

**SENATE, NO. 2526**

[SIMILAR MATTER FILED DURING PAST SESSION  
SEE NO. OF ]



**The Commonwealth of Massachusetts**

IN THE YEAR OF TWO THOUSAND AND EIGHT

**AN ACT** TO PROMOTE COST CONTAINMENT, TRANSPARENCY AND EFFICIENCY IN THE DELIVERY OF QUALITY HEALTH CARE

*Whereas*, The deferred operation of this act would tend to defeat its purpose, which is forthwith to expand access to health care for Massachusetts residents, therefore it is hereby declared to be an emergency law, necessary for the immediate preservation of the public convenience.

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

**Promote Public Transparency of Health Care Quality and Cost**

SECTION 1. Chapter 6A of the General Laws, as appearing in the 2006 Official Edition, is hereby amended by striking section 16K and inserting in place thereof the following section:-

Section 16K. There shall be a health care quality and cost council within, but not subject to the control of, the executive office of health and human services. The council shall promote public transparency of the quality and cost of health care in the commonwealth, and establish health care quality improvement and cost containment goals. The goals shall be designed to promote high-quality, safe, effective, timely,

11 efficient, equitable and patient-centered health care. The council shall receive staff  
12 assistance from the executive office of health and human services and may, subject to  
13 appropriation, employ such additional staff or consultants as it may deem necessary. The  
14 council shall consist of the secretary of health and human services, the auditor of the  
15 commonwealth or his designee, the inspector general or his designee, the attorney general  
16 or his designee, the commissioner of insurance, the executive director of the group  
17 insurance commission, the executive director of the commonwealth connector, the  
18 secretary of administration and finance or his designee, and 7 persons to be appointed by  
19 the governor, 1 of whom shall be a representative of a health care quality improvement  
20 organization recognized by the federal Centers for Medicare and Medicaid services, 1 of  
21 whom shall be a representative of the Institute for Healthcare Improvement, Inc.  
22 recommended by the organization’s board of directors, 1 of whom shall be a  
23 representative of the Massachusetts Chapter of the National Association of Insurance and  
24 Financial Advisors, 1 of whom shall be a representative of the Massachusetts Association  
25 of Health Underwriters, 1 of whom shall be a representative of the Massachusetts  
26 Medicaid Policy Institute, 1 of whom shall be an expert in health care policy from a  
27 foundation or academic institution and 1 of whom shall represent a non-governmental  
28 purchaser of health insurance. The representatives of nongovernmental organizations  
29 shall serve staggered 3-year terms. The council shall be chaired by the secretary of health  
30 and human services.

31

### 32 **Public Reporting and Reimbursement of Serious Reportable Events**

33

34 SECTION 2. Subsection (e) of section 16L of chapter 6A of the General Laws is  
35 hereby amended by adding the following 2 clauses:—

36

37 (i) The council shall promulgate regulations that create a list of “never events”,  
38 so-called, which shall be updated annually, based upon guidelines developed by the  
39 National Quality Forum and other patient safety and medical quality experts. Reporting  
40 of each never event shall be included in the consumer health information website created  
41 by subsection (h). The website shall identify both the never events and the facilities at

42 which each occurred, but shall not include any other identifying information including  
43 but not limited to any of the health care professionals, facility employees or patients  
44 involved.

45  
46 (ii) Notwithstanding any provisions in the General Laws to the contrary, no third  
47 party payer, including the commonwealth, an insurer licensed or otherwise authorized to  
48 transact accident or health insurance organized under chapter 175, a nonprofit hospital  
49 service corporation organized under chapter 176A, a nonprofit medical service  
50 corporation organized under chapter 176B, a health maintenance organization organized  
51 under chapter 176G and an organization entering into a preferred provider arrangement  
52 under chapter 176I, may knowingly reimburse a health care professional or a health care  
53 facility for services that resulted in and from any of the never events identified by the  
54 council, and no health care professional or health care facility may bill the patient for  
55 such services.

56

57 **Enhancing Transparency of Health Care Provider Cost Increases**

58

59 SECTION 3. Section 16L of Chapter 6A of the General Laws is hereby amended  
60 by adding the following 4 subsections:-

61

62 (r) The health care quality and cost council shall hold an annual public hearing to  
63 examine the factors that contribute to the cost increases of the health care delivery system  
64 and strategies employed by the provider community to reduce cost growth. While  
65 considering size, payor mix, geographic representation and specialty, the council shall  
66 identify a broad representative sample of providers in each of the following categories:  
67 integrated delivery systems, acute care hospitals, community health centers, freestanding  
68 ambulatory surgical centers, physician group practices, rehabilitation hospitals and  
69 skilled nursing facilities. Each identified provider shall be required to provide oral and  
70 written testimony at the hearing in a format determined by the council. The council shall  
71 require providers to provide testimony on payment systems; utilization trends, including  
72 volume of services and intensity of services; demographics of populations served; labor

73 and supply costs; community benefits programs; endowment contributions; executive  
74 compensation; administrative costs; capital investments; strategies to contain the rate of  
75 cost growth, including, but not limited to, provider efforts to minimize medical errors,  
76 eliminate waste and duplication in clinical care, manage chronic diseases, reduce the use  
77 of ineffective or inappropriate medical technology or devices, prioritize technology  
78 investments for computerized physician support systems and electronic health records,  
79 determine capital expenditures based on public health needs, and cut administrative costs;  
80 and other matters as determined by the council. The council may consolidate this hearing  
81 with the hearing called for in subsection (j).

82

83 (s) Within 60 days following the hearing called for in the preceding subsection,  
84 the council shall issue a public report summarizing its findings and any  
85 recommendations. The report shall include, but shall not be limited to, the following: (i)  
86 a standard measurement of the annual total health care spending in the Commonwealth,  
87 or the “Massachusetts Global Health Cost Indicator”, as determined by the council; (ii)  
88 the rate of annual increase or decrease of health care costs in total and within health care  
89 sectors; (iii) an analysis of the primary cost drivers in the health care delivery system; (iv)  
90 an evaluation of the scope and effectiveness of provider cost containment efforts; and (v)  
91 regulatory, legislative and other recommendations to control health care costs, as  
92 developed by the council.

93

94 (t) A subcommittee of the council shall be established to pursue public and private  
95 reform of health care purchasing. The subcommittee shall convene public and private  
96 health care purchasers for the purpose of collaborating on common purchasing principles  
97 and strategies for promoting and rewarding higher value health care. The subcommittee  
98 shall identify and develop non-binding payment guidelines and best practices that will  
99 align purchasing incentives around shared quality goals. The subcommittee shall focus  
100 on, but shall not be limited to: (i) encouraging quality, coordinated, and effective care as  
101 opposed to volume of care; (ii) emphasizing chronic disease management programs; (iii)  
102 developing appropriate and feasible measures of quality performance, and rewarding  
103 providers for improving quality performance; (iv) improving compensation and support

104 for primary care providers; (v) developing a “medical home” payment model that  
105 emphasizes a comprehensive approach to patient care; (vi) reducing waste and  
106 duplication in clinical care; (vii) investing in and accelerating the adoption of health  
107 information technology, specifically computerized physician order entry systems, e-  
108 prescribing, and electronic health records; (viii) aligning incentives with federal Medicare  
109 payment policies; (ix) promoting health wellness programs; and (x) empowering  
110 consumers with access to health care information. The subcommittee shall consist of the  
111 attorney general, who shall act as the chair, the secretary of health and human services,  
112 the executive director of the commonwealth connector authority, the executive director of  
113 the group insurance commission, and an advisory committee consisting of 1 member  
114 representing the Massachusetts Association of Health Plans, 1 member representing Blue  
115 Cross Blue Shield of Massachusetts, 1 member representing Associated Industries of  
116 Massachusetts, 1 member representing the Massachusetts Municipal Association, and 4  
117 members to be appointed by the Governor, including 1 health economist, 1 expert in  
118 federal Medicare payment policy, 1 representative of a self-insured labor union, and 1  
119 health care consumer advocate. The council shall provide the subcommittee with staff as  
120 necessary to complete needed research and analysis. The subcommittee shall meet at  
121 least once every 2 months, and at other times as determined by its rules. The  
122 subcommittee shall submit a report annually by July 1 to the governor, the health care  
123 cost and quality council and the general court, by filing the same with the clerks of the  
124 senate and house of representatives, the joint committee on health care financing and the  
125 joint committee on public health on the subcommittee’s progress and activities, and may  
126 recommend legislation or regulatory changes.

127

128 (u) The council shall establish goals for adoption of health information  
129 technology including, but not limited to, electronic prescription transactions for new  
130 prescriptions, prescription renewals, cancellations, changes between prescribers and  
131 dispensers, ancillary messages and administrative transactions known as e-prescribing,  
132 the process of electronic entry of physician instructions for the treatment of patients,  
133 whether hospitalized or ambulatory, under the care of said physician, known as  
134 computerized physician order entry, and individual patient records in digital format or

135 electronic health records; provided, however, that any system, network, software or  
136 equipment utilized in the attainment of said goals shall be certified by the certification  
137 commission for healthcare information technology, an independent, non-profit  
138 organization that has been officially named by the federal government as the “recognized  
139 certification body” for health information technology products and networks; and  
140 provided further, that goals shall state the percentage adoption by providers expected by a  
141 given year, any incentives or other provisions for attainment of the goals, and any  
142 penalties for failure to attain said goals.

143

#### 144 **Ensuring Physician Health Information Competency**

145

146 SECTION 4. Subsection (b) of section 11A of chapter 13 of the General Laws, as  
147 appearing in the 2006 Official Edition, is hereby amended by adding the following  
148 sentence:- The board shall require, as a standard of eligibility for licensure, that  
149 applicants show a pre-determined level of competency in the use of computerized  
150 physician order entry, e-prescribing, electronic health records and other forms of health  
151 information technology, as determined by the board.

152

#### 153 **Enhancing Transparency of Insurer Pricing Structures**

154

155 SECTION 5. Chapter 26 of the General Laws is hereby amended by inserting  
156 after section 8J the following section:

157

158 Section 8K. The Massachusetts Health Insurance Transparency Report.

159

160 (a) As used in this section, an insurer shall be defined as a carrier authorized to  
161 transact accident and health insurance under chapter 175, a nonprofit hospital service  
162 corporation licensed under chapter 176A, a nonprofit medical service corporation  
163 licensed under chapter 176B, a dental service corporation organized under chapter 176E,  
164 an optometric service corporation organized under chapter 176F and a health  
165 maintenance organization licensed under chapter 176G.

166

167 (b) Notwithstanding any general or special law to the contrary, all insurers  
168 marketing small group or large group plans in the commonwealth shall annually submit  
169 to the division of insurance, on or before April 1, the following information: current  
170 average individual and family plan premiums for the insurers' prototype or alternative  
171 prototype plan, as defined in section 1 of chapter 176S for groups of 1 to 5 employees, 6  
172 to 10 employees, 11 to 25 employees, 26 to 50 employees, 51 to 100 employees, 101 to  
173 500 employees, 501 to 1000 employees, 1001 to 2500 employees, 2501 to 5000  
174 employees and 5001 employees and above. Public employer plans shall be similarly  
175 aggregated and reported separately. All reports shall include plan design summaries,  
176 including average benefits and co-pays.

177

178 (c) On or before July 1 of each year, the division of insurance and the division of  
179 health care finance and policy shall annually make available the Massachusetts Health  
180 Insurance Transparency Report for consumer and employer use. The report shall be  
181 compiled using data collected under this section in the preceding year and shall include  
182 the average premium cost results from subsection (b) of this section by insurer, employer  
183 size category and by insurers' prototype or alternative prototype plan, as defined in  
184 section 1 of chapter 176S.

185

### 186 **Establishing the Massachusetts e-Health Institute**

187

188 SECTION 6. Chapter 40J of the General Laws is hereby amended by inserting  
189 after section 6C, the following new section:-

190

191 Section 6D. (a) The corporation shall establish an institute for health care  
192 innovation, technology and competitiveness, to be known as the Massachusetts e-Health  
193 Institute, and a fund to be known as the e-Health Institute Fund, to be held by the  
194 corporation separate and apart from its other funds, to finance the activities of the  
195 institute. The executive director of the corporation shall appoint a qualified individual as  
196 director to manage the affairs of the institute. The corporation, on recommendation of the

197 executive director, shall appoint not less than 7 qualified individuals to a governing board  
198 to assist the corporation in matters related to the institute including a dean of a medical  
199 school, head of an emerging health technology company, a chief information officer of a  
200 major teaching hospital and a technology transfer officer or individual qualified in  
201 technology commercialization from a university in the commonwealth. The executive  
202 director, and the secretary of health and human services shall serve as ex-officio members  
203 of the governing board. The members of the governing board shall consult with the health  
204 care quality and cost council, the Massachusetts health and educational facilities  
205 authority, the joint committee on health care financing, the house and senate committees  
206 ways and means during the preparation of a detailed plan for the operation of the institute  
207 and the matching fund. Upon approval of such detailed plan by the board of directors of  
208 the corporation, it shall delegate such authority to the governing board as it deems  
209 necessary to implement the plan. The members of the governing board shall be deemed to  
210 be directors for purposes of the fourth paragraph of section 3. The purpose of the institute  
211 shall be to serve as an agent of the commonwealth to create and maintain a statewide,  
212 interoperable electronic health records system to improve patient safety and quality, and  
213 to lower costs in the state's health care system, with a particular emphasis on the  
214 deployment of health information technology in discrete and underserved regions by  
215 harnessing local support and involvement in such development activities and by  
216 improving the health information technology infrastructure for such clusters. In  
217 furtherance of these public purposes, the institute shall endeavor to identify regions  
218 where compelling opportunities to make strategic investments appear to be present and  
219 develop strategies therefor. The institute may also provide development support more  
220 generally to organizations to assist the formation and growth of emerging health  
221 technology sectors in those regions and may provide support to departments, agencies,  
222 and quasi-public entities of the commonwealth for activities that are consistent with the  
223 purposes of the institute. The institute may make grants in support of Massachusetts-  
224 based public and private enterprises developing and deploying new technologies to  
225 significantly increase the efficiency, safety and quality of the health care system. The  
226 institute may work in collaboration with the Massachusetts technology collaborative, the  
227 New England Health Care Institute, the Massachusetts Hospital Association, the

228 Massachusetts Association of Community Hospitals, Blue Cross/Blue Shield of  
229 Massachusetts, the Massachusetts Association of Health Plans, and other quasi-public  
230 agencies and not-for-profit organizations. Successful grants should incorporate regional  
231 involvement through alliances among municipalities, colleges, hospitals, health centers,  
232 skilled nursing facilities, business and industry, community based organizations, non-  
233 profit organizations and labor unions. The governing board may apply the provisions of  
234 this chapter that apply to centers and to the center fund to the institute and to the e-health  
235 institute fund. Without limiting the generality of the foregoing, the corporation may apply  
236 moneys in said fund to start-up expenses and project costs of said institute and related  
237 activities, grants or loans to nonprofit or other organizations to promote the use of  
238 electronic health records. The institute shall also file an annual report of its activities  
239 with the joint committee on health care financing, the house and senate committees on  
240 ways and means.

241

242 (b) Before awarding any grant from the e-health institute fund, the corporation  
243 shall consult the public health council and the Massachusetts e-health advisory committee  
244 established by law. The request for consultation shall be submitted not less than 15  
245 business days before the execution of any grant award contract. All successful grant  
246 applications shall define specific goals and expected outcomes and contain corresponding  
247 accountability measures. Applicants who fail to meet these accountability measures shall  
248 be barred from pursuing any additional grants under this section for 5 years from the  
249 effective date of the grant.

250

251 (c) In making the initial round of grants from the innovation institute fund, not  
252 more than \$25,000,000 a year shall be distributed over a 3 year period to each of the 5  
253 geographic regions of the state, defined generally as follows: the central area, comprised  
254 of the Northern Worcester Service Delivery Area and the Southern Worcester Service  
255 Delivery Area as specified in 20 CFR 661.280; the greater Boston area, comprised of the  
256 Boston Service Delivery Area, the Metropolitan North Service Delivery Area and the  
257 Metropolitan South/West Service Delivery Area as specified in 20 CFR section 661.280;  
258 the northeast area, comprised of the Lower Merrimack Valley Service Delivery Area, the

259 Northern Middlesex Service Delivery Area and the Southern Essex Service Delivery  
260 Area as specified in 20 CFR 661.280; the southeast area, comprised of the Bristol Service  
261 Delivery Area, the Brockton Service Delivery Area, the Cape and Islands Service  
262 Delivery Area, the New Bedford Service Delivery Area and the South Coastal Service  
263 Delivery Area as specified in 20 CFR 661.280; and the western area, comprised of the  
264 Berkshire Service Delivery Area, Franklin/Hampshire Service Delivery Area and  
265 Hampden Service Delivery Area as specified in 20 CFR 661.280.

266

267 (d) The Massachusetts e-health institute may not make a grant under this section  
268 unless the recipient organization agrees to use the grant: (1) to develop and implement  
269 an electronic health records (EHR); and (2) to begin implementation of the plan not later  
270 than the beginning of the second year of the grant.

271

272 (e) In selecting grant or loan recipients under this section, the Massachusetts e-  
273 health institute shall consider: (i) existing technological and organizational infrastructure  
274 upon which the health information network can build; (ii) the extent of stakeholder  
275 participation; (iii) health care provider participation commitments; (iv) capacity to  
276 measure quality and efficiency improvements; (v) replicability; (vi) the extent of the  
277 opportunity for a plan to improve health care quality and the health outcomes of patients  
278 in the region to be served; and (vii) other factors that the collaborative considers relevant.

279

280 (f) Any health information network funded in whole or in part under this section  
281 shall comply with any applicable regulatory privacy protections and shall allow patients  
282 to exclude their health information from the health information network.

283

284 (g) In the event of the unauthorized access to or disclosure of individually  
285 identifiable patient health information occurs by or through the statewide health  
286 information network, or by or through any technology grantees funded in whole or in part  
287 under this section, the operator of such network or grantee shall: (i) report the conditions  
288 of such unauthorized access or disclosure as required by the collaborative; and (ii)

289 provide notice to any individuals whose patient health information may have been  
290 compromised as a result of such unauthorized access or disclosure.

291

292 (h) To apply for a grant under this section, an applicant shall submit an  
293 application to the collaborative in such form and manner, and containing such  
294 information and assurances as the collaborative may require.

295

296 (i) (1) The collaborative shall provide to the statewide health information  
297 technology network and to individual technology grantees such technical assistance as  
298 the collaborative deems appropriate to carry out this section, including assistance relating  
299 to questions of governance, financing and technological approaches to the creation of  
300 health information networks.

301

302 (2) The e-health institute shall by contract or grant establish and maintain a  
303 statewide technical assistance center to provide assistance to physicians to facilitate  
304 successful adoption of electronic health records and participation in the development and  
305 implementation of the statewide health information technology plan by such physicians.  
306 The statewide technical assistance center shall assist physicians in all geographical areas  
307 served by a health information network. In assisting physicians under this paragraph, the  
308 statewide technical assistance centers shall prioritize physicians in small physician groups  
309 and, as resources allow, shall assist physicians in larger groups. Technical assistance  
310 provided under this paragraph shall, at a minimum, include the following: (i) A  
311 clearinghouse of best practices, guidelines and implementation strategies directed at the  
312 small medical practices that plan to adopt electronic health records; (ii) a change  
313 management tool kit to enable physicians and their staff to successfully prepare practice  
314 workflows for adoption of electronic medical records and electronic prescribing, to  
315 receive guidance in the selection of vendors of health information technology products  
316 and services that are appropriate within the context of the individual practice and the  
317 community setting, to implement health information technology solutions and manage  
318 the project at the practice level, and to address the ongoing need for upgrades,  
319 maintenance and security of office-based health information technologies; and (iii) the

320 capability to provide consultations and advice to small medical practices to facilitate  
321 adoption of health information technologies.

322

323 (j) No funds under this section may be used for the establishment of a database of  
324 individually identifiable patient health information.

325

326 (k) Not later than 4 years after the date of the enactment of this Act, the e-health  
327 institute shall submit a report to the joint committee on health care financing and the  
328 senate and house committees on ways and means on the progress in realizing the  
329 purposes of this Act, with particular attention to the following: (i) the capacity to  
330 exchange health information between and among components of the health system; (ii)  
331 rates of provider participation in electronic health records; (iii) the security and privacy  
332 of health information technology supported by this section; and (iv) the impact of health  
333 information technology on health care quality, health outcomes of patients, and health  
334 care costs.

335

336 (l) No state funds may be made available to any entity under this section for the  
337 purchase of a health information technology product, unless the product or network, as  
338 the case may be, is certified by the Certification Commission on Healthcare Information  
339 Technology (CCHIT), or any successor agency or organization established for the  
340 purpose of certifying that health information technology shall meet interoperability  
341 standards.

342

### 343 **Pharmacy Academic Detailing Program**

344 SECTION 7. Chapter 111 of the General Laws is hereby amended by inserting  
345 after section 4M the following section:—

346 Section 4N. (a) The department of shall develop, in cooperation with the division of  
347 Commonwealth Medicine of the University of Massachusetts Medical School, implement  
348 and promote an evidence-based outreach and education program designed to provide  
349 information and education on the therapeutic and cost-effective utilization of prescription

350 drugs to physicians, pharmacists and other health care professionals authorized to  
351 prescribe and dispense prescription drugs, subject to appropriation. In developing the  
352 program the department shall consult with physicians, pharmacists, private insurers,  
353 hospitals, pharmacy benefit managers, the MassHealth drug utilization review board and  
354 the University of Massachusetts medical school. The program shall include the following  
355 elements:

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

363 (2) Outreach conducted to physicians and other health care practitioners who  
364 participate in MassHealth, the subsidized catastrophic prescription drug insurance  
365 program authorized in section 39 of chapter 19A, the commonwealth care health  
366 insurance program, to other publicly funded, contracted or subsidized health care  
367 programs in the commonwealth, to academic medical centers and to other prescribers.

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

369 (c) The department shall, to the extent possible, also utilize or incorporate into its  
370 program other independent educational resources or models proven effective in  
371 promoting high quality, evidenced-based, cost-effective information regarding the  
372 effectiveness and safety of prescription drugs, including, but not limited to: (1) the  
373 Pennsylvania PACE/Harvard University Independent Drug Information Service, (2) the  
374 Academic Detailing Program of the University of Vermont College of Medicine Area  
375 Health Education Centers, (3) the Oregon Health and Science University Evidence-based  
376 Practice Center's Drug Effectiveness Review project, and (4) the North Carolina  
377 evidence-based peer to peer education program outreach program.

378 (d) The department is authorized to establish and collect fees for subscriptions and  
379 contracts with private payors and to seek funding from nongovernmental health access  
380 foundations and undesignated drug litigation settlement funds associated with  
381 pharmaceutical marketing and pricing practices.

382 **Establish Massachusetts Center for Primary Care Recruitment and Replacement**  
383

384 SECTION 8. Chapter 111 of the General Laws is hereby amended by inserting  
385 after section 25K the following section:-

386

387 Section 25L. There shall be in the department a center for primary care  
388 recruitment and placement whose purpose shall be to improve access to primary care  
389 services.

390

391 The duties of the center shall consist of the following: (i) coordinate the  
392 department's primary care workforce activities with other state agencies and public and  
393 private entities involved in health care workforce training, recruitment and retention; (ii)  
394 monitor trends in access to primary care and primary care workforce capacity, including  
395 regional disparities; (iii) maintain a public web-based statewide primary care job  
396 database; (iv) conduct outreach and marketing to recruit primary care providers,  
397 regionally and nationally, to practice in Massachusetts; (v) coordinate state and federal  
398 loan repayment and incentive programs for primary care providers; (vi) assist and support  
399 communities, physician groups, community health centers and community hospitals in  
400 developing cost-effective and comprehensive recruitment initiatives; (vii) assist and  
401 support primary care professionals by acting as a career service center and providing job  
402 placement assistance; and (viii) maximize all sources of public and private funds for  
403 recruitment initiatives.

404

405 The center shall submit an annual report to the joint committee on public health,  
406 the joint committee on health care financing, and the house and senate committees on  
407 ways and means regarding the center's activities in recruiting and retaining health care

408 providers for underserved populations and areas throughout the commonwealth. The  
409 annual report shall include, but shall not be limited to, information about: (i) the activities  
410 and accomplishments of the center during the report period; (ii) planned activities for the  
411 next year; (iii) the number and type of providers who have been recruited to work in the  
412 commonwealth as a result of center activities; (iv) the retention rate of providers who  
413 have located in underserved areas as a result of center activities; (v) the utilization rate of  
414 the scholarship and loan repayment programs and other programs or activities authorized  
415 for provider recruitment and retention; and (vi) recommendations for pilot programs and  
416 regulatory or legislative proposals to address workforce needs, shortages, recruitment and  
417 retention. The annual report shall be submitted by October 1 of each year.

418

### 419 **Prevention of Serious Reportable Events**

420

421 SECTION 9. Section 51 of chapter 111 of the General Laws is hereby amended  
422 by inserting after the fourth paragraph the following paragraph:- A hospital licensed  
423 under this chapter shall report each never event occurrence listed in regulations  
424 promulgated under clause (i) of subsection (e) of section 16L of chapter 6A to the Betsy  
425 Lehman center for patient safety and medical error reduction, the department of public  
426 health, the board of registration in medicine's patient care assessment division, and the  
427 health care quality and cost council, as soon as is reasonably and practically possible, but  
428 not later than 15 working days after discovery of the never event. Any licensed hospital  
429 in the commonwealth which does not comply with this section and the rules and  
430 regulation set forth by the department may have its license revoked or suspended by the  
431 department, be fined up to \$1,000 per day per violation, or both.

432

### **Establishment of Patient and Family Advisory Councils**

433 SECTION 10. Chapter 111 of the General Laws is hereby amended by inserting  
434 after section 52 the following section:-

435 Section 52A. (a) All hospitals shall establish and convene patient and family  
436 advisory councils, referred to in this section as the councils.

437 (b) The councils shall be composed of current and former patients and members  
438 of their immediate families. The minimum size of a council shall be 7 members. The  
439 rules and regulations for the councils shall be established by council members.

440 (c) Each hospital shall appoint an employee to serve as a resource to the councils  
441 and to coordinate their activities.

442 (d) Each hospital shall develop a committee to establish and maintain a council  
443 and to empower the council to provide meaningful input into hospital policy and  
444 management. The councils shall meet at least 4 times annually. The hospital shall  
445 provide a meeting place for the council.

446 **Strengthen Determination of Need Process**

447

448 SECTION 11. Chapter 111 of the General Laws is hereby amended by inserting  
449 after section 53D the following section:-

450

451 Section 53E. Notwithstanding any other provisions of law to the contrary, any distinct  
452 freestanding entity that is certified or intends to be certified as an Ambulatory Surgical  
453 Center by the federal Centers for Medicare and Services for participation in the Medicare  
454 program shall be a clinic for purposes of licensure under section 51 of this chapter, and  
455 shall be deemed to be in compliance with the conditions for licensure as a clinic under  
456 said section 51 if it is accredited to provide ambulatory surgery services by the  
457 Accreditation Association for Ambulatory Health Care, Inc., the Joint Commission on  
458 Accreditation of Healthcare Organizations, the American Association for Accreditation  
459 of Ambulatory Surgery Facilities or any other national accrediting body that the  
460 department of public health determines provides reasonable assurances that such  
461 conditions are met. No original license shall be issued pursuant to section fifty-one to  
462 establish any such ambulatory surgical clinic unless there is a determination by the  
463 department that there is need for such a facility. For purposes of this section, "clinic"  
464 shall not include a clinic conducted by a hospital licensed under section 51 or by the

465 federal government or the commonwealth. The department shall promulgate regulations  
466 to implement this section.

467 **Reduction of Medical Storage Requirements I**

468 SECTION 12. Section 70 of chapter 111 of the General Laws, as appearing in the  
469 2006 Official Edition, is hereby amended by striking out the second and third sentences  
470 in the first paragraph and inserting in place thereof the following three sentences-

471 Such records may be made in handwriting, in print, by typewriting, in electronic digital  
472 media or conversion to electronic digital media as originally created by such hospital or  
473 clinic, by the photographic or microphotographic process, or any combination of the  
474 same. Such hospital or clinic, may only destroy said records after the applicable retention  
475 period has elapsed upon notifying the department of public health that the applicable  
476 retention period has elapsed and the records will be destroyed. Such hospital or clinic  
477 shall further provide information through applicable provisions contained in the hospital  
478 or clinic notice of privacy practices that records will be terminated after the applicable  
479 retention period has elapsed since the last date of service.

480 **Reduction of Medical Storage Requirements II**

481 SECTION 13. Said section 70 of said chapter 111, as so appearing, is hereby  
482 further amended by striking out, in line 66, the word “thirty” and inserting in place  
483 thereof the following figure:- 15.

484 **Reporting Requirements for Clinical Laboratories**

485

486 SECTION 14. Chapter 111D of the General Laws is hereby amended by striking  
487 out section 6, as appearing in the 2006 Official Edition, and inserting in place thereof the  
488 following section:

489

490 Section 6. Infectious disease reports; confidential information

491 The department shall require the reporting of any infectious disease found in the  
492 examination of specimens at clinical laboratories whenever, in its opinion, reporting of  
493 such disease is necessary to protect or promote the public health. Every person who and  
494 every agency which maintains a clinical laboratory shall report evidence of any infectious  
495 disease including, but not limited to, hospital acquired infections found in the course of  
496 the examination of specimens, as required by the department, in such form, manner and  
497 detail and within such time as the department shall prescribe. Reports made under this  
498 section shall not be constitute a diagnosis nor shall any person making a report under this  
499 section be held liable in a civil proceeding for having violated a trust or confidential  
500 relationship. Notwithstanding section 10 of chapter 66, every such report shall be kept  
501 confidential by the department and its employees and agents and shall not be subject to  
502 the inspection, examination or copying by any other agency of government or by any  
503 other person; provided, however, that the department shall make public clinical  
504 laboratory reports of hospital acquired infections in a manner that does not identify  
505 individual patients. Failure of a clinical laboratory to submit reports in a timely manner  
506 required under this section shall be punished by a fine, in accordance with regulations  
507 promulgated by the department establishing a schedule of fines or by suspension or  
508 revocation of the laboratory license or both.

#### 509 **Expanding Use of Physician Assistants in Underserved Area**

510

511 SECTION 15. Section 9E of chapter 112 of the General Laws, as appearing in  
512 the 2006 Official Edition, is hereby amended by adding at the end of the first paragraph,  
513 the following sentence:

514

515 Physicians who work in medically underserved areas, as designated by the department  
516 of public health, may supervise up to 4 physician assistants.

517

518

#### 519 **MassHealth Medical Home Demonstration Project**

520

521 SECTION 16. Chapter 118E of the General Laws is hereby further amended by  
522 inserting after section 10F, the following section:-

523

524 Section 10G. MassHealth Medical Home Demonstration Program

525

526 (a) As used in this section, the following word shall have the following  
527 meanings:-

528

529 “Medical home,” a primary care practice that utilizes a comprehensive approach  
530 to providing patient-centered care that is accessible, continuous, and coordinated so that  
531 the relationship between the provider and patient is directed at maintaining a healthy  
532 lifestyle with preventive and ongoing health services and is respectful of, and responsive  
533 to, individual patient preference, needs, and values.

534

535 (b) Notwithstanding any general or special law to the contrary, the office of  
536 Medicaid, subject to appropriation and the availability of federal financial participation,  
537 shall establish a medical home demonstration program for the purpose of redesigning the  
538 health care delivery system to provide targeted, accessible, continuous and coordinated  
539 family-centered care to high need populations including, but not limited to, those with  
540 multiple chronic illnesses that require regular monitoring, advising or treatment.

541

542 Under the demonstration program, case management fees shall be paid to personal  
543 physicians and incentive payments shall be paid to physicians participating in practices  
544 that provide medical home services. Medical homes shall be responsible for: (1)  
545 targeting eligible individuals for program participation; (2) providing safe and secure  
546 technology to promote patient access to personal health information; (3) developing a  
547 health assessment tool for the targeted individuals; and (4) providing training for  
548 personnel involved in the coordination of care.

549

550 The program shall operate for three years in urban, rural, and underserved areas in  
551 up to ten communities and would include physician practices with fewer than three full-

552 time equivalent physicians, as well as larger practices, particularly in rural and  
553 underserved areas.

554

555 Personal physicians who provide first contact and continuous care for their  
556 patients must be board certified. Such personal physicians must also have a staff and  
557 resources to manage the comprehensive and coordinated care of each of their patients.  
558 Participating physicians may be specialists or sub-specialists for patients requiring  
559 ongoing care for specific conditions, multiple chronic conditions such as severe asthma,  
560 complex diabetes, cardiovascular disease, and rheumatologic disorder, or for those with a  
561 prolonged illness.

562

563 Personal physicians must perform or provide for the performance of: (1)  
564 advocates for and providing ongoing support, oversight, and guidance to implement a  
565 plan of care; that provides an integrated, coherent, cross-discipline plan for ongoing  
566 medical care developed in partnership with patients and including all other physicians  
567 furnishing care to the patient involved and other appropriate medical personnel or  
568 agencies such as home health agencies; (2) uses evidence-based medicine and clinical  
569 decision support tools to guide decision-making at the point-of-care based on patient-  
570 specific factors; (3) uses health information technology that may include remote  
571 monitoring and patient registries; and (4) encourages patients to engage in management  
572 of their own health through education and support systems.

573

574 The office of Medicaid may establish a system of supplemental payments for care  
575 management to personal physicians through the establishment of a care management fee,  
576 and shall establish within the office of Medicaid a care management fee code and a value  
577 for these payments.

578

579 The office of Medicaid may also establish a system of supplemental payment for  
580 a medical home to physician group practices through the establishment of a medical  
581 home fee, and shall establish within the office of Medicaid a medical home fee code and  
582 a value for these payments.

583

584           The office of Medicaid shall provide a yearly program evaluation and submit said  
585 report to the senate and house chairs of the joint committee on health care financing and  
586 the chairs of the senate and house committees on ways and means.

587

### **Standardizing Insurance Coding and Forms I**

588

589

SECTION 17. Chapter 118E of the General Laws is hereby amended by adding  
the following section:-

590

591

592

593

Section 61. This section is intended to provide uniformity and consistency in the  
reporting of patient diagnostic information as well as patient care service and procedure  
information as it relates to the processing of health care claims.

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607

(a) Subject to subsection (c), for the purposes of processing claims for health care  
services submitted by a health care provider, the executive office of health and human  
services and its subcontractors shall without local customization accept and recognize  
patient diagnostic information and patient care service and procedure information  
submitted pursuant to and consistent with the current Health Insurance Portability and  
Accountability Act (HIPAA) compliant code sets as adopted by the Centers for Medicare  
and Medicaid Services: the International Classification of Diseases (ICD); the American  
Medical Association's Current Procedural Terminology (CPT) codes, reporting guidelines  
and conventions; and the Centers for Medicare and Medicaid Services Healthcare  
Common Procedure Coding System (HCPCS). The executive office and its  
subcontractors shall adopt the foregoing coding standards and guidelines, and all changes  
thereto, in their entirety effective on the same date as the national implementation date  
established by the entity implementing said coding standards.

608

609

610

611

(b) Subject to subsection (c), the executive office and its subcontractors shall,  
without local customization, use the standardized claim formats for processing health  
care claims as adopted by the National Uniform Claim Committee and the National  
Uniform Billing Committee and implemented pursuant to the federal Health Insurance

612 Portability and Accountability Act. The executive office and its subcontractors shall,  
613 without local customization, adopt and routinely process all changes to such formats  
614 effective on the same date as the implementation date established by the entity  
615 implementing said formats.

616 (c) Other than requirements for consistency and uniformity in coding patient  
617 diagnostic information and patient care service and procedure information, this section  
618 shall not modify or supersede the Executive Office's or its subcontractor's payment  
619 policy or utilization review policy. Nothing in this section shall further preclude the  
620 executive office or its subcontractor from adjudicating a claim pursuant to their billing  
621 guidelines, payment policies, or provider contracts.

622

623 (d) Effective January 1, 2011, the Executive Office and their subcontractors must  
624 accept and recognize at least 85 per cent of all claims submitted by health care providers  
625 pursuant to and consistent with the provisions set forth in this section.

626

627

### **Reduction of Medical Storage Requirements III**

628 SECTION 18. Section 36 of chapter 123, as so appearing, is hereby amended by  
629 adding the following sentences:- Each facility, subject to this chapter and section 19 of  
630 chapter 19, that provides mental health care and treatment shall maintain patient records,  
631 as defined in the first paragraph of section 70 of chapter 111, for at least 15 years after  
632 closing of the record due to discharge, death or last date of service. Such facility may  
633 destroy said records after the applicable retention period has elapsed upon notifying the  
634 department that the applicable retention period has elapsed and the records will be  
635 destroyed. Said facility shall further provide information through applicable provisions  
636 in the hospital or clinic notice of privacy practices that records will be terminated after  
637 the applicable retention period has elapsed since the last date of service.

638

### **Standardizing Insurance Coding and Forms II**

639 SECTION 19. Chapter 176O of the General Laws is hereby amended by inserting  
640 after section 5 the following 2 sections:-

641 Section 5A. Processing of health care claims. This section is intended to provide  
642 uniformity and consistency in the reporting of patient diagnostic information and patient  
643 care service and procedure information as it relates to the submission and processing of  
644 health care claims.

645

646 (a) Subject to subsection (c), for the purposes of processing claims for health care  
647 services submitted by a health care provider, a carrier and its subcontractors shall without  
648 local customization accept and recognize patient diagnostic information and patient care  
649 service and procedure information submitted pursuant to and consistent with the current  
650 Health Insurance Portability and Accountability Act (HIPAA) compliant code sets: the  
651 International Classification of Diseases (ICD); the American Medical Association's  
652 Current Procedural Terminology (CPT) codes, reporting guidelines and conventions; and  
653 the Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding  
654 System (HCPCS). A carrier and its subcontractors shall adopt the foregoing coding  
655 standards and guidelines, and all changes thereto, in their entirety effective on the same  
656 date as the national implementation date established by the entity implementing said  
657 coding standards.

658

659 (b) Subject to subsection (c), a carrier and its subcontractors shall, without local  
660 customization, use the standardized claim formats for processing health care claims as  
661 adopted by the National Uniform Claim Committee and the National Uniform Billing  
662 Committee and implemented pursuant to the federal Health Insurance Portability and  
663 Accountability Act. A carrier and its subcontractors shall, without local customization,  
664 adopt and routinely process all changes to such formats effective on the same date as the  
665 implementation date established by the entity implementing said formats.

666

667 (c) Other than requirements for consistency and uniformity in coding patient  
668 diagnostic information and patient care service and procedure information, this section  
669 shall not modify or supersede a carrier's or its subcontractor's payment policy, utilization  
670 review policy, or benefits under a health benefit plan. Nothing in this section shall

671 further preclude a carrier or its subcontractor from adjudicating a claim pursuant to their  
672 billing guidelines, payment policies, provider contracts or health benefit plans.

673

674 (d) Effective January 1, 2011, carriers and their subcontractors must accept and  
675 recognize at least 85 per cent of all claims submitted by health care providers pursuant to  
676 and consistent with the provisions set forth in this section.

677

678 Section 5B. To ensure uniformity and consistency in the submission and  
679 processing of claims for health care services pursuant to section 5A of chapter 176O, the  
680 bureau of managed care within the division of insurance, after consultation with a  
681 statewide advisory committee including but not limited to the Massachusetts Hospital  
682 Association, the Massachusetts Medical Society, the Massachusetts Association of Health  
683 Plans, the Blue Cross and Blue Shield of Massachusetts, the Massachusetts Health  
684 Information Management Association, the Massachusetts Health Data Consortium, a  
685 representative of America's Health Insurance Plans, a representative of a MassHealth  
686 contracted managed care organization, the executive office of health and human services,  
687 the division of health care finance and policy, the health care quality and cost council, the  
688 Massachusetts house of representatives, and the Massachusetts senate, shall adopt  
689 policies and procedures to enforce section 5A. Said policies and procedures shall include  
690 a system for reporting of inconsistencies related to a carrier's compliance with section  
691 5A. The bureau shall work jointly with the executive office of health and human services  
692 in connection with resolving reports of noncompliance with the requirements of section  
693 53 of chapter 118E. The bureau shall convene the advisory committee annually starting  
694 on January 1, 2009, and as otherwise necessary, to review and discuss issues reported by  
695 health care providers under the section as well as to discuss further recommendations to  
696 improve the uniformity and consistency in the reporting of patient diagnostic information  
697 and patient care service and procedure information as it relates to the submission and  
698 processing of health care claims.

699

### **Expanding Consumer Choice of Nurse Practitioner Services**

700 SECTION 20. The General Laws are hereby amended by inserting after chapter  
701 176Q the following chapter:-

702 CHAPTER 176R

703 CONSUMER CHOICE OF NURSE PRACTITIONER SERVICES

704 Section 1. As used in this chapter, the following words shall have the following  
705 meanings:

706 "Carrier", an insurer licensed or otherwise authorized to transact accident or  
707 health insurance under chapter 175; a nonprofit hospital service corporation organized  
708 under chapter 176A; a nonprofit medical service corporation organized under chapter  
709 176B; a health maintenance organization organized under chapter 176G; an organization  
710 entering into a preferred provider arrangement under chapter 176I; a contributory group  
711 general or blanket insurance for persons in the service of the commonwealth under  
712 chapter 32A; a contributory group general or blanket insurance for persons in the service  
713 of counties, cities, towns and districts, and their dependents under chapter 32B; the  
714 medical assistance program administered by the division of medical assistance pursuant  
715 to chapter 118E and in accordance with Title XIX of the Federal Social Security Act or  
716 any successor statute; and any other medical assistance program operated by a  
717 governmental unit for persons categorically eligible for such program.

718 "Commissioner", the commissioner of insurance.

719 "Insured", an enrollee, covered person, insured, member, policyholder or  
720 subscriber of a carrier.

721 "Nondiscriminatory basis", a carrier shall be deemed to be providing coverage on  
722 a non-discriminatory basis if its plan does not contain any annual or lifetime dollar or unit  
723 of service limitation imposed on coverage for the care provided by a nurse practitioner  
724 which is less than any annual or lifetime dollar or unit of service limitation imposed on  
725 coverage for the same services by other participating providers.

726 "Nurse practitioner", a registered nurse who holds authorization in advanced  
727 nursing practice as a nurse practitioner under section 80B of chapter 112, and regulations  
728 promulgated thereunder.

729 "Participating provider", a provider who, under a contract with the carrier or with  
730 its contractor or subcontractor, has agreed to provide health care services to insureds with  
731 an expectation of receiving payment, other than coinsurance, co-payments or deductibles,  
732 directly or indirectly from the carrier.

733 "Primary care provider", a health care professional qualified to provide general  
734 medical care for common health care problems. The primary care provider supervises,  
735 coordinates, prescribes, or otherwise provides or proposes health care services, initiates  
736 referrals for specialist care, and maintains continuity of care, within their scope of  
737 practice.

738 Section 2. The commissioner and the group insurance commission shall require  
739 that all carriers recognize nurse practitioners as participating providers subject to section  
740 3 of this chapter and shall include coverage, on a nondiscriminatory basis, to their  
741 insureds for care provided by nurse practitioners for the purposes of health maintenance,  
742 diagnosis and treatment. Such coverage shall include benefits for primary care,  
743 intermediate care and inpatient care, including care provided in a hospital, clinic,  
744 professional office, home care setting, long term care setting, mental health or substance  
745 abuse programs, or other settings when rendered by a nurse practitioner who is a  
746 participating provider and is practicing within the scope of her professional license to the  
747 extent that such policy or contract currently provides benefits for identical services  
748 rendered by a provider of health care licensed by the commonwealth.

749 Section 3. A participating nurse practitioner practicing within the scope of her  
750 licensure including all regulations requiring collaboration with a physician under section  
751 80B of chapter 112, shall be considered qualified within the carrier's definition of  
752 primary care provider to an insured.

753           Section 4. Notwithstanding any special or general law to the contrary, all carriers  
754 that require the designation of a primary care provider shall provide their insured with an  
755 opportunity to select a participating provider nurse practitioner as a primary care provider  
756 or to change their primary care provider to a participating provider nurse practitioner at  
757 any time during their coverage period.

758           Section 5. Notwithstanding any special or general law to the contrary, all carriers  
759 shall ensure that all participating provider nurse practitioners are included on any publicly  
760 accessible list of participating providers for the carrier.

761           Section 6. Complaints of noncompliance against carriers shall be filed with and  
762 investigated by the commissioner or the group insurance commission, whichever shall  
763 have regulatory authority over the carrier. The commissioner and the group insurance  
764 commission shall promulgate regulations to enforce sections 2, 3, 4 and 5.

765

766           **Enhancing Transparency of Health Care Insurance Cost Increases**

767

768           SECTION 21. The General Laws are hereby amended by inserting after chapter  
769 176R the following chapter:-

770

CHAPTER 176S

771

HEALTH INSURANCE RATE HEARINGS

772           Section 1. As used in this chapter the following words shall have the following  
773 meanings, unless the context clearly requires otherwise:-

774           "Adjusted weighted average market premium price", the arithmetic mean of all  
775 premium rates for a given prototype plan sold to eligible insureds with similar rate basis  
776 type by all carriers selling prototype plans or alternative prototype plans in the  
777 commonwealth, weighted pursuant to regulations promulgated by the commissioner.

778           "Alternative prototype plan", a health plan which meets the criteria established by  
779 the commissioner and which is intended for sale under section 4 of chapter 176Q, to  
780 eligible individuals and to eligible small groups, as defined in section 1 of chapter 176Q.

781

782           "Carrier", an insurer licensed or otherwise authorized to transact accident and  
health insurance under chapter 175; a nonprofit hospital service corporation organized

783 under chapter 176A; a non-profit medical service corporation organized under chapter  
784 176B; or a health maintenance organization organized under chapter 176G.

785 “Health plan”, any individual, general, blanket or group policy of health, accident  
786 or sickness insurance issued by an insurer licensed under chapter 175 or the laws of any  
787 other jurisdiction; a hospital service plan issued by a nonprofit hospital service  
788 corporation under chapter 176A or the laws of any other jurisdiction; a medical service  
789 plan issued by a nonprofit hospital service corporation under chapter 176B or the laws of  
790 any other jurisdiction; a health maintenance contract issued by a health maintenance  
791 organization under chapter 176G or the laws of any other jurisdiction; and an insured  
792 health benefit plan that includes a preferred provider arrangement issued under chapter  
793 176I or the laws of any other jurisdiction. “Health plan” shall not include accident only,  
794 credit-only, limited scope dental or vision benefits if offered separately, hospital  
795 indemnity insurance policies if offered as independent, noncoordinated benefits which for  
796 the purposes of this chapter shall mean policies issued pursuant to chapter 175 which  
797 provide a benefit not to exceed \$500 per day, as adjusted on an annual basis by the  
798 amount of increase in the average weekly wages in the commonwealth as defined in  
799 section 1 of chapter 152, to be paid to an insured or a dependent, including the spouse of  
800 an insured, on the basis of a hospitalization of the insured or a dependent, disability  
801 income insurance, coverage issued as a supplement to liability insurance, specified  
802 disease insurance that is purchased as a supplement and not as a substitute for a health  
803 plan and meets any requirements the commissioner by regulation may set, insurance  
804 arising out of a workers’ compensation law or similar law, automobile medical payment  
805 insurance, insurance under which benefits are payable with or without regard to fault and  
806 which is statutorily required to be contained in a liability insurance policy or equivalent  
807 self insurance, long-term care if offered separately, coverage supplemental to the  
808 coverage provided under 10 U.S.C. chapter 55 if offered as a separate insurance policy,  
809 or any policy subject to the provisions of chapter 176K. The commissioner may by  
810 regulation define other health coverage as a health plan for the purposes of this chapter.

811

812 “Prototype plan”, a health plan which meets the criteria established by the  
813 commissioner.

814 “Rate basis type”, each category of individual or family composition for which  
815 separate rates are charged for a health benefit plan as determined by the carrier subject to  
816 restrictions set forth in regulations promulgated by the commissioner.

817 Section 2. After a date established annually by the commissioner pursuant to  
818 regulation, every carrier desiring to increase or decrease premiums for any health  
819 insurance policy or desiring to set the initial premium for a new health insurance policy  
820 under any health plan shall file its rates with the commissioner at least 90 days before the  
821 proposed effective date of such new health insurance rates.

822 Section 3. Any increase in premium rates shall continue in effect for not less  
823 than 12 months, except that an increase in benefits or decrease in rates may be permitted  
824 at any time.

825 Section 4. A carrier shall annually report to the commissioner and to the health  
826 care quality and cost council, established under section 16K of chapter 6A, no later than  
827 May 1, the actual loss ratio calculated for each health plan for the previous calendar year.

828 Section 5. If a carrier files for an increase in premium of 7 per cent or more than  
829 the premium previously charged for any rate classification or coverage, or if a carrier  
830 files an initial premium request that is 7 per cent or more than the adjusted weighted  
831 average market premium price, or if the attorney general files with the commissioner,  
832 within 30 days of the carrier’s filing, a preliminary determination that the benefits  
833 provided in any health insurance policy are unreasonable in relation to the premium  
834 charged, the commissioner shall initiate a hearing conducted pursuant to chapter 30A on  
835 any such filing prior to its effective date on at least 10 days notice. The commissioner  
836 may consolidate hearings for more than 1 carrier, and may consolidate hearings for  
837 multiple health plans filed by one carrier. The carrier shall provide information on the  
838 reasons for the proposed premium increase, and members of the public may testify. All  
839 testimony and evidence received shall be public records. The commissioner may  
840 promulgate guidelines to safeguard the confidentiality of contracts that establish rates  
841 between insurers and institutional providers licensed under section 51 of chapter 111  
842 which shall apply when the commissioner obtains such contracts under his authority in  
843 section 8A of chapter 175 for purposes of a hearing under this section.

844

845 The attorney general shall have the authority to intervene in any hearing called for  
846 under this paragraph.

847

848 Such requested premium increase or initial premium request shall be filed at least  
849 90 days before the proposed effective date of such increase, and shall be communicated  
850 to the insureds at least 90 days before the proposed effective date of such increase, in the  
851 manner directed by the commissioner.

852

853 The rate filer shall advertise any public hearing conducted under this section in  
854 newspapers in Boston, Brockton, Fall River, Pittsfield, Springfield, Worcester, New  
855 Bedford and Lowell.

856

857 Within 30 days of the conclusion of any hearing initiated under this section, the  
858 commissioner shall issue a report containing findings of fact from the evidence presented  
859 in the carrier's filing and in the hearing. The findings of fact shall include, but shall not  
860 be limited to:

- 861 1) the carrier's administrative expenses, including but not limited to the  
862 carrier's salary structure, advertising and other marketing expenses, and  
863 commissions, brokerage fees and other distribution expenses, as compared  
864 to other carriers within and without the commonwealth;
- 865 2) the carrier's expenses related to health care contract, including but not  
866 limited to the costs of services rendered by health care providers, the rates  
867 at which it pays for such services and the volume of services provided;
- 868
- 869 3) the carrier's loss experience under the health plan, including evaluations  
870 of the carrier's loss ratio and of utilization by the carrier's insureds, and of  
871 identifiable cost drivers for that health plan, as compared to other carriers  
872 within and without the commonwealth;
- 873 4) cost-sharing assumptions made in the health plan, including, but not  
874 limited to, the use of deductibles, co-payments and coinsurance;
- 875 5) the carrier's provisions in the rates for reserves and surplus; and

876                   6) the carrier's programs of cost containment, as compared to other carriers  
877                   within and without the commonwealth.

878 Nothing in this paragraph shall be construed to prohibit the attorney general from  
879 publishing any report concerning a hearing under this section.

880

881                   This section is not intended to alter any procedures for the approval or  
882 disapproval of health plan rates provided elsewhere in the General Laws, except as  
883 specifically provided herein.

884

885                   The commissioner shall promulgate regulations to specify the conduct and  
886 scheduling of the hearings required pursuant to this section, provided that any such  
887 regulation shall facilitate adequate discovery of information related to the filed rates.

888

889

890                   Section 6. The supreme judicial court shall have jurisdiction in equity upon the  
891 petition of the attorney general, on behalf of the commissioner and upon a summary  
892 hearing, to enforce all lawful orders of the commissioner.

893

894                   Any person aggrieved by any final action, order, finding or decision of the  
895 commissioner under this section may, within 20 days from the filing of such final action,  
896 order, finding or decision in his office, file a petition in the supreme judicial court for the  
897 county of Suffolk for a review of such action, order, finding or decision. The final action,  
898 order, finding, or decision of the commissioner shall remain in full force and effect,  
899 pending the final decision of the court, unless the court or a justice thereof after notice to  
900 the commissioner shall by a special order otherwise direct. Review by the court on the  
901 merits shall be limited to the record of proceedings before the commissioner. The court  
902 shall have jurisdiction to modify, amend, annul, reverse or affirm such action, order,  
903 finding or decision and shall uphold the commissioner's action, order, finding, or decision  
904 if it is consistent with the standards set forth in paragraph 7 of section 14 of chapter 30A.  
905 The court may make any appropriate order or decree and may make such order as to costs  
906 as it deems equitable. The court may make such rules or orders as it deems proper

907 governing proceedings under this section to secure prompt and speedy hearings and to  
908 expedite final decisions thereon.

909

910 Section 7. The commissioner may promulgate regulations to facilitate the  
911 administration and enforcement of this chapter and to govern hearings and investigations  
912 thereunder, and may issue such orders as he finds proper, expedient or necessary to  
913 enforce and administer this chapter and to secure compliance with any rules and  
914 regulations made thereunder.

915

### 916 **Pharmaceutical Industry Gift Ban**

917

918 SECTION 22. The General Laws are hereby amended by inserting after chapter  
919 268B the following chapter:-

920

#### CHAPTER 268C

921

#### PHYSICIAN AND PHARMACEUTICAL MANUFACTURER CONDUCT

922

923 Section 1. As used in this chapter, the following words shall have the following  
924 meanings:-

925

926 "Gift", a payment, entertainment, meals, travel, honorarium, subscription,  
927 advance, services or anything of value, unless consideration of equal or greater value is  
928 received. "Gift" shall not include anything of value received by inheritance, a gift  
929 received from a member of the physician's immediate family or from a relative within the  
930 third degree of consanguinity of the physician or of the physician's spouse or from the  
931 spouse of any such relative, or prescription drugs provided to a physician solely and  
932 exclusively for use by the physician's patients.

933

934 "Immediate family", a spouse and any dependent children residing in the  
935 reporting person's household.

936

937           “Medical device”, an instrument, apparatus, implement, machine, contrivance,  
938 implant, in vitro reagent, or other similar or related article, including any component,  
939 part, or accessory, which is: (1) recognized in the official National Formulary, or the  
940 United States Pharmacopeia, or any supplement to them; (2) intended for use in the  
941 diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or  
942 prevention of disease, in man or other animals; or (3) intended to affect the structure or  
943 any function of the body of man or other animals, and which does not achieve its primary  
944 intended purposes through chemical action within or on the body of man or other animals  
945 and which is not dependent upon being metabolized for the achievement of its primary  
946 intended purposes.

947

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

950

951           “Pharmaceutical marketer”, a person who, while employed by or under contract to  
952 represent a pharmaceutical manufacturing company, engages in pharmaceutical detailing,  
953 promotional activities or other marketing of prescription drugs in this state to any  
954 physician, hospital, nursing home, pharmacist, health benefit plan administrator or any  
955 other person authorized to prescribe, dispense, or purchase prescription drugs. The term  
956 does not include a wholesale drug distributor licensed under section 36A of chapter 112,  
957 a representative of such a distributor who promotes or otherwise markets the services of  
958 the wholesale drug distributor in connection with a prescription drug, or a retail  
959 pharmacist registered under section 37 of chapter 112 if such person is not engaging in  
960 such practices under contract with a manufacturing company.

961

962           “Pharmaceutical manufacturing company”, any entity which is engaged in the  
963 production, preparation, propagation, compounding, conversion or processing of  
964 prescription drugs, either directly or indirectly by extraction from substances of natural  
965 origin, or independently by means of chemical synthesis or by a combination of  
966 extraction and chemical synthesis, or any entity engaged in the packaging, repackaging,  
967 labeling, relabeling or distribution of prescription drugs. The term does not include a

968 wholesale drug distributor licensed under section 36A of chapter 112 or a retail  
969 pharmacist registered under section 37 of chapter 112.

970

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

978

979 “Physician”, a person licensed to practice medicine by the board of  
980 medicine under section 2 of chapter 112 who prescribes prescription drugs for any  
981 person, or the physician’s employees or agents.

982

983 “Prescription drugs”, any and all drugs upon which the manufacturer or  
984 distributor has placed or is required by federal law and regulations to place the following  
985 or a comparable warning: “Caution federal law prohibits dispensing without  
986 prescription.”

987

988 Section 2. No pharmaceutical manufacturer agent shall knowingly and willfully  
989 offer or give to a physician, a member of a physician’s immediate family, a physician’s  
990 employee or agent, a health care facility or employee or agent of a health care facility, a  
991 gift of any value and no physician, a member of a physician’s immediate family, a  
992 physician’s employee or agent, a health care facility or employee or agent of a health care  
993 facility shall knowingly and willfully solicit or accept from any pharmaceutical  
994 manufacturer agent, a gift of any value.

995

996 Section 3. A person who violates this chapter shall be punished by a fine of not more  
997 than \$5,000 or by imprisonment for not more than 2 years, or both.

998

999

### **Expansion of Medical School Enrollment**

1000

1001           SECTION 23. Notwithstanding any general or special law to the contrary, the  
1002 trustees of the University of Massachusetts shall expand the entering class at its medical  
1003 school and increase residencies for medical school graduates for students committed to  
1004 entering the primary care field and to working in underserved regions of the  
1005 commonwealth. The trustees shall develop a master plan for expanding medical student  
1006 enrollment and increasing internships and residencies for medical school graduates who  
1007 are committed to primary care and work in underserved regions without reducing  
1008 academic quality, together with a financial plan to support such expansion, and shall  
1009 report that plan to the joint committee on health care financing and the house and senate  
1010 committees on ways and means not later than January 1, 2009.

1011

### **Primary Care Provider Medical Debt Relief**

1012

1013

1014           SECTION 24. Notwithstanding any general or special law to the contrary, the  
1015 center for primary care recruitment and placement established under section 8 of this act,  
1016 in consultation with the board of higher education and the executive office of health and  
1017 human services, shall, subject to appropriation, establish a primary care workforce  
1018 development and loan forgiveness grant program at community health centers,  
1019 community hospitals and other facilities in underserved areas for the purpose of  
1020 enhancing the recruitment and retention of primary care physicians and nurse  
1021 practitioners who are authorized to practice as provided for in section 80B of chapter 112  
1022 of the General Laws. Loan forgiveness programs or zero interest loan programs or other  
1023 forms of assistance utilizing public funds, in whole or in part, shall require each recipient  
1024 medical or nursing student to enter into a contract with the commonwealth as primary  
1025 care fellows which shall obligate the recipient to perform at least 4 years of service  
1026 within the commonwealth in areas of primary care, public or community service or  
1027 underserved areas as determined by the center.

1028

1029

### **UMass Medical Student Enhanced Learning Contract**

1030

1031           SECTION 25. Notwithstanding any general or special law to the contrary, the  
1032 trustees of the University of Massachusetts, in conjunction with the state health education  
1033 center at the University of Massachusetts medical center, shall establish and maintain an  
1034 enhanced learning contract program available to medical students every academic year.  
1035 The program shall provide full waivers of tuition and fees at the University of  
1036 Massachusetts medical school. The contract shall require payback service, so-called, of at  
1037 least 4 years of service within the commonwealth in areas of primary care, public or  
1038 community service, or underserved areas as determined by the center for primary care  
1039 recruitment and placement and the learning contract committee, in coordination with the  
1040 area health education center and state and regional health planning agencies. If a student  
1041 does not perform payback service as required by an enhanced learning contract, that  
1042 student shall pay the difference between the tuition paid and double the amount of the  
1043 tuition charged together with an origination, or “O,” fee, interest per annum at prime rate  
1044 as reported at the time of origination by the Federal Reserve, a margin and repayment fee  
1045 as set by the board. No payback service or tuition loan repayment shall be required prior  
1046 to the termination of any internship and residency requirements. Interest shall begin to  
1047 accrue upon completion of the requirement for the degree. The commonwealth shall bear  
1048 the cost of such tuition and fee waivers for enhanced learning contracts. The dean of the  
1049 medical school shall report annually on the number of students participating in enhanced  
1050 learning contracts, the area of medicine within which payback will be performed, and the  
1051 number of students utilizing the repayment option. The report shall also outline the  
1052 effects of payback in the underserved areas of the commonwealth.

1053

1054           **Establishment of a Nursing and Allied Health Trust Fund**

1055           SECTION 26. (a) Notwithstanding any general or special law to the contrary,  
1056 there is hereby established and set up on the books of the commonwealth a separate trust  
1057 fund to be known as the Massachusetts Nursing and Allied Health Workforce  
1058 Development Trust Fund, hereinafter referred to as the health care workforce trust fund,  
1059 to which shall be credited any appropriations, bond proceeds or other monies authorized

1060 by the general court and specifically designated to be credited thereto, and additional  
1061 funds including federal grants or loans, or private donations made available to the  
1062 chancellor of higher education for this purpose. The board of higher education shall hold  
1063 this trust fund in an account or accounts separate from other funds or accounts. Amounts  
1064 credited to the fund shall be expended by the chancellor of higher education to carry out  
1065 the purposes set forth in subsection (b). Expenditures from the fund shall not be subject  
1066 to appropriation. Any balance in the trust fund at the close of a fiscal year shall be  
1067 available for expenditure in subsequent fiscal years and shall not revert to the general  
1068 fund.

1069 (b) The public purposes of the Massachusetts Nursing and Allied Health Workforce  
1070 Development Trust Fund shall be to develop and support, in consultation with the  
1071 Massachusetts Nursing and Allied Health Workforce Development Advisory Committee,  
1072 short and long-term strategies that increase the number of Massachusetts public and  
1073 private higher education faculty and students who participate in programs that support  
1074 careers in fields related to nursing and allied health. The chancellor of higher education  
1075 may expend from the health care workforce trust fund such administrative monies as may  
1076 be necessary for the administration of the Massachusetts Nursing and Allied Health  
1077 Workforce Development Initiative. In furtherance of these public purposes, the  
1078 chancellor of higher education shall expend the health care workforce trust fund monies  
1079 on activities that are calculated to increase the number of qualified nursing and allied  
1080 health faculty and students in the commonwealth and improve the nursing and allied  
1081 health educational offerings available in public higher education institutions. Grants and  
1082 other disbursements and activities may involve, without limitation, the University of  
1083 Massachusetts, state and community colleges, private higher education institutions in  
1084 partnership with public higher education institutions, business and industry partnerships,  
1085 regional alliances, workforce investment boards, 501(c)(3) organizations and other  
1086 community groups which promote the nursing profession. Grants and other  
1087 disbursements and activities may support, without limitation: (i) the goal of rapidly  
1088 increasing the number of nurses and allied health workers (ii) enhancing the role of the  
1089 system of public higher education, as institutions and in partnerships with other

1090 stakeholders, in meeting the short and long-term workforce challenges in the nursing and  
1091 allied health professions; (iii) the development and use of innovative curricula, courses,  
1092 programs and modes of delivering education in nursing and allied health professions for  
1093 faculty and students in these fields; (iv) activities with the growing network of  
1094 stakeholders in the nursing and allied health professions to create, implement, share and  
1095 make broadly and publicly available best practices and innovative programs relative to  
1096 instruction, development of partnerships and expanding and maintaining faculty and  
1097 student involvement in careers in these fields; and (v) strengthening the institutional  
1098 capacity to develop and implement long-term programs and policies to respond  
1099 effectively to these challenges.

### 1100 **Housing Assistance Pilot Program for Health Care Professionals**

1101  
1102 SECTION 27. Notwithstanding any general or special law to the contrary, the  
1103 department of housing and community development, in consultation with the executive  
1104 office of health and human services and the department of workforce development, shall  
1105 establish a pilot program to help hospitals, community health centers, and physician  
1106 practices provide housing grants or loans for health care professionals in underserved  
1107 areas. The department shall establish an assisted housing fund that shall provide grants  
1108 or loans for health care professionals who contract to provide care in underserved regions  
1109 of the commonwealth and whose incomes do not exceed certain benchmarks, as  
1110 established by the department. Grants and loans from the assisted housing fund shall be  
1111 spent in the commonwealth and may be used for (i) the cost to purchase housing that is to  
1112 be a principal residence, including cooperative housing, and falls within price guidelines  
1113 established by the department, including costs for down payments, mortgage interest rate  
1114 buy-downs, closing costs and other costs determined to be eligible by the department, and  
1115 (ii) payments for security deposits and advance payments for rental housing. The  
1116 department, subject to appropriation, shall contribute to the assisted housing fund \$1 for  
1117 every \$2 expended by the hospital, community health center, and physician practice from  
1118 the assisted housing fund as provided in this act. The assistance granted pursuant to this  
1119 act shall be determined by the department. The department shall adopt written

1120 procedures for the establishment and operation of the assisted housing fund. Such  
1121 procedures shall include provisions for eligibility and shall specify expenses for which  
1122 grants and loans may be made and provide the documentation and procedures necessary  
1123 to qualify for the assistance. 2 years after the commencement of the pilot program, the  
1124 department shall report to the house and senate committees on ways and means, the joint  
1125 committee on housing and the joint committee on health care financing, the results of the  
1126 pilot program and shall recommend it for expansion, continuation or discontinuation.

1127

### 1128 **Report on Strategies to Increase Primary Care Workforce**

1129

1130 SECTION 28. Notwithstanding any special or general law to the contrary, the  
1131 center for primary care recruitment and placement, in conjunction with the University of  
1132 Massachusetts medical school and area health education centers, shall study the efforts of  
1133 Massachusetts-based public and private graduate medical education institutions to foster  
1134 and expand the supply of primary care physicians in the commonwealth. The study shall  
1135 include, but shall not be limited to, a survey of institutional efforts to both increase the  
1136 percentage of medical residents who choose a primary care specialty and to increase  
1137 overall enrollment of medical students committed to entering the primary care field. The  
1138 study shall recommend innovative primary care educational programs and strategies that  
1139 foster a culture within graduate medical education which embraces primary care. The  
1140 center shall report its findings and recommendations to the house and senate committee  
1141 on ways and means and the joint committee on health care financing no later than  
1142 January 1, 2009.

1143

### 1144 **Commission on Health Insurer Reserves and Surpluses**

1145

1146 SECTION 29. (a) Notwithstanding any general or special laws to the contrary,  
1147 there shall be a special commission to examine options and alternatives available to the  
1148 Commonwealth with respect to the regulation, oversight and disposition of the reserves  
1149 and surpluses of health insurers.

1150 (b) The commission shall consist of the commissioner of insurance, who shall serve as  
1151 chair; the secretary of administration and finance or his designee; the attorney general or  
1152 his designee; the commissioner of the division of health care finance and policy or his  
1153 designee; and 3 members appointed by the governor, including an actuary in good  
1154 standing with the American Society of Actuaries, a health care consumer advocate, and a  
1155 health economist.

1156 (c) This commission shall conduct a study that shall include, but shall not be limited to:  
1157 (1) an analysis of the statutes, regulations and other measures currently in effect in this  
1158 commonwealth which regulate the amount, nature and disposition of surpluses held by or  
1159 for the benefit of health insurers in excess of amounts reasonably anticipated to be  
1160 required to pay claims, taking into account the level of such reserves and surpluses  
1161 necessary to safeguard the solvency of health insurers against unanticipated events and  
1162 other circumstances which could cause extraordinary medical losses; (2) a review of  
1163 recent fiscal practices and financial reporting by health insurers with respect to reserves  
1164 and surpluses under the laws of the commonwealth; (3) a comparison of the  
1165 commonwealth's current statutes and regulations with those of other states which the  
1166 division deems to be reasonably comparable to those of the commonwealth; (4) a review  
1167 and assessment of model acts and regulations and any other information which the  
1168 division finds to be relevant to its inquiry; (5) a summary of alternative approaches to  
1169 regulation of reserves and surpluses, including the disposition of amounts held by or on  
1170 behalf of health insurers, with particular consideration of alternatives that would govern  
1171 the use of those amounts to reduce premiums or to delay or to moderate premium  
1172 increases; and (6) a review of how carriers fund community benefit programs, including,  
1173 but not limited to, how such funding is regulated by other states as to the appropriate  
1174 amount, monitoring and direction of such funding. In compiling this report, the division  
1175 shall seek input from health plans operating in this commonwealth, the attorney general,  
1176 the executive office of health and human services, and the health care quality and cost  
1177 council, established under section 16K of section 6A of the General Laws.

1178 (d) For the purpose of conducting this study, the division may contract with an outside  
1179 organization with expertise in fiscal analysis of the private insurance market. In  
1180 conducting its examination, the organization shall, to the extent possible, obtain and use

1181 actual health plan data; but such data shall be confidential and shall not be a public  
1182 record. The division shall report its findings and recommendations to the house and  
1183 senate committee on ways and means and the joint committee on health care financing no  
1184 later than January 1, 2009.

1185 (e) The commission shall meet no later than October 1, 2008 and shall file a report with  
1186 the clerks of the senate and house of representatives no later than April 1, 2009.

1187

### 1188 **Ensuring Compliance with Hospital-Acquired Infection Rate Regulations**

1189

1190 SECTION 30. Notwithstanding any special or general law to the contrary, the  
1191 department of public health, in consultation with the health care quality and cost council,  
1192 shall promulgate regulations requiring hospitals, as a standard of eligibility for original  
1193 licensure and renewal of licensure, to register with the National Healthcare Safety  
1194 Network. Each hospital that registers with the National Healthcare Safety Network must  
1195 grant access to the department and the Betsy Lehman center for patient safety and  
1196 medical error reduction, in accordance with guidelines of the department to (1) healthcare  
1197 associated infection data elements reportable to the National Healthcare Safety Network  
1198 and (2) hospital specific reports generated by the National Healthcare Safety Network.  
1199 Each registered hospital shall collect and submit to the National Healthcare Safety  
1200 Network healthcare-associated infection data elements in accordance with guidelines of  
1201 the department.

1202

### 1203 **Massachusetts e-Health Advisory Committee**

1204

1205 SECTION 31. Notwithstanding any special or general law to the contrary, there  
1206 is hereby established a Massachusetts e-Health Advisory Committee to advise the  
1207 Massachusetts e-health institute established in section 6.

1208

1209 (a) The members of the Massachusetts e-health advisory committee shall include  
1210 the secretary of health and human services, who shall serve as the chair, the secretary of  
1211 administration and finance or his designee, the executive director of the Massachusetts e-

1212 health institute, the executive director of the health care cost and quality council, and  
1213 additional members to be appointed by the secretary to include persons representing local  
1214 public health agencies, licensed hospitals and other licensed facilities and providers,  
1215 private purchasers, the medical and nursing professions, physicians, health insurers and  
1216 health plans, the state quality improvement organization, academic and research  
1217 institutions, consumer advisory organizations with an interest and expertise in health  
1218 information technology, and other stakeholders as identified by the secretary of health  
1219 and human services.

1220

1221 (b) The committee shall prepare a statewide electronic health records plan that  
1222 shall provide for the following:

1223

1224 (1) the establishment and implementation throughout the commonwealth of a  
1225 statewide health information network that: (i) allows the seamless, secure, electronic  
1226 sharing of health information among health care providers, health plans, and other  
1227 authorized users; (ii) provides consumers with secure, electronic access to their own  
1228 health information; (iii) meets data standards for interoperability adopted by the  
1229 Massachusetts Technology Collaborative, including any standards providing for  
1230 interoperability among other health information networks, in cooperation with the  
1231 Massachusetts e-Health Initiative, the Massachusetts Health Data Consortium, MA-  
1232 SHARE and other appropriate organizations; (iv) provides for interoperability with any  
1233 health information technology product certified by the Massachusetts e-Health Institute;  
1234 (v) meets privacy requirements; (vi) gives patients the option of allowing only designated  
1235 health care providers to access their individually identifiable information concerning  
1236 diagnosis and treatment of sexually transmitted diseases, addiction, and mental illnesses;  
1237 (vii) provides such public health reporting capability as the Secretary of Health and  
1238 Human Services requires; (viii) allows for such reporting of, and access to, health  
1239 information for purposes of research (other than individually identifiable patient health  
1240 information) as the Secretary of Health and Human Services requires; and (ix) allows for  
1241 the reporting of provider-specific health information (other than individually identifiable

1242 patient health information) required for the calculation of any voluntary consensus  
1243 standard endorsed by the National Quality Forum;

1244

1245 (2) the financing and technical assistance required to allow health care providers,  
1246 especially small physician groups, to acquire and implement electronic medical records  
1247 necessary to participate in the statewide health information network; and

1248

1249 (3) agreements among health care stakeholders regarding data reporting,  
1250 reimbursement practices, or other mechanisms to use the statewide health information  
1251 network to improve patient safety, quality, and efficiency within the health care system.

1252

1253 (c) The statewide electronic health records plan prepared under subsection (b)  
1254 shall: (i) be developed with the participation and widespread support of all health care  
1255 stakeholders, including but not limited to hospitals, practicing physicians (including those  
1256 from small physician groups), nursing facilities and skilled nursing facilities, other health  
1257 care providers, health plans, employers, and patient groups; (ii) describe the governance  
1258 structure of the statewide health information network; (iii) describe the technologies and  
1259 systems, including interoperability data standards, that will be used to establish a health  
1260 information network consistent with paragraph (b)(1); (iv) explain what information will  
1261 be able to be accessed, transferred, or exchanged through the health information network  
1262 and what capabilities the network will have to include other types of information in the  
1263 future; (v) describe plans to ensure network reliability, expected frequency of network  
1264 interruptions, and backup procedures in the event of network interruptions; (vi) describe  
1265 a financing model for long-term sustainability of the network that maximizes private  
1266 funds; (vii) describe private sources of financing the acquisition, implementation, and  
1267 maintenance of technology necessary to allow health care providers, especially small  
1268 physician groups, to participate in the health information network; (viii) describe how  
1269 the health information network will be used to improve health care quality and the health  
1270 outcomes of patients; (ix) establish how administrative and clinical savings resulting  
1271 from widespread use of the new health information network will be accounted for and  
1272 allocated; (x) explain how the statewide health information organization involved will

1273 ensure widespread participation by health care providers (especially small physician  
1274 groups) in the health information network and what support and assistance will be  
1275 available to physicians seeking to integrate health information technologies into their  
1276 practices; (xi) describe how patients and caregivers who are not health care providers  
1277 will be able to access and utilize the health information network; (xii) explain how the  
1278 statewide health information network will protect patient privacy and maintain security;  
1279 and (xiii) explain how the statewide health information network will ensure the  
1280 participation of health care providers serving minority communities, including  
1281 communities in which English is not the primary language spoken.

1282

1283 (d) The secretary shall prepare and issue an annual report not later than January  
1284 30 of each year outlining progress to date in implementing a statewide health information  
1285 infrastructure and recommending future projects.

1286

### 1287 **Statewide Adoption of Computerized Physician Order Entry Systems**

1288

1289 SECTION 32. Notwithstanding any special or general law to the contrary, no  
1290 later than October 1, 2012, the department of public health, in consultation with the  
1291 health care quality and cost council, shall promulgate regulations requiring hospitals and  
1292 community health centers, as a standard of eligibility for original licensure and renewal  
1293 of licensure, to implement computerized physician order entry systems as defined by the  
1294 department provided, however, that said product, system or network shall be certified by  
1295 the Certification Commission for Healthcare Information Technology (CCHIT), or any  
1296 successor agency or organization established for the purpose of certifying that health  
1297 information technology shall meet national interoperability standards.

1298

### 1299 **Statewide Adoption of Electronic Health Records**

1300

1301 SECTION 33. Notwithstanding any special or general law to the contrary, no  
1302 later than October 1, 2015, the department of public health, in consultation with the  
1303 health care quality and cost council, shall promulgate regulations requiring hospitals and

1304 community health centers, as a standard of eligibility for original licensure and renewal  
1305 of licensure, to implement interoperable electronic health records systems, as defined by  
1306 the department provided, however, that said product, system or network shall be certified  
1307 by the Certification Commission for Healthcare Information Technology (CCHIT), or  
1308 any successor agency or organization established for the purpose of certifying that health  
1309 information technology shall meet national interoperability standards.

1310

1311 **Maximize Enrollment in the Senior Care Options Program**

1312

1313 SECTION 34. Notwithstanding any special or general law to the contrary, the  
1314 executive office of health and human services shall maximize enrollment of eligible  
1315 persons in the MassHealth Senior Care Options program, or comparable successor  
1316 program, and shall develop a plan to offer similar coverage to Medicaid and Medicare-  
1317 eligible disabled persons under age 65, hereinafter referred to as dual eligible plans.

1318

1319 Not later than 6 months after the effective date of this act, the executive office of health  
1320 and human services shall prepare a report identifying clinical, administrative and  
1321 financial barriers to expanded dual eligible plans, and recommending steps to remove the  
1322 barriers and implement coverage for Medicaid and Medicare-eligible disabled persons  
1323 under age 65. Before finalizing the report, the executive office shall hold a public  
1324 consultative session that includes organizations representing seniors, organizations  
1325 representing disabled persons, organizations representing health care consumers,  
1326 organizations representing racial and ethnic minorities, health delivery systems and  
1327 health care providers. The report shall include consideration of changes in procurement  
1328 standards and MassHealth payment methodologies to promote enrollment in dual eligible  
1329 plans. The report shall include estimates of the costs and benefits of implementing steps  
1330 to remove barriers to expanded enrollment in dual eligible plans, including financial  
1331 savings and improved quality of care.

1332

1333 The report shall be provided to the committee on health care financing, the house and  
1334 senate committees on ways and means.

1335 Subject to appropriation, the executive office of health and human services shall  
1336 implement the steps recommended by the report. Not later than 1 year following the  
1337 filing of the report, the executive office shall issue a progress statement on expanded  
1338 enrollment in dual eligible plans

1339

### 1340 **Registry and Sunset of Physician Letters of Exemption**

1341

1342 SECTION 35. Notwithstanding any general or special law or rule or regulation to  
1343 the contrary, the department of public health shall, by July 1, 2009, establish a registry of  
1344 exemptions granted by the department under section 6 of chapter 350 of the acts of 1993  
1345 and the department's regulations to any person who filed with the department by  
1346 December 23, 1993, a notice of intent to acquire medical, diagnostic or therapeutic  
1347 equipment used to provide an innovative service or which is a new technology, as defined  
1348 in section 25B of chapter 111 of the General Laws. All registered exemptions shall be  
1349 non-transferable. After July 1, 2009, all exemptions qualifying for the registry  
1350 established in this act that have not been registered with the department shall be null and  
1351 void. Holders of registered exemptions for medical, diagnostic or therapeutic equipment  
1352 not placed in regular service by July 1, 2009, shall, upon application, be eligible for an  
1353 expedited determination of need process, as determined by the department. All  
1354 exemptions granted by the department under said section 6 of said chapter 350 of the acts  
1355 of 1993 and the department's regulations to any person who filed with the department by  
1356 December 23, 1993, a notice of intent to acquire medical, diagnostic or therapeutic  
1357 equipment used to provide an innovative service or which is a new technology shall  
1358 expire on July 1, 2010, if the equipment for which the exemption was granted was not  
1359 placed in regular service by July 1, 2009, and if no determination of need was granted by  
1360 the department.

1361

### 1362 **Study of Medical Malpractice Insurance Premiums**

1363 SECTION 36. The division of insurance shall conduct an investigation and study  
1364 of the costs of medical malpractice coverage for health care providers, as defined in  
1365 section 193U of chapter 175. The investigation and study shall include, but shall not be

1366 limited to, examination and analysis of the following: (1) the availability and  
1367 affordability of medical malpractice insurance; (2) the factors considered by medical  
1368 malpractice insurers when increasing premiums; (3) options for decreasing premiums,  
1369 including but not limited to establishing a reinsurance pool with additional stop loss  
1370 coverage, subsidizing premium payments of providers practicing in certain high-risk  
1371 specialties or in specialties where the cost of premiums represents a disproportionately  
1372 high proportion of a health care provider's income, subsidizing premium payments of  
1373 providers who do not qualify for group coverage rates and pay higher premiums for  
1374 commercial market insurance and prorating premiums for providers who practice less  
1375 than full time; and (4) funding mechanisms that would facilitate the implementation of  
1376 recommendations arising out of the study, which may include, but which shall not be  
1377 limited to, charges borne by the health care industry or other entities. The division shall  
1378 hold at least 2 public hearings to take testimony relating to the investigation and study, 1  
1379 of which shall be held outside the metropolitan Boston area. The division shall report its  
1380 findings and recommendations to the house and senate committee on ways and means  
1381 and the joint committee on health care financing no later than January 1, 2009.

1382

1383

1384 **Study of Medicaid Reimbursement Rates for Primary Care Providers**

1385

1386 SECTION 37. Notwithstanding the provisions of any general or special law, the  
1387 medicaid advisory committee, established pursuant to section 6 of chapter 118E of the  
1388 general laws, is hereby authorized and directed to conduct a study of the need for an  
1389 increase in Medicaid rates and/or bonuses for primary care physicians, nurse  
1390 practitioners, and subspecialists who provide primary care services such as preventive  
1391 care, certain evaluation and management procedures, early periodic screening, diagnosis  
1392 and treatment, and scheduled weekend and holiday services in order to focus on  
1393 prevention and wellness and delivery of primary care to identify illness earlier, to better  
1394 manage chronic disease, and to avoid costs associated with emergency room visits and  
1395 hospitalizations. Said committee, in collaboration with the director, shall report,  
1396 including recommendations for the amount of funding and the sources of funding to the

1397 joint committee on health care financing, the house and senate committees on ways and  
1398 means with its recommendations not later than January 1, 2009.

1399

1400

### **Community Benefits Task Force**

1401

1402 SECTION 38. There is hereby established the community benefits taskforce,  
1403 which shall include the attorney general, the commissioner of public health, and other  
1404 members as determined by the attorney general and which shall convene to conduct a  
1405 study of the community benefits contributions by non-profit healthcare providers and  
1406 insurers in the commonwealth. The study shall include, but shall not be limited to,  
1407 examination and analysis of the following: (1) current community benefits programs,  
1408 including but not limited to plans filed with the attorney general's voluntary community  
1409 benefits program; (2) methods used to identify and define communities to be served by  
1410 community benefit programs; (3) methods used to measure and evaluate the contributions  
1411 by non-profit healthcare providers and insurers to various communities; (4) the  
1412 administrative and technological needs of non-profit healthcare providers; and (5)  
1413 potential collaborations between providers to fund improved administrative and  
1414 technological support systems and information infrastructures as part of a statewide  
1415 community benefits program, including but not limited to the creation of a statewide  
1416 electronic medical records database and computerized physician order entry to improve  
1417 access and the portability of health information. The task force shall hold at least 2  
1418 public hearings to take testimony relating to the investigation and study, 1 of which shall  
1419 be held outside the metropolitan Boston area. The task force shall report its findings and  
1420 recommendations to the house and senate committee on ways and means and the joint  
1421 committee on health care financing no later than January 1, 2009.

1422

1423

### **Effective Dates**

1424

1425 SECTION 39. The enhanced learning contract program at the University of  
1426 Massachusetts medical center required under section 25 of this act shall be established by  
1427 the commencement of the 2008 academic year.

1428

1429           SECTION 40. Section 11 shall take effect upon passage of this act. Any entity  
1430 providing ambulatory surgical center services which is in operation or under construction  
1431 on the day when section 53E of chapter 111 becomes effective shall be exempt from the  
1432 determination of need requirement of said section 53E of said chapter 111 and shall be  
1433 eligible for up to 6 months from the effective date of regulations promulgated by the  
1434 department pursuant to section 53E of chapter 111 to make application to the department  
1435 for a clinic license.

1436

1437           SECTION 41. The health care quality and cost council shall promulgate the  
1438 regulations required under clause (i) of subsection (e) of section 16L of chapter 6A of the  
1439 General Laws not later than October 1, 2009.

1440

1441           SECTION 42. The health care quality and cost council shall publish the never  
1442 event occurrences as required under said clause (i) of said subsection (e) of said section  
1443 16L of said chapter 6A, as so appearing, on its consumer health information website not  
1444 later than 1 year after the effective date of said clause (i).

1445

1446           SECTION 43. The department of public health shall promulgate regulations as  
1447 necessary to implement section 4N of chapter 111 of the General Laws in accordance  
1448 with chapter 30A not later than July 1, 2008.

1449

1450           SECTION 44. The department of public health shall begin implementing the  
1451 outreach and education program established under said section 4N of said chapter 111 not  
1452 later than January 1, 2009.

1453

1454           SECTION 45. The last sentence of subsection (m) of section 11A of chapter 13  
1455 as added by Section 4 shall take effect on January 1, 2015.

1456

1457           SECTION 46. Section 61 of chapter 118E is hereby amended by striking  
1458 subsection (d) and inserting the following: - (d) The Executive Office and their

1459 subcontractors must accept and recognize all claims submitted by health care providers  
1460 pursuant to and consistent with the provisions set forth in this section.

1461

1462 SECTION 47. Section 5A of chapter 176O is hereby amended by striking  
1463 subsection (d) and inserting the following:- (d) Carriers and their subcontractors must  
1464 accept and recognize all claims submitted by health care providers pursuant to and  
1465 consistent with the provisions set forth in this section.

1466

1467 SECTION 48. Sections 46 and 47 shall take effect on July 1, 2012.

1468

1469 SECTION 49. Section 20 shall take effect on January 1, 2009.

1470

1471 SECTION 50. Section 30 shall take effect on October 1, 2008.

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in the General Court assembled.

The undersigned, citizen of \_\_\_\_\_, respectfully petitions for the passage of the accompanying bill and for legislation.

TO PROMOTE COST CONTAINMENT, TRANSPARENCY AND EFFICIENCY IN  
THE DELIVERY OF QUALITY HEALTH CARE

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Therese Murray(T M0)	Plymouth and Barnstable
Richard Moore(RTM0)	Worcester and Norfolk
Mark Montigny(MCM0)	Second Bristol and Plymouth
Karen Spilka(KES0)	Second Middlesex and Norfolk
Steven Panagiotakos(SCP0)	First Middlesex
Robert O'Leary(ROL0)	Cape and Islands
Steven Tolman(SAT0)	Second Suffolk and Middlesex
Stephen Buoniconti(SJB0)	Hampden
Susan C. Fargo(SCF0)	Third Middlesex
Steven A. Baddour(SAB0)	First Essex