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December 17, 2008

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

Dear Senators and Representatives:

Pursuant to section 132 of Chapter 58 of the Acts of 2006, I am pleased to provide the General Court with the latest 60-day report on the Patrick Administration's progress in implementing Chapter 58. The last two months have brought significant advancement in the implementation of Chapter 58 as we continue to meet the deadlines for various provisions of the law and enroll people in health insurance at historic rates.

In the last two months of health care reform, Massachusetts had reached an important milestone with the launch of the Health Care Quality and Cost Council's consumer website (www.mass.gov/myhealthcareoptions). The website, as reported in Section 8, offers consumers, providers, employers, and policymakers comparative cost and quality information about medical procedures performed at Massachusetts hospitals and outpatient facilities. It is a significant advance in price transparency for the state, which will continue to evolve as the Council and Patrick Administration work to contain health spending.

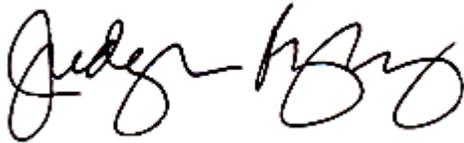
The past two months have also been noteworthy for the Administration's efforts to assist individuals and small business in need of health coverage. The Connector (Section 2) has launched a pilot Contributory Plan for small business, which allows employees of small business to choose from a variety of plans offered by different insurance carriers that would not otherwise be available. Coverage will be effective on February 1 of next year and plans to expand the pilot are underway. For those who have not been able to obtain

coverage in 2008, as reported in Section 8, the Connector has extended the “penalty-free” period for a gap in insurance coverage from 63-days to three months. As we have remained committed to ensuring universal access to health care, the Patrick Administration is also continuing to explore all options to expand affordable coverage.

Looking ahead to the next 60-day period, the Patrick Administration will continue to focus on cost containment strategies and community outreach. The Health Care Quality and Cost Council is in the process of developing the *Roadmap to Cost Containment*, to identify specific changes in the organization, delivery, financing and regulation of health care in Massachusetts that will enable the Commonwealth to better contain health spending. MassHealth (Section 1) is also renewing the EOHHS Outreach and Enrollment Grant Program for FY09. The grant program will award grants to community and consumer-focused public and private non-profit organizations for activities including outreach, enrollment, application assistance and annual open enrollment and eligibility review processes. Grant awards will be announced in February.

If you would like additional information about the activities summarized in this report, please do not hesitate to contact me or my staff.

Sincerely,

A handwritten signature in black ink, appearing to read "JudyAnn Bigby". The signature is fluid and cursive, with the first name "JudyAnn" and the last name "Bigby" clearly distinguishable.

JudyAnn Bigby, M.D.

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

Chapter 58 Implementation Report Update No. 16

Governor Deval L. Patrick

Lieutenant Governor Timothy P. Murray

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

December 17, 2008

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Section 1: MassHealth Update

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

Insurance Partnership

MassHealth successfully implemented an increase in the income limit for eligibility in the Insurance Partnership from 200% to 300% of the federal poverty level (FPL), on October 1, 2006. This expansion allowed a larger number of low-income Massachusetts residents who work for small employers to participate in the IP program. As of November 2008, there are over 7,220 policies through the Insurance Partnership with close to 15,704 covered lives. More than 5,637 employers participate in the program.

Children's Expansion up to 300% FPL

On July 1, 2006, MassHealth implemented expansion of MassHealth Family Assistance coverage to children in families with income greater than 200%, and up to 300% of the FPL. As of November 2008, there were 57,200 children enrolled in Family Assistance, up from 30,000 in June 2006. Approximately 22,300 of those children are new members and/or converted Children's Medical Security Plan members enrolled as a result of the income expansion.

MassHealth Essential

Effective July 1, 2006 the enrollment cap for MassHealth Essential was increased from 44,000 to 60,000. This allowed MassHealth to enroll more than 12,000 applicants who were on a waiting list at that time. As of November 2008, Essential enrollment was 64,700.

EOHHS Outreach and Enrollment Grant Programs

The FY09 state budget has appropriated \$3.5 million for a MassHealth outreach grant program. The grant program will award grants to community and consumer-focused public and private non-profit organizations for activities including outreach, enrollment, application assistance and annual open enrollment and eligibility review processes. Grants will also focus on providing education to new enrollees on how to use their health insurance and the importance of establishing strong primary care community connections to manage their health needs. Outreach and enrollment will be directed at both subsidized and non-subsidized state-enabled health care programs.

MassHealth has posted an RFR to solicit proposals from qualified bidders to perform these activities. Selected grant recipients are targeted to be announced early February 2009.

In the interim, the previous grant cycle direct service grantees were offered a short-term grant award to continue the important outreach and enrollment

activities while a new RFR process takes place. The short-term grant contracts will end January 31, 2009.

The seven network coordination outreach grantees continue to build upon and coordinate outreach and enrollment activities within their networks. Monthly reporting indicates that the composition of these networks is diverse, including organizations that traditionally conduct outreach and enrollment activities along with organizations that have significant general public traffic but have not traditionally performed outreach and enrollment work. Lead organizations are making in-roads on establishing referrals within the networks to ensure uninsured individuals are being directed to organizations that can help them understand the available health insurance options and help with enrollment. Each network grantee is compiling a high-level fact sheet about their network. Information will include network membership and respective focus, strengths, strategies and geographic service area. Grantees are conducting activities throughout the '08 calendar year.

Health Care Reform Outreach and Education Unit

The Health Care Reform Outreach and Education Unit, as required in line item 4000-0300 of the FY08 budget, has been formally established in the Office of Medicaid, to coordinate statewide activities in marketing, outreach, and dissemination of educational materials related to Health Care Reform and to collaborate with the Executive Office of Administration and Finance, the Department of Revenue, the Division of Insurance, and the Commonwealth Health Insurance Connector Authority to develop common strategies and guidelines for providing informational support and assistance to consumers, employers, and businesses.

The Unit's overall functions currently include: supporting and managing EOHHS Outreach and Enrollment Grant Programs; supporting and managing Training and Technical Assistance to community providers, partners, and grantee organizations around health care reform policy and program changes; coordinating and collaborating with state agencies around health care reform policies, and messaging and outreach activities.

Training and Technical Assistance to Providers

The Unit currently manages and supports the MassHealth Training Forum program. This program holds quarterly training sessions in five regions of the state for providers and partners in the community on the latest program and policy changes relevant to health care reform. The Unit is responsible for assisting in identification of presentation topics and updates and the coordination of finalizing these educational materials. The October quarterly progress report indicates that 544 participants attended the October sessions. Presentation topics included: MassHealth policy update, NewMMIS, Health Safety Program

updates, Commonwealth Choice and other Connector updates, Disability Evaluation Services Process overview, and New Virtual Gateway updates.

January presentation topics will include a Department of Revenue presentation on upcoming tax filing season and schedule HC changes; MassHealth policy and program updates, New Virtual Gateway updates, New Medicaid Management Information System implementation updates and an overview of MassHealth premium assistance programs .

State Agency Collaboration

The Unit continues to meet with various state agencies to collaborate around outreach and dissemination of educational materials. The Unit has met and continues to meet with the Connector, Division of Health Care Finance and Policy, Department of Revenue, Department of Public Health, and Department of Transitional Assistance, Office of Refugee and Immigrants and the Division of Unemployment Assistance and is making strides on building stronger collaborative partnerships. These collaborative efforts are increasing agency-to-agency awareness of various processes and efforts across the secretariat, as well as identifying important information to disseminate to providers, partners and grantees.

Section 2: Connector Authority Update

The Connector continues to make progress in implementing many of the important initiatives contained in the health care reform law.

Commonwealth Care

As of December 1st, 162,726 individuals were enrolled in Commonwealth Care. 51,872 of these members (32% of the total) are responsible for paying a monthly premium and 110,854 (68% of the total) have no monthly premium.

Transition to the program's new customer services and premium billing vendor, Perot Systems, was successfully executed on November 3rd. In addition, staff has made several presentations to the Connector's Board of Directors on the MMCO re-procurement process for FY 2010. A Board vote on an RFP is anticipated for the near future.

Commonwealth Choice

As of December 1st, 19,247 individuals have obtained coverage through Commonwealth Choice. This figure includes 15,042 subscribers and 4,205 dependents. Commonwealth Choice Voluntary Plan subscribers—people who are purchasing their health insurance on a pre-tax basis through their employer—account for 1,140 of the total.

The Contributory Plan (CP) for small employers was launched on December 15th on a piloted basis with limited distribution through approximately 30 brokers. Ongoing evaluation will be performed prior to the launch of the full program. CP is an innovative product that allows employees in small businesses to choose from a variety of health plans offered by different insurance carriers. This kind of choice has not previously been available in the Massachusetts small group market. The Connector expects to begin enrolling businesses soon, and the first effective date of coverage will be February 1, 2009.

Additional Updates

Minimum Creditable Coverage

Minimum Creditable Coverage is the lowest threshold health benefit plan that a resident must obtain and maintain in order to be considered in compliance with the individual mandate. In November, the Connector Board voted to finalize revisions to the regulations on minimum creditable coverage. The approved revisions increase flexibility for compliance beginning in tax year 2009. For tax year 2010, they also add a few new standards and make some important clarifications.

Outreach and Communications

The Connector's outreach and communications efforts have continued through the Fall. In conjunction with the MassHealth Training Forum (MTF), staff

completed a series of educational sessions for outreach workers on a variety of timely topics, including the finalized MCC regulations, the launch of the Contributory Plan pilot and changes to the Commonwealth Care billing cycle.

In addition, the Connector continued its partnership with Associated Industries of Massachusetts (AIM) by undertaking a statewide series of educational sessions for employers regarding the finalized MCC regulations and the launch of the Contributory Plan pilot.

The Department of Revenue sent a mailing developed in collaboration with Connector staff to approximately 193,000 Massachusetts employers informing them of the effect that the finalized MCC regulations may have on their Massachusetts employees.

Appeals

The Connector's Appeal Unit has reviewed all tax year 2007 mandate penalty appeals received to date. As of December, over 7,000 mandate appeals have been addressed, and approximately 400 hearings have been held. The Connector has also finished working with the Department of Revenue on the TY 2008 Schedule HC Tax Form and is finalizing related notifications and appeal procedures for TY08, in preparation for the month-to-month penalty calculations.

The Connector has started discussions with the Department of Revenue regarding the minimum creditable coverage standards that will be effective as of January 1, 2009 and the appeals that will result from the new standards.

The Connector's appeals function for the Commonwealth Care program is growing. The appeals volume has grown from approximately 120 appeals in 2007 to approximately 4,500 appeals to as of December 2008.

Section 3: Individual Mandate Preparations

The Department of Revenue (DOR) reports the following progress on Chapter 58 initiatives:

Tax Year 2008 Preparations:

In 2008 and beyond, residents 18 and over who can afford health insurance are required to have coverage for the entire year, except for permitted 63-day gaps in coverage. Those who can afford health insurance but fail to comply face tax penalties for each month of non-compliance. In November, the Connector issued Administrative Bulletin 02-08 extending the “penalty-free” period for a gap in coverage from 63-days to three months in 2008.

In October, DOR issued for public comment the 2008 Schedule HC, which taxpayers will use to document compliance with the individual mandate. DOR incorporated many of the public comments and suggestions into the final 2008 Schedule HC, which is available on DOR’s website at www.mass.gov/dor. The Schedule HC reflects the fact that taxpayers do not face penalties for coverage gaps up to three months in 2008.

DOR continues to work closely with private insurance carriers to fulfill the Form MA 1099-HC requirements. DOR is also working with MassHealth and the Connector to issue the MA 1099-HC form to members with income over 150% FPL, as those under 150% FPL are not subject to penalties in 2008.

To assist taxpayers in completing the Schedule HC, DOR is working on an online video presentation as well as an online affordability calculator. Both are expected to be launched sometime in January concurrent with the start of the 2008 tax filing season.

Taxpayers who have been deemed able to afford health insurance may appeal the imposition of the penalty by claiming that, based on their individual circumstances, a hardship prevented them from purchasing health insurance. The determination of whether to grant an appeal is made by the Connector, based on standards set in state regulations. DOR and the Connector have been working together to implement the penalty appeals process for 2008.

Tax Year 2007 Data:

In June of 2008, DOR released preliminary information on the health insurance status of individuals based on 2007 tax filings received and processed at that time. DOR is preparing to release a report that will provide updated health insurance information on reported compliance along with information on certain demographic characteristics of uninsured tax filers.

Section 4: Health Safety Net Trust Fund and Essential Community Provider Trust Fund Grants

Health Safety Net Trust Fund Regulations

The Division of Health Care Finance and Policy implemented the Health Safety Net Trust Fund in October 1, 2007. The regulations can be found on the Division's website, www.mass.gov.dhcfp. Regulation 114.6 CMR 13.00 addresses eligibility criteria for reimbursable services, the scope of health services eligible for reimbursement from the fund, the standards for medical hardship, the standards for reasonable efforts to collect payments for the cost of emergency care and the conditions and methods by which hospitals and community health centers are paid by the fund.

The Division also implemented regulation 114.6 CMR 14.00 Health Safety Net Payments and Funding. This regulation sets out the conditions and methods by which acute hospitals and community health centers can file claims for services and receive payments from the Health Safety Net Trust Fund. The regulation implements the requirements of Chapter 58 to pay hospitals based upon claims using a Medicare based payment method. The regulation also implements the requirement that the Health Safety Net Trust Fund pay community health centers using the Federally Qualified Health Center visit rate. The regulation can be found on the Division's website, www.mass.gov.dhcfp under regulations, 114.6 CMR 14.00.

Effective July 1, 2008, the Division adopted technical corrections and clarifications to regulations 114.4 CMR 13:00 Health Safety Net Eligible Services and 114.4 CMR 14.00 Health Safety Net Payments and Funding.

The Division recently proposed amendments to the regulations that govern the Health Safety Net. Amendments to regulation 114.6 CMR 13.00 Health Safety Net Eligible Services were largely technical clarifications. Amendments to regulation 114.6 CMR 14.00 Health Safety Net Payments and Funding set out adjustments to the HSN payment system to more closely reflect the Medicare based system required by the health care reform law. A public comment period was conducted for the eligibility regulation and a public hearing was conducted on September 11, 2008 for the payment regulation. Regulations were adopted and took effect on October 1, 2008.

Essential Community Provider Trust Fund

Another responsibility of the Health Safety Net Office under Chapter 58 and as amended by Chapter 118G Section 35 (b)(6) is to administer the Essential Community Provider Trust Fund. The purpose of this fund is to improve and enhance the ability of hospitals and community health centers to serve populations in need more efficiently and effectively including, but not limited to,

the ability to provide community-based care, clinical support, care coordination services, disease management services, primary care services and pharmacy management services. Selection criteria include the institution's financial performance; the services they provide for mental health or substance abuse disorders, the chronically ill, elderly, or disabled; and the pace, payer mix, prior years awards, cultural and linguistic challenges, information technology, twenty-four hour emergency services and extreme financial distress.

The Division of Health Care Finance and Policy, working with the Executive Office of Health and Human Services, developed a grant application process and scoring/review system similar to the process employed last year. For 2007, the process considered applicants' financial and essential characteristics in order to determine grant allocation amounts from the \$28 million dollar fund. A cover letter, grant application, and instructions were sent to providers and posted on EOHHS/DHCFP websites on July 13, 2007. Hospital and community health center applications were due on July 31, 2007. Over 80 hospitals and community health centers have applied and requested over \$108 million in funding.

A supplemental budget appropriation passed by the legislature and approved by the Governor included additional funding of \$9.5 million for the Essential Community Provider Trust Fund, for a total of \$37.5 million.

In October 2007, the EOHHS announced 69 provider grants from the Essential Community Provider Trust Fund. The distribution of grants awards included:

- Twenty-five acute care hospitals for a total of \$26.7 million representing approximately 72% of the funding available. The average grant award was \$1.1 million
- One non-acute care hospital received a \$2 million grant. This represents approximately 5% of the total funding available.
- Forty-three community health centers received a total of \$8.8 million. The average grant award is \$205,000 representing approximately 24% of the funding available.

The Division has contracted with all 69 hospitals and CHCs and has distributed approximately \$37.2 million of the total \$37.5 million in funding as of June 6, 2008. All providers are required to complete a standard report on the use of the funds in February and in April. These reports are reviewed by the Division and used to determine the timing of any additional payments to providers from the ECPTF. All providers except for one facility have submitted the final standard report on the use of the funds for FY 2008 to the Division.

FY 2009 Essential Community Provider Trust Fund

On November 24, 2008, the Secretary of EOHHS sent a cover letter, application, and instructions detailing the specific requirement for the Essential Community Provider Trust Fund for FY 2009. This information was also posted on the EOHHS and Division websites. Responses from providers are due to the Division of Health Care Finance and Policy no later than December 15, 2008. EOHHS and the Division will use a similar evaluation process for the FY 2009 ECPTF as the prior year since the criteria for awarding the funding is almost identical to FY 2008.

The ECPTF is funded at \$25M in FY 2009. This is less than the total funding of \$37.5M in FY 2008, however the ECPTF language requires EOHHS to maximize allowable federal reimbursement under Title XIX and states that the maximum expenditures from the fund can not exceed \$37.5M. EOHHS and the Division are currently examining available options to maximize FFP. As required by Chapter 182 § 88(d) of the Acts of 2008, a report summarizing the distribution plan for the ECPTF for FY 2009 and the extent to which expenditures may qualify for federal financial participation was provided to the House and Senate Ways and Means in mid September. EOHHS is still considering other options that may further increase federal financial participation matching on this fund.

EOHHS will distribute payments in the form of provider rates and as payments under the provisions of 815 CMR 2.00. Providers do not have to file an application to participate in provider rate distributions, if any, from the Fund. However, providers must submit an application to be considered for grant distributions from the Fund.

Section 5: Public Health Implementation

Community Health Workers (CHWs)

Community health workers are critical to the ongoing success of Health Care Reform. Under Section 110 of Chapter 58, the Massachusetts Department of Public Health (MDPH) is required to make an “investigation relative to a) using and funding of community health workers by public and private entities, b) increasing access to health care, particularly Medicaid-funded health and public health services, and c) eliminating health disparities among vulnerable populations.”

The *Community Health Worker Advisory Council* is chaired by MDPH Commissioner John Auerbach and was first convened in August, 2007. It has met quarterly since. In addition to the fourteen named organizations in the legislation, fifteen other organizations were identified as key stakeholders and have participated in the Council, yielding a working body including officials of multiple state agencies and representatives from the state community health worker (CHW) association, health providers, insurance, higher education, employers, CHW training organizations, and advocates. The Council was divided into four sub-committees; each of which met frequently to address legislative mandates:

- The **Research Workgroup** investigated the impacts of CHWs on increasing access to health care, quality of care, health outcomes, system costs, and eliminating health disparities among vulnerable populations. The workgroup employed a combination of quantitative and qualitative methods.
- The **Survey Workgroup** developed, administered and analyzed the results of a CHW employer survey that addressed the use and funding of CHWs by public and private organizations in Massachusetts. Conducted under contract with the University of Massachusetts Medical School, the survey was completed by CEOs or senior program managers of 187 eligible employers across the state.
- The **Workforce Training Workgroup** assessed the current status of CHW training in the Commonwealth, and developed recommendations related to workforce development, including a CHW training curriculum and a statewide certification program. Toward this end, the Workforce Training Workgroup conducted a range of activities to gather information to assist with the development of recommendations.
- The **Finance Policy Workgroup** developed recommendations for public and private sector funding for a sustainable statewide CHW program.

A Steering Committee also met almost weekly from March through June to coordinate the work of the different sub-committees. The CHW Advisory Council's final report is in production.

Section 6: Insurance Market Update

Health Access Bureau

Chapter 58 of the Acts of 2006 directs the Division of Insurance to establish a Health Care Access Bureau within the Division of Insurance. The actuary and research analyst are in place and working on projects. The Bureau continues to work to recruit a financial analyst. The Bureau has contracted with outside actuaries to develop targeted reports.

Minimum Standards and Guidelines

Chapter 58 of the Acts of 2006 directs the Division of Insurance, in consultation with the Connector, to establish and publish minimum standards and guidelines at least annually for each type of health benefit plan provided by insurers and health maintenance organizations doing business in the Commonwealth. The Division of Insurance is developing guidelines, working with the Connector, the insurance industry and other interested parties and plans to publish standards in 2008. The Division of Insurance will finalize guidelines after the Connector releases revised Minimum Creditable Coverage regulations.

Section 7: Employer Provisions

Division of Health Care Finance and Policy

Division of Health Care Finance and Policy (DHCFP) reports the following progress on implementation of the requirements imposed on employers by Chapter 58.

Employer Fair Share Contribution

The Division of Health Care Finance and Policy adopted 114.5 CMR 16.00: Employer Fair Share Contribution on September 8, 2006. This regulation governs the determination of whether an employer makes a fair and reasonable premium contribution to the health costs of its employees, as required by Chapter 58. The Division has determined that Section 16.03 (2) (a), "Employee Leasing Companies," requires clarification. Under that section, employee leasing companies will be required to perform the fair share contribution tests separately for each client company. Although the employee leasing company is responsible for collecting and remitting the Fair Share Contribution on behalf of its client companies, the client company is responsible for any Fair Share Contribution liability.

The Division of Unemployment Assistance held a public hearing on its proposed regulations governing the administration and collection of the Employer Fair Share Contribution. The regulations were subsequently adopted.

The Division of Health Care Finance and Policy proposed amendments to regulation 114.5 CMR 16.00, which governs the Employer Fair Share Contribution. The proposed amendments would have required employers of eleven or more full time equivalent workers to enroll at least 25% of their full time workers in their employer sponsored group health plan and to make a contribution of at least 33% of the cost of the premium. A public hearing on the proposed regulation was held on September 5, 2008. At the hearing, businesses expressed concern with some aspects of the proposal. After considering the testimony, the division modified the proposal and adopted the regulation on September 30, 2008. The regulation is effective January 1, 2009 and allows employers of 50 or fewer full time equivalent (FTE) workers to satisfy the Fair Share requirements by meeting either the 25% enrollment standard or the 33% contribution standard. Employers with more than 50 FTE's must meet both the enrollment and contribution requirements unless the employer's enrollment percentage is equal to or greater than 75%. The regulation also changes the test from an annual basis to a quarterly basis as required by Chapter 302 of the Acts of 2008.

Employer Surcharge for State-Funded Health Costs

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

The Division adopted regulation 114.5 CMR 17.00 on an emergency basis on July 1, 2007. The regulation reflects the amended legislation, clarifying that a "non-providing employer" subject to surcharge is an employer that does not comply with the requirement in M.G.L. c. 151F to offer a Section 125 cafeteria plan in accordance with the rules of the Connector. The effective date of the regulation is consistent with the July 1, 2007 effective date of the Section 125 cafeteria plan requirement implemented by the Connector. The Division conducted a public hearing on the emergency regulation on September 6, 2007 and has subsequently certified the regulation.

Health Insurance Responsibility Disclosure

The Division of Health Care Finance and Policy initially implemented M.G.L. c. 118G, § 6C through its adoption of 114.5 CMR 18.00: Health Insurance Responsibility Disclosure. It was adopted as an emergency regulation effective January 1, 2007, but subsequently repealed the regulation. Chapter 450 of the Acts of 2007 changed the effective date of M.G.L. c. 118G, § 6C from January 1, 2007 to July 1, 2007.

The Division adopted regulation 114.5 CMR 18.00 Health Insurance Responsibility Disclosure on an emergency basis on July 1, 2007. The regulation incorporates the provisions of Chapter 324 which significantly reduce the amount of information the Division is required to collect from employers. In addition, only employees that have declined to enroll in employer sponsored insurance or to participate in a Section 125 cafeteria plan are required to sign an Employee HIRD form. Employers will retain Employee HIRD forms and will submit them upon request by either the Division of Health Care Finance and Policy or the Department of Revenue. The Division has posted a copy of the Employee HIRD on its website at:

http://www.mass.gov/Eeohhs2/docs/dhcfp/g/hcr/employee_hird_08.pdf

The Division conducted a public hearing on the emergency regulation on September 5, 2007 and subsequently certified the regulation.

Division of Unemployment Assistance

The Division of Unemployment Assistance at the Executive Office of Labor and Workforce Development reports the following progress on the implementation of provisions of Chapter 58 affecting employers.

Employer Fair Share Contribution (FSC)

The second annual FSC filing period began on October 1, 2008, for the 12-month FSC liability determination period from 10/1/07 – 9/30/08. The timely filing due date for this year's filing was November 15, 2008. As of early December, about 62% of the 34,000 employers required to file had done so. DUA is pursuing the remaining non-filers.

DUA is preparing for the implementation of the new regulations promulgated by the Division of Health Care Finance and Policy (DHCFP), which introduces more stringent criteria for employers with over 50 full-time equivalent employees to meet the test for making a fair and reasonable contribution to its employees' health care coverage. The new test criteria will take effect on January 1, 2009, and will be reflected in filing and payment activity due in May of 2009.

Following the enactment of Chapter 302 of the Acts of 2008 on August 8, DUA began the process of revamping its FSC procedures, notices, and automated systems to accommodate the transition to a quarterly filing and liability determination schedule. The first quarterly report by employers will cover the period 10/1/08 – 12/31/08, and will be due by February 15, 2009. Notices to File, accompanied by information about the new "fair and reasonable" tests and the change to quarterly liability determinations, were sent to employers on Dec. 12, 2008.

In response to the business community's request to minimize the burden to employers created by the legislative change to a quarterly filing / liability determination schedule, DUA has worked with A&F and DHCFP to develop a "filing simplification" approach, since most filers are not liable for FSC payments. Under this approach, all employers will be required to file in the first quarter of the year, but only those employers previously liable for FSC and those at risk of not passing the "fair and reasonable" test in subsequent quarters will be required to file each quarter. All other filers will certify annually their liability status in each non-filed quarter of the year.

Section 8: Health Care Quality and Cost Council

FY 2009 Priorities

At its June 30, 2008 retreat, held at Worcester State College, the Health Care Quality and Cost Council established two over-arching priorities for state fiscal year 2009:

- 1) Successfully launch and expand the Council's consumer-friendly health care quality and cost information website; and
- 2) Develop a Roadmap to Cost Containment for the Commonwealth of Massachusetts.

Website Development

On December 10, 2008, the Council launched its website (www.mass.gov/myhealthcareoptions) that provides comparative cost and quality information about health care services in a user friendly format, as required by M.G.L. c.6A, s.16L. The website includes quality and cost information for 18 inpatient hospital conditions and procedures and 18 outpatient diagnostic procedures, as well as overall hospital patient safety and patient experience measures. Over time, the Council will expand the data available on its website to include additional cost and quality measures calculated from its claims dataset, including measures for a broad range of health care facilities and services.

Health Care Data

Council staff sent each hospital and each health plan its own data for review in order to ensure that the data displayed on the website is accurate. In general, health plans and hospitals verified that the data is accurate. Staff will review and verify specific data elements in the limited number of cases where hospitals noted a difference between the Council's data and their own data.

Web Application Development

The Council's Web Application Developer, Medullan, Inc., built the web application in accordance with the Council's design specifications. The Council's Clinical Consultant, Dr. John Freedman; its Health Literacy Consultant, Helen Osborne; and its Communications vendor, Solomon McCown, worked together to draft text for the site to explain the data presented on each page.

Medullan implemented recommendations from the Council, the Council's Advisory Committee, and members of the Health Care for All consumer quality group to improve the web application's ease of use. Medullan has demonstrated that the website has met accessibility standards required by the Americans with Disabilities Act.

Roadmap to Cost Containment

In 2007, the Health Care Quality and Council established a goal to reduce the annual rise in health care costs to no more than the unadjusted growth in Gross Domestic Product (GDP) by 2012.

The Council is committed to developing a “Roadmap to Cost Containment” to demonstrate in concrete terms how the Commonwealth could accomplish this goal. The purpose of the Roadmap is to identify specific changes in the organization, delivery, financing and regulation of health care in Massachusetts that will enable the Commonwealth to achieve this cost containment goal; to recommend strategies and timelines for implementing those changes; and to build broad support for this plan. The Council will submit this Roadmap to the legislature for consideration.

The Council selected Bailit Health Purchasing, LLC, as its Roadmap Director vendor to guide and coordinate the work of the Council and its Committees in developing the Roadmap. This vendor will help to organize and facilitate the Roadmap development, including ensuring participation from a broad cross-section of stakeholders and using critical data to inform the Council’s deliberations and recommendations

The Council also established a Cost Containment Committee, which will manage Bailit and oversee the development of the Roadmap.

Section 9: STATUTORY CHANGES TO CHAPTER 58 SINCE ENACTMENT

The Legislature has enacted four amendment bills since Chapter 58 first became law in 2006. The most recent amendment bill enacted was Chapter 305 of the Acts of 2008, which aimed to build on health care reform by promoting cost containment, transparency and efficiency initiatives. It focused on systemic challenges in the Commonwealth and encouraged further innovation in the development of long-term quality and cost improvement strategies.

Prior to Chapter 305, the Legislature enacted Chapter 205 of the Acts of 2007 to ensure that health care reform works as intended. It addressed some operational challenges encountered or anticipated by state and independent agencies charged with implementing various aspects of reform.

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