

SENATE NO. 1238

AN ACT CONTROLLING HEALTH CARE COSTS AND IMPROVING QUALITY

*Be it enacted by the Senate and House of Representatives in General Court assembled,
And by the authority of the same, as follows:*

1 SECTION 1. Chapter 111 of the General Laws is hereby amended by inserting after
2 section 4L the following sections:–

3 Section 4M. The department shall, subject to appropriation, establish a chronic disease
4 self-management program. The program shall support coordinated strategies to provide patients
5 and their families with education and support to increase skills and confidence and empower
6 patients to manage chronic conditions as active partners in their own care.

7 The department shall provide pilot demonstration project grants to non-profit
8 community organizations to implement a variety of chronic disease self-management
9 approaches. Grants shall focus on providing assistance in diverse settings that focus on
10 underserved populations and racial and ethnic minority populations.

11 No more than two years following the start of the initial pilot demonstration projects, the
12 department shall evaluate the pilot demonstration projects. Based on the evaluations, the
13 department shall develop a comprehensive statewide plan to implement chronic disease self
14 management programs throughout the commonwealth. The plan shall be filed with the
15 committees on public health, health care financing and ways and means.

16 Section 4N. (a) The department shall develop, implement, and promote an evidence-
17 based outreach and education program designed to provide information and education on the
18 therapeutic and cost-effective utilization of prescription drugs to physicians, pharmacists, and
19 other health care professionals authorized to prescribe and dispense prescription drugs. In
20 developing the academic detailing program the department shall consult with physicians,
21 pharmacists, private insurers, hospitals, pharmacy benefit managers, the Masshealth drug
22 utilization review board, and the University of Massachusetts Medical School. The program
23 shall include the following elements:

24 (1) The opportunity for physicians, pharmacists and nurses under contract with the
25 program to conduct face-to-face visits with prescribers, utilizing evidence-based materials and
26 borrowing methods from behavioral science, educational theory and where appropriate,
27 pharmaceutical industry data and outreach techniques. To the extent possible, the program shall
28 inform prescribers about drug marketing that is intended to circumvent competition from
29 generic or other therapeutically equivalent pharmaceutical alternatives or other evidence-based
30 treatment options.

31 (2) Outreach to physicians and other health care practitioners who participate in
32 MassHealth, the Prescription Advantage program, the Commonwealth Care Health Insurance
33 Program, and other publicly funded, contracted or subsidized health care programs in the
34 commonwealth, to academic medical centers, and to other prescribers.

35 (b) The program shall be made available to private payors on a subscription basis.

36 (c) While recognizing the particular geographic and demographic characteristics of the
37 commonwealth, the program shall be modeled where practicable on the Pennsylvania
38 PACE/Harvard University Independent Drug Information Service. The department shall, to the

39 extent possible, also utilize or incorporate into its program other independent educational
40 resources or models proven effective in promoting high quality, evidenced-based, cost-effective
41 information regarding the effectiveness and safety of prescription drugs, including but not
42 limited to (1) the Academic Detailing Program of the University of Vermont College of
43 Medicine Area Health Education Centers, (2) the Oregon Health and Science University
44 Evidence-based Practice Center's Drug Effectiveness Review project, and (3) the North
45 Carolina evidence-based peer to peer education program outreach program.

46 (d) The department shall promulgate regulations as necessary to implement this Section
47 in accordance with chapter 30A no later than January 1, 2008, and shall begin implementing the
48 program no later than July 1, 2008.

49 (e) The department is authorized to establish and collect fees for subscriptions and
50 contracts with private payors and to seek funding from nongovernmental health access
51 foundations and undesignated drug litigation settlement funds associated with pharmaceutical
52 marketing and pricing practices.

53 SECTION 2. Chapter 111 of the General Laws is hereby further amended by inserting
54 after section 51G the following section:—

55 Section 51H. The department shall establish emergency room patient flow management
56 standards for acute care hospitals. The standards shall require each acute care hospital with an
57 emergency department to evaluate its elective surgical procedure scheduling policy to determine
58 if scheduling changes would reduce overcrowding in the hospital's emergency department. The
59 department shall by regulation define the minimum requirements of the evaluation required by
60 this section.

61 The department shall require a hospital to change its elective surgical procedure
62 scheduling policy if the evaluation demonstrates that the change would significantly reduce
63 emergency department overcrowding or reduce waiting time for emergency services. The
64 department may deny the renewal of a hospital license pursuant to section 51 for violation of a
65 requirement of this section.

66 The department shall annually report on the effectiveness of this section on reducing
67 emergency room overcrowding, improving health quality, and saving costs.

68 SECTION 3. Chapter 111 of the General Laws is hereby further amended by inserting
69 after section 70G the following section:–

70 Section 70H. (a) As used in this section, unless the context otherwise indicates, the
71 following terms shall have the following meanings:–

72 “Carrier”, an insurer licensed or otherwise authorized to transact accident and health
73 insurance under chapter 175; a nonprofit hospital service corporation organized under chapter
74 176A; a non-profit medical service corporation organized under chapter 176B; a health
75 maintenance organization organized under chapter 176G, or an organization entering into a
76 preferred provider arrangement under chapter 176I.

77 “Administrator”, any person who receives or collects charges, contributions or
78 premiums for, or adjusts or settles claims in connection with any type of health benefit provided
79 under the plan as an alternative to insurance.

80 “Commercial purpose”, advertising, marketing, promotion, or any similar activity that is
81 used or intended to be used to influence sales or the market share of a pharmaceutical drug, to
82 influence or elevate the prescribing behavior of a prescriber, market prescription drugs to
83 individuals or to elevate the effectiveness of a professional pharmaceutical detailing sales force.

84 “De-identified”, information that cannot be used to directly or indirectly identify the
85 patient or the prescriber. Information that may identify the patient or prescriber includes a
86 person’s name, address, telephone number, facsimile number, electronic mail address,
87 photograph or likeness, account, credit card, medical record, social security number, or any
88 other unique number, characteristic, code or information which is likely to lead to the
89 identification of the patient or prescriber.

90 “Electronic transmission intermediary”, an entity that provides the infrastructure that
91 connects the computer systems or other electronic devices used by health care practitioners,
92 prescribers, pharmacies, health care facilities and pharmacy benefit managers, carriers,
93 administrators and agents and contractors of those persons and entities in order to facilitate the
94 secure transmission of an individual’s prescription drug order, refill, authorization request,
95 claim, payment or other prescription drug information.

96 “Health care facility”, a licensed facility, institution or entity licensed that offers health
97 care to persons in the commonwealth, including a health care provider, home health care
98 provider, hospice program and a pharmacy.

99 “Health care practitioner”, a person licensed to provide or otherwise lawfully providing
100 health care or a partnership or corporation made up of those persons or an officer, employee,
101 agent or contractor of that person acting in the course and scope of employment, agency or
102 contract related to or supportive of the provision of health care to individuals.

103 “Health plan”, a health plan providing prescription drug coverage as authorized under
104 the federal Medicare Prescription Drug, Improvement and Modernization Act of 2003, Public
105 Law 108-173.

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

107 “Pharmacy”, any retail drug business registered by the board of registration in pharmacy
108 in accordance with section 39 of chapter 112 that is authorized to dispense controlled
109 substances, including a retail drug businesses as defined in section 1 of chapter 94C and a mail
110 order pharmacy.

111 “Pharmacy benefits manager”, an entity that performs pharmacy benefits management.

112 “Pharmacy benefits manager” includes a person or entity acting for a pharmacy benefits
113 manager in a contractual or employment relationship in the performance of pharmacy benefits
114 management for a covered entity and includes mail service pharmacy.

115 “Prescriber”, a person who is licensed, registered or otherwise authorized to prescribe
116 and administer drugs in the course of professional practice.

117 “Prescription drug information”, information concerning prescription drugs which under
118 federal law, is required, prior to being dispensed or delivered, to be labeled “Caution: Federal
119 law prohibits dispensing without prescription” or is required by an applicable federal or state
120 law or rule to be dispensed on prescription only or is restricted to use by practitioners only, and
121 includes lawful written or oral order of a practitioner for a drug or device, issued on a
122 prescription form or by electronic transmission.

123 “Prescription drug information intermediary”, a person or entity that communicates,
124 facilitates or participates in the exchange of prescription drug information regarding an
125 individual or a prescriber. “Prescription drug information intermediary” includes, but shall not
126 be limited to, a pharmacy benefits manager, a health plan, an administrator and an electronic
127 transmission intermediary.

128 “Regulated transaction”, a prescription for a drug that is written by a prescriber within
129 the commonwealth or that is dispensed within the commonwealth.

130 (b) With regard to a regulated transaction, a prescriber, carrier, pharmacy, or
131 prescription drug information intermediary may not license, use, sell, transfer or exchange for
132 value, for any commercial purpose, prescription drug information that identifies directly or
133 indirectly the individual or the prescriber except if expressly permitted as a regulated
134 transaction that is allowed under subsection (c).

135 (c) The following regulated transactions are allowed and are not subject to the
136 prohibitions of this section:-

137 (1) transfers of prescription drug information, including identification of the individual
138 and prescriber, as required under the chapter 94C;

139 (2) the dispensing of prescription drugs to an individual or the individual's authorized
140 representative, the transmission of prescription drug information between a prescriber and a
141 pharmacy or other health care practitioner caring for the individual and the transfer of
142 prescription information between pharmacies;

143 (3) the transfer of prescription records that may occur when a pharmacy's ownership is
144 changed or transferred;

145 (4) care management educational communications provided to an individual about the
146 individual's health condition, adherence to a prescribed course of therapy or other information
147 relating to the drug being dispensed, treatment options or clinical trials;

148 (5) transfers for the limited purpose of pharmacy reimbursement, prescription drug
149 formulary or prior authorization compliance, patient care management, utilization review, health
150 care research or as required by law; and

151 (6) the collection, use, transfer or sale of prescription drug information that is de-
152 identified and that does not directly or indirectly identify the individual or prescriber.

153 (d) A violation of this section shall be an unfair or deceptive act or practice in the
154 conduct of trade in violation of section 2 of chapter 93A. Any person whose rights under this
155 section have been violated or attempted to be violated may institute and prosecute in his own
156 name and on his own behalf, or the attorney general, acting on behalf of the commonwealth,
157 may institute a civil action for injunctive and other equitable relief.

158 SECTION 4. The General Laws are hereby amended by inserting after section 111K the
159 following chapter:–

160 CHAPTER 111L

161 PRESCRIPTION DRUG MARKETING RESTRICTIONS AND DISCLOSURE

162 Section 1. As used in this chapter, unless the context otherwise indicates, the following
163 terms shall have the following meanings:–

164 “Bona fide clinical trial”, any research project that prospectively assigns human subjects
165 to intervention and comparison groups to study the cause and effect relationship between a
166 medical intervention and a health outcome.

167 “Health care practitioner” or “practitioner”, a person who prescribes prescription drugs
168 for any person and licensed to provide or is otherwise lawfully providing health care or a
169 partnership or corporation made up of those persons or an officer, employee, agent or contractor
170 of that person acting in the course and scope of employment, agency or contract related to or
171 supportive of the provision of health care to individuals.

172 “Gift”, a payment, food, entertainment, travel, honorarium, subscription, advance,
173 services or anything of value, unless consideration of equal or greater value is received. A gift
174 includes anything of value provided to a health care practitioner for less than market value.

175 “Gift” shall not include anything of value received by inheritance, a gift received from a
176 member of the health care practitioner’s immediate family or from a relative within the third
177 degree of consanguinity of the health care practitioner or of the practitioner’s spouse or from the
178 spouse of any such relative, or prescription drugs provided to a health care practitioner solely
179 and exclusively for use by the practitioner’s patients.

180 “Immediate family”, a spouse and any dependent children residing in the reporting
181 person's household.

182 “Labeler”, a person or entity that (a) receives prescription drugs or biological products
183 from a manufacturer or wholesaler; (b) repackages the drugs or biological products for later
184 resale; and (c) has a labeler code from the federal Food and Drug Administration under section
185 207.20 of Title 21 of the Code of Federal Regulations.

186 “Marketing”, advertising and promotional activities, including, but not limited to, the
187 activities described in section 2.

188 “Medical device”, an instrument, apparatus, implement, machine, contrivance, implant,
189 in vitro reagent, or other similar or related article, including any component, part, or accessory,
190 which is:

191 (1) recognized in the official National Formulary, or the United States Pharmacopeia, or
192 any supplement to them;

193 (2) intended for use in the diagnosis of disease or other conditions, or in the cure,
194 mitigation, treatment, or prevention of disease, in man or other animals; or

195 (3) intended to affect the structure or any function of the body of man or other animals,
196 and which does not achieve its primary intended purposes through chemical action within or on
197 the body of man or other animals and which is not dependent upon being metabolized for the
198 achievement of its primary intended purposes.

199 "Person", a business, individual, corporation, union, association, firm, partnership,
200 committee, or other organization or group of persons.

201 "Pharmaceutical marketer", a person who, while employed by or under contract to
202 represent a pharmaceutical manufacturing company, engages in pharmaceutical detailing,
203 promotional activities, or other marketing of prescription drugs in this state to any physician,
204 hospital, nursing home, pharmacist, health benefit plan administrator, or any other person
205 authorized to prescribe, dispense, or purchase prescription drugs. The term does not include a
206 wholesale drug distributor licensed under section 36A of chapter 112, a representative of such a
207 distributor who promotes or otherwise markets the services of the wholesale drug distributor in
208 connection with a prescription drug, or a retail pharmacist registered under section 37 of chapter
209 112 if such person is not engaging in such practices under contract with a manufacturing
210 company.

211 "Pharmaceutical manufacturing company", any entity which is engaged in the
212 production, preparation, propagation, compounding, conversion, or processing of prescription
213 drugs, either directly or indirectly by extraction from substances of natural origin, or
214 independently by means of chemical synthesis, or by a combination of extraction and chemical
215 synthesis, or any entity engaged in the packaging, repackaging, labeling, relabeling, or
216 distribution of prescription drugs. The term does not include a wholesale drug distributor

217 licensed under section 36A of chapter 112 or a retail pharmacist registered under section 37 of
218 chapter 112 or a medical device manufacturer that distributes drugs as an incidental part of its
219 device business.

220 “Pharmaceutical manufacturer agent”, a pharmaceutical marketer or any other person
221 who for compensation or reward does any act to promote, oppose or influence the prescribing of
222 a particular prescription drug or medical device or category of prescription drugs or medical
223 devices. The term shall not include a licensed pharmacist, licensed physician or any other
224 licensed health care professional with authority to prescribe prescription drugs who is acting
225 within the ordinary scope of the practice for which he is licensed.

226 “Prescription drugs”, any and all drugs upon which the manufacturer or distributor has
227 placed or must, in compliance with federal law and regulations, place the following or a
228 comparable warning: “Caution federal law prohibits dispensing without prescription.”

229 “Significant educational, scientific or policy-making conference or seminar”, an
230 educational, scientific or policy-making conference or seminar that offers continuing medical
231 education credit, features multiple presenters on scientific research, or is authorized by the
232 sponsoring association to recommend or make policy.

233 Section 2. No pharmaceutical manufacturer agent shall knowingly and willfully offer or
234 give to a health care practitioner or a member of a health care practitioner’s immediate family or
235 a health care facility or employee or agent of a health care facility a gift of any value. No health
236 care practitioner or a member of a health care practitioner’s immediate family or health care
237 facility or employee or agent of a health care facility shall knowingly and willfully solicit or

238 accept from any pharmaceutical manufacturer, a gift of any value. The restrictions in this
239 paragraph do not include the following items which would otherwise be considered “gifts”:

240 (1) payment to the sponsor of a significant educational, scientific or policy-making
241 conference or seminar medical conference, provided the payment is not made directly to a
242 health care practitioner and is used solely for bona fide educational purposes and that the
243 amount and use of the funds is posted on a publicly available internet site;

244 (2) reasonable honoraria and payment of the reasonable expenses of a health care
245 practitioner who serves on the faculty at a bona fide significant educational, scientific or policy-
246 making conference or seminar medical conference, provided that honoraria for speaking take
247 place with an explicit contract with specific deliverables which are restricted to scientific issues,
248 not marketing efforts;

249 (3) compensation for the substantial professional or consulting services of a practitioner
250 in connection with a bona fide clinical trial, provided that the consulting is done under an
251 explicit contract with specific deliverables which are restricted to scientific issues, not
252 marketing efforts;

253 (4) publications and educational materials.

254 Section 3. (a) A manufacturer or labeler of prescription drugs dispensed in the
255 commonwealth that employs, directs or utilizes marketing representatives in the
256 commonwealth shall report marketing costs for prescription drugs in the commonwealth as
257 provided in this section.

258 (b) By July 1st each year a manufacturer or labeler of prescription drugs that
259 directly or indirectly distributes prescription drugs for dispensation to residents of the
260 commonwealth shall file a report with the department of public health, in the form and

261 manner provided by the department. The report must be accompanied by payment of a
262 fee, as set by the department.

263 (c) The annual report filed under subsection (b) must include the following
264 information as it pertains to marketing activities conducted within the commonwealth in a
265 form that provides the value, nature, purpose and recipient of the expense:

266 (1) All expenses associated with advertising, marketing and direct promotion of
267 prescription drugs through radio, television, magazines, newspapers, direct mail and
268 telephone communications as they pertain to residents of the commonwealth, including a
269 reasonable estimate of the value of expenses associated with advertising purchased for a
270 regional or national market that includes advertising within the commonwealth. The
271 expenses shall include, but not be limited to, direct and indirect payments in support of
272 independent or continuing medical education programs, including payments to medical
273 education companies; design, printing and production costs of patient education materials
274 and disease management materials distributed within the commonwealth; consulting fees
275 and expenses, participation in speakers' bureaus and honoraria or other payments for time
276 while speaking at or attending meetings, lectures or conferences; writing articles or
277 publications; charitable grants, either directly or earmarked, even if unrestricted; market
278 research surveys or other activities undertaken in support of developing advertising and/or
279 marketing strategies.

280 (2) With regard to all persons and entities licensed to provide health care,
281 including health care practitioners and persons employed by them, carriers licensed under
282 chapters 175, 176A, 176B, 176G, and 176I, health plans and benefits managers,

283 pharmacies, hospitals, nursing facilities, clinics and other entities licensed to provide
284 health care under this chapter, the following information:

285 (i) All expenses associated with educational or informational programs, materials
286 and seminars and remuneration for promoting or participating in educational or
287 informational sessions, regardless of whether the manufacturer or labeler provides the
288 educational or informational sessions or materials;

289 (ii) All expenses for gifts not otherwise prohibited in section 2, and anything
290 provided to a health care professional for less than market value. The report must identify
291 recipients by their state board numbers or DEA numbers.

292 (iii) All expenses associated with product samples; and

293 (iv) The aggregate cost of all employees or contractors of the manufacturer or
294 labeler who directly or indirectly engage in the advertising or promotional activities listed
295 in paragraphs (1) and (2) including all forms of payment to those employees. The cost
296 reported under this paragraph must reflect only that portion of payment to employees or
297 contractors that pertains to activities within the commonwealth or to recipients of the
298 advertising or promotional activities who are residents of or are employed in the
299 commonwealth.

300 (d) The following marketing expenses are not subject to the requirements of this
301 section:

302 (1) expenses of \$25 or less;

303 (2) reasonable compensation and reimbursement for expenses in connection with a
304 bona fide clinical trial of a vaccine, therapy or treatment; and

305 (3) scholarships and reimbursement of expenses for attending a significant bona
306 fide educational, scientific or policy-making conference or seminar of a national, regional
307 or specialty medical or other professional association if the recipient of the scholarship is
308 chosen by the association sponsoring the conference or seminar.

309 Section 4. By January 1, 2009 and every 2 years after that date, the department
310 of public health shall file a report with the clerks of the senate and house of representatives
311 and the attorney general, containing an analysis of the data submitted to the department,
312 including the scope of prescription drug marketing activities and expenses and their effect
313 on the cost, utilization and delivery of health care services and any recommendations with
314 regard to marketing activities of prescription drug manufacturers and labelers.

315 Section 5. Information submitted to the department pursuant to this section is a
316 public record except to the extent that it includes information that is protected by state or
317 federal law as a trade secret. Data compiled by the department for the purposes of
318 reporting required by this section is a public record, as long as it does not reveal
319 information that is protected by state or federal law as a trade secret. Notwithstanding any
320 other provision of law, the identity of health care practitioners and other recipients of gifts,
321 payments and materials required to be reported in this chapter shall not constitute
322 confidential information or trade secrets protected under this section.

323 Section 6. This section may be enforced in a civil action brought by the Attorney
324 General. A person who violates this section shall be punished by a fine of not more than \$5,000
325 or by imprisonment for not more than 2 years, or both.

326 SECTION 5. Chapter 118E of the General Laws is hereby amended by inserting after
327 section 17 the following section:–

328 Section 17A. (a) As used in this section, unless the context otherwise indicates,
329 the following term has the following meaning:

330 “Evidence-based”, based on criteria and guidelines that reflect high-quality, cost-
331 effective care. The methodology used to determine such guidelines shall meet recognized
332 standards for systematic evaluation of all available research and shall be free from conflicts of
333 interest. Consideration of the best available scientific evidence shall not preclude consideration
334 of experimental or investigational treatment or services under a clinical investigation approved
335 by an institutional review board.

336 (b) The executive office of health and human services shall coordinate an evidence-
337 based pharmaceutical purchasing and prescribing program for state agencies administering state
338 purchased health care programs and entities participating in state subsidized health care
339 programs. The program shall ensure, to the extent practicable, the adoption of uniform policies
340 for prudent, cost-effective pharmaceuticals purchasing; maximize efficiencies in administration;
341 improvements in the quality of care; and reduction in administrative burdens on health care
342 providers participating in state purchased health care programs. The policies adopted should be
343 based, to the extent possible, upon the best available scientific and medical evidence.

344 (c) The executive office shall, by October 1, 2007, convene a pharmaceutical quality and
345 cost management task force, hereinafter referred to as the task force. The task force shall
346 coordinate and exchange information among state agencies, stakeholder groups, advisory
347 committees, and provide advice to the executive office and agencies thereof. The executive
348 office and the office of medicaid shall consult with the task force on at least a quarterly basis on

349 significant policy decisions related to implementation of the purchasing and prescribing
350 programs established in this section. The executive office shall provide necessary staffing
351 services to the task force, which shall consist of the following members appointed by the
352 secretary:

- 353 (1) the secretary of health and human services, who shall serve as chair;
- 354 (2) the Medicaid director or a designee;
- 355 (3) the commissioner of public health or a designee;
- 356 (4) the commissioner of mental health or a designee;
- 357 (5) the commissioner of mental retardation or a designee;
- 358 (6) the commissioner of corrections or a designee;
- 359 (7) a representative of private payors;
- 360 (8) a representative of the division of industrial accidents;
- 361 (9) a representative of the group insurance commission;
- 362 (10) a representative of the University of Massachusetts Medical School;
- 363 (11) a member representing public education;
- 364 (12) a member representing municipalities or local governments;
- 365 (13) a clinical pharmacist;
- 366 (14) two licensed prescribers;
- 367 (15) a representative of the Masshealth drug utilization review board;
- 368 (16) a representative of the Commonwealth Medicine division of the University
369 of Massachusetts Medical School;
- 370 (17) a representative of an organization representing racial and ethnic minorities;
- 371 (18) a representatives of a health care consumer quality advocacy group; and

372 (19) a representatives of a health care consumer legal advocacy group.

373 (d) In consultation with the task force, the secretary shall develop and implement an
374 evidenced-based preferred drug list, hereinafter referred to as PDL, to be used in the
375 administration of prescription drug benefits by MassHealth. Decisions regarding drugs to be
376 included in the PDL must be based on available, reliable evidence-based health information
377 concerning pharmaceutical efficacy, adverse effects and appropriate clinical trials, as well as
378 cost effectiveness. The PDL must also ensure that less expensive generic drugs, other
379 therapeutically equivalent alternatives or other evidence-based treatment options will be
380 substituted for brand name drugs where the quality of care is not diminished, and consider the
381 approval of drugs with lower abuse potential in substitution for drugs with significant abuse
382 potential.

383 (e) In order to implement the purposes of this section, the office of medicaid shall
384 develop and implement a prior authorization program to be administered in coordination with
385 the PDL. The program shall:

386 (1) identify clinically efficacious high-quality prescription drugs that are also cost-
387 effective; these drugs may not require prior approval;

388 (2) be designed to ensure timely access to certain medically necessary medications
389 prescribed to medically fragile beneficiaries, including persons with mental illnesses, while
390 allowing for the exploration of appropriate options for reducing the costs of pharmaceutical
391 benefits and programs;

392 (3) minimize administrative burdens on health care practitioners and patients and insure
393 prompt turnaround on prior authorization decisions;

394 (4) incorporate effective outreach to medical providers, pharmacists and patients about
395 how the program works;

396 (5) incorporate a transparent review process for the PDL and prior authorization criteria
397 while avoiding pharmaceutical industry influence and conflicts of interest; and

398 (6) adopt rules allowing prescribers to be exempted from certain provisions of the prior
399 authorization rules upon formal endorsement of the PDL and associated procedures developed
400 as part of the program authorized by this section.

401 (f) To insure quality and efficiencies in the delivery of health care services, while
402 maximizing the use of evidence-based criteria, the secretary shall to the extent practicable
403 develop the PDL to harmonize with preferred drug lists and formularies in use throughout state
404 agencies and in publicly funded, administered or subsidized health programs including without
405 limitation, programs of the Commonwealth Health Insurance Connector Authority, the group
406 insurance commission, the departments of mental health, mental retardation and corrections,
407 and other agencies of the commonwealth.

408 (g) The executive office, in consultation with the task force, shall directly or by contract,
409 develop a joint pharmaceuticals purchasing consortium. The consortium's purchasing activities
410 shall be based upon the evidence-based prescription drug program and PDL established in this
411 chapter.

412 (1) Participation in the purchasing consortium shall be offered as an option on a
413 voluntary basis to the Commonwealth Care Health Insurance program and the departments of
414 mental health, mental retardation and corrections, and other agencies of the commonwealth no
415 later than January 1, 2008. By July 1, 2008, the secretary shall, in consultation with the task
416 force, develop a plan and an implementation timetable to require, to the extent practicable and

417 consistent with the purposes of this chapter, all state purchasers and publicly funded,
418 administered or subsidized health programs to participate in the consortium by January 1, 2010.
419 In developing the consortium and the underlying harmonized PDL, the department will seek to
420 ensure, unless otherwise agreed to by participating entities, that:

421 (i) participating plans are not fundamentally altered and that the independent nature of
422 any of the health plans involved in the consortium is not compromised;

423 (ii) rebates are negotiated on behalf of the entire consortium, and all participating plans
424 share in the savings realized through the pooled purchasing effort.

425 (2) Participation in the consortium shall be purely voluntary for units of local
426 government, private entities, labor organizations, and for individuals who lack or are
427 underinsured for prescription drug coverage. The department may set reasonable fees, including
428 enrollment fees, to cover administrative costs attributable to participation in the prescription
429 drug consortium.

430 (3) If the department contracts on behalf of the consortium for services with a pharmacy
431 benefits manager or administrator or other private entity for the negotiation of savings and
432 rebates, it shall insure full transparency of all financial terms and contracts between the
433 negotiating entity and the members of the consortium; pass through of all financial benefits
434 including rebates and other discounts and payments without limitation; and a fiduciary
435 relationship between the negotiating entity and the consortium.

436 (4) There is hereby established an account within the executive office of health human
437 services known as the prescription drug consortium account. All receipts from activities related
438 to administration of the drug purchasing consortium on behalf of participating individuals and
439 organizations, other than state purchased health care programs, shall be deposited into the

440 account. The receipts shall include, but not be limited to, rebates from manufacturers, and the
441 fees established pursuant to clause (2). Funds in the account may be expended without further
442 appropriation by the secretary for the purposes of this section.

443 (h) The executive office is authorized to participate in joint purchasing opportunities
444 with other states that are consistent with the evidence-based policies and other criteria
445 established herein. If the state participates in a multi-state purchasing pool that contracts with a
446 private entity for the negotiation of savings and rebates, it shall insure full transparency of all
447 financial terms and contracts between the negotiating entity and the members of the consortium;
448 pass through of all financial benefits including rebates and other discounts and payments
449 without limitation; and a fiduciary relationship between the negotiating entity and the
450 consortium.

451 (i) The department may implement other strategies to control costs of drugs without
452 reducing the quality of care consistent with the evidence-based approach in this chapter,
453 including but not limited to authorizing reimbursement for drugs only in economical quantities
454 and limiting the prices paid for drugs by such means as negotiated discounts from
455 pharmaceutical manufacturers, central purchasing, volume contracting, or setting maximum
456 prices to be paid.

457 (j) The department shall enter into a contractual agreement with the Oregon Health and
458 Science University Drug Effectiveness Review Project to provide technical and clinical support
459 in the development and the administration of the PDL and other evidence-based programs
460 established in this section.

461 (k) On March 1, 2008 and every year thereafter, the department shall submit a report to
462 the house and senate chairs of the joint committee on health care financing and the chairs of the

463 senate and house committees on ways and means, on the progress in meeting the timetable and
464 goals of this section, as well as savings achieved and any issues that need to be addressed.

465 Section 7. The department shall adopt regulations as necessary to implement this
466 section.

467 SECTION 6. The General Laws are hereby amended by inserting after chapter 118H the
468 following chapter:–

469 CHAPTER 118I

470 HEALTH CARE COST CONTROL

471 Section 1. As used in this chapter, the following words shall, unless the context clearly
472 requires otherwise, have the following meanings:–

473 “Public payors”, agencies of the Commonwealth that purchase or contract for health care
474 and health care insurance services, including, but not limited to, the Group Insurance
475 Commission established by section 3 of chapter 32A, the Commonwealth Health Insurance
476 Connector Authority, established by section 2 of chapter 176Q, and the Medicaid and
477 MassHealth programs established by sections 9 and 9A of chapter 118E.

478 “Potentially preventable hospital readmission”, a patient’s readmission to a hospital
479 within 30 days of a discharge from a hospital, due to a condition that indicates the readmission
480 was potentially preventable during the initial hospital stay, as further defined by regulations.

481 “Potentially preventable hospital complication”, a potentially preventable harmful event
482 or negative outcome that occurs to a patient while in a hospital that results from the process of
483 care and treatment and not from any underlying disease, as further defined by regulations.

484 Section 2. The executive office of health and human services shall coordinate the
485 creation of common, transparent quality and payment metrics among public payors to facilitate

486 administrative savings and create standard, transparent methods for evaluating health care prices
487 and quality. The common quality and payment metrics may include:

- 488 (1) a standard claims payment data set;
489 (2) standard units of payment, including cases, visits and payment methods; and
490 (3) a standard menu of performance measures, including severity and risk adjustments.

491 Upon adoption of the common quality and payment metrics by regulation, all public
492 payors shall, to the extent possible, shall implement the common quality and payment metrics.

493 Section 3. The executive office of health and human services shall direct hospitals and
494 insurers to provide data on potentially preventable hospital readmissions. The secretary shall
495 initially consult with the health care quality and cost council established by section 16K of
496 chapter 6A, and its advisory committee, regarding the data to be collected, and shall collect
497 sufficient data to determine for each hospital a rate of potentially preventable hospital
498 readmissions. The initial determinations for a hospital shall be provided to the hospital for
499 review, but shall not be public information.

500 Following the review of its data by each hospital, the secretary shall promulgate
501 regulations directing hospitals and insurers to provide data on potentially preventable hospital
502 readmissions. No more than one year following the initial determination of hospital potentially
503 preventable hospital readmission rates, the secretary shall post on the consumer health
504 information internet site the potentially preventable hospital readmission data and rates for each
505 hospital. The rates shall be adjusted annually, or as the secretary determines.

506 The secretary shall coordinate the creation of a common, transparent payment
507 methodology among public payors to reduce potentially preventable hospital readmissions. The
508 methodology shall reduce or eliminate payment for potentially preventable hospital

509 readmissions. Upon adoption of the payment methodology by regulation, all public payors shall,
510 to the extent possible, implement the common payment methodology.

511 Section 4. The executive office of health and human services shall direct hospitals and
512 insurers to provide data on potentially preventable hospital complications. The secretary shall
513 initially consult with the health care quality and cost council established by section 16K of
514 chapter 6A, and its advisory committee, regarding the data to be collected, and shall collect
515 sufficient data to determine for each hospital a rate of potentially preventable hospital
516 complications. The initial determinations for a hospital shall be provided to the hospital for
517 review, but shall not be public information.

518 Following the review of its data by each hospital, the secretary shall promulgate
519 regulations directing hospitals and insurers to provide data on potentially preventable hospital
520 complications. No more than one year following the initial determination of hospital potentially
521 preventable hospital complication rates, the secretary shall post on the consumer health
522 information internet site the potentially preventable hospital complication data and rates for
523 each hospital. The rates shall be adjusted annually, or as the secretary determines.

524 The secretary shall coordinate the creation of a common, transparent payment
525 methodology among public payors to reduce potentially preventable hospital complications.
526 The methodology shall reduce or eliminate payment for potentially preventable hospital
527 complications. Upon adoption of the payment methodology by regulation, all public payors
528 shall, to the extent possible, implement the common payment methodology.

529 Section 5. The executive office of health and human services shall coordinate the
530 creation of a common, transparent prospective payment methodology among public payors for
531 outpatient procedures. The methodology shall provide a single prospective payment for all

532 services provided in an outpatient visit in a hospital or ambulatory surgery facility, and may
533 include a single prospective payment for a physician office visit. Upon adoption of the
534 prospective payment methodology by regulation, all public payors shall, to the extent possible,
535 implement the common prospective payment methodology.

536 Section 6. The executive office of health and human services shall coordinate the
537 implementation of transparent evidence-based episodes of care payment rates among public
538 payors for patients with chronic illnesses. Episodes of care payment rate methodologies shall
539 encourage clinically integrated care based on evidence-based guidelines that reflect high-
540 quality, cost-effective care. The methodology used to determine such guidelines shall meet
541 recognized standards for systematic evaluation of all available research and shall be free from
542 conflicts of interest. The methodology shall include a comprehensive evaluation process that
543 assesses clinical quality and patient satisfaction. All details of the payment system and care
544 evaluation shall be transparent to patients and providers. The rate methodologies shall provide
545 an annual severity-adjusted payment to a care coordination entity that will provide all clinically
546 appropriate care for the year. A portion of the payments shall be contingent upon meeting
547 clinical quality goals and patient satisfaction standards. Upon adoption of the payment
548 methodology by regulation of the council, all public payors shall, to the extent possible,
549 implement the evidence-based episodes of care payment rates for patients with chronic
550 conditions.

551 SECTION 7. Chapter 175 of the General Laws is hereby amended by inserting after
552 section 47Z the following section:-

553 Section 47AA. (a) For purposes of this section, health insurance plan shall include a
554 policy or policies of group life and accidental death and dismemberment insurance covering

555 persons in the service of the commonwealth, and group general or blanket insurance providing
556 hospital, surgical, medical, dental, and other health insurance benefits covering persons in the
557 service of the commonwealth, and their dependents organized under chapter 32A, individual or
558 group health insurance policies offered by an insurer licensed or otherwise authorized to
559 transact accident or health insurance organized under chapter 175, a nonprofit hospital service
560 corporation organized under chapter 176A, a nonprofit medical service corporation organized
561 under chapter 176B, a health maintenance organization organized under chapter 176G, or an
562 organization entering into a preferred provider arrangement under chapter 176I, any health plan
563 issued, renewed, or delivered within or without the commonwealth to a natural person who is a
564 resident of the commonwealth, including a certificate issued to an eligible natural person which
565 evidences coverage under a policy or contract issued to a trust or association for said natural
566 person and his dependent, including said person's spouse organized under chapter 176M, and
567 medical assistance and medical benefits under the Medicaid and MassHealth programs
568 established by sections 9 and 9A of chapter 118E, and coverage provided by the
569 Commonwealth Care Health Insurance Program under chapter 118H.

570 For purposes of this section, preventive care shall include any periodic, routine,
571 screening or other services designed for the prevention and early detection of illness. This
572 includes, but is not limited to, immunizations; periodic health exams for adults and children, as
573 well as those mammograms, cytological exams and diagnostic tests associated with periodic
574 health exams; prenatal maternity care; well child care, including vision and auditory screening;
575 voluntary family planning; nutrition counseling; and health education. Preventive health care
576 shall also include supplies, equipment, medication and specialist provided treatments and
577 services for persons with chronic illnesses or disabling conditions.

578 For purposes of this section, copayments or coinsurance includes a fixed dollar or
579 proportional amount that a person pays under a health insurance plan in connection with the
580 provision of medical services, as further defined by regulations of the division.

581 (b) No health insurance plan shall charge copayments or coinsurance for preventive
582 health care.

583 SECTION 8. Subsection (a) of section 3 of chapter 176J of the General Laws, as most
584 recently amended by section 82 of chapter 58 of the acts of 2006, is hereby further amended by
585 inserting after clause (6) the following clause:-

586 (7) Every carrier desiring to increase premiums or desiring to set the initial premium
587 shall file a rate filing or application with the commissioner at least 90 days before the proposed
588 effective date of such new rates. The commissioner may disapprove the proposed rates if the
589 benefits provided are unreasonable in relation to the rate charged, or if they are excessive,
590 inadequate or unfairly discriminatory or do not otherwise comply with the requirements of this
591 chapter.

592 If a carrier files for an increase in premium of more than 7 percent than the premium
593 previously charged, or if a carrier files an initial premium request that is more than 7 percent
594 greater than the average premium for the similar policies offered by carriers in the same market,
595 the carrier's rate, in addition to being subject to all other provisions of this chapter and other
596 provisions of law, shall be subject to prior approval of the commissioner. In granting such prior
597 approval, the commissioner shall make a finding on the basis of information submitted by the
598 carrier and investigated by the division and shall be subject to a public hearing pursuant to this
599 clause. The hearing shall comply with the requirements of chapter 30A. The commissioner
600 may consolidate hearings for more than one carrier. The carrier shall provide information on

601 the reasons for the proposed increase in rates, and members of the public may testify. All
602 testimony and evidence received shall be public records. The provisions of section 8A of
603 chapter 175 authorized the commissioner by summons to require the attendance and testimony
604 of witnesses under oath and the production of books, records and papers touching upon the
605 matters in question at such hearing shall apply to hearings under this clause.

606 SECTION 9. The executive office of health and human services shall convene a long-
607 term care payment coordination task force to develop a common comprehensive and transparent
608 long-term care payment methodology that rewards efficient, clinically proper care in the most
609 appropriate setting, without undue incentives to choose a particular setting, that provides high
610 value and best meets patient and family needs. The task force shall consist of all agencies of the
611 commonwealth concerned with long-term care policy, including the office of medicaid, the
612 executive office of elder affairs, the division of health care finance and policy, and the
613 department of public health. The task force shall consult with experts in the field of long-term
614 care, long-term care providers, consumer health organizations, and organizations representing
615 the elderly, the disabled and racial and ethnic minority groups. The task force shall invite
616 participation by the Centers for Medicare and Medicaid Services.

617 The secretary shall file a report detailing the findings, recommendations and
618 implementation plan of the task force, along with any legislation needed to implement its
619 recommendations, with the committee on health care financing and the committees on ways and
620 means no later than 6 months after the effective date of this act.

621 SECTION 10. The executive office of health and human services shall maximize
622 enrollment of eligible persons in the MassHealth Senior Care Options program and shall

623 develop a plan to offer similar coverage to Medicaid and Medicare-eligible disabled persons
624 under age 65, hereinafter referred as dual eligible plans.

625 No later than 6 months after the effective date of this act, the executive office of health
626 and human services shall prepare a report identifying clinical, administrative and financial
627 barriers to expanded dual eligible plans, and recommended steps to remove the barriers and
628 implement coverage for Medicaid and Medicare-eligible disabled persons under age 65. Before
629 finalizing the report, the executive office shall hold a public consultative session that includes
630 organizations representing seniors, organizations representing disabled persons, organizations
631 representing health care consumers, organizations representing racial and ethnic minorities,
632 health delivery systems, and health care providers. The report shall consider changes in
633 procurement standards and MassHealth payment methodologies to promote enrollment in dual
634 eligible plans. The report shall estimate the costs and benefits of implementing steps to remove
635 barriers to expanded enrollment in dual eligible plans, including financial savings and improved
636 quality of care.

637 The report shall be provided to the committee on health care financing, the house and
638 senate committees on ways and means, and shall be posted on the internet site of the executive
639 office of health and human services.

640 Subject to appropriation, the executive office of health and human services shall
641 implement the steps recommended by the report. No later than one year following the filing of
642 the report, the executive office shall issue a progress statement on expanded enrollment in dual
643 eligible plans.

644 SECTION 11. The executive office of health and human services and the
645 Commonwealth Health Insurance Connector Authority shall prepare and implement a plan to

646 make MassHealth and Commonwealth Care leaders in the use of advanced health information
647 technology and electronic health records. The plan shall be developed in consultation with the
648 Massachusetts e-Health Collaborative, the Massachusetts Health Data Consortium, MassPRO,
649 consumer health organizations, consumer privacy organizations, providers and others concerned
650 about health information technology and electronic health records.

651 The secretary shall file a report detailing the findings, recommendations and
652 implementation plan, along with any legislation needed to implement its recommendations, with
653 the committee on health care financing and the committees on ways and means no later than 6
654 months after the effective date of this act.

655 SECTION 12. There is hereby established a special commission to strengthen primary
656 care. The commission shall consist of the secretary of health and human services, who shall
657 serve as chair, 2 senators appointed by the president of the senate, 2 members of the house of
658 representatives appointed by the speaker, the commissioner of public health, a representative of
659 the Massachusetts Academy of Family Physicians, a representative of the Massachusetts
660 Medical Society, a representative of the Massachusetts chapter of the American College of
661 Physicians, a representative of the Massachusetts Nurses Association, a representative of the
662 Massachusetts Association of Nurse Practitioners, a representative of the Massachusetts League
663 of Community Health Centers, a representative of University of Massachusetts Medical School,
664 a representative of the Massachusetts Public Health Association, a representative of the
665 Massachusetts Association of Physician Assistants and a representative of Health Care For All.

666 The commission shall conduct a study and make recommendations for executive and
667 legislative action to strengthen primary care in the commonwealth. The study shall review the
668 availability of primary care services, identify regions of the state with impaired access to

669 primary care, examine the impact of lack of access to primary care on the health status of the
670 commonwealth, including racial, ethnic, gender, income and other disparities in health due to
671 the lack of access to primary care, estimate the additional costs to the health care system due to
672 the lack of availability of primary care, recommend methods to recruit and increase the
673 availability of primary care practitioners, recommend changes in licensing, reimbursement rates
674 and methodologies to strengthen primary care, and make such other findings and
675 recommendations as the commission shall determine.

676 The commission shall hold at least three public hearings in different regions to receive
677 testimony from the public on primary care concerns.

678 The commission shall report its findings to the clerks of the house and senate no later
679 than December 31, 2007. The commission's report shall be posted on the internet site of the
680 executive office of health and human services.