

HOUSE No. 4974

The Commonwealth of Massachusetts

HOUSE OF REPRESENTATIVES, July 15, 2008.

The committee on Ways and Means, to whom was referred the Senate Bill to promote cost containment, transparency and efficiency in the delivery of quality health care (Senate, No. 2660), reports that the same ought to pass with an amendment by striking out all after the enacting clause and inserting in place thereof the text contained in House document numbered 4974.

For the committee,

ROBERT A. DELEO.

Text of an amendment recommended by the committee on Ways and Means, as changed by the House committee on Bills in the Third Reading, and as amended by the House, to the Senate Bill to promote cost containment, transparency and efficiency in the delivery of quality health care (Senate, No. 2660). July 16, 2008.

The Commonwealth of Massachusetts

In the Year Two Thousand and Eight.

By striking out all after the enacting clause and inserting in place thereof the following:

1 SECTION 1. Paragraph (d) of Section 38C of Chapter 3 of the
2 General Laws, as appearing in the 2006 Official Edition, is hereby
3 amended by striking out the third sentence and inserting in place
4 thereof the following sentence:—

5 The division shall enter into interagency agreements as neces-
6 sary with the office of Medicaid, the group insurance commission,
7 the department of public health, the division of insurance, the
8 health care quality and cost council, and other state agencies
9 holding utilization, cost, or claims data relevant to the division's
10 review under this section.

1 SECTION 2. Chapter 6A of the General Laws is hereby
2 amended by striking out Section 16K, as so appearing, and
3 inserting in place thereof the following section:—

4 Section 16K. (a) There shall be established a health care quality
5 and cost council within, but not subject to control of, the execu-
6 tive office of health and human services. The council shall pro-
7 mote high-quality, safe, effective, timely, efficient, equitable and
8 patient-centered health care by:— (i) being a repository of health
9 care quality and cost data for consumers, health care providers
10 and insurers; (ii) disseminating health care quality and cost data to
11 consumers, health care providers, and insurers via a consumer
12 health information website pursuant to subsection (e) and (h); (iii)

13 establishing quality improvement and cost containment goals pur-
14 suant to subsection (i); and (iv) establishing transparency stan-
15 dards, quality performance benchmarks, and statewide health
16 information technology adoption goals for health care providers
17 and insurers pursuant to subsection (j).

18 (b) The council shall consist 18 members and shall be com-
19 prised of:— (i) 9 ex-officio members, including the secretary of
20 health and human services, who shall serve as the chair, the secre-
21 tary of administration and finance, the auditor, the inspector
22 general, the attorney general, the commissioner of insurance, the
23 commissioner of health care finance and policy, the commissioner
24 of public health, and the executive director of the group insurance
25 commission, or their designees; and (ii) 9 representatives of non-
26 governmental organizations be appointed by the governor,
27 including 1 representative of a health care quality improvement
28 organization recognized by the federal Centers for Medicare and
29 Medicaid Services, 1 representative of the Institute for Healthcare
30 Improvement recommended by the organization's board of direc-
31 tors, 1 representative of the Massachusetts Chapter of the National
32 Association of Insurance and Financial Advisors, 1 representative
33 of the Massachusetts Association of Health Underwriters, Inc., 1
34 representative of the Massachusetts Medicaid Policy Institute,
35 Inc., 1 expert in health care policy from a foundation or academic
36 institution, 1 representative of a non-governmental purchaser of
37 health insurance, and 2 clinicians, who must be either a physician
38 or nurse practitioner and practice in a primary care or community
39 hospital setting. Members of the council shall be appointed for
40 terms of 3 years or until a successor is appointed. Members shall
41 be eligible to be reappointed and shall serve without compensa-
42 tion, but may be reimbursed for actual and necessary expenses
43 reasonably incurred in the performance of their duties which may
44 include reimbursement for reasonable travel and living expenses
45 while engaged in council business.

46 (c) All meetings of the council shall be in compliance with
47 Chapter 30A, except that the council, through its bylaws, may
48 provide for executive sessions of the council. No action of the
49 council shall be taken in an executive session.

50 The council may, subject to Chapter 30B and subject to appro-
51 priation, procure equipment, office space, goods and services.

52 The council shall receive staff assistance from the executive
53 office of health and human services and may, subject to appropria-
54 tion, appoint an executive director and employ such additional
55 staff or consultants as it deems necessary. The executive office
56 shall provide administrative support to the council as requested.

57 The council shall promulgate rules and regulations and may
58 adopt by-laws necessary for the administration and enforcement
59 of this section.

60 (d) The council shall be a repository of health care quality and
61 cost data. The council shall disseminate this data to consumers,
62 health care providers and insurers through:— (i) a publicly acces-
63 sible consumer health information website, (ii) reports on perfor-
64 mance provided to health care providers and (iii) any other
65 analysis and reporting the council deems appropriate.

66 When collecting data for the repository the council shall, to the
67 extent possible, utilize existing public and private data sources
68 and agency processes for data collection, analysis, and technical
69 assistance. The council may enter into an interagency service
70 agreement with the division of health care finance and policy for
71 data collection analysis, and technical assistance.

72 The council may, subject to Chapter 30B, contract with an inde-
73 pendent health care organization for data collection, analysis, or
74 technical assistance related to its duties; provided, however, that
75 the organization has a history of demonstrating the skill and
76 expertise necessary to:— (i) collect, analyze and aggregate data
77 related to quality and cost across the health care system; (ii) iden-
78 tify, through data analysis, quality improvement areas; (iii) work
79 with Medicare, MassHealth, and other insurers' data and clinical
80 performance measures; (iv) collaborate in the design and imple-
81 mentation of quality improvement measures; (v) establish and
82 maintain security measures necessary to maintain confidentiality
83 and preserve the integrity of the data; and (vii) identify and, when
84 necessary, develop appropriate measures of quality and cost for
85 public reporting of quality and cost information.

86 Insurers and health care providers shall submit data to the
87 council, to an independent health care organization with which the
88 council has contracted, or to the division of health care finance
89 and policy, as required by the council's regulations. The council,
90 through its rules and regulations, may determine what type of

91 information may reasonably be required and the format in which it
92 should be provided.

93 If any insurer or health care provider fails to submit required
94 data to the council on a timely basis, the council shall provide
95 written notice to the insurer or health care provider. An insurer or
96 health care provider that fails, without just cause, to provide the
97 required information within 2 weeks following receipt of the
98 written notice may be required to pay a penalty of \$1,000 for each
99 week of delay; provided, however, that the maximum annual
100 penalty under this section shall be \$50,000.

101 (e) The council shall, in consultation with the advisory com-
102 mittee established by Section 16L, establish and maintain a con-
103 sumer health information website. The website shall contain
104 information comparing the quality and cost of health care services
105 and may also contain general health care information as the
106 council deems appropriate. The website shall be designed to assist
107 consumers in making informed decisions regarding their medical
108 care and informed choices among health care providers. Informa-
109 tion shall be presented in a format that is understandable to the
110 average consumer. The council shall take appropriate action to
111 publicize the availability of its website.

112 The council shall, in consultation with its advisory committee,
113 develop and adopt, on an annual basis, a reporting plan specifying
114 the quality and cost measures to be included on the consumer
115 health information website and the security measures used to
116 maintain confidentiality and preserve the integrity of the data. In
117 developing the reporting plan, the council, to the extent possible,
118 shall collaborate with other organizations or state or federal agen-
119 cies that develop, collect, and publicly report health care quality
120 and cost measures and the council shall give priority to those mea-
121 sures that are already available in the public domain. As part of
122 the reporting plan, the council shall determine for each service the
123 comparative information to be included on the consumer health
124 information website, including whether to:— (i) list services sepa-
125 rately or as part of a group of related services; and (ii) combine
126 the cost information for each facility and its affiliated clinicians
127 and physician practices or to list facility and professional costs
128 separately.

129 The council shall, after due consideration and public hearing,
130 adopt or reject the reporting plan or any revisions. If the council
131 rejects the reporting plan or any revisions, the council shall state
132 its reasons for the rejection. The reporting plan and any revisions
133 adopted by the council shall be promulgated by the council. The
134 council shall submit the reporting plan and any periodic revisions
135 to the chairs of the house and senate committees on ways and
136 means and the chairs of the joint committee on health care
137 financing and the clerks of the house and senate.

138 The website shall provide updated information on a regular
139 basis, at least annually, and additional comparative quality and
140 cost information shall be published as determined by the council,
141 in consultation with the advisory committee. To the extent pos-
142 sible, the website shall include:— (i) comparative quality infor-
143 mation by facility, clinician or physician group practice for each
144 service or category of service for which comparative cost informa-
145 tion is provided, (ii) general information related to each service or
146 category of service for which comparative information is pro-
147 vided; (iii) comparative quality information by facility, clinician
148 or physician practice that is not service-specific, including infor-
149 mation related to patient safety and satisfaction; and (iv) data con-
150 cerning healthcare-acquired infections and serious reportable
151 events reported under Section 51H of Chapter 111.

152 (f) The council, through its rules and regulations, shall provide
153 access to data it collects pursuant to this section under conditions
154 that:— (i) protect patient privacy; (ii) prevent collusion or anti-
155 competitive conduct; and (iii) prevent the release of data that
156 could reasonably be expected to increase the cost of health care.
157 The council may limit access to data based on its proposed use,
158 the credentials of the requesting party, the type of data requested
159 or other criteria required to make a determination regarding the
160 appropriate release of the data. The council shall also limit the
161 requesting party's use and release of any data to which that party
162 has been given access by the council.

163 Data collected by the council under this section shall not be a
164 public record under clause Twenty-sixth of Section 7 of Chapter 4
165 or under Chapter 66, except as specifically otherwise provided by
166 the council.

167 The council shall, through interagency service agreements,
168 allow the use of its data by other state agencies, including by the
169 division of health care finance and policy for review and evalua-
170 tion of mandated health benefit proposals as required by Section
171 38C of Chapter 3.

172 (h) The council, in consultation with its advisory committee,
173 shall disseminate to health care providers their individualized de-
174 identified data, including comparisons with other health care
175 providers on the quality, cost and other data to be published on the
176 consumer health information website.

177 (i) The council, in consultation with its advisory committee,
178 shall develop annual health care quality improvement and cost
179 containment goals using the data collected under subsection (d).
180 For each goal, the council shall identify the steps needed to
181 achieve the goal; estimate the cost of implementation; project the
182 anticipated short-term or long-term financial savings achievable to
183 the health care providers, insurers, or the Commonwealth, and
184 estimate the expected improvements in the health status of health
185 care consumers in the Commonwealth. The council may recom-
186 mend legislation or regulatory changes to achieve these goals.

187 (j) The council, in consultation with its advisory committee,
188 relevant state agencies, and public and private health care organi-
189 zations, shall develop and annually publish:— (i) transparency
190 standards, including, standardization of claims processing,
191 common and consistent reporting of quality measures, common
192 use of measures used for pay-for-performance reimbursement; (ii)
193 quality performance benchmarks for health care providers and
194 insurers that: (1) are clinically important, evidence-based, stan-
195 dardized, timely, (2) include both process and outcome measures,
196 (3) encourage health care providers and insurers to improve their
197 quality of health and (4) are developed based on the work of
198 national organizations, including the National Quality Forum and
199 the Hospitals Quality Alliance, and (iii) goals for statewide adop-
200 tion of health information technology certified by the certification
201 commission for health care information technology.

202 (k) The council shall conduct annual public hearings at which
203 health care providers, insurers, relevant state agencies, and public
204 and private health care organizations shall report their progress
205 towards achieving the quality improvement and cost containment

206 goals, adopting the transparency standards and meeting the quality
207 performance benchmarks. The council shall provide health care
208 providers, insurers, state agencies and the general court with the
209 following, at least 60 days prior to the public hearings:— (i) rec-
210 ommended action required by each entity to achieve the specified
211 quality and cost containment goals; and (ii) recommendations for
212 adoption of each transparency standard, quality performance
213 benchmark, and health information technology adoption goal
214 established by the council.

215 (l) The council shall file a report, not less than annually, with
216 the chairs of the house and senate committees on ways and means
217 and the chairs of the joint committee on health care financing and
218 the clerks of the house and senate on its progress in achieving the
219 goals of improving quality and containing or reducing health care
220 costs data provided pursuant to Chapter 111N. The report shall
221 include, at minimum, a review of the progress towards achieving
222 the quality improvement and cost containment goals, adoption of
223 transparency standards, meeting the quality performance bench-
224 marks, and achieving the health information technology adoption
225 goals.

226 The council shall provide its advisory committee with reason-
227 able opportunity to review and comment on all reports before their
228 public release.

229 Reports of the council shall be published on the consumer
230 health information website.

1 SECTION 3. Said Chapter 6A is hereby further amended by
2 striking out Section 16L, as amended by Section 1 of Chapter 205
3 of the acts of 2007, and inserting in place thereof the following
4 section:—

5 Section 16L. (a) There shall be established an advisory com-
6 mittee to the health care quality and cost council, established by
7 Section 16K, to allow the broadest possible involvement of the
8 health care industry and others concerned about health care
9 quality and cost.

10 (b) The advisory committee shall consist of at least 28 members
11 to be appointed by the governor, 1 of whom shall be a representa-
12 tive of the Massachusetts Medical Society, 1 of whom shall be a
13 representative of the Massachusetts Hospital Association, Inc., 1

14 of whom shall be a representative of the Massachusetts Associa-
15 tion of Health Plans, Inc., 1 of whom shall be a representative of
16 Blue Cross Blue Shield of Massachusetts, Inc., 1 of whom shall be
17 a representative of the Massachusetts AFL-CIO Council, Inc., 1 of
18 whom shall be a representative of the Massachusetts League of
19 Community Health Centers, Inc., 1 of whom shall be a representa-
20 tive of Health Care For All, Inc., 1 of whom shall be a representa-
21 tive of the Massachusetts Public Health Association, 1 of whom
22 shall be a representative of the Massachusetts Association of
23 Behavioral Health Systems, Inc., 1 of whom shall be a representa-
24 tive of the Massachusetts Extended Care Federation, Inc., 1 of
25 whom shall be a representative of the Massachusetts Council of
26 Human Service Providers, Inc., 1 of whom shall be a representa-
27 tive of the Home Care Alliance of Massachusetts, Inc., 1 of whom
28 shall be a representative of Associated Industries of Massachu-
29 setts, Inc., 1 of whom shall be a representative of the Massachu-
30 setts Business Roundtable, Inc., 1 of whom shall be a
31 representative of the Massachusetts Taxpayers Foundation, 1 of
32 whom shall be a representative of the Massachusetts chapter of
33 the National Federation of Independent Business, 1 of whom shall
34 be a representative of the Massachusetts Biotechnology Council,
35 Inc., 1 of whom shall be a representative of the Blue Cross Blue
36 Shield of Massachusetts Foundation, Inc., 1 of whom shall be a
37 representative of the Massachusetts chapter of the American
38 Association of Retired Persons, 1 of whom shall be a representa-
39 tive of the Massachusetts Coalition of Taft-Hartley Trust Funds,
40 Inc., and additional members including, but are not limited to, a
41 representative of the mental health field, a representative of pedi-
42 atric health care, a representative of primary health care, a repre-
43 sentative of medical education, a representative of racial or ethnic
44 minority groups concerned with health care, a representative of
45 hospice care, a representative of the nursing profession and a rep-
46 resentative of the pharmaceutical field. Members of the advisory
47 committee shall be appointed for terms of 3 years or until a suc-
48 cessor is appointed. Members shall be eligible to be reappointed
49 and shall serve without compensation.

50 (c) The members of the advisory committee shall annually elect
51 a chair, vice chair, and secretary and may adopt by-laws gov-
52 erning the affairs of the advisory committee.

53 (d) The advisory committee shall have the following duties:—
54 (i) advise the council on the consumer health information website
55 and health care provider and insurer reports; (ii) advise the
56 council on the annual health care quality improvement and cost
57 containment goals, transparency standards and quality perfor-
58 mance benchmarks; and (iii) review and comment on all reports of
59 the council before public release, including the annual reporting
60 plan and any revisions and the annual report to the General Court.
61 (e) A written record of all meetings of the committee shall be
62 maintained by the secretary and a copy filed within 15 days after
63 each meeting with the council.

1 SECTION 4. Chapter 40J of the General Laws is hereby
2 amended by inserting after Section 6C the following 2 sections:—

3 Section 6D. (a) There shall be established a health information
4 technology advisory council within the corporation. The council
5 shall advance the dissemination of health information technology
6 across Commonwealth, including the deployment of electronic
7 health records systems in all health care provider settings that are
8 networked through a statewide health information exchange.

9 (b) The council shall consist of 7 members:— 1 of whom shall
10 be the secretary of health and human services, who shall serve as
11 the chair; 1 of whom shall be the secretary of administration and
12 finance, or a designee; 1 of whom shall be the executive director
13 of the health care quality and cost council; 4 of whom shall be
14 appointed by the governor and shall be health information tech-
15 nology experts; 2 of whom shall be experts in the areas of law and
16 health policy. Appointive members of the council shall serve for
17 terms of 2 years or until a successor is appointed. Members shall
18 be eligible to be reappointed and shall serve without compensa-
19 tion.

20 The members of the advisory council shall be deemed to be
21 directors for purposes of the fourth paragraph of Section 3; pro-
22 vided that, notwithstanding the provisions of said Section 3 and
23 Sections 5, 6 and 7 of Chapter 268A, no member of the advisory
24 council shall be precluded from participating in matters before the
25 council because he, or a related party within the scope of Section
26 6 of said Chapter 268A, has a financial interest in a matter being
27 considered by the council, if such interest or involvement was dis-

28 closed in advance to the advisory council and recorded in the min-
29 utes of the advisory council's proceedings; and provided further,
30 that no member shall be deemed to violate Section 4 of said
31 Chapter 268A because of his receipt of his usual and regular com-
32 pensation from his employer during the time in which the member
33 participates in the activities of the advisory council.

34 (c) The council shall advance the dissemination of health infor-
35 mation technology by:— (i) facilitating the implementation and
36 use of electronic health records systems by health care providers
37 in order to improve health care delivery and coordination, reduce
38 unwarranted treatment variation, eliminate wasteful paper-based
39 processes, help facilitate chronic disease management initiatives,
40 and establish transparency; (ii) facilitating the creation and main-
41 tenance of a statewide interoperable electronic health records net-
42 work that allows individual health care providers in all health care
43 settings to exchange patient health information with other
44 providers; and (iii) identifying and promoting an accelerated dis-
45 semination in the commonwealth of emerging health care tech-
46 nologies that have been developed and employed and that are
47 expected to improve health care quality and lower health care
48 costs, but that have not been widely implemented in the Common-
49 wealth.

50 (d) The council shall develop community-based implementation
51 plans that assess a municipality's or region's readiness to imple-
52 ment and use electronic health record systems and an interoper-
53 able electronic health records network within the referral market
54 for a defined patient population.

55 Each implementation plan shall address the development,
56 implementation and dissemination of electronic health records
57 systems among health care providers in the community, particu-
58 larly providers, such as community health centers, who serve
59 underserved populations, including, but not limited to, racial,
60 ethnic and linguistic minorities, uninsured persons, and areas with
61 a high proportion of public payer care.

62 Each implementation plan shall:— (i) allow seamless, secure
63 electronic exchange of health information among health care
64 providers, health plans, and other authorized users; (ii) provide
65 consumers with secure, electronic access to their own health infor-
66 mation; (iii) meet all applicable federal and state privacy and

67 security requirements, including requirements imposed by 45 CFR
68 §§160, 162, 164; (iv) meet standards for interoperability adopted
69 by the council; (v) give patients the option of allowing only desig-
70 nated health care providers to disseminate their individually iden-
71 tifiable information; (vi) provide public health reporting capability
72 as required under state law; and (vii) allow reporting of health
73 information other than identifiable patient health information for
74 purposes of such activities as the secretary of health and human
75 services may from time to time consider necessary.

76 (e) The corporation shall contract with organizations that have
77 a proven history of success in implementing electronic health
78 records and health information technology programs, including
79 vendor selection, practice workflow design, hardware and soft-
80 ware implementation, training, and support. These implementation
81 organizations shall:— (i) facilitate a public-private partnership
82 that includes representation from hospitals, physicians and other
83 health care professionals, health insurers, employers, and other
84 health care purchasers, health data and service organizations, and
85 consumer organizations; (ii) provide resources and support to
86 recipients of grants awarded under subsection (f) to implement
87 each program within the designated community pursuant to the
88 implementation plan; (iii) certify and disburse funds to subcon-
89 tractors, when necessary; (iv) provide technical assistance to facil-
90 itate successful practice redesign, adoption of electronic health
91 records, and utilization of care management strategies; (v) ensure
92 that electronic health records systems are fully interoperable and
93 secure and that sensitive patient information is kept confidential
94 by exclusively utilizing electronic health records products that are
95 certified by the Certification Commission for Health Information
96 Technology; and (vi) work with the council to certify a group of
97 subcontractors who will provide the necessary hardware and soft-
98 ware for system implementation.

99 (f) Funding for the council's activities shall be through the
100 Health Information Technology Fund, established in Section 6E.
101 The council shall develop mechanisms for funding health infor-
102 mation technology, including a grant program to assist health care
103 providers with costs associated with health information technolo-
104 gies, including electronic health records systems, and coordinated

105 with other electronic health records projects seeking federal reim-
106 bursement.

107 All grants shall be approved by the council, which shall work
108 with the implementation organization to oversee the grant-making
109 process. The council shall allow the use of financial participation
110 of the grantee and any other factors it deems relevant as a condi-
111 tion for awarding grants. Each recipient of monies from this pro-
112 gram shall:— (i) capture and report certain quality improvement
113 data, as determined by the council in consultation with the health
114 care quality and cost council; (ii) implement the system fully,
115 including all clinical features, no later than the second year of the
116 grant; and (iii) make use of the system's full range of features.

117 Applications for funding shall be in the form and manner deter-
118 mined by the corporation, and shall include the information and
119 assurances required by the corporation.

120 (g) The council shall receive staff assistance from the corpora-
121 tion and may employ such additional staff or consultants as it
122 deems necessary.

123 (h) The council shall file an annual report, no later than January
124 30, with the joint committee on health care financing, the joint
125 committee on economic development and emerging technologies,
126 and the house and senate committees on ways and means con-
127 cerning the activities of the council in general and, in particular,
128 describing the progress to date in implementing a statewide elec-
129 tronic health records system and recommending such further leg-
130 islative action as it deems appropriate.

131 Section 6E. There shall be established and set up on the books
132 of the corporation the Health Information Technology Fund, here-
133 inafter referred to as "the fund," for the purpose of supporting the
134 advancement of health information technology in the common-
135 wealth including, but not limited to, the full deployment of elec-
136 tronic health records. There shall be credited to the fund any
137 appropriations, proceeds of any bonds or notes of the Common-
138 wealth issued for the purpose, or other monies authorized by the
139 general court and designated thereto; any federal grants or loans;
140 and any private gifts, grants, or donations made available. The
141 corporation shall hold the fund in an account or accounts separate
142 from other funds. The fund shall be administered by the executive
143 director of the Massachusetts Technology Park Corporation

144 without further appropriation, provided that any disbursement or
145 expenditure of funds shall be approved by the health information
146 technology advisory council established under Section 6D.
147 Amounts credited to the fund shall be available for expenditures
148 on the grant program established in said Section 6D and for other
149 forms of financial assistance that the advisory council determines
150 are necessary to support the dissemination and development of
151 health information technology in the Commonwealth. The execu-
152 tive director of the corporation shall seek, to the greatest extent
153 possible, private gifts, grants, and donations to the fund.

154 Section 6F. Any implementation plan created by the health
155 information technology advisory council or recipient of monies
156 for the adoption of health information technology approved by the
157 health information technology advisory council shall:—

158 (1) establish a mechanism to allow patients to opt-in to the
159 health information network and to opt-out at any time;

160 (2) maintain identifiable health information in physically and
161 technologically secure environments by means including but not
162 limited to prohibiting the storage or transfer of identifiable health
163 information on portable data storage devices, requiring data
164 encryption, unique alpha-numerical identifiers, password protec-
165 tion, and other methods to prevent unauthorized access to identifi-
166 able health information; and

167 (3) provide individuals the option of, upon request, obtaining a
168 list of individuals and entities that have accessed their identifiable
169 health information.

170 Section 6G. In the event of an unauthorized access to or disclo-
171 sure of individually identifiable patient health information by or
172 through the statewide health information network or by or through
173 any technology grantees funded in whole or in part under this
174 section, the operator of such network or grantee shall:— (i) report
175 the conditions of such unauthorized access or disclosure as
176 required by the Massachusetts Technology Collaborative; and (ii)
177 provide notice, as defined in Section 1 of Chapter 93H of the
178 General Laws, as soon as practicable, but not later than 10 busi-
179 ness days, to person whose patient health information may have
180 been compromised as a result of such unauthorized access or dis-
181 closure, and shall report the conditions of such unauthorized
182 access or disclosure.

183 Any aggrieved individual claiming violations of GL Chapter
184 40J sec. 6D may bring a civil action in Superior Court. The
185 Attorney General may bring a civil action in Superior Court to
186 enforce GL Chapter 40J, sec 6D.

187 A court shall find a violation of this chapter and order relief if
188 it determines that any of the following circumstances has
189 occurred:—

190 (1) the failure to impose and maintain safeguards for the confi-
191 dentiality and security of protected health information as required
192 by this statute or any rule or regulation promulgated pursuant to
193 this chapter;

194 (2) the disclosure of protected health information in violation of
195 this chapter; or

196 (3) any other violation of this chapter.

197 The court may order a health information network or any par-
198 ticipating entity or individual to comply with this chapter and may
199 order any other appropriate civil or equitable relief, including an
200 injunction to prevent non-compliance. If the court determines that
201 there has been a violation of this chapter, the aggrieved person is
202 entitled to recover damages for losses sustained as a result of this
203 violation. The measure of damages shall be the greater of the
204 aggrieved person's actual damages, or liquidated damages of
205 \$1,000 for each violation, provided that liquidated damages shall
206 not exceed \$10,000 for any particular claim.

207 If the court determines that there has been a violation of this
208 chapter that results from willful or grossly negligent conduct, the
209 aggrieved person may recover punitive damages not to exceed
210 \$10,000, exclusive of any other loss, for each violation from the
211 offending party.

212 If the aggrieved person prevails, the court shall assess reason-
213 able attorney's fees and all other expenses reasonably incurred in
214 the litigation against the non-prevailing parties.

215 Responsible parties are jointly and severally liable for any com-
216 pensatory damages, attorney's fees or other costs awarded.

217 Any action under this section is barred unless the action is com-
218 menced within three years after the cause of action accrues or was
219 or should reasonably have been discovered by the aggrieved
220 person or the person's lawful representative.

221 No employee shall be terminated, discharged, or retaliated
222 against because he does any of the following based on a reason-
223 able belief that an activity, policy or practice of the employer or
224 another entity with whom the employer has a relationship is in
225 violation of this chapter or any rule or regulation promulgated
226 pursuant to this chapter:—

227 (1) objects to or refuses to participate in any such activity,
228 policy or practice of the employer;

229 (2) discloses or threatens to disclose such activity, policy or
230 practice to a manager or to a public body; or

231 (3) provides information to or testifies before any public body
232 conducting an investigation, hearing or inquiry into any violation
233 of this chapter, or rule or regulation promulgated pursuant to this
234 chapter.

1 SECTION 5. Chapter 111 of the General Laws is hereby
2 amended by inserting after section 4M the following section:—

3 Section 4N. (a) The department shall, in cooperation with Com-
4 monwealth Medicine at the University of Massachusetts medical
5 school, develop, implement and promote an evidence-based out-
6 reach and education program about the therapeutic and cost-effec-
7 tive utilization of prescription drugs for physicians, pharmacists
8 and other health care professionals authorized to prescribe and
9 dispense prescription drugs. In developing the program, the
10 department shall consult with physicians, pharmacists, private
11 insurers, hospitals, pharmacy benefit managers, the MassHealth
12 drug utilization review board and the University of Massachusetts
13 medical school.

14 (b) The program shall provide for physicians, pharmacists and
15 nurses under contract with the department to conduct face-to-face
16 visits with prescribers, utilizing evidence-based materials and bor-
17 rowing methods from behavioral science, educational theory and,
18 where appropriate, pharmaceutical industry data and outreach
19 techniques; provided, however, that to the extent possible, the pro-
20 gram shall inform prescribers about drug marketing that is
21 intended to circumvent competition from generic or other thera-
22apeutically-equivalent pharmaceutical alternatives or other evi-
23dence-based treatment options.

24 The program shall include outreach to physicians and other
25 health care practitioners who participate in MassHealth, the subsi-
26 dized catastrophic prescription drug insurance program authorized
27 in section 39 of chapter 19A, the commonwealth care health insur-
28 ance program, to other publicly-funded, contracted or subsidized
29 health care programs, to academic medical centers and to other
30 prescribers.

31 The department shall, to the extent possible, utilize or incorpo-
32 rate into its program other independent educational resources or
33 models proven effective in promoting high quality, evidenced-
34 based, cost-effective information regarding the effectiveness and
35 safety of prescription drugs, including, but not limited to:— (i) the
36 Pennsylvania PACE/Harvard University Independent Drug Infor-
37 mation Service; (ii) the Academic Detailing Program of the Uni-
38 versity of Vermont College of Medicine Area Health Education
39 Centers; (iii) the Oregon Health and Science University Evidence-
40 based Practice Center's Drug Effectiveness Review project; and
41 (iv) the North Carolina evidence-based peer-to-peer education
42 program outreach program.

43 (c) The department may establish and collect fees for subscrip-
44 tions and contracts with private payers. The department may seek
45 funding from nongovernmental health access foundations and
46 undesignated drug litigation settlement funds associated with
47 pharmaceutical marketing and pricing practices.

1 SECTION 6. Said Chapter 111 is hereby further amended by
2 inserting after Section 25K the following 3 sections:—

3 Section 25L. (a) There shall be in the department a health care
4 workforce center to improve access to health care services. The
5 center, in consultation with the health care workforce advisory
6 council established by section 25M and the commissioner of labor
7 and workforce development, shall:— (i) coordinate the depart-
8 ment's health care workforce activities with other state agencies
9 and public and private entities involved in health care workforce
10 training, recruitment and retention; (ii) monitor trends in access to
11 primary care providers, nurse practitioners practicing as primary
12 care providers, and other physician and nursing providers, through
13 activities including:—

14 (1) review of existing data and collection of new data as needed
15 to assess the capacity of the health care workforce to serve

16 patients, including patient access and regional disparities in access
17 to physicians or nurses and to examine physician and nursing sat-
18 isfaction;

19 (2) review existing laws, regulations, policies, contracting or
20 reimbursement practices, and other factors that influence recruit-
21 ment and retention of physicians and nurses;

22 (3) make projections on the ability of the workforce to meet the
23 needs of patients over time; identify strategies currently being
24 employed to address workforce needs, shortages, recruitment and
25 retention; study the capacity of public and private medical and
26 nursing schools in Massachusetts to expand the supply of primary
27 care physicians and nurse practitioners practicing as primary care
28 providers; (iii) establish criteria to identify underserved areas in
29 the commonwealth for administering the loan repayment program
30 established under section 25N and for determining statewide
31 target areas for health care provider placement based on the level
32 of access; and (iv) address health care workforces shortages
33 through the following activities, including:—

34 (1) coordinating state and federal loan repayment and incentive
35 programs for health care providers;

36 (2) providing assistance and support to communities, physician
37 groups, community health centers and community hospitals in
38 developing cost-effective and comprehensive recruitment initia-
39 tives;

40 (3) maximizing all sources of public and private funds for
41 recruitment initiatives;

42 (4) designing pilot programs and make regulatory and legisla-
43 tive proposals to address workforce needs, shortages, recruitment
44 and retention; and

45 (5) making short-term and long-term programmatic and policy
46 recommendations to improve workforce performance, address
47 identified workforce shortages and recruit and retain physicians
48 and nurses.

49 (c) The center shall maintain ongoing communication and coor-
50 dination with the health care quality and cost council, established
51 by Section 16K of Chapter 6A, and the health disparities council,
52 established by Section 16O of said Chapter 6A.

53 (d) The center shall annually submit a report, no later than
54 March 1, to the governor; the health care quality and cost council

55 established by Section 16K of Chapter 6A, the health disparities
56 council established by Section 16O of Chapter 6A; and the
57 general court, by filing the report with the clerk of the house of
58 representatives, the clerk of the senate, the joint committee on
59 labor and workforce development, the joint committee on health
60 care financing, and the joint committee on public health. The
61 report shall include:— (i) data on patient access and regional dis-
62 parities in access to physicians, by specialty and sub-specialty,
63 and nurses, (ii) data on factors influencing recruitment and reten-
64 tion of physicians and nurses, (iii) short and long-term projections
65 of physician and nurse supply and demand, (iv) strategies being
66 employed by the council or other entities to address workforce
67 needs, shortages, recruitment and retention, (v) recommendations
68 for designing, implementing and improving programs or policies
69 to address workforce needs, shortages, recruitment and retention,
70 (vi) proposals for statutory or regulatory changes to address work-
71 force needs, shortages, recruitment and retention.

72 Section 25M. (a) There shall be a healthcare workforce advi-
73 sory council within, but not subject to the control of, the health
74 care workforce center established by Section 25L. The council
75 shall advise the center on the capacity of the healthcare workforce
76 to provide timely, effective, culturally competent, quality physi-
77 cian and nursing services.

78 (b) The council shall consist of 14 members who shall be
79 appointed by the governor:— 1 of whom shall be a representative
80 of the Massachusetts Extended Care Federation; 1 of whom shall
81 be a physician with a primary care specialty designation who
82 practices in a rural area; 1 of whom shall be a physician with a
83 primary care specialty who practices in an urban area; 1 of whom
84 shall be a physician with a medical subspecialty; 1 of whom shall
85 be an advanced practice nurse, authorized under Section 80B of
86 said Chapter 112, who practices in a rural area; 1 of whom shall
87 be an advanced practice nurse, authorized under Section 80B of
88 said Chapter 112, who practices in an urban area; 1 of whom shall
89 be a representative of the Massachusetts Organization of Nurse
90 Executives;; 1 of whom shall be a representative of the Massachu-
91 setts Academy of Family Physicians; 1 of whom shall be a repre-
92 sentative of the Massachusetts Workforce Board Association; 1 of
93 whom shall be a representative of the Massachusetts League of

94 Community Health Centers, Inc.; 1 of whom shall be a representa-
95 tive of the Massachusetts Medical Society; the Massachusetts
96 Center for Nursing, Inc.; 1 of whom shall be a representative of
97 the Massachusetts Nurses Association; 1 of whom shall be a rep-
98 resentative of the Massachusetts Hospital Association, Inc.; and 1
99 of whom shall be a representative of Health Care For All, Inc.
100 Members of the council shall be appointed for terms of 3 years or
101 until a successor is appointed. Members shall be eligible to be
102 reappointed and shall serve without compensation, but may be
103 reimbursed for actual and necessary expenses reasonably incurred
104 in the performance of their duties. Vacancies of unexpired terms
105 shall be filled within 60 days by the appropriate appointing
106 authority.

107 The members of the council shall annually elect a chair, vice
108 chair, and secretary and may adopt by-laws governing the affairs
109 of the council.

110 The council shall meet at least bimonthly, at other times as
111 determined by its rules, and when requested by any 8 members.

112 (c) The council shall advise the center on:— (i) trends in access
113 to primary care and physician subspecialties and nursing services;
114 (ii) the development and administration of the loan repayment
115 program, established under section 25N, including criteria to iden-
116 tify underserved areas in the commonwealth; (iii) solutions to
117 address identified health care workforces shortages; and (iv) the
118 center's annual report to the General Court.

119 Section 25N. (a) There shall be a health care workforce loan
120 repayment program, administered by the health care workforce
121 center established by Section 25L. The program shall provide
122 repayment assistance for medical school loans to participants
123 who:— (i) are graduates of medical or nursing schools; (ii) spe-
124 cialize in family health or medicine, internal medicine, pediatrics,
125 or obstetrics/gynecology and commit to providing those special-
126 ties in medically underserved areas for a minimum of 2 years or
127 specialize in psychiatry and commit to providing public sector
128 psychiatry at state facilities under the control of or contract with
129 the department of mental health for a minimum of 2 years; (v)
130 demonstrate competency in health information technology
131 including, use of electronic medical records, computerized physi-

132 cian order entry and e-prescribing; and (vi) meet other eligibility
133 criteria, including service requirements, established by the board.

134 (b) The center shall promulgate regulations for the administra-
135 tion and enforcement of this section which shall include penalties
136 and repayment procedures if a participant fails to comply with the
137 program's requirements.

138 The center shall, in consultation with the health care workforce
139 advisory council and the public health council, establish criteria to
140 identify medically underserved areas within the commonwealth.
141 These criteria shall consist of quantifiable measures, which may
142 include the availability of primary care medical services within
143 reasonable traveling distance, poverty levels, and disparities in
144 health care access or health outcomes.

145 (c) The center shall evaluate the program annually, including
146 exit interviews of participants to determine their post-program
147 service plans and to solicit program improvement recommenda-
148 tions.

149 (d) The center shall, not later than July 1, file an annual report
150 with the governor, the clerk of the house of representatives, the
151 clerk of the senate, the house committee on ways and means, the
152 senate committee ways and means, the joint committee on health
153 care financing, the joint committee on mental health and sub-
154 stance abuse and the joint committee on public health. The report
155 shall include annual data and historical trends of: (i) the number
156 of applicants, the number accepted, and the number of participants
157 by race, gender, medical specialty, medical school, residence prior
158 to medical school, and where they plan to practice after program
159 completion; (ii) the service placement locations and length of
160 service commitments by participants; (iii) the number of partici-
161 pants who fail to fulfill the program requirements and the reason
162 for the failure; (iv) the number of former participants who con-
163 tinue to serve in underserved areas; and (v) program expenditures.

1 SECTION 7. Said Chapter 111 is hereby further amended by
2 inserting after Section 51G the following section:—

3 Section 51H. (a) As used in this section the following words
4 shall, unless the context clearly requires otherwise, have the
5 following meanings:—

6 "Facility", a hospital, institution for the care of unwed mothers
7 or clinic providing ambulatory surgery as defined by Section 25.

8 “Healthcare-associated infection”, a localized or systemic con-
9 dition that results from an adverse reaction to the presence of an
10 infectious agent or its toxins that:— (i) occurs in a patient in a
11 facility, (ii) was not present or incubating at the time of the admis-
12 sion during which the reaction occurs, and (iii) if occurring in a
13 hospital, meets the criteria for a specific infection site as defined
14 by the federal Centers for Disease Control and Prevention and its
15 national health care safety network.

16 “Serious reportable event”, an event that results in a serious
17 adverse patient outcome that is clearly identifiable and measur-
18 able, reasonably preventable, and that meets any other criteria
19 established by the department in regulations.

20 (b) A facility shall report data and information about health-
21 care-associated infections and serious reportable events. A serious
22 reportable event shall be reported by a facility no later than 15
23 working days after its discovery. Reports shall be made in the
24 manner and form established by the department in its regulations.
25 The department may require facilities to register in and report to
26 nationally recognized quality and safety organizations.

27 (c) The department shall, through interagency service agree-
28 ments, transmit data collected under this section to the Betsy
29 Lehman center for patient safety and medical error reduction and
30 to the health care quality and cost council for publication on its
31 consumer health information website. Any facility failing to
32 comply with this section may:— (i) be fined up to \$1,000 per day
33 per violation; (ii) have its license revoked or suspended by the
34 department; or (iii) be fined up to \$1,000 per day per violation and
35 have its license revoked or suspended by the department.

1 SECTION 8. Said Chapter 111 is hereby further amended by
2 inserting after section 51G the following section:—

3 Section 51H. (a) As used in this section the following words
4 shall, unless the context clearly requires otherwise, have the
5 following meanings:

6 “Facility”, a hospital, institution for the care of unwed mothers
7 or clinic providing ambulatory surgery as defined by section 25.

8 “Healthcare-associated infection”, a localized or systemic con-
9 dition that results from an adverse reaction to the presence of an
10 infectious agent or its toxins that:— (i) occurs in a patient in a

11 facility, (ii) was not present or incubating at the time of the admis-
12 sion during which the reaction occurs, and (iii) if occurring in a
13 hospital, meets the criteria for a specific infection site as defined
14 by the federal Centers for Disease Control and Prevention and its
15 national health care safety network.

16 “Serious adverse drug event”, any preventable event that causes
17 inappropriate medication use in a hospital or ambulatory surgical
18 center that leads to harm to a patient, as further defined in regula-
19 tions of the department.

20 “Serious reportable event”, an event that results in a serious
21 adverse patient outcome that is clearly identifiable and measur-
22 able, reasonably preventable, and that meets any other criteria
23 established by the department in regulations.

24 (b) A facility shall report data and information about health-
25 care-associated infections, serious reportable events, and serious
26 adverse drug events. A serious reportable event shall be reported
27 by a facility no later than 15 working days after its discovery.
28 Reports shall be made in the manner and form established by the
29 department in its regulations. The department may require facili-
30 ties to register in and report to nationally recognized quality and
31 safety organizations.

32 (c) The department, through interagency service agreements,
33 shall transmit data collected under this section to the Betsy
34 Lehman center for patient safety and medical error reduction and
35 to the health care quality and cost council for publication on its
36 consumer health information website. Any facility failing to
37 comply with this section may:— (i) be fined up to \$1,000 per day
38 per violation; (ii) have its license revoked or suspended by the
39 department; or (iii) be fined up to \$1,000 per day per violation and
40 have its license revoked or suspended by the department.

1 SECTION 9. Said chapter 111 is hereby further amended by
2 inserting after section 53D the following 3 sections:—

3 Section 53E. The department shall promulgate regulations for
4 the establishment of a patient and family advisory council at each
5 hospital in the Commonwealth. The council shall advise the hos-
6 pital on matters including, but not limited to, patient and provider
7 relationships, institutional review boards, quality improvement
8 initiatives and patient education on safety and quality matters.

9 Members of a council may act as reviewers of publicly reported
10 quality information, members of task forces, members of awards
11 committees for patient safety activities, members of advisory
12 boards, participants on search committees and in the hiring of new
13 staff, and may act as co-trainers for clinical and nonclinical staff,
14 in-service programs, and health professional trainees or as partici-
15 pants in reward and recognition programs.

16 Section 53F. The department shall require acute care hospitals
17 to have a suitable method for health care staff members, patients
18 and families to request additional assistance directly from a spe-
19 cially-trained individual if the patient's condition appears to be
20 deteriorating. The acute care hospital shall have an early recogni-
21 tion and response method most suitable for the hospital's needs
22 and resources, such as a rapid response team. The method shall be
23 available 24 hours per day.

24 Section 53G. Any entity that is certified or seeking certification
25 as an ambulatory surgical center by the Centers for Medicare and
26 Medicaid Services for participation in the Medicare program shall
27 be a clinic for the purpose of licensure under Section 51, and shall
28 be deemed to be in compliance with the conditions for licensure
29 as a clinic under said Section 51 if it is accredited to provide
30 ambulatory surgery services by the Accreditation Association for
31 Ambulatory Health Care, Inc., the Joint Commission on Accredi-
32 tation of Healthcare Organizations, the American Association for
33 Accreditation of Ambulatory Surgery Facilities or any other
34 national accrediting body that the department determines provides
35 reasonable assurances that such conditions are met. No original
36 license shall be issued pursuant to said section 51 to establish any
37 such ambulatory surgical clinic unless there is a determination by
38 the department that there is a need for such a facility. For purposes
39 of this section, "clinic" shall not include a clinic conducted by a
40 hospital licensed under said Section 51 or by the federal govern-
41 ment or the Commonwealth. The department shall promulgate
42 regulations to implement this section.

1 SECTION 10. The first paragraph of Section 70 of said chapter,
2 as appearing in the 2006 Official Edition, is hereby amended by
3 striking out the second and third sentences and inserting in place
4 thereof the following 4 sentences:— These records may be hand-

5 written, printed, typed or in electronic digital media or converted
6 to electronic digital media as originally created by such hospital
7 or clinic, by the photographic or microphotographic process, or
8 any combination thereof. The hospital or clinic may destroy
9 records only after the applicable retention period has elapsed and
10 after notifying the department of public health, in accordance with
11 its regulations, that the records will be destroyed. The department,
12 through its regulations, shall establish an appropriate notification
13 process. On the notice of privacy practices distributed to its
14 patients, a hospital or clinic shall provide:— (i) information con-
15 cerning the provisions of this section and (ii) the hospital or clin-
16 ic's records termination policy.

1 SECTION 11. Said Section 70 of said Chapter 111, as so
2 appearing, is hereby further amended by striking out, in line 66,
3 the word “thirty” and inserting in place thereof the following
4 figure:— 20.

1 SECTION 12. The General Laws are hereby amended by
2 inserting after Chapter 111M the following chapter:—

3 **CHAPTER 111N.**
4 **PHARMACEUTICAL AND MEDICAL DEVICE**
5 **MANUFACTURER CONDUCT.**

6 Section 1. As used in this chapter the following words shall,
7 unless the context clearly requires otherwise, have the following
8 meanings:—

9 “Department”, the department of public health.

10 “Drug” or “medicine”, (i) articles recognized in the official
11 United States Pharmacopoeia, the official Homeopathic Pharma-
12 copoeia of the United States, or official National Formulary, or
13 any supplement to any of them; (ii) articles and devices intended
14 for use in the diagnosis, cure, mitigation, treatment or prevention
15 of disease in man or other animals; (iii) articles, other than food,
16 aspirin and effervescent saline analgesics, intended to affect the
17 structure or any function of the body of man or other animals; (v)
18 articles intended for use as a component of any article specified in
19 clause (i), (ii) or (iii); or any controlled substance.

20 “Manufacturer”, a person who:— (i) derives, produces, pre-
21 pares, compounds, mixes, cultivates, grows or processes any drug
22 or medicine; (ii) repackages any drug or medicine for the purposes
23 of resale; or (iii) produces or makes any devices or appliances that
24 are restricted by federal law to sale by or on the order of a physi-
25 cian.

26 “Wholesaler”, a wholesale distributor who supplies or distrib-
27 utes drugs, medicines or chemicals or devices or appliances that
28 are restricted by federal law to sale by or on the order of a physi-
29 cian to a person other than the consumer or patient, including a
30 person who derives, produces, prepares or repackages drugs, med-
31 icines or chemicals or devices or appliances that are restricted by
32 federal law to sale by or on the order of a physician on sales
33 orders for resale; but not including a nonprofit cooperative agri-
34 cultural organization which supplies or distributes veterinary
35 drugs and medicines only to its own members.

36 Section 2. (a) A wholesaler or manufacturer who employs a
37 person to sell or market a drug, medicine, chemical, device or
38 appliance in the Commonwealth shall adopt a written marketing
39 code of conduct establishing the practices and standards that
40 govern the marketing and sale of its products. The marketing code
41 of conduct shall be based on applicable legal standards and incor-
42 porate principles of health care including, without limitation,
43 requirements that the activities of the wholesaler or manufacturer
44 be intended to benefit patients, enhance the practice of medicine
45 and not interfere with the independent judgment of health care
46 professionals. Adoption of the most recent version of the Code on
47 Interactions with Healthcare Professionals developed by the Phar-
48 maceutical Research and Manufacturers of America satisfies the
49 requirements of this subsection. Adoption of the most recent ver-
50 sion of the Code on Interactions with HealthCare Professionals
51 developed by the Advanced Medical Technology Association sat-
52 isfies the requirements of this subsection.

53 (b) A wholesaler or manufacturer who employs a person to sell
54 or market a drug, medicine, chemical, device or appliance in the
55 Commonwealth shall adopt a training program to provide regular
56 training to appropriate employees including, without limitation,
57 all sales and marketing staff, on the marketing code of conduct.

58 (c) A wholesaler or manufacturer who employs a person to sell
59 or market a drug, medicine, chemical, device or appliance in the
60 Commonwealth shall conduct annual audits to monitor compli-
61 ance with the marketing code of conduct.

62 (d) A wholesaler or manufacturer who employs a person to sell
63 or market a drug, medicine, chemical, device or appliance in the
64 commonwealth shall adopt policies and procedures for investi-
65 gating instances of noncompliance with the marketing code of
66 conduct including, without limitation, the maintenance of effec-
67 tive lines of communication for employees to report noncompli-
68 ance, the investigation of reports of noncompliance, the taking of
69 corrective action in response to noncompliance and the reporting
70 of instances of noncompliance to law enforcement authorities in
71 appropriate circumstances.

72 (e) A wholesaler or manufacturer who employs a person to sell
73 or market a drug, medicine, chemical, device or appliance in the
74 commonwealth shall identify a compliance officer responsible for
75 developing, operating and monitoring the marketing code of con-
76 duct.

77 Section 3. A wholesaler or manufacturer who employs a person
78 to sell or market a drug, medicine, chemical, device or appliance
79 in the commonwealth shall annually submit to the department:—

80 (i) a copy of its marketing code of conduct; (ii) a description of its
81 training program; (iii) a description of its investigation policies;
82 (iv) the name, title, address, telephone number and electronic mail
83 address of its compliance officer; and (v) certification that it has
84 conducted its annual audit and is in compliance with its marketing
85 code of conduct.

86 Section 4. On or before January 15 of each odd-numbered year,
87 the department shall prepare and submit to the governor, and to
88 the chairs of the joint committee on health care financing and the
89 chairs of the house and senate committee on ways and means, a
90 compilation of the information submitted to the department pur-
91 suant to Section 3, other than any information identified as a trade
92 secret in the information submitted to the department.

93 Section 5. The department shall determine the manner and form
94 of the submissions required under Section 3 and shall define com-
95 pliance for the purposes of this chapter. The department shall not
96 require the disclosure of the results of an audit conducted pursuant

97 to subsection (c) of Section 2. The department shall publish on its
98 website information concerning the compliance of all wholesalers
99 and manufacturers with the requirements of this chapter. The
100 department shall not disclose any proprietary or confidential busi-
101 ness information that it receives pursuant to this section.

102 Section 6. The department shall promulgate rules and regula-
103 tions for the administration and enforcement of this chapter.

1 SECTION 13. The last paragraph of Section 2 of Chapter 112
2 of the General Laws, as appearing in the 2006 Official Edition, is
3 hereby amended by adding the following sentence:—

4 The board shall require, as a standard of eligibility for licen-
5 sure, that applicants show a predetermined level of competency in
6 the use of computerized physician order entry, e-prescribing, elec-
7 tronic health records and other forms of health information tech-
8 nology, as determined by the board.

1 SECTION 14. Section 9E of said Chapter 112, as so appearing,
2 is hereby amended by striking out, in line 6, the word “two” and
3 inserting in place thereof the following figure:— 4.

1 SECTION 15. Said Chapter 112 is hereby further amended by
2 inserting after section 39C the following 2 sections:—

3 Section 39D. (a) As used in this section the following words
4 shall, unless the context clearly requires otherwise, have the
5 following meanings:—

6 “Administrator”, any person who receives or collects charges,
7 contributions or premiums for, or adjusts or settles claims in con-
8 nection with, any type of health benefit provided under the plan as
9 an alternative to insurance.

10 “Carrier”, an insurer licensed or otherwise authorized to
11 transact accident and health insurance under Chapter 175; a non-
12 profit hospital service corporation organized under Chapter 176A;
13 a non-profit medical service corporation organized under Chapter
14 176B; a health maintenance organization organized under Chapter
15 176G; or an organization entering into a preferred provider
16 arrangement under Chapter 176I.

17 “Commercial purpose”, advertising, marketing, promotion, or
18 any similar activity that is used or intended to be used to influence

19 sales or the market share of a pharmaceutical drug, to influence or
20 elevate the prescribing behavior of a prescriber, market prescrip-
21 tion drugs to individuals or to elevate the effectiveness of a pro-
22 fessional pharmaceutical detailing sales force.

23 “Electronic transmission intermediary”, an entity that provides
24 the infrastructure that connects the computer systems or other
25 electronic devices used by health care practitioners, prescribers,
26 pharmacies, health care facilities and pharmacy benefit managers,
27 carriers, administrators and agents and contractors of those per-
28 sons and entities in order to facilitate the secure transmission of
29 an individual’s prescription drug order, refill, authorization
30 request, claim, payment or other prescription drug information.

31 “Health care facility”, a licensed facility, institution or entity
32 licensed that offers health care to persons in the Commonwealth,
33 including a health care provider, home health care provider, hos-
34 pice program and a pharmacy.

35 “Health care practitioner”, a person licensed to provide or oth-
36 erwise lawfully providing health care or a partnership or corpora-
37 tion made up of those persons or an officer, employee, agent or
38 contractor of that person acting in the course and scope of
39 employment, agency or contract related to or supportive of the
40 provision of health care to individuals.

41 “Health plan”, a health plan providing prescription drug cov-
42 erage as authorized under the federal Medicare Prescription Drug,
43 Improvement and Modernization Act of 2003, Public Law 108-
44 173.

45 “Identifying information”, information that can be used to
46 directly or indirectly identify the individual or the prescriber,
47 including a person’s name, address, telephone number, facsimile
48 number, electronic mail address, photograph or likeness, account,
49 credit card, medical record, social security number, or any other
50 unique number, characteristic, code or information which is likely
51 to lead to the identification of the individual or prescriber.

52 “Individual”, a natural person who is the subject of prescription
53 drug information.

54 “Pharmacy”, any retail drug business registered by the board of
55 registration in pharmacy in accordance with Section 39 that is
56 authorized to dispense controlled substances, including a retail

57 drug businesses as defined in Section 1 of Chapter 94C and a mail
58 order pharmacy.

59 “Prescriber”, a person who is licensed, registered or otherwise
60 authorized to prescribe and administer drugs in the course of pro-
61 fessional practice.

62 “Prescription drug information”, information concerning a pre-
63 scription drug that:— (i) is required under federal law to be
64 labeled “Caution: Federal law prohibits dispensing without pre-
65 scription” prior to being dispensed or delivered, (ii) is required by
66 an applicable federal or state law or rule to be dispensed on pre-
67 scription only, or (iii) is restricted to use by practitioners only;
68 including the lawful written or oral order of a practitioner for a
69 drug or device, issued on a prescription form or by electronic
70 transmission.

71 “Prescription drug information intermediary”, a person or entity
72 that communicates, facilitates or participates in the exchange of
73 prescription drug information regarding an individual or a pre-
74 scriber, including, but shall not limited to, a pharmacy benefits
75 manager, a health plan, an administrator and an electronic trans-
76 mission intermediary.

77 “Regulated transaction”, a prescription for a drug that is written
78 by a prescriber within the Commonwealth or that is dispensed
79 within the Commonwealth.

80 (b) A prescriber, carrier, pharmacy, or prescription drug infor-
81 mation intermediary shall not license, use, sell, transfer or
82 exchange for value, for any commercial purpose, prescription
83 drug information related to a regulated transaction that has identi-
84 fying information, except for:— (i) the transfer of prescription
85 drug information, including identification of the individual and
86 prescriber, as required under the Chapter 94C; (ii) the dispensing
87 of prescription drugs to an individual or the individual’s autho-
88 rized representative, the transmission of prescription drug infor-
89 mation between a prescriber and a pharmacy or other health care
90 practitioner caring for the individual and the transfer of prescrip-
91 tion information between pharmacies; (iii) the transfer of prescrip-
92 tion records that may occur when a pharmacy’s ownership is
93 changed or transferred; (iv) care management educational commu-
94 nications provided to an individual about the individual’s health
95 condition, adherence to a prescribed course of therapy or other

96 information relating to the drug being dispensed, treatment
97 options or clinical trials; (v) transfers for the limited purpose of
98 pharmacy reimbursement, prescription drug formulary or prior
99 authorization compliance, patient care management, utilization
100 review, health care research or as required by law; and (vi) the
101 collection, use, transfer or sale of prescription drug information
102 that is de-identified and that does not directly or indirectly iden-
103 tify the individual or prescriber.

104 (c) A violation of this section shall be an unfair or deceptive act
105 or practice in the conduct of trade in violation of Section 2 of
106 Chapter 93A. Any person whose rights under this section have
107 been violated may institute and prosecute in his own name and on
108 his own behalf, or the attorney general, acting on behalf of the
109 Commonwealth, may institute a civil action for injunctive and
110 other equitable relief.

111 Section 39E. Stores or pharmacies engaged in the drug busi-
112 ness, as defined in section 37, shall inform the department of
113 public health of any improper dispensing of prescription drugs
114 that results in serious injury or death, as defined by the depart-
115 ment in regulations, as soon as is reasonably and practically pos-
116 sible, but not later than 15 working days after discovery of the
117 improper dispensing. The department of public health shall pro-
118 mulgate regulations for the administration and enforcement of this
119 section.

1 SECTION 16. Chapter 118E of the General Laws is hereby
2 amended by adding the following section:—

3 Section 55. (a) Subject to subsection (c), for the purposes of
4 processing claims for health care services submitted by a health
5 care provider and to provide uniformity and consistency in the
6 reporting of patient diagnostic information, patient care service
7 and procedure information as it relates to the submission and pro-
8 cessing of health care claims, the executive office of health and
9 human services and its subcontractors shall, without local cus-
10 tomization, accept and recognize patient diagnostic information
11 and patient care service and procedure information submitted pur-
12 suant to, and consistent with, the current Health Insurance Porta-
13 bility and Accountability Act compliant code sets as adopted by
14 the Centers for Medicare and Medicaid Services:— the Interna-

15 tional Classification of Diseases; the American Medical Associa-
16 tion's Current Procedural Terminology codes, reporting guidelines
17 and conventions; and the Centers for Medicare and Medicaid
18 Services Healthcare Common Procedure Coding System. The
19 executive office and its subcontractors shall adopt the aforemen-
20 tioned coding standards and guidelines, and all changes thereto, in
21 their entirety, which shall be effective on the same date as the
22 national implementation date established by the entity imple-
23 menting the coding standards.

24 (b) Subject to subsection (c), the executive office and its sub-
25 contractors shall, without local customization, use the standard-
26 ized claim formats for processing health care claims as adopted by
27 the National Uniform Claim Committee and the National Uniform
28 Billing Committee and implemented pursuant to the federal
29 Health Insurance Portability and Accountability Act. The execu-
30 tive office and its subcontractors shall, without local customiza-
31 tion, adopt and routinely process all changes to such formats
32 which shall be effective on the same date as the implementation
33 date established by the entity implementing the formats.

34 (c) Except for the requirements for consistency and uniformity
35 in coding patient diagnostic information and patient care service
36 and procedure information, this section shall not modify or super-
37 sede the executive office's or its subcontractor's payment policy
38 or utilization review policy. Nothing in this section shall preclude
39 the executive office or a subcontractor thereof from adjudicating a
40 claim pursuant to its billing guidelines, payment policies or
41 provider contracts.

42 (d) The executive office and its subcontractors shall accept and
43 recognize at least 85 per cent of all claims submitted by health
44 care providers pursuant to this section.

1 SECTION 17. Section 55 of said Chapter 118E, added by
2 section 16, is hereby amended by striking out subsection (d) and
3 inserting in place thereof the following subsection:—

4 (d) The executive office and its subcontractors shall accept and
5 recognize all claims submitted by health care providers pursuant
6 to this section.

1 SECTION 18. Section 1 of Chapter 118G of the General Laws,
2 as appearing in the 2006 Official Edition, is hereby amended by
3 inserting after the definition of “Pediatric specialty unit” the
4 following definition:—

5 “Private health care payer”, a carrier authorized to transact
6 accident and health insurance under Chapter 175, a nonprofit hos-
7 pital service corporation licensed under Chapter 176A, a nonprofit
8 medical service corporation licensed under Chapter 176B, a dental
9 service corporation organized under Chapter 176E, an optometric
10 service corporation organized under Chapter 176F, or a health
11 maintenance organization licensed under Chapter 176G.

1 SECTION 19. Said Section 1 of said Chapter 118G, as so
2 appearing, is hereby further amended by inserting after the defini-
3 tion of “Provider” the following definition:—

4 “Public health care payer”, the Medicaid program established in
5 Chapter 118E; any carrier or other entity that contracts with the
6 office of Medicaid or the Commonwealth health insurance con-
7 nector to pay for or arrange the purchase of health care services on
8 behalf of individuals enrolled in health coverage programs under
9 Titles XIX or XXI, or under the Commonwealth care health insur-
10 ance program, including prepaid health plans subject to the provi-
11 sions of Section 28 of Chapter 47 of the acts of 1997; the group
12 insurance commission established under chapter 32A; and any
13 city or town with a population of more than 60,000 that has
14 adopted Chapter 32B.

1 SECTION 20. Section 2 of said Chapter 118G, as so appearing,
2 is hereby amended by striking out the second paragraph and
3 inserting in place thereof the following paragraph:—

4 The commissioner shall appoint and may remove such agents
5 and subordinate officers as the commissioner may deem necessary
6 and may establish such subdivisions within the division as the
7 commissioner deems appropriate from time to time to fulfill the
8 following duties:— (i) to collect, analyze and disseminate health
9 care data to assist in the formulation of health care policy and in
10 the provision and purchase of health care services; (ii) to work
11 with other state agencies including, but not limited to, the depart-
12 ments of public health and mental health, the health care quality

13 and cost council and the divisions of medical assistance and insur-
14 ance to collect and publish data concerning the cost of health
15 insurance in the Commonwealth and the health status of individ-
16 uals; (iii) to hold annual hearings concerning health care provider
17 and payer costs and cost trends, and to provide an analysis of
18 health care spending trends with recommendations for strategies
19 to promote an efficient health delivery system; and (iv) to admin-
20 ister the health safety net office and trust fund established under
21 Sections 35 and 36 of this chapter.

1 SECTION 21. Section 6 of said chapter 118G, as so appearing,
2 is hereby amended by striking out the third paragraph and
3 inserting in place thereof the following 4 paragraphs:—

4 The division may promulgate regulations necessary to ensure
5 the uniform reporting of information from private and public
6 health care payers that enables the division to analyze:— (i)
7 changes over time in health insurance premium levels, (ii)
8 changes in the benefit and cost-sharing design of plans offered by
9 these payers, and (iii) changes in measures of plan cost and uti-
10 lization; provided that this analysis shall facilitate comparison
11 among plans and between public and private payers.

12 The division shall require the submission of data and other
13 information from each private health care payer offering small or
14 large group health plans including, without limitation:— (i)
15 average annual individual and family plan premiums for each pay-
16 er's most popular plans for a representative range of group sizes,
17 as further determined in regulations, and average annual indi-
18 vidual and family plan premiums for the lowest cost plan in each
19 group size that meets the minimum standards and guidelines
20 established by the division of insurance under Section 8H of
21 Chapter 26; (ii) information concerning the actuarial assumptions
22 that underlie the premiums for each plan; (iii) summaries of the
23 plan designs for each plan; (iv) information concerning the med-
24 ical and administrative expenses, including medical loss ratios for
25 each plan; (v) information concerning the payer's current level of
26 reserves and surpluses; and (vi) information on provider payment
27 methods and levels.

28 The division shall require the submission of data and other
29 information from public health care payers including, without lim-

30 itation:— (i) average premium rates for health insurance plans
31 offered by public payers and information concerning the actuarial
32 assumptions that underlie these premiums; (ii) average annual per-
33 member per-month payments for enrollees in MassHealth primary
34 care clinician and fee for service programs; (iii) summaries of
35 plan designs for each plan or program; (iv) information con-
36 cerning the medical and administrative expenses, including med-
37 ical loss ratios for each plan or program; (v) where appropriate,
38 information concerning the payer's current level of reserves and
39 surpluses; and (vi) information on provider payment methods and
40 levels, including information concerning payment levels to each
41 hospital for the 25 most common medical procedures provided to
42 enrollees in these programs, in a form that allows payment com-
43 parisons between Medicaid programs and managed care organiza-
44 tions under contract to the office of Medicaid.

45 The division shall, before adopting regulations under this
46 section, consult with other agencies of the Commonwealth and the
47 federal government, affected providers, and affected payers, as
48 applicable, to ensure that the reporting requirements imposed
49 under the regulations are not duplicative or excessive. If reporting
50 requirements imposed by the division result in additional costs for
51 the reporting providers, these costs may be included in any rates
52 promulgated by the division for these providers. The division may
53 specify categories of information which may be furnished under
54 an assurance of confidentiality to the provider; provided that such
55 assurance shall only be furnished if the information is not to be
56 used for setting rates.

1 SECTION 22. Said Chapter 118G is hereby further amended by
2 inserting after section 6 the following section:—

3 Section 6½. (a) The division shall hold annual public hearings
4 based on the information submitted under Sections 6 and 6A con-
5 cerning health care provider and private and public health care
6 payer costs and cost trends, with particular attention to factors that
7 contribute to cost growth within the Commonwealth's health care
8 system and to the relationship between provider costs and payer
9 premiums.

10 (b) Hearings shall be held by the commissioner or a designee,
11 or a hearings officer, if authorized by the commissioner. Public

12 notice of any hearing shall be provided at least 60 days in
13 advance.

14 (c) The division shall, 30 days before the date of any hearing,
15 publish a preliminary report of its findings based on information
16 provided under section 6. The division may contract with an out-
17 side organization with expertise in issues related to the topics of
18 the hearings to produce this preliminary report. The division shall
19 use this preliminary report as a basis for designing the format and
20 content of the hearing.

21 (d) The division shall identify as potential witnesses at the
22 public hearing a representative sample of providers and payers,
23 including:— (i) at least 3 academic medical centers, including the
24 2 acute hospitals with the highest level of net patient service rev-
25 enue; (ii) at least 3 disproportionate share hospitals, including the
26 2 hospitals whose largest percent of gross patient service revenue
27 is attributable to Title XVIII and XIX of the federal Social Secu-
28 rity Act or other governmental payers; (iii) community hospitals
29 from at least 3 separate regions of the state; (iv) freestanding
30 ambulatory surgical centers from at least 3 separate regions of the
31 state; (v) community health centers from at least 3 separate
32 regions of the state; (vi) the 5 private health care payers with the
33 highest enrollments in the state; (vii) any managed care organiza-
34 tion that provides health benefits under Title XIX or under the
35 commonwealth care health insurance program; (viii) the group
36 insurance commission; and (ix) at least 3 municipalities that have
37 adopted Chapter 32B.

38 (e) Witnesses shall provide testimony at the public hearing in a
39 manner and form to be determined by the division, including
40 without limitation:— (i) in the case of providers, testimony con-
41 cerning payment systems, payer mix, cost structures, administra-
42 tive and labor costs, capital and technology costs, adequacy of
43 public payer reimbursement levels, reserve levels, utilization
44 trends, and cost-containment strategies, the relation of private
45 payer reimbursement levels to public payer reimbursements for
46 similar services, efforts to improve the efficiency of the delivery
47 system, efforts to reduce the inappropriate or duplicative use of
48 technology; and (ii) in the case of private and public payers, testi-
49 mony concerning factors underlying premium cost increases, the
50 relation of reserves to premium costs, the payer's efforts to

51 develop benefit design and payment policies that enhance product
52 affordability and encourage efficient use of health resources and
53 technology, efforts by the payer to increase consumer access to
54 health care information, and efforts by the payer to promote the
55 standardization of administrative practices, and any other matters
56 as determined by the division.

57 (f) The division shall compile an annual report concerning
58 spending trends and underlying factors, along with any recom-
59 mendations for strategies to increase the efficiency of the health
60 care system. The report shall be based on the division's analysis
61 of information provided at the hearings by providers and insurers,
62 data collected by the division under Sections 6 and 6A of this
63 chapter, and any other information the division considers neces-
64 sary to fulfill its duties under this section, as further defined in
65 regulations promulgated by the division. The division shall con-
66 sult with the health care quality and cost council when developing
67 any measures or criteria to be used in its analysis. The report shall
68 be submitted to the chairs of the house and senate committees on
69 ways and means, the chairs of the joint committee on health care
70 financing and shall be published and available to the public no
71 later than December 31st.

1 SECTION 23. Section 36 of Chapter 123 of the General Laws,
2 as appearing in the 2006 Official Edition, is hereby amended by
3 adding the following 4 sentences:— Each facility, subject to this
4 chapter and Section 19 of Chapter 19, that provides mental health
5 care and treatment shall maintain patient records, as defined in the
6 first paragraph of Section 70 of Chapter 111, for at least 20 years
7 after the closing of the record due to discharge, death or last date
8 of service. A facility shall not destroy such records until after the
9 retention period has elapsed and only upon notifying the depart-
10 ment of public health that the records will be destroyed, provided
11 that the department shall promulgate regulations further defining
12 an appropriate notification process. On the notice of privacy prac-
13 tices distributed to its patients, each facility shall provide:— (i)
14 information concerning the provisions of this section and (ii) the
15 hospital or clinic's records termination policy.

1 SECTION 24. Chapter 176O of the General Laws is hereby
2 amended by inserting after section 5 the following 2 sections:—

3 Section 5A. (a) Subject to subsection (c), for the purposes of
4 processing claims for health care services submitted by a health
5 care provider and to provide uniformity and consistency in the
6 reporting of patient diagnostic information, patient care service
7 and procedure information as it relates to the submission and pro-
8 cessing of health care claims, a carrier and its subcontractors
9 shall, without local customization, accept and recognize patient
10 diagnostic information and patient care service and procedure
11 information submitted pursuant to, and consistent with the current
12 Health Insurance Portability and Accountability Act compliant
13 code sets:— the International Classification of Diseases; the
14 American Medical Association’s Current Procedural Terminology
15 codes, reporting guidelines and conventions; and the Centers for
16 Medicare and Medicaid Services Healthcare Common Procedure
17 Coding System. A carrier and its subcontractors shall adopt the
18 aforementioned coding standards and guidelines, and all changes
19 thereto, in their entirety, which shall be effective on the same date
20 as the national implementation date established by the entity
21 implementing the coding standards.

22 (b) Subject to subsection (c), a carrier and its subcontractors
23 shall, without local customization, use the standardized claim for-
24 mats for processing health care claims as adopted by the National
25 Uniform Claim Committee and the National Uniform Billing
26 Committee and implemented pursuant to the Health Insurance
27 Portability and Accountability Act. A carrier and its subcontrac-
28 tors shall, without local customization, adopt and routinely
29 process all changes to such formats which shall be effective on the
30 same date as the implementation date established by the entity
31 implementing the formats.

32 (c) Except for the requirements for consistency and uniformity
33 in coding patient diagnostic information and patient care service
34 and procedure information, this section shall not modify or super-
35 sede a carrier’s or its subcontractor’s payment policy, utilization
36 review policy or benefits under a health benefit plan. Nothing in
37 this section shall further preclude a carrier or a subcontractor
38 thereof from adjudicating a claim pursuant to its billing guide-
39 lines, payment policies, provider contracts or health benefit plans.

40 (d) Carriers and subcontractors thereof shall accept and recog-
41 nize at least 85 per cent of all claims submitted by health care
42 providers pursuant to this section.

43 Section 5B. To ensure uniformity and consistency in the sub-
44 mission and processing of claims for health care services pursuant
45 to Section 5A, the bureau of managed care within the division of
46 insurance, after consultation with a statewide advisory committee
47 including, but not limited to, representatives of the Massachusetts
48 Hospital Association, the Massachusetts Medical Society, the
49 Massachusetts Association of Health Plans, the Blue Cross and
50 Blue Shield of Massachusetts, the Massachusetts Health Informa-
51 tion Management Association, the Massachusetts Health Data
52 Consortium, a representative of America's Health Insurance Plans,
53 a representative of a MassHealth contracted managed care organi-
54 zation, the executive office of health and human services, the divi-
55 sion of health care finance and policy, the health care quality and
56 cost council, the house of representatives and the senate, shall
57 adopt policies and procedures to enforce said Section 5A. The
58 policies and procedures shall include a system for reporting incon-
59 sistencies related to a carrier's compliance with said Section 5A.
60 The bureau shall work jointly with the executive office of health
61 and human services to resolve reports of noncompliance with the
62 requirements of Section 61 of Chapter 118E. The bureau shall
63 convene the advisory committee annually to review and discuss
64 issues reported by health care providers pursuant to this section
65 and to discuss further recommendations to improve the uniformity
66 and consistency of the reporting of patient diagnostic information
67 and patient care service and procedure information as it relates to
68 the submission and processing of health care claims.

1 SECTION 25. Section 5A of said Chapter 176O, inserted by
2 Section 24, is hereby amended by striking out subsection (d) and
3 inserting in place thereof the following subsection:—

4 (d) Carriers and their subcontractors shall accept and recognize
5 all claims submitted by health care providers pursuant to this
6 section.

1 SECTION 26. The General Laws are hereby amended by
2 inserting after chapter 176Q the following chapter:—

3 **CHAPTER 176R.**
4 **CONSUMER CHOICE OF**
5 **NURSE PRACTITIONER SERVICES.**

6 Section 1. As used in this chapter the following words shall,
7 unless the context clearly requires otherwise, have the following
8 meanings:—

9 “Carrier”, an insurer licensed or otherwise authorized to
10 transact accident or health insurance under Chapter 175; a non-
11 profit hospital service corporation organized under Chapter 176A;
12 a nonprofit medical service corporation organized under Chapter
13 176B; a health maintenance organization organized under Chapter
14 176G; an organization entering into a preferred provider arrange-
15 ment under Chapter 176I; a contributory group general or blanket
16 insurance for persons in the service of the Commonwealth under
17 Chapter 32A; a contributory group general or blanket insurance
18 for persons in the service of counties, cities, towns and districts,
19 and their dependents under Chapter 32B; the medical assistance
20 program administered by the division of medical assistance pur-
21 suant to Chapter 118E and in accordance with Title XIX of the
22 Social Security Act or any successor statute; and any other med-
23 ical assistance program operated by a governmental unit for per-
24 sons categorically eligible for such program, except as otherwise
25 prohibited by state or federal law or regulation.

26 “Commissioner”, the commissioner of insurance.

27 “Insured”, an enrollee, covered person, insured, member, poli-
28 cyholder or subscriber of a carrier.

29 “Nondiscriminatory basis”, a carrier shall be deemed to be pro-
30 viding coverage on a non-discriminatory basis if its plan does not
31 contain any annual or lifetime dollar or unit of service limitation
32 imposed on coverage for the care provided by a nurse practitioner
33 which is less than any annual or lifetime dollar or unit of service
34 limitation imposed on coverage for the same services by other
35 participating providers.

36 “Nurse practitioner”, a registered nurse who holds authorization
37 in advanced nursing practice as a nurse practitioner under Section
38 80B of Chapter 112 and regulations promulgated thereunder.

39 “Participating provider”, a health care professional qualified to
40 provide general medical care for common health care problems,

41 supervises, coordinates, prescribes, or otherwise provides or pro-
42 poses health care services, initiates referrals for specialist care,
43 and maintains continuity of care within the scope of practice.

44 “Physician’s Assistant”, a person duly registered by the Board
45 of Registration in Medicine and meets all requirements of Sec-
46 tions 9E and 9F of Chapter 112 and regulations promulgated
47 thereafter.

48 “Primary care provider”, a health care professional qualified to
49 provide general medical care for common health care problems,
50 supervises, coordinates, prescribes, or otherwise provides or pro-
51 poses health care services, initiates referrals for specialist care,
52 and maintains continuity of care within the scope of practice.

53 Section 2. The commissioner and the group insurance commis-
54 sion shall require that all carriers recognize nurse practitioners
55 and physician’s assistants as participating providers subject to
56 Section 3 and shall include coverage on a nondiscriminatory basis
57 to their insureds for care provided by nurse practitioners and
58 physician’s assistants for the purposes of health maintenance,
59 diagnosis and treatment. Such coverage shall include benefits for
60 primary care, intermediate care and inpatient care, including care
61 provided in a hospital, clinic, professional office, home care set-
62 ting, long-term care setting, mental health or substance abuse pro-
63 gram, or any other setting when rendered by a nurse practitioner
64 who is a participating provider and is practicing within the scope
65 of his professional license to the extent that such policy or con-
66 tract currently provides benefits for identical services rendered by
67 a provider of health care licensed by the Commonwealth.

68 Section 3. A participating nurse practitioner practicing within
69 the scope of license, including all regulations requiring collabora-
70 tion with a physician under Section 80B of Chapter 112, shall be
71 considered qualified within the carrier’s definition of primary care
72 provider to an insured.

73 Section 4. Notwithstanding any general or special law to the
74 contrary, a carrier that requires the designation of a primary care
75 provider shall provide its insured with an opportunity to select a
76 participating provider nurse practitioner as a primary care
77 provider or to change its primary care provider to a participating
78 provider nurse practitioner at any time during their coverage
79 period.

80 Section 5. Notwithstanding any general or special law to the
81 contrary, a carrier shall ensure that all participating provider nurse
82 practitioners and physician's assistants are included on any pub-
83 licly accessible list of participating providers for the carrier.

84 Section 6. A complaint for noncompliance against a carrier
85 shall be filed with and investigated by the commissioner or the
86 group insurance commission, whichever shall have regulatory
87 authority over the carrier. The commissioner and the group insur-
88 ance commission shall promulgate regulations for the administra-
89 tion and enforcement of this chapter.

1 SECTION 27. Section 10 of Chapter 182 of the acts of 2008 is
2 hereby repealed.

1 SECTION 27A. Section 87 of said Chapter 182 is hereby
2 repealed.

1 SECTION 28. Notwithstanding any general or special law to
2 the contrary, on or before October 1, 2008, the comptroller shall
3 transfer \$15,000,000 from the Medical Security Trust Fund, estab-
4 lished under Section 14G of Chapter 151A of the General Laws to
5 the Health Information Technology Fund established in
6 Section 6E of Chapter 40J of the General Laws.

1 SECTION 29. Notwithstanding any general or special law to
2 the contrary, the trustees of the University of Massachusetts shall
3 expand the entering class at its medical school and increase resi-
4 dencies for medical school graduates for students committed to
5 entering the primary care field and to working in underserved
6 regions of the Commonwealth. The trustees shall develop a master
7 plan for expanding medical student enrollment and increasing
8 internships and residencies for medical school graduates who are
9 committed to primary care and work in underserved regions
10 without reducing academic quality, together with a financial plan
11 to support such expansion, and shall report that plan to the clerk
12 of the house of representatives who shall forward the same to the
13 joint committee on health care financing and the house and senate
14 committees on ways and means on or before January 1, 2009.

1 SECTION 30. Notwithstanding any general or special law to
2 the contrary, the trustees of the University of Massachusetts, in
3 conjunction with the state health education center at the Univer-
4 sity of Massachusetts medical center, shall establish and maintain
5 an enhanced learning contract program available to medical stu-
6 dents every academic year. The program shall provide full waivers
7 of tuition and fees at the University of Massachusetts medical
8 school. In exchange for the waivers, the contract shall require at
9 least 4 years of service within the Commonwealth in areas of pri-
10 mary care, public or community service or underserved areas, as
11 determined by the health care workforce center established under
12 Section 25L of Chapter 111 of the General Laws and the learning
13 contract committee, in coordination with the area health education
14 center and state and regional health planning agencies. If a student
15 fails to perform the service required by an enhanced learning con-
16 tract, that student shall pay the difference between the tuition paid
17 and double the amount of the tuition charged together with an
18 origination fee, interest per annum at prime rate as reported at the
19 time of origination by the Federal Reserve, a margin and repay-
20 ment fee as established by the board. No service or tuition loan
21 repayment shall be required prior to the termination of any intern-
22 ship and residency requirements. Interest shall begin to accrue
23 upon completion of the requirements for the degree. The common-
24 wealth shall bear the cost of such tuition and fee waivers for
25 enhanced learning contracts. The dean of the medical school shall
26 report annually the number of students participating in enhanced
27 learning contracts, the area of medicine within which payback is
28 to be performed and the number of students utilizing the repay-
29 ment option. The report shall also outline the effects of payback in
30 the underserved areas of the Commonwealth.

1 SECTION 31. (a) Notwithstanding any general or special law
2 to the contrary, there shall be established and set up on the books
3 of the Commonwealth a separate fund to be known as the Massa-
4 chusetts Nursing and Allied Health Workforce Development Trust
5 Fund to which shall be credited any appropriations, bond proceeds
6 or other monies authorized by the general court and specifically
7 designated to be credited thereto, and additional funds, including
8 federal grants or loans or private donations made available to the

9 commissioner of higher education for this purpose. The depart-
10 ment of higher education shall hold the fund in an account sepa-
11 rate and apart from other funds or accounts. Amounts credited to
12 the fund shall be expended by the commissioner of higher educa-
13 tion to carry out subsection (b). Any balance in the fund at the
14 close of a fiscal year shall be available for expenditure in subse-
15 quent fiscal years and shall not revert to the General Fund.

16 (b) the fund shall be used to develop and support, in consulta-
17 tion with the Massachusetts Nursing and Allied Health Workforce
18 Development Advisory Committee, short-term and long-term
19 strategies to increase the number of public and private higher edu-
20 cation faculty and students who participate in programs that sup-
21 port careers in fields related to nursing and allied health. The
22 commissioner of higher education may expend such funds as may
23 be necessary for the administration of the Massachusetts Nursing
24 and Allied Health Workforce Development Initiative. In further-
25 ance of these public purposes, the commissioner of higher educa-
26 tion shall expend funds in the fund for activities that are
27 calculated to increase the number of qualified nursing and allied
28 health faculty and students and improve the nursing and allied
29 health educational offerings available in public higher education
30 institutions. Grants and other disbursements and activities may
31 involve, without limitation, the University of Massachusetts, state
32 and community colleges, private higher education institutions, pri-
33 vate higher education institutions in partnership with public
34 higher education institutions, business and industry partnerships,
35 regional alliances, workforce investment boards, organizations
36 granted tax-exempt status under section 501(c)(3) of the Internal
37 Revenue Code and other community groups which promote the
38 nursing profession. Grants and other disbursements and activities
39 may support, without limitation:— (i) the goal of rapidly
40 increasing the number of nurses and allied health workers; (ii)
41 enhancing the role of the system of public and private higher edu-
42 cation, as institutions and in partnerships with other stakeholders,
43 in meeting the short-term and long-term workforce challenges in
44 the nursing and allied health professions; (iii) the development
45 and use of innovative curricula, courses, programs and modes of
46 delivering education in nursing and allied health professions for
47 faculty and students in these fields; (iv) activities with the

48 growing network of stakeholders in the nursing and allied health
49 professions to create, implement, share and make broadly and
50 publicly available best practices and innovative programs relative
51 to instruction, development of partnerships and expanding and
52 maintaining faculty and student involvement in careers in these
53 fields; and (v) strengthening the institutional capacity to develop
54 and implement long-term programs and policies to effectively
55 respond to these challenges.

1 SECTION 32. Notwithstanding any general or special law to
2 the contrary, the department of housing and community develop-
3 ment, in consultation with the executive office of health and
4 human services, the department of workforce development and the
5 Massachusetts housing finance agency, shall establish a pilot grant
6 or loan program to assist hospitals, community health centers, and
7 physician practices in providing housing grants or loans for health
8 care professionals who commit to practicing in underserved areas,
9 identified by the health care workforce center, established under
10 section 25L of chapter 111, and who meet income eligibility
11 guidelines established by the department. Grants and loans may be
12 used for:— (i) purchasing a principal residence, including cooper-
13 ative housing, that falls within price guidelines established by the
14 department, including costs for down payments, mortgage interest
15 rate buy-downs, closing costs and other costs determined to be eli-
16 gible by the department; and (ii) payments for security deposits
17 and advance payments for rental housing. The department, to the
18 extent possible shall seek matching funds from hospitals and other
19 private entities.

20 The department shall promulgate rules and regulations for the
21 administration and enforcement of this section including, estab-
22 lishing provisions for eligibility, specifying the expenses for
23 which grants and loans may be made, and determining the proce-
24 dures necessary to qualify for assistance.

25 Two years after the commencement of the pilot program, the
26 department shall report to the house and senate committees on
27 ways and means, the joint committee on housing and the joint
28 committee on health care financing, the results of the pilot pro-
29 gram and shall recommend it for expansion, continuation or dis-
30 continuation.

1 SECTION 33. Notwithstanding any general or special law to
2 the contrary, the MassHealth payment policy advisory board,
3 established in Section 16M of Chapter 6A of the General Laws,
4 shall conduct a study of the need for an increase in Medicaid rates
5 or bonuses for primary care physicians, nurse practitioners and
6 subspecialists who provide primary care services, such as preven-
7 tive care, certain evaluation and management procedures, early
8 periodic screening, diagnosis and treatment and scheduled
9 weekend and holiday services, in order to focus on prevention and
10 wellness and delivery of primary care to identify illness earlier, to
11 better manage chronic disease and to avoid costs associated with
12 emergency room visits and hospitalizations. The committee shall
13 report its findings, including recommendations for the amount of
14 funding and the sources of funding, to the clerk of the house of
15 representatives who shall forward the same to the joint committee
16 on health care financing, and the house and senate committees on
17 ways and means on or before January 1, 2009.

1 SECTION 34. Notwithstanding any general or special law to
2 the contrary, on or before October 1, 2012, the department of
3 public health shall adopt regulations requiring hospitals and com-
4 munity health centers, as a standard of eligibility for original
5 licensure and renewal of licensure, to implement computerized
6 physician order entry systems as defined by the department. The
7 systems shall be certified by the Certification Commission for
8 Healthcare Information Technology or a successor agency or orga-
9 nization established for the purpose of certifying that health infor-
10 mation technology meets national interoperability standards.

1 SECTION 35. Notwithstanding any general or special law to
2 the contrary, on or before October 1, 2015, the department of
3 public health shall adopt regulations requiring hospitals and com-
4 munity health centers, as a standard of eligibility for original
5 licensure and renewal of licensure, to implement interoperable
6 electronic health records systems, as defined by the department.
7 The system shall be certified by the Certification Commission for
8 Healthcare Information Technology or a successor agency or orga-
9 nization established for the purpose of certifying that health infor-
10 mation technology meets national interoperability standards.

1 SECTION 36. Notwithstanding any general or special law to
2 the contrary, the executive office of health and human services
3 shall maximize enrollment of eligible persons in the MassHealth
4 Senior Care Options program, the Program of All Inclusive Care
5 for the Elderly, the Enhanced Community Options Program and
6 the Community Choices program, or comparable successor pro-
7 grams, and shall develop dual eligible plans. For the purposes of
8 this section, “dual eligible plans” shall be plans that offer similar
9 coverage to Medicaid and Medicare-eligible disabled persons
10 under age 65.

11 On or before January 1, 2009, the executive office of health and
12 human services shall prepare a report identifying clinical, admin-
13 istrative and financial barriers to the expansion of dual eligible
14 plans, and shall recommend steps to remove the barriers and
15 implement the plans. The executive office shall also explore the
16 feasibility of developing a process to passively enroll any eligible
17 beneficiary who has not voluntarily enrolled in an approved pro-
18 gram. Before finalizing the report, the executive office shall hold
19 a public consultative session that shall include organizations rep-
20 resenting seniors, organizations representing disabled persons,
21 organizations representing health care consumers, organizations
22 representing racial and ethnic minorities, health delivery systems
23 and health care providers. The report shall include consideration
24 of changes in procurement standards and MassHealth payment
25 methodologies to promote enrollment in dual eligible plans. The
26 report shall include estimates of the costs and benefits of imple-
27 menting steps to remove barriers to expanded enrollment in dual
28 eligible plans, including financial savings and improved quality of
29 care.

30 The report shall be provided to the committee on health care
31 financing and the house and senate committees on ways and
32 means. Subject to appropriation, the executive office of health and
33 human services shall implement any steps recommended by the
34 report. Not later than 1 year after the filing of the report, the exec-
35 utive office shall issue a progress statement on expanded enroll-
36 ment in dual eligible plans.

1 SECTION 37. Notwithstanding any general or special law to
2 the contrary, the division of insurance shall conduct an investiga-

3 tion and study of the costs of medical malpractice coverage for
4 health care providers, as defined in section 193U of chapter 175 of
5 the General Laws. The investigation and study shall include, but
6 not be limited to, an examination and analysis of the following:—
7 (1) the availability and affordability of medical malpractice insur-
8 ance;
9 (2) the factors considered by medical malpractice insurers when
10 increasing premiums;
11 (3) options for decreasing premiums including, but not limited
12 to, establishing a reinsurance pool with additional stop loss cov-
13 erage, subsidizing premium payments of providers practicing in
14 certain high-risk specialties or in specialties for which the cost of
15 premiums represents a disproportionately high proportion of a
16 health care provider's income, subsidizing premium payments of
17 providers who do not qualify for group coverage rates and pay
18 higher premiums for commercial market insurance and prorating
19 premiums for providers who practice less than full-time; and
20 (4) funding mechanisms that would facilitate the implementa-
21 tion of recommendations arising out of the study which may
22 include, but shall not be limited to, charges borne by the health
23 care industry or other entities. The division shall hold at least 2
24 public hearings to take testimony relating to the investigation and
25 study, 1 of which shall be held outside the metropolitan Boston
26 area. The division shall report its findings and recommendations
27 to the clerk of the house of representatives who shall forward the
28 same to the house and senate committee on ways and means and
29 the joint committee on health care financing on or before
31 January 1, 2009.

1 SECTION 38. Notwithstanding any general or special law to
2 the contrary, on or before January 1, 2009, the executive office of
3 health and human services, in consultation with the commission
4 on end-of-life care established by Section 480 of Chapter 159 of
5 the acts of 2000, shall initiate a public awareness campaign to
6 highlight the importance of end-of-life care planning. The cam-
7 paign shall include, but not be limited to, dissemination of infor-
8 mation and other activities that educate the public about existing
9 options for care at the end of life and how to communicate their

10 end-of-life care wishes to family members and health care
11 providers.

1 SECTION 39. Notwithstanding any general or special law to
2 the contrary, the executive office of health and human services, in
3 consultation with the commission on end-of-life care established
4 by Section 480 of Chapter 159 of the acts of 2000, shall establish
5 a pilot program to test the implementation of the physician order
6 for life-sustaining treatment paradigm program to assist individ-
7 uals in communicating end-of-life care directives across care set-
8 tings in at least 1 region of the Commonwealth. The pilot program
9 shall include educational outreach to patients, families, caregivers
10 and health care providers regarding the physician order for life-
11 sustaining treatment paradigm program. The executive office of
12 health and human services, in conjunction with the end-of-life
13 commission, shall develop measures to test the success of the pilot
14 program and make recommendations for the establishment of a
15 state-wide program.

1 SECTION 40. Notwithstanding any general or special law to
2 the contrary, the executive office of health and human services, in
3 consultation with the health care quality and cost council, com-
4 mission on end-of-life care established by Section 480 of Chapter
5 159 of the Acts of 2000, and the Betsy Lehman Center for Patient
6 Safety and the Reduction of Medical Errors, shall convene an
7 expert panel on end-of-life care for patients with serious chronic
8 illnesses. The panel shall investigate and study health care
9 delivery for these patients and the variations in delivery of such
10 care among health care providers in the commonwealth. For the
11 purposes of this investigation and study, “health care providers”
12 shall mean facilities and health care professionals licensed to pro-
13 vide acute inpatient hospital care, outpatient services, skilled
14 nursing, rehabilitation and long-term hospital care, home health
15 care and hospice services. The panel shall identify best practices
16 for end-of-life care, including those that minimize disparities in
17 care delivery and variations in practice or spending among geo-
18 graphic regions and hospitals, and shall present recommendations
19 for any legislative, regulatory, or other policy changes necessary
20 to implement its recommendations.

1 SECTION 41. Notwithstanding any general or special law to
2 the contrary, the secretary of administration and finance and the
3 secretary of health and human services shall prepare and submit a
4 report to the general court about the allocation for and use of state
5 funds by acute care hospitals, non-acute care hospitals, Medicaid
6 managed care organizations, other managed care organizations,
7 community health centers and carriers contracting with the com-
8 monwealth health insurance connector authority. The report shall
9 include:— (1) a comprehensive review of the current manner,
10 amount and purposes of annual state funding received by those
11 entities, including a description of the source of the funding;
12 (2) an assessment of the change in total state funding for those
13 entities over the past 5 years, with particular attention paid to the
14 impact of Chapter 58 of the acts of 2006;
15 (3) an assessment of how those entities use state funds;
16 (4) an assessment of whether the current payment structure
17 assures the delivery of quality health care in the most cost-effec-
18 tive way;
19 (5) an analysis of financial and management practices of those
20 entities by benchmarking performance with respect to quality and
21 cost effectiveness against national performance levels and similar
22 health care providers in the Commonwealth;
23 (6) identification of common factors that may contribute to the
24 fiscal instability of those entities;
25 (7) recommendations for the development of performance and
26 operational benchmarks;
27 (8) recommendations for ensuring that the entities are spending
28 state and other funds in a fiscally-responsible manner and pro-
29 viding quality care;
30 (9) recommendations for legislative and other action necessary
31 to strengthen state oversight and ensure greater accountability of
32 state resources;
33 (10) an assessment of the manner in which hospitals seek pay-
34 ment from consumers, including an analysis of the impact that
35 court filing fees have on their ability to collect payment; and
36 (11) recommendations for regulations regarding the due dili-
37 gence that facilities shall exercise in seeking to collect payment
38 from consumers before seeking reimbursement from the Com-
39 monwealth.

1 SECTION 42. (a) Notwithstanding any general or special law
2 to the contrary, there shall be a special commission on the health
3 care payment system that shall investigate reforming and restruc-
4 turing the system to provide incentives for efficient and effective
5 patient-centered care and to reduce variations in the quality and
6 cost of care.

7 (b) The commission shall consist of the secretary of administra-
8 tion and finance and the commissioner of health care finance and
9 policy, who shall serve as co-chairs, the executive director of the
10 group insurance commission, 1 person to be appointed by the
11 senate president, 1 person to be appointed by the speaker of the
12 house, 1 person to be appointed jointly by the minority leader of
13 the senate and the minority leader of the house of representatives,
14 and 5 members to be appointed by the governor, 1 of whom shall
15 be a representative of the Massachusetts Association of Health
16 Plans, Inc., 1 of whom shall be a representative of Blue Cross and
17 Blue Shield of Massachusetts, Inc., 1 of whom shall be a represen-
18 tative of the Massachusetts Hospital Association, Inc., 1 of whom
19 shall be a representative of the Massachusetts Medical Society,
20 and 1 of whom shall be a health economist or expert in the area of
21 payment methodology.

22 The commission shall adopt rules and establish procedures it
23 considers necessary for the conduct of its business. The commis-
24 sion may expend funds as may be appropriated or made available
25 for its purposes. No action of the commission shall be considered
26 official unless approved by a majority vote of the commission.

27 (c) The commission (i) shall examine payment methodologies
28 and purchasing strategies, including, but not limited to, alterna-
29 tives to fee-for-service models such as blended capitation rates,
30 episodes-of-care payments, medical home models, and global
31 budgets; pay-for-performance programs; tiering of providers; and
32 evidence-based purchasing strategies, (ii) recommend a common
33 transparent payment methodology that promotes coordination of
34 care and chronic disease management; rewards primary care
35 physicians for improving health outcomes; reduces waste and
36 duplication in clinical care; decreases unnecessary hospitaliza-
37 tions and use of ancillary services; and provides appropriate reim-
38 bursement for investment in health information technology that
39 reduces medical errors and enables coordination of care, and (iii)

40 recommend a plan for the implementation of the common pay-
41 ment methodology across all public and private payers in the
42 Commonwealth, including a plan under which the Commonwealth
43 shall seek a waiver from federal Medicare rules to facilitate the
44 implementation of the common payment system.

45 (d) In making its investigation, the commission shall consult
46 with the health care quality and cost council, the division of health
47 care finance and policy, health care economists, and others indi-
48 viduals or organizations with expertise in state and federal health
49 care payment methodologies and reforms. The commission shall
50 use data and recommendations gathered in the course of these
51 consultations as a basis for its findings and recommendations.

52 (e) The commission shall file a report of its findings and rec-
53 ommendations, including any proposed legislation needed to
54 implement the recommendations.

55 Before a final vote on any recommendations, the commission
56 shall consult with a reasonable variety of parties likely to be
57 affected by its recommendations, including, but not limited to, the
58 office of Medicaid, the division of health care finance and policy,
59 the commonwealth health insurance connector, the Massachusetts
60 Council of Community Hospitals, Inc., the Massachusetts League
61 of Community Health Centers, Inc., 1 or more academic medical
62 centers, 1 or more hospitals with a high proportion of public
63 payors, 1 or more Taft-Hartley plans, 1 or more self-insured plans
64 with membership of more than 500, the Massachusetts Municipal
65 Association, Inc. and organizations representing health care con-
66 sumers.

67 The commission shall hold its first meeting no later than Sep-
68 tember 15, 2008 and shall file the report of its findings and recom-
69 mendations together with legislation, if any, with the clerks of the
70 senate and the house of representatives and with the governor on
71 or before April 1, 2009.

1 SECTION 43. Notwithstanding any general or special law to
2 the contrary, the secretary of health and human services, in con-
3 sultation with the health care quality and cost council, shall:— (i)
4 examine the feasibility of the commonwealth entering into an
5 interstate compact with 1 or more states to establish an indepen-
6 dent entity to research the comparative effectiveness of medical

7 procedures, drugs, devices, and biologics, so that research results
8 can be used as a basis for health care purchasing and payment
9 decisions, and (ii) make recommendations concerning the entity's
10 design. The secretary shall consider existing state and country
11 models, including, but not limited to, the Washington State Health
12 Care Authority's Health Technology Assessment program, the
13 National Institute for Health and Clinical Excellence in Britain,
14 and the Institut für Qualität und Wirtschaftlichkeit im Gesund-
15 heitswesen in Germany. The secretary shall file a report with the
16 results of the study together with legislation, if any, with the clerk
17 of the senate and the clerk of the house of representatives on or
18 before March 30, 2009.

1 SECTION 44. Notwithstanding any general or special law to
2 the contrary, the office of Medicaid, subject to appropriation and
3 the availability of federal financial participation, and in consulta-
4 tion with the MassHealth payment policy advisory board, shall
5 restructure its payment system to support primary care practices
6 that use a medical home model and shall develop a program to
7 support primary care providers in developing an organizational
8 structure necessary to provide a medical home. The office of Med-
9 icaid shall work with Medicaid managed care organizations to
10 develop and implement the program.

11 The office shall consider payment methodologies that support
12 care-coordination through multi-disciplinary teams, including
13 payment for care of patients with chronic diseases and the elderly,
14 and that encourage services such as:— (i) patient or family educa-
15 tion for patients with chronic diseases; (ii) home-based services;
16 (iii) telephonic communication; (iv) group care; and (v) culturally
17 and linguistically appropriate care. Payment shall reward quality
18 and improved patient outcomes.

19 The office shall identify practices, for participation in the pro-
20 gram, that provide care to its patients using a medical home
21 model, which at minimum shall include primary care practices
22 with a multi-specialty team that provides patient-centered care
23 coordination through the use of health information technology and
24 chronic disease registries, across the patient's life-span and across
25 all domains of the health care system and the patient's community.

26 The office shall promulgate regulations for the phase-in and
27 implementation of this restructured primary care payment system.

28 The office, subject to appropriation and in coordination with
29 the health care workforce center and the Massachusetts Academy
30 of Family Physicians, shall develop a program to provide support
31 to practices interested in developing an organizational structure
32 necessary to provide a medical home.

33 The office shall conduct an annual program evaluation
34 including documentation of cost savings achieved through imple-
35 mentation; health care screening rates, outcomes and hospitaliza-
36 tion rates for patients with chronic illnesses such as pediatric
37 asthma, diabetes, heart disease, hospitalization and readmission
38 rates for the frail elderly. The office shall submit a report of the
39 evaluation to the senate and house chairs of the joint committee
40 on health care financing and the chairs of the senate and house
41 committees on ways and means.

1 SECTION 45. Notwithstanding any general or special law to
2 the contrary, the first report of health care workforce center
3 required by Section 25L of Chapter 111 of the General Laws shall
4 be filed on or before December 31, 2009 and shall focus on the
5 primary care workforce, defined as physicians with a medical spe-
6 cialty in family medicine, internal medicine, pediatrics, or obstet-
7 rics/gynecology or nurse practitioners practicing as primary care
8 providers.

1 SECTION 46. Notwithstanding any general or special law to
2 the contrary, the department of public health shall, no later than
3 January 1, 2009, establish a registry of exemptions granted by the
4 department pursuant to section 6 of chapter 350 of the acts of
5 1993 to persons who filed a notice of intent to acquire medical,
6 diagnostic, or therapeutic equipment used to provide an innova-
7 tive service or which is a new technology, as defined in Section
8 25B of Chapter 111 of the General Laws. Registered exemptions
9 shall be non-transferable. After January 1, 2009, all such exemp-
10 tions that have not been registered shall be void. Exemptions
11 granted by the department pursuant to said Section 6 of said
12 Chapter 350 of the acts of 1993, but for which the equipment has

13 not been placed in regular service, shall expire on January 1,
14 2010.

1 SECTION 47. Any entity providing ambulatory surgical center
2 services which is in operation or under construction, as deter-
3 mined by the department of public health, on December 31, 2008
4 shall be exempt from the determination of need requirement of
5 said Section 53G of said Chapter 111 and shall be eligible for up
6 to 6 months after the effective date of regulations promulgated by
7 the department pursuant to said Section 53G of said Chapter 111
8 to be granted a clinic license. For the purposes of this section
9 under construction shall be defined as having made application for
10 a building permit including, but not limited to, applying to envi-
11 ronment, historical or any other boards necessary for approval.

1 SECTION 48. Notwithstanding any general or special law to
2 the contrary, the department of public health shall promulgate reg-
3 ulations necessary to implement, administration and enforcement
4 of Section 4N of Chapter 111 of the General Laws in accordance
5 with chapter 30A on or before October 1, 2008, and shall begin
6 implementation of the outreach and education program established
7 under said Section 4N on or before January 1, 2009.

1 SECTION 49. Notwithstanding any general or special law to
2 the contrary, the bureau of managed care within the division of
3 insurance shall convene the first advisory committee required
4 under Section 5B of Chapter 176O of the General Laws on or
5 before January 1, 2009.

1 SECTION 50. Notwithstanding any general or special law to
2 the contrary, on or before July 31, 2012, the health information
3 technology oversight council established by Section 6D of
4 Chapter 40J, shall submit a report to the joint committee on health
5 care financing and the senate and house committees on ways and
6 means on the status of health information technology in the Com-
7 monwealth. The report shall include the status of:— (i) the imple-
8 mentation and use of electronic health records systems, such as
9 rate of provider participation; (ii) the statewide interoperable elec-
10 tronic health records network and its capacity to exchange health

11 information between and among components of the health system,
12 with special focus on ambulatory care providers; (iii) the security
13 and privacy of health information technology developed and dis-
14 seminated through activities of the council; and (iv) the impact of
15 health information technology on health care quality, health out-
16 comes of patients, and health care costs.

1 SECTION 51. Notwithstanding any general or special law to
2 the contrary, the health information technology oversight council,
3 established by Section 6D of Chapter 40J of the General Laws,
4 shall have as its goal full implementation of electronic health
5 records systems and the statewide interoperable electronic health
6 records network by January 1, 2015.

1 SECTION 52. Subsection (d) of Section 61 of Chapter 118E of
2 the General Laws, as appearing in Section 16, shall take effect on
3 January 1, 2011.

1 SECTION 53. Subsection (d) of Section 5A of Chapter 176O of
2 the General Laws, as appearing in Section 24, shall take effect on
3 January 1, 2011.

1 SECTION 53A. Section 15 shall take effect on July 1, 2009.

1 SECTION 54. Sections 17 and 25 shall take effect on January
2 1, 2012.

1 SECTION 55. Section 8 shall take effect on October 1, 2012.

1 SECTION 56. Sections 10, 11, 13 and 23 shall take effect on
2 October 1, 2015.

1 SECTION 57. (a) For the purposes of this section the following
2 terms will have the following meanings:—
3 “Prescriber”, an individual licensed to prescribe medication
4 according to Section 9 of Chapter 94C.
5 “Unused medication”, any unused or expired prescription med-
6 ications, including but not limited to, controlled substances and
7 over the counter medications.

8 (b) There is hereby established a task force to investigate and
9 study the disposal of unused medications, and to consider innova-
10 tive and coordinated measures to prevent and reduce unused med-
11 ications. The task force shall develop a pilot program for the safe
12 disposal of unused medications. The department shall implement
13 said pilot program. The task force shall remain as an advisory
14 body to the department.

15 The task force shall consist of the following members:— the
16 commissioner of the department of public health, or his designee,
17 who shall serve as chair of the task force; the commissioner of the
18 department of environmental protection or his designee; commis-
19 sioner of the department of public safety or his designee; 3 mem-
20 bers of the house of representatives, 2 of whom shall be appointed
21 by the speaker of the house and 1 of whom shall be appointed by
22 the house minority leader; 3 members of the senate, 2 of whom
23 shall be appointed by the senate president and 1 of whom shall be
24 appointed by the senate minority leader; the diversion program
25 manager of the Federal Drug Enforcement Administration for the
26 New England Field Division or his designee; one member from
27 the board of registration of pharmacists; one member from the
28 board of the registry in medicine; a representative from the
29 Massachusetts department of public health, bureau of substance
30 abuse services; a representative from Massachusetts biotech-
31 nology council; a representative of Massachusetts association of
32 health plans; a representative from Massachusetts pharmacy asso-
33 ciation; a representative of the Massachusetts Aging Services
34 Association.

35 (c) The task force shall investigate and report the following
36 entities, but not be limited to, (1) data collected on the types and
37 quantities of unused or expired medications not being used by
38 consumers, (2) the results of a survey that investigates why con-
39 sumers are not utilizing medications, (3) analysis of the pre-
40 scribing policies of entities, such as health insurance plans or
41 prescriber practices which result in significant amounts of unused
42 medications, (4) a quantification of the amount healthcare dollars
43 wasted on unused medications and (5) research detailing any or all
44 other reasons for unused medications.

45 The task force shall develop a pilot program to take-back
46 unused medications to be implemented by the department. The

47 pilot program may include, but not be limited to, secure locations
48 for the drop-off and collection of unused medications, processes
49 for the documentation of collected unused medication, processes
50 for the environmentally safe disposal of unused medications, and
51 public education of potential participating consumers. Said pilot
52 program shall include measures to improve training and expansion
53 of physician awareness regarding the types of medications being
54 prescribed with excess amounts remaining unused by the intended
55 consumer. Said pilot program shall include measures to expand
56 public education regarding patient adherence to prescribed med-
57 ications, education regarding proper and effective disposal of
58 unused medications, and the potential need for expanded use of
59 warning labels on drugs that present potentials for dependence
60 and addiction.

61 The department shall implement, under advisory of the task
62 force, said pilot program to take-back unused medications for safe
63 disposal.

64 (d) Said task force shall report to the speaker of the house of
65 representatives, the president of the senate, the house and senate
66 clerks, and the house and senate chairs of the joint committee on
67 public health the results of the investigation and study and pro-
68 posal for said pilot program on or before July 1, 2009.

1 SECTION 58. Section 26 shall take effect on January 1, 2009.