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August 14, 2007

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

Dear Senators and Representatives:

Pursuant to section 132 of Chapter 58, I am pleased to provide the General Court with the eighth update on out progress in implementation of Chapter 58. We continue to make significant progress towards full implementation as we complete various requirements of the law. July 1, 2007 marked the initial target enrollment date for compliance with the individual mandate. The MassHealth program has seen great success in enrolling additional members into the Insurance Partnership program and, as of July 1, 2007, has enrolled an additional 4,320 people in health plans through this program. Additionally, 15,600 new and/or converted Children's Medical Security Plan members have been enrolled in MassHealth Family Assistance and approx 8,000 individuals have been enrolled in the expanded Essential program for the long-term unemployed. Overall enrollment in MassHealth continues to grow due to eligibility expansions and ongoing outreach and enrollment efforts. As of August 1, 2007 the Massachusetts Health Insurance Connector Authority successfully enrolled 105,000 people in subsidized health insurance programs who have incomes at or below 300% of the federal poverty level ($30,630 annual income for an individual).

The Commonwealth reached another landmark achievement in July when individuals enrolled in Commonwealth Choice, the Connector's commercial health insurance

program, began receiving coverage. These plans include the three benefit levels of Gold, Silver, and Bronze, as well as the newly designed Young Adult Plans for individuals aged 19-26. As of August 1, 2007, over 5,000 individuals were receiving health insurance coverage through these new commercial products. The Connector is equippe d with the ability to give direct premium quotes over the phone and explain the new options available to individuals throughout the state. We are pleased that the Connector has experienced a very high call volume as residents take advantage of the new opt ions available to them.

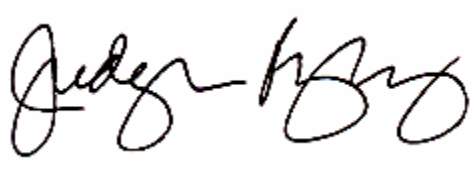
The great successes experienced in expanding access to health insurance is due in large part to the many outreach efforts being undertaken by each of the state agencies involved and their many community partners. MassHealth receiv ed funding in the FY 2008 Budget to continue awarding community outreach grants which have been a primary method of communicating the availability of new insurance products and opportunities with grassroots organizations and directly with communities. The Connector has continued strengthening partnerships with organizations such as the Boston Red Sox and New England Sports News to broadly distribute their message throughout the Commonwealth. Additionally, over the last few months, the Department of Revenu e, in conjunction with the Connector, has completed a direct mailing to each taxpaying individual and business in the Commonwealth informing them of the new options and requirements of the individual mandate. The availability of web -based information regarding health care coverage and information has continued to increase with the creation of a website for the Health Care Quality and Cost Council in addition to the existing sites for the Connector at www.Mahealthconnector.org and the educational site of www.gethealthcoverage.net.

In order to ensure that Chapter 58 implementation goes as smoothly as possible, many agencies have been partnering with members of the private community to pilot various aspects of implementation. Many insurance carriers worked through a pilot reporting program with the Department of Revenue in preparation for annual reporting of health insurance program. The employer community has been very involved in shaping the processes which will guide several key pieces of implementation over the coming year. The Division of Unemployment Assistance conducted a pilot test of the Fair Share Contribution system with 25 employers in the Commonwe alth to identify any potential concerns and ideas for improvement before the system is fully launched.

The many partnerships that have formed throughout the implementation of health care reform are the cornerstone to the success we have had to date. We c ontinue to work closely with the Legislature in implementing the many facets of Chapter 58 and identifying any key changes which will enhance the success of this reform effort. Business leaders, government agencies, the legislature, community organization s and individuals throughout the Commonwealth have contributed greatly to the success we have realized to date. It is with the continued sense of collaboration that implementation will achieve the best results and I am confident that together we will reac h our goals of increased access to care for every man, woman, and child in the Commonwealth.

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

Sincerely,



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. 8

Governor Deval L. Patrick

Lieutenant Governor Timothy P. Murray

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

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Section 1: MassHealth Update

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

Insurance Partnership
On October 1, 2006, MassHealth successfully implemented an increase in the income limit for eligibility in the Insurance Partnership from 200% to 300% of the federal poverty level (FPL). This expansion allowed a greater number of low-income Massachusetts residents who work for small employers to participate in the IP program. As of July 2007, the Insurance Partnership has added 4,321 covered lives through expansion of the program, exceeding projected goals for SFY 2007.

In accordance with Chapter 58 provisions, on July 1, 2007, MassHealth discontinued the Insurance Partnership (IP) employer subsidy for the self-employed. Advance notice of this change was mailed to approximately 4,280 affected self-employed members in mid-June emphasizing that employee premium assistance subsidies will continue. Subsidies for qualified employers and employees were not affected.

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% up to 300% of the FPL. As of June 2007, there were 54,700 children enrolled in Family Assistance, up from 31,000 in June 2006. More than 15,600 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 June 2007, Essential enrollment was 51,700. Given the amount of additional enrollment capacity for the program, MassHealth does not anticipate having to reinstate the waiting list for Essential.

Wellness Program
Section 54 of Chapter 58 requires that MassHealth collaborate with the Massachusetts Department of Public Health (DPH) to implement a wellness program for MassHealth members. It specifies five clinical domains: diabetes and cancer screening for early detection, stroke education, smoking cessation, and teen pregnancy prevention. The law mandates co-payment and premium reduction for members who meet wellness goals. However, since members do

not pay significant copayments or premiums, alternative incentives have been recommended.

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

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

In February the Wellness Program project management team developed a two-phase implementation process in order to permit the development of a flexible and sustainable incentive program and to ensure that MassHealth members and providers support and buy-in to the idea of wellness. The first phase began in June of 2007 with the distribution of the MassHealth Wellness Program brochure. Phase one focuses on promoting and educating MassHealth members about the concept of wellness and healthy lifestyle activities. This education is coordinated with the MassHealth providers and with support from the Department of Public Health. Phase two of the Wellness Program, the incentive system, is in the planning phase to be implemented following research about the best way to track wellness activities and provide incentives to MassHealth members. Implementing the Wellness program incentive system requires surveying the marketplace which will be accomplished with a formal Request for Information (RFI) to vendors throughout the state.

MassHealth has met as scheduled with the Wellness Program External Advisory Group to discuss outreach and education ideas and incentive options for members. Additionally the Wellness Program management has met with MassHealth executives and CMS to discuss federal support for the member incentive system being investigated through the RFI. Currently the RFI document is in its final draft and planned for distribution to the public in September 2007. Since early April, the Wellness Program team has completed the design, review, finalization, and distribution of an English and Spanish wellness brochure, as well as an all-provider bulletin to educate providers about the program. In June the brochure distribution through the PCC plan materials catalog and the MassHealth customer service team was completed. The MassHealth Wellness Program Manager presented at the regional MassHealth Training forums in July about the Program, with a focus on opportunities to use the brochure to educate new and current MassHealth members.

The project is on the following implementation time track:

- Creation of overall program structure: May through August 2006 (complete)
- Research and program design: September 2006 through February 2007 (complete)
- Phase 1 & 2 implementation planning: January through May 2007 (complete)
- Phase 1 outreach and education implementation: June 2007 (complete)
- Phase 1 and 2 program activities and development and subsequent evaluation: July 2007 and ongoing (on schedule)

As previously reported, the copayment/premium reduction to reward wellness efforts required in the law has proven problematic. Most MassHealth members pay no premiums, and those who do generally pay negligible amounts. Consequently, MassHealth and DPH have concluded that such an incentive structure would have little impact on member compliance, and are currently exploring alternative member incentives. The Office of Medicaid has recommended changes to the legislation to implement a different benefit for members that participate successfully in the Wellness Program. The FY08 Budget includes such language which will give MassHealth flexibility in designing incentives for wellness compliance.

Outreach Grants

In November 2006, MassHealth and the Commonwealth Health Insurance Connector Authority (Connector) awarded grants to community and consumer-focused public and private non-profit organizations for activities directed at reaching and enrolling eligible Commonwealth residents in MassHealth programs and the Commonwealth Care program.

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

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

The Fiscal Year 2008 budget appropriated $3.5million for these outreach and enrollment grants. MassHealth is currently consulting with the Commonwealth

Connector Authority and the UMass Office of Community Programs to formulate a revised Request for Response (RFR) for outreach grants that will be issued in August or September of 2007. The revised RFR will conform to new language in budgetary line item 4000-0352 requiring that FY08 grant recipients also provide outreach to enroll individuals in Commonwealth Choice. It is likely that the FY08 RFR will include the Model A but not the Model B grant format, because the Connector media and education campaign is filling this need. This will allow the Outreach grants to focus on the ever-increasing need to conduct face-to-face, hands-on outreach.

As required in line item 4000-0300 of the FY08 budget, MassHealth is also developing plans for a Health Care Reform Outreach and Education unit 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.

MassHealth Premium Changes

Effective July 1, 2007, MassHealth made two important changes to premium requirements in the program. First, MassHealth no longer charges premiums to enrollees in families with income less than 150% FPL. This change aligns MassHealth with the affordability standards established by the Connector.

Second, MassHealth premiums will be waived for children in MassHealth in families where there is a parent or caretaker who is enrolled in a Commonwealth Care health plan type that requires an enrollee contribution. MassHealth will check for Commonwealth Care enrollment status prior to monthly billing to determine if the premium should be waived. This is an important adjustment to the MassHealth program to help ensure that total health insurance costs are affordable to families participating in these programs. MassHealth sent notification to affected families in mid-June.

There has been a 44% decrease in the number of premium-paying members (from over 52,000 to fewer than 30,000) and a 24% decrease in premiums charged as the result of the premium elimination for members at or below 150% FPL and the waiver/suppression of children's premiums for families with parents in a Commonwealth Care plan.

Based on MassHealth data, there are approximately 11,000 families with premiums charged to children that can be potentially waived if a parent or guardian in the family is enrolled in a Commonwealth Care plan with a required enrollee contribution. About 26% of this population was eligible for a waiver of

premiums in July 2007. This percentage is expected to increase throughout the fiscal year as more Commonwealth Care-eligible parents enroll over time.

Section 2 Connector Authority Update

The Connector Authority has made significant progress in implementin g many of the important initiatives contained in the landmark health care reform legislation.

Commonwealth Care
Enrollment in Commonwealth Care is 104,807 as of August 1. Implementation and operationalization of the July 1 program changes have been compl eted. The income threshold for those individuals not paying a premium was raised from 100% to 150% of the Federal Poverty Level (FPL). New enrollment packages were recently sent to all eligible but not enrolled members between 100 and 150% FPL. Of the premium-payers, over 90% are paying on time. The Commonwealth Care call center continues to experience very high call volume and has added additional Customer Service Representatives to handle the increased volume and keep the abandonment rate low. The Connect or is also conducting a study to understand why those individuals eligible for the program have not yet enrolled.

The Connector recently signed 6-month contract extensions with the four Commonwealth Care MCOs, providing a 4% increase in payment rates for this additional six months. Current contracts will remain in place until June 2008. Planning has begun for an open enrollment period that will begin late this Fall. The Connector also recently completed 5 state-wide outreach sessions on Commonwealth Care and Health Care Reform.

Commonwealth Choice
The Connector's commercial program continues to grow since its May 1 launch and now has 5,046 members as of August 1. Call volume remains high at the Commonwealth Choice call center. Callers who provide their bir th date, zip code and industry in which they work are able to receive premium quotes over the phone.

Section 125
More than 2,500 businesses have signed up with the Connector to allow part-time and contract workers to purchase health insurance on a pre-tax basis. Among the employers who have committed to adopt Section 125 plans through the Connector are the Commonwealth of Massachusetts, Boston College, Boston Red Sox, DeMoulas Market Basket, Fidelity, Gap, Partners HealthCare and TJX. Administrative Bulletin 02-07 was issued instructing employers that they do not have to file Sec. 125 documents until October 1, 2007.

Website
The Connector's website, www.mahealthconnector.org, continues to experience a very high number of visits and new functionality is be ing developed to improve the shopping experience. Employer groups now have the ability to complete the

employer set-up and employee enrollment process online for Section 125 plans. In August, web capability in support of employer Section 125 plans will allow additional automated processing of pre-tax billing and premium payments from employers to the Connector for Commonwealth Choice. The website also offers comprehensive and regularly updated Frequently Asked Questions (FAQs) on insurance, Connector programs, and all matters of health care reform.

Affordability and Premium Schedule

The Connector board approved the affordability and premium schedules. These schedules are used to help individuals decide if insurance is affordable for them. The Connector's website has an interactive tool that helps people navigate the schedules to determine whether they will be subject to the mandate. An appeals and waiver process for the mandate is in development.

Marketing and Outreach

The Red Sox, as part of their partnership with the Connector, offered space on the big concourse at Fenway Park for a Health Connector information booth. The Connector began staffing this booth on July 1 and the booth will be staffed for all home games for the duration of the season. The booth serves as a place for people to receive information on the health insurance options available to them. Connector television ads are also running during Red Sox games on NESN.

Since the public education campaign was launched the Connector is receiving 50,000 inquiries a week through its website and call center. Ninety three employer outreach and training sessions have been completed. Further train-the-trainer events on Commonwealth Care and Commonwealth Choice are currently being scheduled. The Connector also completed a series of health insurance broker training sessions across the state.

Section 3: Changes in the Legislation

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

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

The Connector Authority

- Chapter 58 allowed for the creation of more affordable insurance products for young adults, ages 19 to 26. This language should be amended to allow 18 year olds to purchase young adult plans, because the individual mandate will apply to 18 year olds who may not be eligible for MassHealth or Commonwealth Care.

- Language in chapter 151F, as amended by Chapter 58, should be further amended to remove the requirement that the Connector collect section 125 plans from all employers. The Connector should maintain the authority to request any employer's section 125 plan, in help enforce compliance, but need not collect one from every employer.

Executive Office of Health and Human Services/ MassHealth

- The definition of "creditable coverage," for use in implementing the individual mandate should include coverage under Title XXI of the Social Security Act, the State Children's Health Insurance Program (SCHIP). SCHIP, as a comprehensive coverage plan, should be included as providing creditable coverage under Health Care Reform.

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

Division of Unemployment Assistance

- The Division of Unemployment assistance needs legislative authorization to share information it will receive from businesses concerning the health insurance they offer with the Division of Health Care Finance and Policy and the Connector Authority. The legislature, in section 17 of the FY 08 budget, intended to authorize DUA to share information with the Division of Health Care Finance and Policy, but did not authorize DUA to share information with the Connector. The Governor sent section 17 back with amendments to ensure that DUA can share information with both DHCFP and the Connector. The legislature has yet to act on those amendments.

Department of Revenue

- The Office of Medicaid currently collects health insurance information directly from insurance carriers to identify private health insurance for Medicaid patients and individuals who use the uncompensated care pool. This information can only be used for certain authorized purposes. An amendment would authorize the Division to share this information with DOR for purposes of enforcing the individual mandate.

- Technical amendments would allow the Connector, the Division of Health Care Finance and Policy and the Office of Medicaid to receive wage and tax information from DOR for the administration or enforcement of health care reform.

- Technical amendments are necessary to permit the use of social security numbers for MassHealth purposes only when submitting health insurance information to DOR in connection with the individual mandate. This exception is necessary because in most cases the MassHealth policy number is the social security number. A related amendment is necessary to allow DOR to release information received from insurance carriers to the Executive Office of Health and Human Services.

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

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

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

- Effective October 1, 2007, the Health Safety Net Office must promulgate regulations requiring acute hospitals to submit data "that will enable the department of revenue to pursue recoveries from individuals who are ineligible for reimbursed health services and on whose behalf the Health Safety Net Trust Fund has made payments to acute hospitals for emergency bad debt." Technical amendments would allow DOR to share wage reporting information with the Health Safety Net Office in order to determine financial eligibility and to intercept tax refunds to recover payments owed to the Health Safety Net Trust Fund.

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

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

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

Division of Insurance

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

- Changes made in section 4 of Chapter 4 50, which amended the Chapter 175 section 110(O), nondiscrimination of premium contribution provision by excluding stand-alone dental services from the requirement inadvertently dropped the provision to allow separate contribution levels under collective bargaining agreements.

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

Health Care Quality and Cost Council

- The Council is charged with collecting and publishing health care information for consumers on the internet. The Council is authorized to collect data from insurers and health care providers. The Council needs the authority to collect data from Third Party Administrators as well, because these entities administer the data for approximately half of all private payer health care claims.

- The initial date for a the Health Care Quality and Cost Council's public website to report cost and quality data should be updated to reflect a more realistic timeline for the Council. This language establishes new deadlines for publication of a website to September 1, 2007 and updates to the specific dates for comparative data to be posted to March 1, 2008 which is necessary for collection and aggregation purposes. In addition, the current language of the statute directs the Council to post data that has been aggregated for all insurers, but not data on an insurer by insurer basis.

Section 4: Individual Mandate Preparations

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

MA 1099-HC (for health care)

Beginning in 2008, insurance carriers and certain employers must send an annual written statement, called the MA 1099-HC, to every resident for whom coverage was provided in the previous calendar year. Taxpayers will use this statement, similar to other 1099-like statements, to transcribe the information from the MA 1099-HC onto the tax return. Every issuer of MA 1099-HC's will send the Department of Revenue (DOR) an electronic tape that contains all of the data on the MA 1099 HC's issued to their policyholders. DOR will match the data on the tax return to that data to verify the accuracy of the information provided by the taxpayer. In April, DOR, in partnership with six insurance carriers, began a health insurance pilot program, which concluded in July. The goals of the pilot were to:

- Identify the process by which MA 1099-HC data will be sent, to DOR and to subscribers;
- Identify the data elements and formats required for filing with DOR;
- Test registration;
- Test transmission of xml files; and
- Identify necessary business rules.

The pilot was successful for DOR and the carriers that participated and valuable lessons were learned that will assist us as we move forward with the remainder of the insurance carriers. The pilot phase confirmed that the overall strategy for verifying health insurance information reported by taxpayers is a workable solution by which carriers have the capability to comply. Furthermore, DOR was able to reduce the amount of information originally sought by DOR from the carriers, thereby making this effort more straightforward and less burdensome for both DOR and the carriers. The next steps are to continue to work with the pilot members and to start rolling out the process of registering and transmitting test files to all non-participating pilot members. Earlier this month, DOR initiated the next phase with non-participating pilot members. For more information about this process, please visit DOR's website at: www.mass.gov/dor/hcinfo.

2007 Tax Forms

The Department developed Draft Schedule HC for the 2007 tax return that will be used by taxpayers to report proof of health insurance. The draft copy of Schedule HC is available on DOR's website, www.mass.gov/dor/hcinfo, and is subject to revision based on comments and suggestions. Draft instructions and a worksheet to assist taxpayers in completing the Schedule HC will be posted on

DOR’s website later this month, and will also be subject to change based on public comments. The Department has also actively so ught the feedback of consumer groups and advocates to ensure that the form is as easily understood as possible.

Appeals Process

The Department continues to work with the Connector to develop an appeal process to allow taxpayers to claim that a penalty shou ld not be assessed because of a financial hardship that prevented them from purchasing coverage.

Outreach

The Department mailed close to 3 million postcards to taxpayers and over 193,000 letters to employers, informing them of the requirements under th e new law.

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

Health Safety Net Trust Fund Regulations

The Division of Health Care Finance and Policy is required to propose regulations implementing the Health Safety Net T rust Fund effective October 1, 2007. Chapter 58 requires that the regulations address eligibility criteria for reimbursable services, the scope of health services eligible for reimbursement from the fund, the standards for medical hardship, the standards f or reasonable efforts to collect payments for the cost of emergency care and the conditions and methods by which hospitals and Community Health Centers will be paid by the fund. In advance of this regulatory proposal, the Division conducted a consultative session on June 19, 2007. The purpose of the session was to solicit input from interested parties and stakeholders in order to inform the process of formulating policy options regarding services and eligibility under the new Health Safety Net Regulation s.

After considering the input received the Division issued proposed regulation 114.6 CMR 13.00 Health Safety Net Eligible Services. A public hearing is scheduled on this proposal for August 22, 2007.

The Division has also proposed regulation 114.6 C MR 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 propose d regulation implements the requirements of Chapter 58 to pay hospitals based upon claims using a Medicare based payment method. The proposed regulation also implements the requirement that the Health safety Net trust Fund pay Community Health Centers usi ng the Federally Qualified Health Center visit rate. A public hearing on this proposed regulation is also scheduled for August 22, 2007.

The Division looks forward to receiving comments and testimony regarding the proposed regulations and will carefully consider the points raised before adopting the regulation in September. The regulations are scheduled to go into effect on October 1, 2007.

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. The criteria for selection includes 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, has developed a grant application process and scoring/review system, similar to the process employed last year. This process will consider 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 have requested over $108 million in funding. DHCFP and EOHHS staff will review and score these applications based upon the criteria specified. After the process is completed, the Secretary of Health and Human Services will award these grants in mid September. It is anticipated that funds will be distributed to providers beginning in October 2007.

Section 6 Boards, Councils, Commissions, and Reports

Health Care Quality and Cost Council

The Health Care Quality and Cost Council has continued meeting regularly to make progress on the statutory goal of reducing cost while improving quality of care for the Commonwealth. The Council, Advisory Committee, and Subcommittees have heard from many experts and worked to shape an agenda for advancing cost and quality goals for Massachusetts.

Statewide Goals for the Commonwealth

The Health Care Quality and Cost Council established the following statewide health care quality improvement goals that are intended to lower or contain the growth in health care costs while improving the quality of care, including reductions in racial and ethnic health disparities. The Council established these goals as required by M.G.L. c.6A, s.16L.

1. Reduce the cost of health care. Reduce the annual rise in health care costs to no more than the unadjusted growth in Gross Domestic Product (GDP) by 2012.
   a. Promote cost-efficiency through development of a website providing comparative cost information. Develop a website that will enable consumers to compare the cost of health care procedures at different hospitals and outpatient facilities.
   b. Reduce health care spending by preventing the need for avoidable hospital stays.

2. Ensure Patient Safety and Effectiveness of Care:
   a. Reduce hospital-associated infections (HAI) during FY08. Eliminate hospital-associated infections by 2012.
   b. Eliminate "Never Events" as defined by the National Quality Forum. Eliminate events that should never happen in hospitals, such as wrong surgery, wrong site, or wrong patient.

3. Improve screening for and management of chronic illnesses in the community:
   a. Improve chronic and preventive care. Improve care of chronic diseases, such as congestive heart failure, diabetes and asthma.
   b. Reduce disease complication rates, readmission rates and avoidable hospitalizations.

4. Develop and provide useful measurements of health care quality in areas of health care for which current data are inadequate:
   a. Develop processes and measures to improve adherence to patients' wishes in providing care at the end of life. Ensure that health care

providers ask about and follow patients' wishes with respect to invasive treatments, do not resuscitate orders, hospice and palliative care, and other treatments at the end of life.

5. Eliminate racial and ethnic disparities in health and in access to and utilization of health care; health indicators will be consistent and consistently improving across all racial and ethnic groups:
   a. Reduce disparities in health care-associated infections.
   b. Eliminate disparities in "Never Events."
   c. Reduce, and ultimately eliminate, disparities in disease complication rates, readmission rates, and avoidable hospitalizations.
   d. Reduce disparities in screening and management of chronic illnesses.

6. Promote quality improvement through transparency:
   a. Promote quality improvement through development of a website and other materials providing comparative quality information.

Over the next few months, the Council will consider specific steps to advance these goals. These steps will include setting state standards and benchmarks; recommending specific actions necessary to achieve these goals; and estimating the costs of implementing strategies and the associated savings.

Website Development

The Council has also taken several steps toward creating a website that will provide comparative cost and quality information about health care services in a user friendly format, as required by M.G.L. c.6A, s.16L.

- First, the Council established a website at www.mass.gov/healthcare that includes links to other internet sites that display comparative cost and quality information, as required by St.2006, c.58, s.136.
- Second, the Council proposed a regulation that set standards for collecting claims data from insurers. The Council will use this data in order to post comparative cost and quality information by service and by provider on its website. The Council will also use this data to improve its understanding of both the drivers of health care costs and the variation in practice patterns and quality of care.
- Finally, the Council has issued two Requests for Proposals (RFPs) to solicit vendors to assist with this project. The first RFP is for a Web Design and Communications Consultant to develop methods to communicate health care quality and cost information in an easily understood format. The second RFP is for a Data Manager to collect claims data from insurers and edit, maintain and secure that data.

MassHealth Payment Policy Advisory Board

The MassHealth Payment Policy Advisory Board held its third meeting on July 20, 2007. Medicaid Director Tom Dehner chaired the meeting, and the board heard two presentations relating to pay-for-performance. The first presentation, by Elizabeth Pressman and Terri Yannetti of the Office of Acute and Ambulatory Care, described implementation of MassHealth's hospital pay-for-performance program. The second presentation, by board member Bob Seifert and Robin Weinick of Massachusetts General Hospital, described recommendations regarding pay-for-performance by the Massachusetts Medicaid Disparities Policy Roundtable. At the conclusion of the meeting, Division of Health Care Finance and Policy Commissioner Sarah Iselin distributed a draft version of a MassHealth provider payment rate method matrix that is expected to be discussed in detail at the next meeting of the board.

Attending the meeting were board members Tom Dehner, Deborah Enos, An Hee Foley, Vicker DiGravio III, Patricia Kelleher, Joe Kirkpatrick, Robert LeBow, Sarah Iselin, David Matteodo, Robert Moran, Scott Plumb, Mark Reynolds, Bob Seifert, and David Torchiana. Pat Edraos attended on behalf of Tristam Blake.

Section 7 Public Health Implementation

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

Prostate Cancer (Men's Health Partnership) (4513-1112) - $1,000,000
The Men's Health Partnership utilized this funding to strengthen and enhance existing services and activities related to prostate cancer. The primary focus was on outreach and education to high-risk populations to reduce disparities related to screening and outcomes. This included the redesign of all materials and the translation of education materials into 5 languages. Two targeted education campaigns were developed for both print and radio for four weeks each across 10 sites statewide. This categorical funding has been included in 4513-1111 Health Promotion and Disease Prevention line item.

Stroke Education (4513-1121) - $200,000
This initiative built on the current stroke program and focused on the development and dissemination of culturally appropriate stroke education materials in English, Spanish and Portuguese. The Spanish version marks the first time that a new product for stroke education has been developed specifically for Spanish speakers. In addition, the program worked with community-based Spanish organizations to educate leaders on use of the materials so that in can be incorporated with other educational efforts within Spanish communities. Spanish orientations have been scheduled in Boston and Lawrence with additional orientations planned. This categorical funding has been included in 4513-1111 Health Promotion and Disease Prevention line item.

Breast Cancer (Women's Health Network) (4570-1500) - 4,000,000
In 2006, the program expanded services to approximately 3000 women who would otherwise have been on a wait list for WHN services. In 2007, the program continued to rely on health care reform funding to supplement federal funding for provision of screening services and facilitation of outreach and education services. Work has continued on the Enterprise Invoice Management/Enterprise Service Management system to replace the current ACES information system. This proposed model is currently being reviewed and is expected to be modified significantly as more information becomes available regarding the effects of health reform on the program. The goal will be to target the resources to those individuals and areas of the state with the highest need to assure that all women receive screening services and referral for treatment if necessary. This categorical funding has been included in 4513-1111 Health Promotion and Disease Prevention line item.

Osteoporosis Prevention (4513-1115) – $250,000
This initiative has revised and updated the osteoporosis directory and the Home Safety Checklist. The Home Safety Checklist is an educational tool for seniors to

use to "fall proof" their home by doing simple things such as removing scatter rugs and using night lights. These materials are being distributed through the DPH Clearinghouse to elder agencies, Councils on Aging and other interested providers and individuals. In addition, the Department is promoting the Keep Moving program, a walking program for seniors, and publicizing a searchable physical activity inventory that includes updated walking clubs and programs for persons with disabilities. This categorical funding has been included in 4513 - 1111 Health Promotion and Disease Prevention line item.

Diabetes (4516-0254) - $350,000
The Diabetes Prevention and Control Program (DPCP) initiated several activities to identify and increase the number of individuals with undiagnosed diabetes or prediabetes, or who are at risk for these conditions, who undergo a risk assessment and, if appropriate, undergo screening for these conditions. Initiatives were also geared to providing community support for healthful behaviors aimed at reducing the risk of developing diabetes, as well as educating providers about the importance of identifying and supporting prevention efforts in high-risk individuals. These activities included: 1) surveillance initiatives of the Cape Verdean community in southeastern Massachusetts, a high -risk population; 2) conducting a Community Survey of all cities and towns in the Commonwealth regarding facilities and opportunities for people to improve their nutrition and increase their physical activity levels; and 3) issuing clinical guidelines for the identification and treatment of children and adults w ith type 2 diabetes and women with gestational diabetes, which puts them and their children at a higher risk of developing Type 2 Diabetes later in life. An intiative is currently being planned with CDC to work with providers to ensure that women with gest ational diabetes are linked into primary care for follow -up. This categorical funding has been included in 4513-1111 Health Promotion and Disease Prevention line item.

Ovarian Cancer (4513-1122) – $200,000
This funding was utilized to enhance the 2006 O varian Cancer Awareness Campaign. This campaign was developed by a coalition comprised of the National Ovarian Cancer Coalition, Inc. (NOCC), the Ovarian Cancer Education and Awareness Network at Massachusetts General Hospital (OCEAN), the Massachusetts G eneral Hospital Cancer Center, and the M. Patricia Cronin Foundation to Fight Ovarian Cancer, Inc. The coalition successfully employed a concerted effort to raise awareness of ovarian cancer throughout Massachusetts. This campaign included media advertisi ng (TV, radio, print, transit), a Web site, media event alignment, a cable television show), government and legislative efforts and far exceeded the results of prior campaigns. This categorical funding has been included in 4513-1111 Health Promotion and Di sease Prevention line item.

Multiple Sclerosis (4513-1115) – $250,000
Chapter 58 earmarked funds for the Central New England Chapter of the Multiple Sclerosis Society. The contract was amended to undertake enhanced data

collection and outcome measurement, expansion of B.Fit, a wellness and rehabilitation program, increased outreach for people with MS, increased services for individuals with MS, and provision of short-term care management services during June and July 2005. This categorical funding has be en included in 4513-1111 Health Promotion and Disease Prevention line item.

Renal Disease (4513-1116) – $100,000
These funds are earmarked for the National Kidney Foundation of MA, RI, NH, and VT. The funds will be used for the same types of services currently provided by the Foundation through an earmark on account 4510-0600. The program will provide nutritional supplements and early intervention services for people with kidney disease as well as those at risk for renal disease. This categorical funding has been included in 4513-1111 Health Promotion and Disease Prevention line item.

Tobacco Control (4590-0300) - $4,000,000
The Tobacco Control Program utilized these funds to enhance and supplement current activities. These funds were used to promote tobacco cessation and systems changes in 8 community health centers and hospitals, expand and target radio and other media efforts, secure additional compliance checks in unfunded areas of the state experiencing high rates of sales to minors, expand mini-grants to youth groups for the promotion of smoke-free schools and playgrounds through the creation of a youth website, promotion of video contest, and a youth summit,. Funding was also targeted in order to reduce exposure to secondhand smoke by increasing inspections to enforce the statewide smoke-free workplace law. A retailer education kits, school signs to promote no smoking policies, and materials for healthcare providers and consumers around cessation and the new MassHealth benefits was developed and distributed. These activities will continue in FY08 through funding in the 4590-0300 line item.

Pediatric Palliative Care (4570-1503) - $800,000
The state-wide Pediatric Palliative Care program was developed and implemented. Contracts are in place with 10 licensed hospices to provide pediatric palliative care services to residents of all cities and towns in Massachusetts. Major activities during the the past year have included development of program criteria and standards of care, training staff to address gaps in knowledge and experience given limited pediatric hospice services in the past, setting up procedures for pediatric intakes and services, and development of outreach materials for physicians and parents. All providers began actively enrolling children with life-limiting illness and family members (parents and siblings primarily) in late January. The program has received over 100 referrals in the first 6 weeks with over 70 children and 120 family members receiving some kind of service (bereavement, counseling, etc.). Line item 4590-1506 assures the continuation of the program within the DPH budget.

State Laboratory Account – (4516-1000) $2,418,000

The $2.418m in healthcare reform supplemental funding awarded to the State Lab account enabled DPH to finance a number of essential services at the State Lab that were in deficiency. These funds were intended to cover the State Lab's occupancy costs that had been severely underfunded for several years, as well as to restore funding to help overcome several years of underfunding of laboratory operations particularly for lab supplies, equipment and essential laboratory and disease control personnel.

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

Hepatitis C Program

The Hepatitis C Program has utilized the additional funds to expand available services to people at-risk for or infected with hepatitis C virus (HCV) and to increase the education for the general public and health care and social service providers. Additionally, funding has gone towards surveillance and evaluation efforts to ensure that data are collected on the extent of the problem and the impact of the initiatives to address it. All services have been integrated into HIV/AIDS or substance abuse services where possible. All projects are reviewed by the Statewide Hepatitis C Advisory Committee which meets on a quarterly basis.

Betsy Lehman Center for Patient Safety and Medical Error Reduction (4000 - 0141) $500,000

The Betsy Lehman Center for Patient Safety and Medical Error Reduction (Lehman Center), established in Section 16E of Chapter 6A of the General Laws, was given a $500,000 appropriation for Fiscal Year 2007 in Line Item #4000 - 0140 of Chapter 58 of the Acts of 2006. The mission of the Lehman Center is to "serve as a clearinghouse for the development, evaluation and dissemination, including, but not limited to, the sponsorship of training and education programs, of best practices for patient safety and medical error reduction." The Lehman Center was launched in 2004. It released a landmark report on best practices in weight loss surgery from its Expert Panel in 2004, and also established a Patient Safety Ombudsman Office that same year. A conference convening experts to discuss a patient safety was held. In addition, the Weight Loss Surgery Expert Panel recommendations were revised and recommendations developed by an expert panel on healthcare-associated infection prevention. A project to study patient safety in obstetrics is in the planning phase. This categorical funding has been included in 4513-1111 Health Promotion and Disease Prevention line item.

Infection Control and Prevention Program
The goal of the Infection Prevention and Control Program is to develop a statewide infection prevention and control program in licensed health care facilities. The initial project is focused on hospitals. An Expert Panel provides overall guidance to a series of Task Groups who develop recommendations on four of the most common infections seen in facilities - ventilator associated (VAP), blood stream/surgical site (BSI/SSI) and MRSA. Two other groups are focusing on data collection and reporting and designing the framework for recommendations. The literature review for ranking the evidence was completed except in cases where additional evidence is sought.

The infection related groups have submitted their second set of recommendations. The Public Reporting group is reviewing measurements that are based on good science, compatible with existing measurements and that fall within hospital capability. Science and evidence are the priority criteria. The Program Design group is examining the issues related to the impact of public reporting on infection control programs and vaccinations for healthcare workers. The Leadership Group met with the information technology vendor Strategic, Solutions Group (SSG), to establish the parameters of the electronic data portion of the project. SSG will update the Expert Panel in June on their progress. Relevant data from the Hospital Survey is being used by each of the task groups. The Public Reporting and Program Design groups continue to develop frameworks for measuring and reporting HAIs. The Public Reporting and Communication Task Group have drafted "plain language" explanations for HAI terms appropriate for readers with various levels of literacy. The hospital survey has provided guidance on current reporting of outcome and process measures, infrastructure for data collection, prevention, surveillance, screening and staffing. The VAP group is working to standardize definitions. MRSA is focusing on surveillance. BSI/SSI is looking at the complexity of those infections. As the groups formulate more of their recommendations, they are considering hospital capacity for data collection and reporting and measures recommended by national groups studying the same issues. Meetings with hospital CEOs are being conducted to gather feedback. Discussions are beginning on the best way to disseminate findings and educate hospital professionals on best processes. Working with the Betsy Lehman Center and expert panels, DPH will review all recommendations from the sub-committees and final evidence-based recommendations on the surveillance, prevention and reporting of specific health-care associated infections will be developed.

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

Massachusetts State Plan for Suicide Prevention are in process. The activities moving forward in this area will be funded through 4513-1026.

Teen Pregnancy Prevention Services (4530-9000) - $1,000,000
Fifteen vendors currently receiving funds to implement science-based teen pregnancy prevention received additional funds to implement additional teen pregnancy prevention services to youth, parents/families and providers in communities with high teen birth rates. Additional programs and activities implemented by current vendors include a provider conference, implementation of parent curricula and additional science-based curricula, HPV and teen pregnancy prevention awareness campaigns and collaboration with community agencies to open a teen center in one community. New programs in Attleboro, Taunton and Southbridge have begun serving youth. In recognition of May being Teen Pregnancy Prevention Month, Glynis Shea from Konopoka Institute, conducted a training for DPH and other state agency staff on how to frame adolescent health issues. These services will continue to receive funding in FY08.

Community Health Workers
Section 110 of Chapter 58 requires the Department to "make an investigation and study relative to (a) using and funding of community health workers by public and private entities in the commonwealth, (b) increasing access to heath care, particularly Medicaid-funded health and public health services, and (c) eliminating health disparities among vulnerable populations." Due to an initial lack of funding, timely implementation was delayed until a minimal amount of funding was identified on a federal grant allowing for the hiring of a student to assist in this process. Three main activities were undertaken:

1) A survey of DPH community-based vendors who do outreach was developed to measure the utilization and funding of CHWs, including an assessment of their effectiveness in increasing access to care. The survey has been pilot-tested and is being adapted to an electronic format. An electronic distribution list of vendors has been compiled, with assistance from AIDS Bureau staff, and the Commissioner will soon send out the survey to vendors.

2) The DPH CHW Advisory Council has been established and the first meeting is scheduled for August 15, 2007. This council will assist with the investigation and contribute recommendations for inclusion in the Advisory Council's final report to the Legislature.

3) A literature review on the role of CHWs in increasing access to health care and in reducing health disparities is being designed and will be conducted this summer. The review will focus on Massachusetts-specific data.

Section 8: Insurance Market Update

Young Adult Health Benefit Plan

The Division of Insurance (DOI) published the Young Adult Health Benefit Plan Regulations, 211 CMR 63.00, as emergency regulations on April 7, 2007. A hearing was held on May 30, 2007. The DOI did not make any changes to the regulations as a result of the hearing and the effective date of the regulations remains April 7, 2007. The DOI will work with the Connector to determine if any changes should be made to the regulations for subsequent years.

Health Access Bureau

The Division of Insurance developed job descriptions and posted positions for an actuary, a research analyst and a financial analyst within the newly formed Health Access Bureau. The Division is currently interviewing for these positions. To complete some of the duties required by the Health Access Bureau prior to filling the internal positions, the Division 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 DOI has initiated discussions with the Connector on such standards and guidelines and will begin discussions with the carriers and other interested parties beginning in August.

Section 9: Updates on Employer Provisions

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

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

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 has scheduled a public hearing on the emergency regulation for September 6, 2007.

Health Insurance Responsibility Disclosure

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

The Division 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/regs/employee_hird_form.pdf

The Division has schedule a public hearing on the emergency regulation for September 5, 2007.

Division of Unemployment Assistance in the Department of Workforce Development (DUA)

Fair Share Contribution:
The Division of Unemployment Assistance completed the promulgation of the Fair Share Employer Contributions Regulations following a public notice and hearing. These Regulations will guide the process for the first annual reporting period from employers which will begin on October 1, 2007.

DUA conducted a pilot the week of July 14, 2007 with 25 employers to test the online filing application that will be used to determine their Fair Share Contribution liability. Following the pilot, DUA held a feedback session for the employers to share their experiences of going through the pilot filing. Representatives from the Division of Health Care Finance and Policy and Associated Industries of Massachusetts took part in both the pilot and the feedback sessions. A meeting is being held to in response to employer feedback about the primary test for determining liability to ensure any issues have been addressed.

DUA is in the process of interviewing candidates for positions in the new Fair Share Contribution unit within our Revenue Services organization to staff up the

team in preparation for the beginning of the annual reporting period which will begin on October 1, 2007.

Legislative Updates:
Governor Patrick signed into law legislation that provides funds to DUA to administer the Fair Share Contribution by allowing it to: (a) deduct its administrative costs from the FSC collections and (b) use its regular UI collection tools for collecting delinquent FSC contributions.