small group markets, because not enough time and transition between the two groups has occurred to date to have a meaningful impact on rates.

This view is also shared by the Massachusetts Business Association (MBA), which purchases insurance on behalf of over 40,000 small employers in Massachusetts. The MBA membership has reported premium increases for small employers (1-10 FTEs) as high as 25-30% annually for the past 3 years. The base premium rates are adjusted by age, size of the pool, claims paid and other factors to create the actual premiums for the following year. MBA indicates that very little effect (to date) on premium increases can be attributed to the merger of the non-group and small group markets. MBA will have more specific data on rate increases when it negotiates next year's contracts in April, 2008. MBA also indicated that the new minimum creditable coverage standards developed by the Connector will represent additional premium increases for many of its members who will need to upgrade their plans to include drug coverage and other required components.

The Associated Industries of Massachusetts (AIM) officials observed that health insurance premium increases experienced by their membership averaged a range of 10-15% (including trend) over the previous year. AIM will be performing a survey of its membership in January 2008 to confirm rate increases for small group members.

Early observation of actual premium increases for small groups by the Massachusetts Association of Health Plans (MAHP), who represent the major HMOs in the state, indicated rate increases of 17-19% (including trend increases). New non-group individuals (most previously insured by Blue Cross) entering the HMO small group market are typically older and more in need of medical care, and have not historically been part of the HMO risk pool. However, MAHP explained that there are many mitigating factors that could affect the impact of the merger of these two groups, such as the short term of experience with the new configuration, new changes in the benefits of plans (eliminating a true comparison to previous rates), and overly conservative risk

rating based on uncertainty and lack of history with the service utilization patterns of the new population.

Chapter 58 also requires that the DOI establish a health care access bureau for oversight of the small group and individual group insurance markets. As of the end of November, this bureau has not yet been fully established at the DOI, who are in the process of recruiting the actuary and research analyst to staff this function. Currently, DOI is utilizing consultant actuaries to review carrier actuary opinions, look at benefit purchaser trends and analyze increased health insurance premium costs over the last four years.

Are there limitations on approvals of health plan annual increases to small groups?

According to officials at the DOI, the health insurance market is an open competitive market and company rates are submitted, but not generally reviewed by the DOI, unless certain circumstances arise. Health insurance companies set their rates based on their own expenses and costs and risk losing business in the market if their rates are not competitive with other firms.

DOI regulations (211 CMR 43.08) do require each HMO to submit proposed rates and benefits, or changes thereof, on or before their effective dates or at least at the beginning of each calendar quarter. More importantly, Section 16 of Chapter 176G of the General Laws, which covers Health Maintenance Organizations, states that "The subscriber contracts, rates and evidence of coverage shall be subject to the disapproval of the commissioner. No such contracts shall be approved if the benefits provided therein are unreasonable in relation to the rate charged, nor if the rates are excessive, inadequate or unfairly discriminatory." Similar language appears in Chapter 175, which is for insurance generally, and 176A and B, which combinded, cover Blue Cross Blue Shield.

Carriers are currently allowed to offer products in the small group health insurance market, provided that the rates being charged do not differ from one small employer to another by more than a 2 to1 band (representing the difference between the highest risk rated individual and lowest risk rated individual in the group). These differences are only based on permissible rating factors. Although the Division of Insurance does not review company health insurance rate filings, it relies on actuarial certifications from the carrier's actuaries that the carriers are totally in compliance with permissible rate restrictions. DOI anticipates that its health care access bureau, once fully established, will monitor these actuary reports and follow up with the carriers, if indicated.

The Connector reports that it is currently developing strategies to strongly encourage the insurance companies marketing the Commonwealth Choice products to small companies to be very creative and cost conscious in presenting their plans and premiums for the next year, including one strategy that limits the amount of premium increases.

Is there any evidence that limited provider networks are being developed and used by insurers or employers to confine the rise in health costs by excluding or applying higher co-pays for non-cost effective providers?

Even though the DOI reports that it has assisted certain health plans to develop and obtain approval for limited provider networks in the past, there does not appear to be a current viable demand for such plans. These plans, which restrict access to higher cost hospitals or other providers, or charge the policy holder more for utilizing those providers and less for utilizing more cost effective providers, have not had a large following in Massachusetts. We have learned that this is most likely a result of the strong consumer demand for unrestricted access to in-town teaching hospitals and, thus far, the small financial incentive to change providers. In fact, when the Massachusetts Association of Health Plans (MAHP) issued its seventeen point legislative package to reduce rising health costs in early December 2007, there was no mention of limited provider networks as a cost cutting strategy. The Connector has recently considered implementing a differential rate for certain services at teaching hospitals that would be more in line with community hospital rates.

The state's Group Insurance Commission (GIC) has offered a range of community choice products to state employees, which include plans with limited provider networks at Fallon Health Plan, Neighborhood Health Plan and Unicare, encouraging member use of (certain) community hospitals. Although these plans are less costly to members than other options, they are "not wildly popular" according to GIC officials. GIC has also tiered physician networks based on quality and cost standards for all plans, which include slightly higher co-pays ($25 versus $10) for lower tiered physicians. Some hospitals are also tiered by GIC resulting in higher co-pays for inpatient services ($400 versus $200). These initiatives have also had limited impact, according to GIC, because the differential is not substantial enough to cause a change in consumer behavior. However, when GIC offered financial incentives to members to use generic alternatives to higher cost name brand drugs (where members are required to pay the difference between the generic version and name brand version), GIC reported that there was a dramatic shift by members to the lower cost generic drugs.

The Connector Board, at its annual retreat in October, discussed various strategies that could reduce health insurance premium charges anywhere from 3.4% to 8.6%, depending on the plan and options chosen. Examples include increasing co-pays for PCPs, specialists, and pharmaceuticals, promoting completion of health risk assessments and follow up with at-risk respondents, encouraging the use of disease management program for individuals with chronic illnesses, and requiring prior authorization of high cost scans, discretionary procedures, etc. Various strategies to audit and improve the accuracy of claims payment were also noted.

Our review of this area revealed that once credible quality and cost comparisons are available for public review, insurers felt that employers would be more likely than consumers to make informed purchasing decisions about which providers offer services with the highest quality and most reasonable costs. Additionally, as more first dollar cost shifts to the policy holder (as with the higher deductible, co-pay and co-insurance components of many of the Commonwealth Choice plans), consumer demand for limited provider networks and other cost savings approaches may increase as consumers are more apt to scrutinize how they spend their self-pay dollars.

Issue 7. Connector Auto-Assignment Standards and Complaint Resolution

There have been concerns that some individuals enrolled in Commonwealth Care, who have been auto-assigned by the Connector to an MMCO, have been enrolled in plans that do not have extensive provider networks in their geographic areas. Please describe how the auto-assignment process was designed and implemented over the last year. What is the current percentage breakdown of auto-assignments/self-selection to MMCOs?

The auto-assignment process that the Connector utilizes was modeled after the process used by MassHealth, and is supported through MassHealth's Medicaid Management Information System. Based on rate negotiations with the MMCOs in September 2006, the Connector developed an auto-assignment methodology that provides for 100% of the auto-assignment volume in a designated service area to be assigned to the lowest bidder who covers that geographic area. In those areas where another bidder's rates were within 3% of the lowest bidder, 25% of the auto-assignments in the service area would go to that MMCO and 75% would go to the lowest bidder.

Upon review of this topic with the Connector, staff reported that customized enrollment materials were provided to prospective members to encourage self-selection of the most appropriate plan for the individual and family. By statute, enrollment in Commonwealth Care is limited in the first three years to the four designated MMCOs. Members are only auto-assigned to a health plan if they have not selected one on their own.

When Commonwealth Care began enrollment in late 2006, auto-assignment rates moved quickly to over 50%. Chart 10 tracks the auto-assignment/self-selection breakdown of the Commonwealth Care enrollees from November 2006 through November 2007. As of November 2007, the percent of auto-assigned members in Commonwealth Care had eventually declined to approximately 30% (or self-selection increased to 70%).

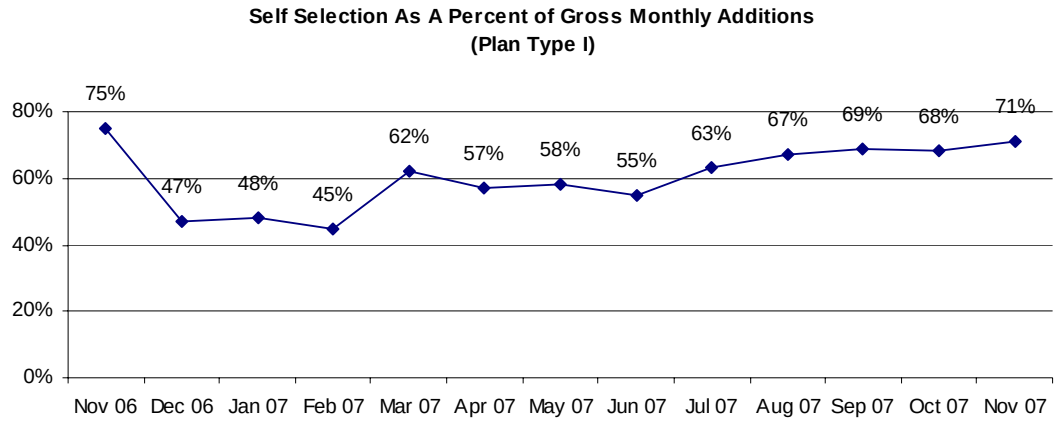


Chart 10
Source: The Commonwealth Connector

Following auto-assignment, Commonwealth Care program rules then allow members to change plans for any reason within 60 days of the first day of enrollment. If a change is requested after the 60 day period, the member must have a valid clinical reason for the

change and present a letter from a clinician justifying the request. Starting November 1, 2007 through December 15, 2007, during the Connector's annual open enrollment period, any member could change plans, or make changes within plans.

The Connector has specific provider access standards, consistent with those mandated by the DOI, in its contracts with the MMCOs. According to the Connector, all Commonwealth Care MMCOs have reported consistent compliance with these access standards from the inception of Commonwealth Care, and have continued to add to their networks over time.

However, as seen in Chart 11 below, volume and payments to community health centers has declined since 2006 (although much of this decline was determined to be caused by the temporary elimination of dental coverage). Some disruption has occurred by the auto-assignment of individuals into the four MMCOs, which may have removed individuals from the community health center network of providers, unless they have contracts with the MMCOs.

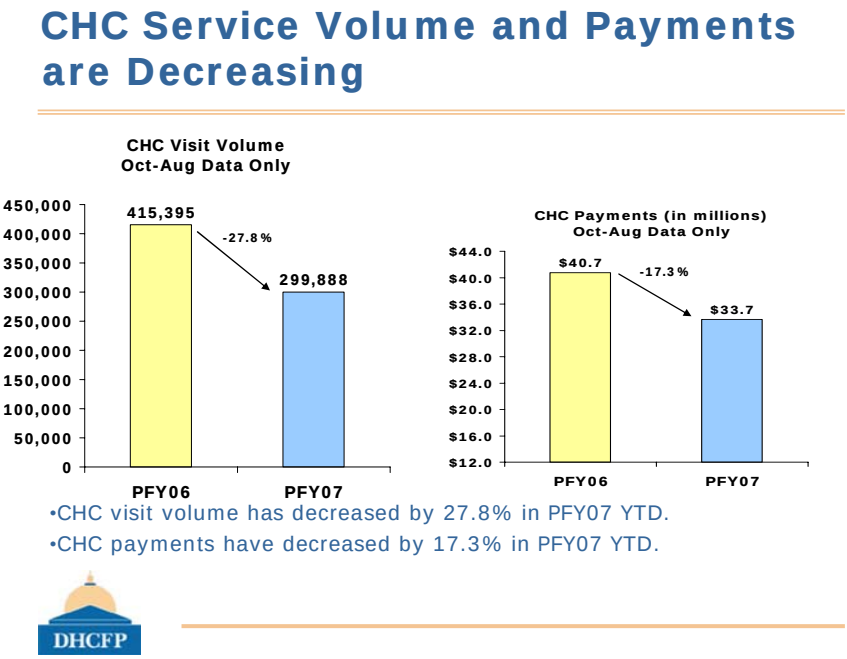


Chart 11
Source: The Division of Health Care Finance and Policy, 2007

Connector staff indicated that since the beginning of the Commonwealth Care program, the four MMCOs have added more than 1,000 new providers to their collective networks to adequately cover their geographic areas, including community health centers.

The Massachusetts League of Community Health Centers currently reports that most of the individuals seeking care in area community health centers have been accommodated by their new health plans by changes to the plan or by the plan adding the community health center to its network.

How has the Connector handled complaints involving geographic related lack of access to primary care and other health care services for certain auto-assigned individuals? How many individuals have been able to change their MMCOs based on difficulty in accessing care, etc.?

Whenever a call is received from a Commonwealth Care member who is experiencing difficulty in accessing health care, the Connector indicated that it immediately involves the member's current MMCO in resolving the issue. In most cases, the member's MMCO is able to resolve the access issue through offering alternative choices of health care provider or facilitating access with the member's initial choice of provider.

When enrollment in Commonwealth Care began in October of 2006, the Connector reported that there were complaints from individuals who were unhappy with their auto assigned plans. In those instances when the member's access issue involves a pre-existing relationship with a health care provider and the member's current MMCO does not have a contract with that provider, the Connector uses different approaches depending upon the member's duration of enrollment. As stated earlier, if the issue arises within the first 60 days of the member's MMCO enrollment, then the health plan change request is automatically processed by Commonwealth Care Customer Service Representatives when it becomes aware of the issue. If the issue arises after the initial 60 days of enrollment, the member must formally submit a request to the Connector that demonstrates that there is a clinically important pre-existing relationship with a health care provider that is not part of their current MMCO's network. Connector staff indicated that if it is demonstrated that there are compelling clinical indications supporting remaining with the current provider, the Connector reports that the individual's request to change health plans has generally been approved.

The Connector indicated that throughout the year about 250 individuals objected to auto-assignment into an MMCO that did not include their local doctor or hospital, and 116 were allowed to change plans. The Massachusetts League of Community Health Centers reported that it has assisted a number of individuals who had difficulty in their assigned health plan and network.

As stated earlier, any member may change their MMCO or benefits during the Connector's annual open enrollment period, which occurs this year from November 1-December 15, 2007. As of December 12, 2007, the Connector reports that almost 1,450 individuals have requested changes to their MMCOs. Changes will become effective January 1, 2008.

The Access to Covered Services Standards, included in each MMCO contract with the Connector for Commonwealth Care, is listed below.

> **Access Standards from the Connector contracts with the MMCOs**
>
> **Section 2.6 Access**
> The Contractor shall require adequate access to Covered Services for all Enrollees. Adequate access shall include physical, telephone and geographic access, as well as access to all forms of communication.

A. Proximity Requirements

1. The Contractor shall execute and maintain, and require that its Material Subcontractor(s) execute and maintain, written contracts with Providers to ensure that Enrollees have access to Covered Services substantially in accordance with the following access standards:

a. Physical and behavioral health services:

1) Acute inpatient services - at least 1 hospital within each County; and
2) Physician Services - at least two PCP sites with open panels in different locations within each Service Area or located within 15 miles or 30 minutes travel time from the Enrollee's residence.

2. The Contractor shall document and submit to the Authority, in writing, a justification for any exceptions to the standards specified in Section 2.6.A.1. above. Such justification shall be based on the community standards for accessing care.

B. Waiting Time

1. The Contractor shall require that Enrollees have access to Covered Services as provided below:

a. Physical Health Services

1) Emergency Services - immediately upon Enrollee presentation at the service delivery site, including non-Network and out-of-area facilities.
The Contractor shall provide coverage for Emergency Services to Enrollees 24 hours a day and 7 days a week without regard to prior authorization or the Emergency Service provider's contractual relationship with the Contractor;

2) Primary Care- within 48 hours of the Enrollee's request for Urgent Care, within 10 days of the Enrollee's request for Non-urgent, Symptomatic Care; and within 45 calendar days of the Enrollee's request for Non-Symptomatic Care;

3) Specialty Care - within 48 hours of the Enrollee's request for Urgent Care, within 30 calendar days of the Enrollee's request for Non-urgent, Symptomatic Care; and within 60 calendar days for Non-Symptomatic Care;

4) All Other Services - in accordance with the community standards; and

5) ESP Services - immediately on a 24-hour basis, 7 days a week, with unrestricted access, to Enrollees who present.

2. The Contractor shall require that Network Providers offer hours of operation that are no less than the hours of operation offered to commercial insurance enrollees.

3**.** The Contractor shall have a system in place to monitor and document waiting times and appointment scheduling standards. The Contractor shall use statistically valid sampling methods for monitoring compliance with the appointment waiting times standards specified above in Section 2.6.B. 1. and shall promptly address any access deficiencies. Annually, in accordance with Appendix A, the Contractor shall evaluate and report to the Authority network-wide compliance with the standards specified in Section 2.6.B. 1.

C. Access for Non-English Speaking Enrollees

The Contractor shall require that multi-lingual Providers and skilled medical interpreters are available for the most commonly used languages in a particular geographic area in the Contractor's Service Area. In said area, the Contractor shall require that non-English speaking Enrollees have a choice of at least two PCPs who can provide services to, and speak to the Enrollee in his or her

primary language provided that such PCP capacity exists within the Service Area. To the extent such PCP capacity does not exist, the Contractor shall develop alternative arrangements acceptable to the Authority.

D. Access for Enrollees with Disabilities

The Contractor shall require access to Covered Services for Enrollees with disabilities by ensuring that physical and communication barriers do not inhibit Enrollees with disabilities from obtaining services from the Contractor's Plan.

Issue 8. Sustainability of Connector Premiums

There is widespread concern that health care costs for the Connector insurance products will grow at an unsustainable rate due, in part, to the early enrollment of a high utilizing population, mandated coverage criteria and diminished bargaining power of the Connector. What steps can be taken to help control the growth of rates of Connector products?

With nearly 160,000 individuals enrolled in Commonwealth Care by the beginning of December, the program is exceeding its 2007 budgeted enrollment goal of 136,000, even though there are likely more than 200,000 individuals still uninsured in the Commonwealth. Focus is now shifting to managing the financial and clinical issues evolving from this newly insured population in Commonwealth Care.

The Connector has reported at its recent board retreat and last two board meetings that there are valid concerns that the Connector may be facing a double digit rate increase for its heavily subsidized Commonwealth Care population. This could add $60-80 million to the cost of Commonwealth Care to the state in the next year. The Connector is discussing using a number of levers that can help mitigate the premium increases for its Commonwealth Care population. Included are: restructuring auto-assignment; addressing provider reimbursement rates; adjusting co-pays and out of pocket maximums; pharmacy management; modifying dental benefits; merging plan types III and IV; providing reinsurance for plan types III and IV; instituting risk adjusted premiums; and performing contract audit review. These are baseline strategies that should be enacted to help validate expenditures and provide a competitive bid environment for rate negotiations. There are other areas that merit further study by the state to determine if they would have a positive impact on decreasing the premium rate increases for the coming years.

- ***Encourage enrollment of younger and healthier population through the Connector versus directly through private carriers***.

  Private carriers have been deliberate in marketing to the younger and healthier populations for their plans. There has been a notable increase in advertising and media coverage from the private plans following the passing of the initial November 15, 2007 deadline for enrollment through the Connector, offering to extend enrollment to individuals through December 31st. This may be related to the tendency of younger and healthier individuals without health insurance to wait until the very end to enroll in a health plan to reduce their expenses for the year. This is a population that the Connector must compete for especially in the Commonwealth Choice plans to help balance its medical risk ratios by offsetting the existing medically needier population that has enrolled earlier this year.

- ***Modify benefit composition and individual contribution amounts to reduce premiums and promote consumerism in seeking cost effective services.***

Although raised by the Connector as a cost control lever to utilize (adjusting co-pays and out of pocket maximums), this area should be strongly considered for individuals participating in Commonwealth Care. Since the program is heavily subsidized, the issue of weighing impeding access to care (by increased individual payments), to the state being able to continue to afford the coverage in general, should be assessed. Preliminary review by the Connector of patient service utilization patterns revealed some problematic issues, including:

1. The Connector reports that Fallon Health Plan has witnessed use of emergency rooms from its Commonwealth Care population at the rate of 669 visits per 1,000 population, versus average use by its commercial population of 200 visits per 1,000. Since Commonwealth Care members are required to have the same coverage benefits as MassHealth, there are no co-payments for emergency room visits. With no financial consequences to continuing to use emergency room services like Uncompensated Care Pool patients, individuals insured through Commonwealth Care are not accessing the more cost effective service options offered by insurance coverage. There should be a balance of co-payments and incentives to promote more cost effective consumer choice of service selection, use of preventative and early intervention services, and adherence to treatment protocols and compliance with medication regimens to help reduce health care costs.
2. The Connector also indicated that the $1 and $3 co-pay differential between generic drugs and brand name drugs is not large enough to promote cost effective choices. Recent input from GIC related to utilization of generic drugs, indicated a significant interest in increased consumerism as individual out of pocket costs are impacted.

- ***Audit the MMCOs to confirm incurred costs, assure performance of cost effective utilization management and pharmaceutical management, and negotiation of competitive rates with participating provider institutions and clinicians.***

  Also suggested by the Connector (addressing provider reimbursement rates; perform contract audit review), this action is essential, in part, because the two largest MMCOs are owned and managed by the largest contract provider in their respective networks. Comparative enrollment practices, utilization trends, clinical outcomes and provider reimbursement rates should be analyzed to assure a level playing field in these MMCO contracts. There have already been alleged attempts by an MMCO to violate the contract by attempting to manipulate enrollment through unauthorized marketing to the Connector population which proposed to restrict access to providers.

- ***Combine the bargaining power of all state purchasers including the Connector, MassHealth, the Group Insurance Commission (GIC) and other public sector financed purchasers when negotiating with the health plans and provider groups.***

  One of the limiting factors in rate negotiations with any health plan or provider is the lack of volume to impact the plan or provider to obtain the best rates possible for the population represented. The Connector began with an unknown potential membership size and a lack of historical utilization experience, together with mandated restricted use of a limited health plan group (MMCOs). The open enrollment process seemed to be the only effective drive to reduce rates because it was correctly assumed that this population, who was involuntarily enrolled, tended to be less needy of medical services. Although the current Connector

population of 160,000 represents a more considerable impact on the health plans and providers, more is needed to assure bargaining power to impact future rate increases. Combining the bargaining power and administrative capabilities of the major public payers in rate negotiations to assure the best possible impact on providers and payers should be explored. When combined, the Connector, MassHealth and GIC represent almost 1.5 million members, the largest single purchasing group in the state by far. This number can be further increased by the addition of other municipalities who may join GIC in the future. Although not all of this collective membership will flow through the plans and providers affected by the Connector, this could still have a positive impact on rate negotiations and increased effectiveness of collective negotiating standards and other cost saving activities on behalf of this entire state funded population.

As part of this effort to seek the advantages of combined administrative capabilities and purchasing power, the Health Safety Net program should be assessed for the status of implementation of improved provider utilization management and reimbursement practices. This program, designed to serve a large but diminishing population over the next few years, is the key financial resource for future funding of the subsidized Connector insurance programs of health reform.

- ***Consider reinsurance for high dollar cases that will have a positive impact on premiums***.

  This strategy was also suggested by the Connector (providing reinsurance for plan types III and IV) and should be strongly considered for all state funded populations. Actuaries should be engaged to determine the most advantageous reinsurance levels to purchase to cap the medical cost liability of the health plan and reduce premiums accordingly. Together with this reinsurance process, an active chronic care management program and end of life service initiatives (such as those being studied by the Health Care Quality and Cost Council) should be enacted for all state funded populations, to provide member and provider incentives to help manage the costs of the 10-15% of individuals who are responsible for over 75% of high dollar medical costs experienced by the state and most other payers.

- ***Implement strong Determination of Need and other regulatory controls to stem widespread high dollar capital project;, and consider reinstituting rate setting to monitor cost increases while the newly insured population begin to settle into more stable utilization patterns.***

  In the past few years, hospital capital projects under the state's Determination of Need program have grown tremendously with no end in sight. Since calendar year 2004 to the present, the Department of Public Health reports that nearly $1.5 billion of hospital capital projects have been approved, whose costs will eventually impact health care reimbursement formulas in the future. Although some of this construction represents necessary renovations for safety, appropriate modernization and need-based expansion and technology accommodation, high cost project trends have begun to emerge in what is now considered the most expensive health care market in the world (Massachusetts).

  Reports from DHCFP indicate that over a recent 10 year period (1993-2003), lower cost community hospital bed capacity has decreased by almost 50% and

higher cost teaching hospital bed capacity has increased by more than 30% in the Commonwealth. New capacity being added by teaching hospitals is coming into the market at the highest rates in the state while drawing more patients from community hospital service areas. Over 75% of the net increase of hospital discharges in the state is coming from teaching hospitals.

Recently, through various hospital and physician alliances and mergers, it appears that inflated hospital and physician rates have emerged in community settings with no significant changes in service quality or intensity. This inflationary competitive activity is also impacting community hospitals and non-aligned providers who may eventually seek legislative appropriations to maintain adequate levels of services and counter subsequent losses.

Consideration should be given to standardizing hospital and physician rates for routine services that are commonly provided in community settings, at community rates, regardless of where they are provided. Greater use of community health centers should be encouraged and supported. It is suggested that the state study the re-institution of provider rate setting and the strengthening of the Determination of Need program so both processes can work collaboratively to assure that new capital costs are warranted, and that the expanded capacity at teaching hospitals, and among their network providers, are priced favorably to the state, communities and consumers.