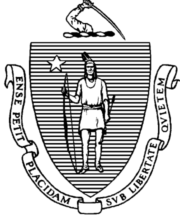
SENATE, NO. 2650

[Senate, April 15, 2008 - Recommended new draft (Ways and Means) for Senate, No. 2526]



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 to expand forthwith 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 health.

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

1 SECTION 1. Section 16J of chapter 6A of the General Laws, as appearing in the 2006
2 Official Edition, is hereby amended by striking out the words “and 16L”, in line 1, and inserting
3 in place thereof the following words:- 16L and 16K.

4 SECTION 2. Said section 16J of said chapter 6A, as so appearing, is hereby further
5 amended by inserting before the definition of “Clinician” the following 2 definitions:-

6 “Adverse”, a negative consequence of care that results in unintended injury or illness,
7 which may or may not have been preventable.

8 “Associated with”, that it is reasonable to initially assume that the adverse event was
9 directly due to the referenced course of care.
10 SECTION 3. Said section 16J of said chapter 6A, as so appearing, is hereby further
11 amended by adding the following 2 definitions:-
12 “Preventable”, an event that could have been reasonably anticipated and prepared for but
13 which occurred because of an error or other system failure.
14 “Serious disability”, an event that results in death, loss of a body part, physical disability
15 or loss of bodily function lasting at least 7 days or occurring at the time of discharge from an
16 inpatient health care facility.
17 SECTION 4. Said chapter 6A is hereby further amended by striking out section 16K, as
18 so appearing, and inserting in place thereof the following section:-
19 Section 16K. There shall be a health care quality and cost council within, but not subject to
20 the control of, the executive office of health and human services. The council shall promote
21 public transparency of the quality and cost of health care in the commonwealth and shall
22 establish health care quality improvement and cost containment goals. The goals shall be
23 designed to promote high-quality, safe, effective, timely, efficient, equitable and patient-
24 centered health care. The council shall receive staff assistance from the executive office of
25 health and human services and may, subject to appropriation, employ such additional staff or
26 consultants as it may deem necessary. The council shall consist of the secretary of health and
27 human services, the auditor of the commonwealth or his designee, the inspector general or his
28 designee, the attorney general or his designee, the commissioner of insurance, the executive
29 director of the group insurance commission, the executive director of the commonwealth
30 connector, the secretary of administration and finance or his designee, and 7 persons to be

31 appointed by the governor, 1 of whom shall be a representative of a health care quality
32 improvement organization recognized by the federal Centers for Medicare and Medicaid
33 services, 1 of whom shall be a representative of the Institute for Healthcare Improvement, Inc.
34 recommended by the organization's board of directors, 1 of whom shall be a representative of
35 the Massachusetts Chapter of the National Association of Insurance and Financial Advisors, 1
36 of whom shall be a representative of the Massachusetts Association of Health Underwriters, 1 of
37 whom shall be a representative of the Massachusetts Medicaid Policy Institute, 1 of whom shall
38 be an expert in health care policy from a foundation or academic institution and 1 of whom shall
39 represent a nongovernmental purchaser of health insurance. The representatives of
40 nongovernmental organizations shall serve staggered 3-year terms. The council shall be chaired
41 by the secretary of health and human services.
42 SECTION 5. Section 16L of said chapter 6A, as so appearing, is hereby amended by
43 adding the following 2 subsections:-
44 (r) A subcommittee of the council shall be established to pursue public and private
45 reform of health care purchasing. The subcommittee shall convene public and private health
46 care purchasers for the purpose of collaborating on common purchasing principles and
47 strategies for promoting and rewarding higher value health care. The subcommittee shall
48 identify and develop non-binding payment guidelines and best practices that will align
49 purchasing incentives around shared quality goals. The subcommittee shall focus on, but shall
50 not be limited to: (i) encouraging quality, coordinated, and effective care as opposed to volume
51 of care; (ii) emphasizing chronic disease management programs; (iii) developing appropriate
52 and feasible measures of quality performance, and rewarding providers for improving quality
53 performance; (iv) improving compensation and support for primary care providers; (v)

54 developing a "medical home" payment model that emphasizes a comprehensive approach to
55 patient care; (vi) reducing waste and duplication in clinical care; (vii) investing in and
56 accelerating the adoption of health information technology, specifically computerized physician
57 order entry systems, e-prescribing, and electronic health records; (viii) aligning incentives with
58 federal Medicare payment policies; (ix) promoting health wellness programs; and (x)
59 empowering consumers with access to health care information. The subcommittee members
60 shall be determined by the chair of the council, and shall consult with an advisory committee
61 consisting of 1 member representing the Massachusetts Association of Health Plans, 1 member
62 representing Blue Cross Blue Shield of Massachusetts, 1 member representing Associated
63 Industries of Massachusetts, 1 member representing the Massachusetts Municipal Association,
64 and 4 members to be appointed by the Governor, including 1 health economist, 1 expert in
65 federal Medicare payment policy, 1 representative of a self-insured labor union, and 1 health
66 care consumer advocate. The council shall provide the subcommittee with staff as necessary to
67 complete needed research and analysis. The subcommittee shall meet at least once every 2
68 months, and at other times as determined by its rules. The subcommittee shall submit a report
69 annually by July 1 to the governor, the health care cost and quality council and the general
70 court, by filing the same with the clerks of the senate and house of representatives, the joint
71 committee on health care financing and the joint committee on public health on the
72 subcommittee's progress and activities, and may recommend legislation or regulatory changes.
73 (s) The council shall establish goals for adoption of health information technology
74 including, but not limited to, electronic prescription transactions for new prescriptions,
75 prescription renewals, cancellations, changes between prescribers and dispensers, ancillary
76 messages and administrative transactions known as e-prescribing, the process of electronic entry

77 of physician instructions for the treatment of patients, whether hospitalized or ambulatory,
78 under the care of said physician, known as computerized physician order entry, and individual
79 patient records in digital format or electronic health records; provided, however, that any
80 system, network, software or equipment utilized in the attainment of said goals shall be certified
81 by the certification commission for healthcare information technology, an independent, non-
82 profit organization that has been officially named by the federal government as the "recognized
83 certification body" for health information technology products and networks; and provided
84 further, that goals shall state the percentage adoption by providers expected by a given year, any
85 incentives or other provisions for attainment of the goals, and any penalties for failure to attain
86 said goals.

87 SECTION 6. Said chapter 6A is hereby further amended by inserting after section 16O
88 the following section:-

89 Section 16P. (a) The secretary of health and human services shall adopt regulations to
90 create a list of serious reportable events consistent with the list established by the National
91 Quality Forum. The executive office of health and human services, its agencies and the health
92 care quality and cost council shall utilize the list created by the secretary's regulations for all
93 standardized reporting of serious reportable events. Each serious reportable event shall be
94 reported on the consumer health information website created by subsection (h) of section 16L.
95 The website shall identify each serious reportable event and the facility at which it occurred but
96 shall not include any other identifying information, including, but not limited to, the identities of
97 any of the health care professionals, facility employees or patients involved.

98 (b) The secretary shall adopt regulations prohibiting a health care facility from charging
99 or seeking reimbursement for services associated with a serious reportable event. In adopting

100 the regulations, the secretary shall consider that the list of serious reportable events established
101 under subsection (a) is intended to facilitate public reporting and was not designed to serve as a
102 basis for determining whether reimbursement shall be sought or foregone. A health care facility
103 shall not charge or seek reimbursement for a serious reportable event that the health care facility
104 has determined, through a documented review process, was (i) preventable; (ii) within its
105 control; (iii) unambiguously the result of a system failure based on the health care provider's
106 policies and procedures; and (iv) resulted in a serious disability.

107 (c) The health care facility shall include in any ongoing reporting of serious reportable
108 events to the department of public health, the decision to seek or forego reimbursement and
109 charges for the serious reportable event. The department may review any such reports for
110 consistency with the regulations promulgated under subsection (b).

111 (d) Notwithstanding any general or special law to the contrary, all communications and
112 documentation regarding whether reimbursement for health care services that are directly
113 associated with an occurrence of a serious reportable event shall be sought or foregone shall be
114 privileged and confidential, shall be exempt from the disclosure of public records under section
115 10 of chapter 66 and shall not be subject to subpoena or discovery or introduced into evidence
116 in any judicial or administrative proceeding.

117 SECTION 7. Clause (b) of the sixth paragraph of section 11A of chapter 13 of the
118 General Laws, as appearing in the 2006 Official Edition, is hereby amended by adding the
119 following sentence:- The board shall require, as a standard of eligibility for licensure, that
120 applicants show a predetermined level of competency in the use of computerized physician
121 order entry, e-prescribing, electronic health records and other forms of health information
122 technology, as determined by the board.

123 SECTION 8. Chapter 26 of the General Laws is hereby amended by inserting after
124 section 8J the following section:
125 Section 8K. (a) As used in this section, an insurer shall be defined as a carrier
126 authorized to transact accident and health insurance under chapter 175, a nonprofit hospital
127 service corporation licensed under chapter 176A, a nonprofit medical service corporation
128 licensed under chapter 176B, a dental service corporation organized under chapter 176E, an
129 optometric service corporation organized under chapter 176F and a health maintenance
130 organization licensed under chapter 176G.
131 (b) Notwithstanding any general or special law to the contrary, all insurers marketing
132 small group or large group plans shall annually submit to the division of insurance, on or before
133 April 1, the following information: current average individual and family plan premiums for the
134 insurer's prototype or alternative prototype plan, as defined in section 1 of chapter 176S, for
135 groups of 1 to 5 employees, 6 to 10 employees, 11 to 25 employees, 26 to 50 employees, 51 to
136 100 employees, 101 to 500 employees, 501 to 1000 employees, 1001 to 2500 employees, 2501
137 to 5000 employees and 5001 employees and above. Public employer plans shall be similarly
138 aggregated and reported separately. All reports shall include plan design summaries, including
139 average benefits and co-pays.
140 (c) On or before July 1 of each year, the division of insurance and the division of health
141 care finance and policy shall annually make available the massachusetts health insurance
142 transparency report for consumer and employer use. The report shall be compiled using data
143 collected under this section in the preceding year and shall include the average premium cost
144 results from subsection (b) by insurer, employer size category and by insurer's prototype or
145 alternative prototype plan, as defined in section 1 of chapter 176S.

146 SECTION 9. Chapter 40J of the General Laws is hereby amended by inserting after
147 section 6C the following section:-
148 Section 6D. (a) The corporation shall establish an institute for health care innovation,
149 technology and competitiveness, to be known as the e-health institute, and a fund to be known
150 as the e-Health Institute Fund, to be held by the corporation separate and apart from its other
151 funds, to finance the activities of the institute. The institute shall transform care delivery and the
152 utilization of care process redesign supported by a statewide, interoperable electronic health
153 records system in order to improve patient safety and quality, and to lower costs in the state's
154 health care system, with a particular emphasis on the deployment of quality improvement
155 efforts and health information technology in discrete and underserved regions by harnessing
156 local support and involvement in such development activities and by improving the health
157 information technology infrastructure for such clusters. In furtherance of these public purposes,
158 the institute shall endeavor to identify regions where compelling opportunities to make strategic
159 investments appear to be present and develop strategies therefore. The institute may also
160 provide development support more generally to organizations to assist in quality improvement
161 activities and the formation and growth of emerging health technology sectors in those regions
162 and may provide support to departments, agencies and quasi-public entities of the
163 commonwealth for activities that are consistent with the purposes of the institute.
164 The executive director of the corporation shall appoint a qualified individual as director
165 to manage the affairs of the institute, who shall be an employee of the corporation, report to the
166 executive director and manage the affairs of the institute. The corporation shall establish a
167 governing board to assist it in matters related to the institute. The governing board shall be
168 comprised of not less than 9 individuals, including the executive director of the corporation and

169 the secretary of health and human services who shall serve ex-officio. The corporation, on
170 recommendation of the executive director, shall appoint no less than 7 qualified individuals to a
171 governing board to assist the corporation in matters related to the institute including a dean of a
172 medical school, head of an emerging health technology company, a chief information officer of
173 a major teaching hospital and a technology transfer officer or individual qualified in technology
174 commercialization from a university in the commonwealth. Each member of the governing
175 board appointed by the corporation shall serve for such term as the corporation may designate
176 upon such member's appointment, but no term shall be for less than one year and no longer than
177 three years. The corporation may appoint a member for an unlimited number of additional
178 terms, the length of each such term being determined by the corporation at the time of
179 appointment to each such additional term. The members of the governing board shall develop
180 and submit to the board, for its review, modification and approval, a detailed plan for the
181 operation of the institute and the administration of the fund. Upon approval of such detailed
182 plan by the board of directors of the corporation, it shall delegate such authority to the
183 governing board as it deems necessary to implement the plan.

184 Upon consultation with the advisory committee established in subsection (b), the
185 governing board shall prepare, and update annually, a statewide electronic health records plan
186 and submit such plan and each update to the board for approval. In developing the plan the
187 governing board may consult with any individual, agency or organization, including but not
188 limited to the Massachusetts technology collaborative, the New England Health Care Institute,
189 Masspro, the Massachusetts Health Data Consortium, MA-SHARE, the Institute for Health
190 Improvement, Massachusetts League of Community Health Centers, Inc., the Massachusetts
191 Hospital Association, the Massachusetts Association of Community Hospitals, Blue Cross/Blue

192 Shield of Massachusetts, the Massachusetts Association of Health Plans, the Mental Health and
193 Substance Abuse Corporations of Massachusetts, and other quasi-public agencies and not-for-
194 profit organizations. The institute may make grants in support of Massachusetts-based public
195 and private enterprises developing and deploying new technologies to significantly increase the
196 efficiency, safety and quality of the health care system. Successful grants should incorporate
197 regional involvement through alliances among municipalities, colleges, hospitals, health centers,
198 skilled nursing facilities, business and industry, community based organizations, community-
199 based behavioral health care providers, non-profit organizations and labor unions. The
200 governing board may apply the provisions of this chapter that apply to centers and to the center
201 fund to the institute and to the e-health institute fund. Without limiting the generality of the
202 foregoing, the corporation may apply moneys in said fund to pay for start-up expenses, project
203 costs and current expenses associated with said institute and related activities, grants or loans to
204 nonprofit or other organizations to promote its purposes as consistent with the purposes of this
205 section. The institute shall file a report, by no later than January 31 of each year, with the joint
206 committee on health care financing and the house and senate committees on ways and means
207 addressing the activities of the institute, in general, and describing progress to date in
208 implementation of a statewide electronic health records system and recommendations for any
209 further legislative action that it may deem necessary or appropriate.
210 (b) There shall be an e-health advisory committee to advise the institute and the
211 governing board relative to the electronic health records plan and implementing the institute's
212 purposes and responsibilities under this section. The advisory committee shall review and offer
213 guidance on the establishment and implementation of the statewide electronic health records
214 system, as well as the financing and technical assistance required to allow all health care

215 providers to acquire and implement electronic medical records necessary to participate in the
216 statewide system. The members of the advisory committee shall include the secretary of health
217 and human services, who shall serve as the chair, the secretary of administration and finance or
218 his designee, the executive director of the Massachusetts e-health institute, the executive
219 director of the health care cost and quality council established pursuant to section 16K of
220 chapter 6A, and additional members as the secretary may determine and appoint, provided that
221 the such appointees shall include persons with expertise and experience in one or more of he
222 following areas: the development and dissemination of electronic health records systems,
223 implementation of electronic health record systems by small physician groups or ambulatory
224 care providers, or the interoperability of systems of electronic health record systems, and shall,
225 in addition, include persons representing organizations within the commonwealth interested in
226 and affected by the development of networks and electronic health records systems, including
227 but not limited to persons representing local public health agencies, licensed hospitals and other
228 licensed facilities and providers, private purchasers, the medical and nursing professions,
229 physicians, health insurers and health plans, the state quality improvement organization,
230 academic and research institutions, consumer advisory organizations with an interest and
231 expertise in health information technology, and other stakeholders as identified by the secretary
232 of health and human services. Each member of the advisory committee, appointed by the
233 secretary shall serve for such term as the secretary may designate upon such member's
234 appointment, but no term shall be less than one year nor more than three years. The secretary
235 may appoint a member for an unlimited number of additional terms, the length of each such
236 term being determined by the secretary at the time of appointment to each such additional term.
237 The members of the advisory committee shall be deemed to be directors for purposes of the

238 fourth paragraph of section 3; provided, however, that notwithstanding said section 3 and
239 sections 5, 6 and 7 of chapter 268A, no member of the advisory committee shall be precluded
240 from participating in matters before the committee because he, or a related party within the
241 scope of said section 6 of said chapter 268A has a financial interest in a matter being considered
242 by the committee, provided that such interest or involvement shall have been disclosed in
243 advance to the advisory committee and recorded in the minutes of the advisory committee's
244 proceedings.
245 (c) Each electronic health records plan developed and approved pursuant to subsection
246 (a) shall address the development, implementation and dissemination of systems of electronic
247 health records among ambulatory care providers in the commonwealth, with a particular focus
248 on those ambulatory care providers, such as community health centers, that care for a significant
249 number of persons in underserved populations. Each plan shall also address the establishment
250 and implementation throughout the commonwealth of one or more networks that: (i) allow the
251 seamless, secure, electronic sharing of health information among health care providers, health
252 plans, and other authorized users; (ii) provide consumers with secure, electronic access to their
253 own health information; (iii) meet standards for interoperability adopted from time to time by
254 the institute; (iv) meet all applicable federal and state-specific privacy and security
255 requirements; (v) give patients the option of allowing only designated health care providers to
256 access their individually identifiable information concerning diagnosis and treatment of sexually
257 transmitted diseases, addiction, mental illnesses, and termination of pregnancy; (vi) provide
258 such public health reporting capability as the secretary of health and human services may
259 determine; (vii) allow for reporting of, and access to, health information, other than PHI
260 (identifiable personal health information), for purposes of such research activities as the

261 secretary of health and human services may determine; (viii) provide for the development and
262 maintenance of a data warehouse for research purposes, which shall not contain PHI; (ix) allow
263 for the reporting of provider-specific health information required for the calculation of any
264 voluntary consensus standard endorsed by the National Quality Forum.

265 (d) Before awarding any grant from the e-Health Institute Fund, the corporation shall
266 consult the public health council and the e-health advisory committee. The request for
267 consultation shall be submitted not less than 15 business days before the execution of any grant
268 award contract. All successful grant applications shall define specific goals and expected
269 outcomes and contain corresponding accountability measures. Applicants who fail to meet these
270 accountability measures shall be barred from pursuing any additional grants under this section
271 for 5 years from the effective date of the grant.

272 (e) In awarding grants, which are to be distributed from the e-Health Institute Fund, not
273 more than $25,000,000 shall be granted annually and uniformly distributed to all geographic
274 regions, including the central area, the greater Boston area, the northeast area, the southeast area
275 and the western area.

276 (f) The institute shall not make a grant under this section unless the recipient
277 organization agrees to use the grant to: (1) redesign care processes; (2) utilize care management
278 techniques; (3) develop and implement an electronic health record system; and (4) begin
279 implementation of the plan not later than the beginning of the second year of the grant.

280 (g) In selecting grant or loan recipients under this section, the institute shall consider:
281 (i) existing technological and organizational infrastructure upon which the health information
282 network can build; (ii) the extent of stakeholder participation; (iii) health care provider
283 participation commitments; (iv) capacity to measure quality and efficiency improvements;

284 (v) replicability; (vi) the extent of the opportunity for a plan to improve health care quality and
285 the health outcomes of patients in the region to be served; (vii) the participation in health
286 information exchange efforts; (viii) care redesign and management efforts; (ix) technological
287 capacity to maintain the security of identifiable health data by means including, but not limited
288 to, data segregation, encryption, the use of unique alpha-numerical identifiers to track stored or
289 transferred patient records, and other administrative protections; (x) any history of security and
290 data breaches; and (ix) other factors that the collaborative considers relevant.

291 (h) Any health information network funded in whole or in part under this section shall:
292 (1) be required to establish within the system a mechanism to allow patients to opt-in to the
293 health information network; (2) comply with any applicable regulatory privacy protections; (3)
294 upon request, provide individuals with a list of individuals and entities who have accessed their
295 identifiable health information; (4) develop and distribute written guidelines addressing privacy,
296 confidentiality and security of health information and inform individuals of what information
297 about them is available, who has access, and for what purposes their information can be
298 accessed.

299 (i) In the event of an unauthorized access to or disclosure of individually identifiable
300 patient health information by or through the statewide health information network, or by or
301 through any technology grantees funded in whole or in part under this section, the operator of
302 such network or grantee shall: (i) report the conditions of such unauthorized access or disclosure
303 as required by the collaborative; and (ii) provide notice as soon as practicable but not later than
304 10 business days, to person whose patient health information may have been compromised as a
305 result of such unauthorized access or disclosure, and shall report the conditions of such
306 unauthorized access or disclosure.

307

308 (j) To apply for a grant under this section, an applicant shall submit an application to
309 the collaborative in such form and manner, and containing such information and assurances as
310 the collaborative may require.

311 (k) (1) The collaborative shall provide to the statewide health information technology
312 network and to individual technology grantees such technical assistance as the collaborative
313 deems appropriate to carry out this section, including assistance relating to questions of
314 governance, financing and technological approaches to the creation of health information
315 networks.

316 (2) The institute shall by contract or grant establish and maintain a statewide technical
317 assistance center to provide assistance to physicians to facilitate successful practice redesign,
318 adoption of electronic health records, utilization of care management strategies, and
319 participation in advanced programs such as the statewide health information network, medical
320 homes program, pay for performance and other incentive programs by such physicians. The
321 statewide technical assistance center shall assist physicians in all geographical areas served by a
322 health information network. In assisting physicians under this paragraph, the statewide
323 technical assistance centers shall prioritize physicians in small physician groups and, as
324 resources allow, shall assist physicians in larger groups. Technical assistance provided under
325 this paragraph shall, at a minimum, include the following: (i) A clearinghouse of best practices,
326 guidelines and implementation strategies directed at the small medical practices that plan to
327 redesign their practices; (ii) a change management tool kit to enable physicians and their staff
328 to successfully prepare practice workflows for adoption of electronic medical records and
329 electronic prescribing, to receive guidance in the selection of vendors of health information

330 technology products and services that are appropriate within the context of the individual
331 practice and the community setting, to implement health information technology solutions and
332 manage the project at the practice level, and to address the ongoing need for upgrades,
333 maintenance and security of office-based health information technologies; and (iii) the
334 capability to provide consultations and advice to small medical practices to facilitate adoption of
335 health information technologies.

336 (l) No funds under this section shall be used for the establishment of a database of
337 individually identifiable patient health information.

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

343 SECTION 10. Chapter 111 of the General Laws is hereby amended by inserting after
344 section 4M the following section:–

345 Section 4N. (a) The department of public health shall develop, in cooperation with the
346 Division of Commonwealth Medicine at the University of Massachusetts Medical School,
347 implement and promote an evidence-based outreach and education program designed to provide
348 information and education on the therapeutic and cost-effective utilization of prescription drugs
349 to physicians, pharmacists and other health care professionals authorized to prescribe and
350 dispense prescription drugs, subject to appropriation. In developing the program the department
351 shall consult with physicians, pharmacists, private insurers, hospitals, pharmacy benefit

352 managers, the MassHealth drug utilization review board and the University of Massachusetts
353 medical school. The program shall include the following elements:

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

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

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

367 (c) The department shall, to the extent possible, also utilize or incorporate into its
368 program other independent educational resources or models proven effective in promoting high
369 quality, evidenced-based, cost-effective information regarding the effectiveness and safety of
370 prescription drugs, including, but not limited to: (1) the Pennsylvania PACE/Harvard University
371 Independent Drug Information Service, (2) the Academic Detailing Program of the University
372 of Vermont College of Medicine Area Health Education Centers, (3) the Oregon Health and

373 Science University Evidence-based Practice Center's Drug Effectiveness Review project, and
374 (4) the North Carolina evidence-based peer to peer education program outreach program.

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

379 SECTION 11. Section 25B of said chapter 111, as appearing in the 2006 Official Edition
380 is hereby amended by striking out the definition of "Expenditure minimum with respect to
381 substantial capital expenditures" and inserting in place thereof the following definition:-

382 "Expenditure minimum with respect to substantial capital expenditures", shall mean,
383 with respect to expenditures and acquisitions made by or for (1) acute-care hospitals and
384 comprehensive cancer centers as defined in section thirty-one of chapter six A, only, seven and
385 one-half million dollars, except that expenditures for or the acquisition of, major movable
386 equipment not otherwise defined by the department as new technology or innovative services
387 shall not require a determination of need, and shall not be included in the calculation of the
388 expenditure minimum; and (2) health care facilities, other than acute-care hospitals, and
389 facilities subject to licensing under chapter one hundred and eleven B, with respect to (a)
390 expenditures for, or the acquisition of, medical, diagnostic or therapeutic equipment, four
391 hundred thousand dollars, and (b) all other expenditures and acquisitions, eight hundred
392 thousand dollars; provided, however, that expenditures for, or the acquisition of, any
393 replacement of medical, diagnostic or therapeutic equipment defined as new technology or
394 innovative services for which a determination of need has issued or which was exempt from
395 determination of need, shall not require a determination of need and shall not be included in the

396 calculation of the expenditure minimum; provided, further, that expenditures and acquisitions
397 concerned solely with outpatient services other than ambulatory surgery, not otherwise defined
398 as new technology or innovative services by the department, shall not require a determination of
399 need and shall not be included in the calculation of the expenditure minimum; unless said
400 expenditures and acquisitions are equal to or greater than twenty five million dollars, in which
401 case a determination of need shall be required. Notwithstanding the above limitations, acute-
402 care hospitals only may elect at their option to apply for determination of need for expenditures
403 and acquisitions less than the expenditure minimum.

404 SECTION 12. Said chapter 111 hereby further amended by inserting after section 25K
405 the following section:-
406 Section 25L. There shall be in the department a center for primary care recruitment and
407 placement to improve access to primary care services.
408 The center shall: (i) coordinate the department's primary care workforce activities with
409 other state agencies and public and private entities involved in health care workforce training,
410 recruitment and retention; (ii) monitor trends in access to primary care and primary care
411 workforce capacity, including regional disparities; (iii) determine statewide target areas for
412 provider placement based on level of access to primary care; (iv) maintain a public web-based
413 statewide primary care job database; (v) conduct outreach and marketing to recruit primary care
414 providers, regionally and nationally, to practice in the commonwealth; (vi) coordinate state and
415 federal loan repayment and incentive programs for primary care providers; (vii) assist and
416 support communities, physician groups, community health centers and community hospitals in
417 developing cost-effective and comprehensive recruitment initiatives; (viii) act as a career

418 service center to assist and support primary care professsionals and provide job placement
419 assistance; and (ix) maximize all sources of public and private funds for recruitment initiatives.
420 The center shall submit an annual report, not later than October 1, to the joint committee
421 on public health, the joint committee on health care financing, and the house and senate
422 committees on ways and means regarding the center's activities in recruiting and retaining
423 health care providers for underserved populations and areas throughout the commonwealth. The
424 annual report shall include, but shall not be limited to, information about: (i) the activities and
425 accomplishments of the center during the report period; (ii) planned activities for the next year;
426 (iii) the number and type of providers who have been recruited to work in the commonwealth as
427 a result of center activities; (iv) the retention rate of providers who have located in target areas
428 as a result of center activities; (v) the utilization rate of the scholarship and loan repayment
429 programs and other programs or activities authorized for provider recruitment and retention; and
430 (vi) recommendations for pilot programs and regulatory or legislative proposals to address
431 workforce needs, shortages, recruitment and retention.
432 SECTION 13. Section 51 of said chapter 111, as appearing in the 2006 Official Edition,
433 is hereby amended by inserting after the fourth paragraph the following paragraph:-
434 A hospital licensed under this chapter shall report each serious reportable event listed in
435 regulations promulgated under subsection (a) of section 16P of chapter 6A to the Betsy Lehman
436 center for patient safety and medical error reduction and the department of public health as soon
437 as is reasonably and practically possible, but not later than 15 working days after the discovery
438 of the serious reportable event. Any licensed hospital that fails to comply with this section and
439 the rules and regulation set forth by the department may have its license revoked or suspended
440 by the department, be fined up to $1,000 per day per violation, or both.

441 SECTION 14. Said chapter 111 is hereby further amended by inserting after section
442 53D the following 3 sections:-

443 Section 53E. (a) The department shall promulgate regulations for the establishment of
444 patient and family advisory councils (hereafter referred to councils in this section) by hospitals.
445 The councils may advise the hospital on matters including but not limited to patient/provider
446 relationships, institutional review boards, quality improvement initiatives and patient education
447 on safety and quality matters. Members of a council may act as reviewers of publicly reported
448 quality information, members of task forces, members of awards committees for patient safety
449 activities, members of Advisory Boards, participants on search committees and hiring of new
450 staff , co-trainers for clinical and non-clinical staff, in-service programs, health professional
451 trainees, and participants in reward and recognition programs. The department may require
452 hospitals to report annually on the membership and work of their councils.

453 Section 53F. (a) The department shall promulgate regulations requiring acute care
454 hospitals to implement a suitable method that enables health care staff members, patients, and/or
455 families to directly request additional assistance from a specially trained individual when the
456 patient's condition appears to be deteriorating. The regulations shall require an early
457 recognition and response method most suitable for the hospital's needs and resources, such as a
458 rapid response team. The method shall be available 24 hours per day.

459 (b) The regulations shall include criteria for calling additional assistance to respond to a
460 change or perception of change in a patient's condition by the staff, patients or families. The
461 regulations shall include criteria for hospitals to educate patients and family members about the

462 methods for recognition and response to changes in patients' conditions , their purposes and
463 how to activate the methods.

464 Section 53G. Notwithstanding any other provisions of law to the contrary, any distinct
465 freestanding entity that is certified or intends to be certified as an Ambulatory Surgical Center
466 by the federal Centers for Medicare and Services for participation in the Medicare program shall
467 be a clinic for purposes of licensure under section 51 of this chapter, and shall be deemed to be
468 in compliance with the conditions for licensure as a clinic under said section 51 if it is
469 accredited to provide ambulatory surgery services by the Accreditation Association for
470 Ambulatory Health Care, Inc., the Joint Commission on Accreditation of Healthcare
471 Organizations, the American Association for Accreditation of Ambulatory Surgery Facilities or
472 any other national accrediting body that the department of public health determines provides
473 reasonable assurances that such conditions are met. No original license shall be issued pursuant
474 to section fifty-one to establish any such ambulatory surgical clinic unless there is a
475 determination by the department that there is need for such a facility. For purposes of this
476 section, "clinic" shall not include a clinic conducted by a hospital licensed under said section 51
477 or by the federal government or the commonwealth. The department shall promulgate
478 regulations to implement this section.

479 SECTION 15. The first paragraph of section 70 of said chapter 111, as appearing in the
480 2006 Official Edition, is hereby amended by striking out the second and third sentences and
481 inserting in place thereof the following 3 sentences-Such records may be handwritten, printed,
482 typed or in electronic digital media or conversion to electronic digital media as originally
483 created by such hospital or clinic, by the photographic or microphotographic process, or any

484 combination of the same. Such hospital or clinic, may only destroy said records after notifying
485 the department of public health and the patient that the applicable retention period has elapsed
486 and the records will be destroyed. Such notification shall occur through appropriate notice,
487 such as, but not limited to, the hospital or clinic's privacy notice, that records will be destroyed
488 after the applicable retention period has elapsed. Such hospital or clinic shall further provide
489 information through applicable provisions contained in the hospital or clinic notice of privacy
490 practices that records will be terminated after the applicable retention period has elapsed since
491 the last date of service.

492 SECTION 16. Said section 70 of said chapter 111, as so appearing, is hereby further
493 amended by striking out, in line 66, the word "thirty" and inserting in place thereof the
494 following figure:- 15.

495 SECTION 17. The first paragraph of section 9E of chapter 112 of the General Laws, as
496 so appearing, is hereby amended by adding the following sentence:- Physicians may supervise
497 up to 4 physician assistants.

498 SECTION 18. Chapter 118E of the General Laws is hereby amended by inserting after
499 section 10F the following section:-

500 Section 10G. (a) As used in this section, the following term shall have the following
501 meaning:-

502

503 "Medical home," a primary care practice that utilizes a comprehensive approach to
504 providing patient-centered care that is accessible, continuous, and coordinated so that the
505 relationship between the provider and patient is directed at maintaining a healthy lifestyle with

506 preventive and ongoing health services and is respectful of, and responsive to, individual patient

507 preference, needs, and values.

508

509 (b) Notwithstanding any general or special law to the contrary, the office of Medicaid,

510 subject to appropriation and the availability of federal financial participation, shall establish a

511 medical home demonstration program for the purpose of redesigning the health care delivery

512 system to provide targeted, accessible, continuous and coordinated family-centered care to high

513 need populations including, but not limited to, those with multiple chronic illnesses that require

514 regular monitoring, advising or treatment. The office of Medicaid shall work with Medicaid

515 managed care organizations in development and implementation of the program.

516 (c) Under the demonstration program, case management fees shall be paid to personal

517 physicians and incentive payments shall be paid to physicians and providers participating in

518 practices that provide medical home services. Medical homes shall be responsible for: (1)

519 targeting eligible individuals for program participation; (2) providing safe and secure

520 technology to promote patient access to personal health information; (3) developing a health

521 assessment tool for the targeted individuals; and (4) providing training for personnel involved in

522 the coordination of care.

523 (d) The program shall operate for 3 years in urban, rural and underserved areas in up to

524 10 communities and shall include physician practices with less than 3 full-time equivalent

525 physicians, as well as larger practices, particularly in rural and underserved areas.

526 (e) Personal physicians who provide first contact and continuous care for their patients

527 shall be board certified. Such personal physicians must also have a staff and resources to

528 manage the comprehensive and coordinated care of each of their patients. Participating

529 providers may be specialists or sub-specialists for patients requiring ongoing care for specific
530 conditions, multiple chronic conditions such as severe asthma, complex diabetes, cardiovascular
531 disease, and rheumatologic disorder, or for those with a prolonged illness.
532 (f) Personal physicians shall perform or provide for the performance of: (1) advocates
533 for and providing ongoing support, oversight and guidance to implement a plan of care; that
534 provides an integrated, coherent, cross-discipline plan for ongoing medical care developed in
535 partnership with patients and including all other physicians furnishing care to the patient
536 involved and other appropriate health care providers or agencies such as home health agencies;
537 (2) uses evidence-based medicine and clinical decision support tools to guide decision-making
538 at the point-of-care based on patient-specific factors; (3) uses health information technology that
539 may include remote monitoring and patient registries; and (4) encourages patients to engage in
540 management of their own health through education and support systems.
541 (g) The office of Medicaid may establish a system of supplemental payments for care
542 management to personal physicians through the establishment of a care management fee, and
543 shall establish within the office of Medicaid a care management fee code and a value for these
544 payments.
545 (h) The office of Medicaid may also establish a system of supplemental payment for a
546 medical home to physician group practices through the establishment of a medical home fee,
547 and shall establish a medical home fee code and a value for these payments.
548
549 (i) The office of Medicaid shall provide a yearly program evaluation and submit a report
550 to the senate and house chairs of the joint committee on health care financing and the chairs of
551 the senate and house committees on ways and means.

552 SECTION 19. Said chapter 118E is hereby further amended by adding the following
553 section:-

554 Section 61. (a) Subject to subsection (c), for the purposes of processing claims for
555 health care services submitted by a health care provider, the executive office of health and
556 human services and its subcontractors shall, without local customization, accept and recognize
557 patient diagnostic information and patient care service and procedure information submitted
558 pursuant to, and consistent with, the current Health Insurance Portability and Accountability Act
559 compliant code sets as adopted by: the Centers for Medicare and Medicaid Services; the
560 International Classification of Diseases; the American Medical Association's Current Procedural
561 Terminology codes, reporting guidelines and conventions; and the Centers for Medicare and
562 Medicaid Services Healthcare Common Procedure Coding System. The executive office and its
563 subcontractors shall adopt the foregoing coding standards and guidelines and changes thereto
564 effective on the same date as the national implementation date established by the entity
565 implementing said coding standards.
566 (b) Subject to subsection (c), the executive office and its subcontractors shall, without
567 local customization, use the standardized claim formats for processing health care claims as
568 adopted by the National Uniform Claim Committee and the National Uniform Billing
569 Committee and implemented pursuant to the federal Health Insurance Portability and
570 Accountability Act. The executive office and its subcontractors shall, without local
571 customization, adopt and routinely process all changes to such formats effective on the same
572 date as the implementation date established by the entity implementing said formats.
573 (c) Other than requirements for consistency and uniformity in coding patient diagnostic
574 information and patient care service and procedure information, this section shall not modify

575 nor supersede the executive office's or its subcontractor's payment policy or utilization review

576 policy. Nothing in this section shall further preclude the executive office or a subcontractor

577 thereof from adjudicating a claim pursuant to its billing guidelines, payment policies or provider

578 contracts.

579 (d) The executive office and its subcontractors shall accept and recognize at least 85 per

580 cent of all claims submitted by health care providers pursuant to this section.

581 SECTION 20. Said section 61 of said chapter 118E, as appearing in section 19, is hereby

582 amended by striking out subsection (d) and inserting the following:- (d) The executive office

583 and its subcontractors shall accept and recognize all claims submitted by health care providers

584 pursuant to and consistent with this section.

585 SECTION 21. Chapter 118G of the General Laws, as appearing in the 2006 Official

586 Edition, is hereby amended by adding the following section:-

587 Section 40. (a) The division shall hold an annual public hearing to examine the factors

588 that contribute to the cost increases of the health care delivery system and strategies employed

589 by the provider community to reduce cost growth. While considering size, payor mix,

590 geographic representation and specialty, the division shall identify a broad representative

591 sample of providers in each of the following categories: integrated delivery systems; acute care

592 hospitals; community health centers; freestanding ambulatory surgical centers; physician group

593 practices; rehabilitation hospitals; and skilled nursing facilities. Each identified provider shall

594 be required to provide oral and written testimony at the hearing in a format determined by the

595 division. The division shall require providers to provide testimony relative to: payment

596 systems; utilization trends, including volume of services and intensity of services; demographics

597 of populations served; labor and supply costs; community benefits programs; endowment

598 contributions; executive compensation; administrative costs; capital investments; strategies to
599 contain the rate of cost growth including, but not limited to, provider efforts to minimize
600 medical errors, eliminate waste and duplication in clinical care, manage chronic diseases, reduce
601 the use of ineffective or inappropriate medical technology or devices, prioritize technology
602 investments for computerized physician support systems and electronic health records,
603 determine capital expenditures based on public health needs, and cut administrative costs; and
604 other matters as determined by the division.

605 (b) Within 60 days following the hearing conducated pursuant to subsection (a), the
606 division shall issue a public report summarizing its findings and any recommendations. The
607 report shall include, but shall not be limited to, the following: (i) a standard measurement of the
608 annual total health care spending in the commonwealth, or the "Massachusetts Global Health
609 Cost Indicator", as determined by the health care quality and cost council; (ii) the rate of annual
610 increase or decrease of health care costs in total and within health care sectors; (iii) an analysis
611 of the primary cost drivers in the health care delivery system; (iv) an evaluation of the scope
612 and effectiveness of provider cost containment efforts; and (v) regulatory, legislative and other
613 recommendations to control health care costs, as developed by the division.

614 SECTION 22. Section 36 of chapter 123 of the General Laws, as so appearing, is
615 hereby amended by adding the following 4 sentences:- Each facility, subject to this chapter and
616 section 19 of chapter 19, that provides mental health care and treatment shall maintain patient
617 records, as defined in the first paragraph of section 70 of chapter 111, for at least 15 years after
618 the closing of the record due to discharge, death or last date of service. No facility may destroy
619 such records unless it first provides notice to the department of public health and to patients that
620 the applicable retention period has elapsed and that records will be destroyed. The means of

621 providing such notice shall include, but not be limited to, the provision of the hospital or clinic's
622 privacy notice that records will be destroyed after the applicable retention period has elapsed. A
623 facility shall further provide information through a provision of the hospital or clinic notice of
624 privacy practices that records will be terminated after the applicable retention period has elapsed
625 after the last date of service.

626 SECTION 23. Chapter 176O of the General Laws is hereby amended by inserting after
627 section 5 the following 2 sections:-

628 Section 5A. (a) Subject to subsection (c), for the purposes of processing claims for
629 health care services submitted by a health care provider, a carrier and its subcontractors shall,
630 without local customization, accept and recognize patient diagnostic information and patient
631 care service and procedure information submitted pursuant to, and consistent with, the current
632 Health Insurance Portability and Accountability Act compliant code sets as adopted by: the
633 International Classification of Diseases; the American Medical Association's Current Procedural
634 Terminology codes, reporting guidelines and conventions; and the Centers for Medicare and
635 Medicaid Services Healthcare Common Procedure Coding System. A carrier and its
636 subcontractors shall adopt the foregoing coding standards and guidelines, and changes thereto,
637 effective on the same date as the national implementation date established by the entity
638 implementing said coding standards.
639 (b) Subject to subsection (c), a carrier and its subcontractors shall, without local
640 customization, use the standardized claim formats for processing health care claims as adopted
641 by the National Uniform Claim Committee and the National Uniform Billing Committee and
642 implemented pursuant to the federal Health Insurance Portability and Accountability Act. A

643 carrier and its subcontractors shall, without local customization, adopt and routinely process all
644 changes to such formats effective on the same date as the implementation date established by
645 the entity implementing said formats.

646 (c) Other than requirements for consistency and uniformity in coding patient diagnostic
647 information and patient care service and procedure information, this section shall not modify
648 nor supersede a carrier's or its subcontractor's payment policy, utilization review policy or
649 benefits under a health benefit plan. Nothing in this section shall further preclude a carrier or a
650 subcontractor thereof from adjudicating a claim pursuant to its billing guidelines, payment
651 policies, provider contracts or health benefit plans.

652 (d) Carriers and subcontractors thereof shall accept and recognize at least 85 per cent of
653 all claims submitted by health care providers pursuant to this section.

654

655 Section 5B. To ensure uniformity and consistency in the submission and processing of
656 claims for health care services pursuant to section 5A of chapter 176O, the bureau of managed
657 care within the division of insurance, after consultation with a statewide advisory committee
658 including, but not limited to, the Massachusetts Hospital Association, the Massachusetts
659 Medical Society, the Massachusetts Association of Health Plans, the Blue Cross and Blue
660 Shield of Massachusetts, the Massachusetts Health Information Management Association, the
661 Massachusetts Health Data Consortium, a representative of America's Health Insurance Plans, a
662 representative of a MassHealth contracted managed care organization, the executive office of
663 health and human services, the division of health care finance and policy, the health care quality
664 and cost council, the house of representatives, and the senate, shall adopt policies and
665 procedures to enforce said section 5A. The policies and procedures shall include a system for

666 reporting inconsistencies related to a carrier's compliance with said section 5A. The bureau
667 shall work jointly with the executive office of health and human services, to resolve reports of
668 noncompliance with the requirements of section 53 of chapter 118E. The bureau shall convene
669 the advisory committee annually to review and discuss issues reported by health care providers
670 pursuant to this section as well as to discuss further recommendations to improve the uniformity
671 and consistency of the reporting of patient diagnostic information and patient care service and
672 procedure information as it relates to the submission and processing of health care claims.

673 SECTION 24. Said section 5A of said chapter 176O, as appearing in section 23, is
674 hereby amended by striking out subsection (d) and inserting in place thereof the following
675 subsection:-

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

678 SECTION 25. The General Laws are hereby amended by inserting after chapter 176Q
679 the following 2 chapters:-

680 CHAPTER 176R

681 CONSUMER CHOICE OF NURSE PRACTITIONER SERVICES

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

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

686 176A; a nonprofit medical service corporation organized under chapter 176B; a health
687 maintenance organization organized under chapter 176G; an organization entering into a
688 preferred provider arrangement under chapter 176I; a contributory group general or blanket
689 insurance for persons in the service of the commonwealth under chapter 32A; a contributory
690 group general or blanket insurance for persons in the service of counties, cities, towns and
691 districts, and their dependents under chapter 32B; the medical assistance program administered
692 by the division of medical assistance pursuant to chapter 118E and in accordance with Title XIX
693 of the Federal Social Security Act or any successor statute; and any other medical assistance
694 program operated by a governmental unit for persons categorically eligible for such program.

695 "Commissioner", the commissioner of insurance.

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

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

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

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

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

714 Section 2. The commissioner and the group insurance commission shall require that all
715 carriers recognize nurse practitioners as participating providers subject to section 3 and shall
716 include coverage, on a nondiscriminatory basis, to their insureds for care provided by nurse
717 practitioners for the purposes of health maintenance, diagnosis and treatment. Such coverage
718 shall include benefits for primary care, intermediate care and inpatient care, including care
719 provided in a hospital, clinic, professional office, home care setting, long term care setting,
720 mental health or substance abuse programs, or other settings when rendered by a nurse
721 practitioner who is a participating provider and is practicing within the scope of her professional
722 license to the extent that such policy or contract currently provides benefits for identical
723 services rendered by a provider of health care licensed by the commonwealth.

724 Section 3. A participating nurse practitioner practicing within the scope of her licensure
725 including all regulations requiring collaboration with a physician under section 80B of chapter
726 112, shall be considered qualified within the carrier’s definition of primary care provider to an
727 insured.

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

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

736 Section 6. Complaints of noncompliance against carriers shall be filed with and
737 investigated by the commissioner or the group insurance commission, whichever shall have
738 regulatory authority over the carrier. The commissioner and the group insurance commission
739 shall promulgate regulations to enforce this chapter.
740
741 CHAPTER 176S
742 HEALTH INSURANCE RATE HEARINGS
743 Section 1. As used in this chapter the following words shall have the following
744 meanings, unless the context clearly requires otherwise:-
745 "Actual loss ratio", the ratio between provider claims incurred by a carrier and
746 premiums earned by that carrier under a health plan, to be calculated in a manner established by
747 the commissioner pursuant to regulation.
748 "Adjusted weighted average market premium price", the arithmetic mean of all premium
749 rates for a given prototype plan sold to eligible insureds with similar rate basis type by all

750 carriers selling prototype plans or alternative prototype plans in the commonwealth, weighted
751 pursuant to regulations promulgated by the commissioner.
752 "Alternative prototype plan", a health plan which meets the criteria established by the
753 commissioner and which is intended for sale under section 4 of chapter 176Q, to eligible
754 individuals and to eligible small groups, as defined in section 1 of chapter 176Q.
755 "Carrier", an insurer licensed or otherwise authorized to transact accident and health
756 insurance under chapter 175; a nonprofit hospital service corporation organized under chapter
757 176A; a non-profit medical service corporation organized under chapter 176B; or a health
758 maintenance organization organized under chapter 176G.
759 "Commissioner", the commissioner of insurance.
760 "Health plan", any individual, general, blanket or group policy of health, accident or
761 sickness insurance issued by an insurer licensed under chapter 175 or the laws of any other
762 jurisdiction; a hospital service plan issued by a nonprofit hospital service corporation under
763 chapter 176A or the laws of any other jurisdiction; a medical service plan issued by a nonprofit
764 hospital service corporation under chapter 176B or the laws of any other jurisdiction; a health
765 maintenance contract issued by a health maintenance organization under chapter 176G or the
766 laws of any other jurisdiction; and an insured health benefit plan that includes a preferred
767 provider arrangement issued under chapter 176I or the laws of any other jurisdiction. "Health
768 plan" shall not include accident only, credit-only, limited scope dental or vision benefits if
769 offered separately, hospital indemnity insurance policies if offered as independent,
770 noncoordinated benefits which for the purposes of this chapter shall mean policies issued
771 pursuant to chapter 175 which provide a benefit not to exceed $500 per day, as adjusted on an
772 annual basis by the amount of increase in the average weekly wages in the commonwealth as

773 defined in section 1 of chapter 152, to be paid to an insured or a dependent, including the spouse
774 of an insured, on the basis of a hospitalization of the insured or a dependent, disability income
775 insurance, coverage issued as a supplement to liability insurance, specified disease insurance
776 that is purchased as a supplement and not as a substitute for a health plan and meets any
777 requirements the commissioner by regulation may set, insurance arising out of a workers'
778 compensation law or similar law, automobile medical payment insurance, insurance under
779 which benefits are payable with or without regard to fault and which is statutorily required to be
780 contained in a liability insurance policy or equivalent self insurance, long-term care if offered
781 separately, coverage supplemental to the coverage provided under 10 U.S.C. 55 if offered as a
782 separate insurance policy, or any policy subject to the provisions of chapter 176K. The
783 commissioner may by regulation define other health coverage as a health plan for the purposes
784 of this chapter.
785
786 "Prototype plan", a health plan which meets the criteria established by the commissioner.
787 "Rate basis type", each category of individual or family composition for which separate
788 rates are charged for a health benefit plan as determined by the carrier subject to restrictions set
789 forth in regulations promulgated by the commissioner.
790 Section 2. After a date established annually by the commissioner pursuant to regulation,
791 every carrier desiring to increase or decrease premiums for any health insurance policy or
792 desiring to set the initial premium for a new health insurance policy under any health plan shall
793 file its rates with the commissioner at least 90 days before the proposed effective date of such
794 new health insurance rates.

795 Section 3. Any increase in premium rates shall continue in effect for not less than 12
796 months, except that an increase in benefits or decrease in rates may be permitted at any time.
797 Section 4. A carrier shall annually report to the commissioner and to the health care
798 quality and cost council, established under section 16K of chapter 6A, not later than May 1, the
799 actual loss ratio calculated for each health plan for the previous calendar year.
800 Section 5. The commissioner shall initiate a hearing conducted pursuant to chapter 30A
801 on any filing under section 2 prior to its effective date on at least 10 days' notice. The
802 commissioner may consolidate hearings for more than 1 carrier and may consolidate hearings
803 for multiple health plans filed by 1 carrier. The carrier shall provide information on the reasons
804 for the proposed premium change, and members of the public may testify. All testimony and
805 evidence received shall be public records. The commissioner may promulgate guidelines to
806 safeguard the confidentiality of contracts that establish rates between insurers and institutional
807 providers licensed under section 51 of chapter 111 which shall apply when the commissioner
808 obtains such contracts pursuant to section 8A of chapter 175 for purposes of a hearing under this
809 section.
810
811 The attorney general shall have the authority to intervene in any hearing called for under
812 this section and may require that a party to such a hearing produce any documents related to the
813 proposed premium change or documents that the attorney general deems necessary to enable
814 him or the commissioner to evaluate the merits of the proposed premium change. The attorney
815 general shall keep all information and documents obtained under this section confidential and
816 shall not disclose such information or documents to any person except as necessary in a case

817 brought by the attorney general under this chapter. Such information and documents shall not
818 be public records and shall be exempt from disclosure under section 10 of chapter 66.
819
820 Such requested premium change or initial premium request shall be filed at least 90 days
821 before the proposed effective date of such increase, and shall be communicated to the insureds
822 at least 90 days before the proposed effective date of such change, in the manner directed by the
823 commissioner.
824
825 The rate filer shall advertise any public hearing conducted under this section in
826 newspapers in Boston, Brockton, Fall River, Pittsfield, Springfield, Worcester, New Bedford
827 and Lowell.
828
829 Within 90 days after the conclusion of any hearing initiated under this section, the
830 commissioner shall issue a report containing findings of fact from the evidence presented in the
831 carrier's filing and in the hearing. The findings of fact shall include, but shall not be limited to:
832 1) the carrier's administrative expenses, including but not limited to the carrier's
833 salary structure, advertising and other marketing expenses, and commissions,
834 brokerage fees and other distribution expenses, as compared to other carriers
835 within and without the commonwealth;
836 2) the carrier's expenses related to health care contracts, including but not limited to
837 the costs of services rendered by health care providers, the rates at which it pays
838 for such services and the volume of services provided;
839

3) the carrier’s loss experience under the health plan, including evaluations of the carrier’s actual loss ratio and of utilization by the carrier’s insureds, and of identifiable cost drivers for that health plan, as compared to other carriers within and without the commonwealth;
4) cost-sharing assumptions made in the health plan, including, but not limited to, the use of deductibles, co-payments and coinsurance;
5) the carrier’s provisions in the rates for reserves and surplus; and
6) the carrier’s programs of cost containment, as compared to other carriers within and without the commonwealth.

Nothing in this paragraph shall prohibit the attorney general from publishing any report concerning a hearing under this section.

This section shall not affect any procedures for the approval or disapproval of health plan rates provided elsewhere in the General Laws, except as specifically provided herein.

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

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

863

864 Any person aggrieved by any final action, order, finding or decision of the commissioner

865 under this section may, within 20 days from the filing of such final action, order, finding or

866 decision in his office, file a petition in the supreme judicial court for the county of Suffolk for a

867 review of such action, order, finding or decision. The final action, order, finding, or decision of

868 the commissioner shall remain in full force and effect, pending the final decision of the court,

869 unless the court or a justice thereof after notice to the commissioner shall by a special order

870 otherwise direct. Review by the court on the merits shall be limited to the record of proceedings

871 before the commissioner. The court shall have jurisdiction to modify, amend, annul, reverse or

872 affirm such action, order, finding or decision and shall uphold the commissioner's action, order,

873 finding, or decision if it is consistent with the standards set forth in paragraph 7 of section 14 of

874 chapter 30A. The court may make any appropriate order or decree and may make such order as

875 to costs as it deems equitable. The court may make such rules or orders as it deems proper

876 governing proceedings under this section to secure prompt and speedy hearings and to expedite

877 final decisions thereon.

878

879 Section 7. The commissioner may promulgate regulations to facilitate the

880 administration and enforcement of this chapter and to govern hearings and investigations

881 thereunder, and may issue such orders as he finds proper, expedient or necessary to enforce and

882 administer this chapter and to secure compliance with any rules and regulations made

883 thereunder.

884

885 SECTION 26. The General Laws are hereby amended by inserting after chapter 268B

886 the following chapter:-

887 CHAPTER 268C

888 PHYSICIAN AND PHARMACEUTICAL MANUFACTURER CONDUCT

889

890 Section 1. As used in this chapter, the following words shall have the following

891 meanings:-

892

893 "Gift", a payment, entertainment, meals, travel, honorarium, subscription, advance,

894 services or anything of value, unless consideration of equal or greater value is received. “Gift"

895 shall not include anything of value received by inheritance, a gift received from a member of the

896 physician’s immediate family or from a relative within the third degree of consanguinity of the

897 physician or of the physician’s spouse or from the spouse of any such relative, or prescription

898 drugs provided to a physician solely and exclusively for use by the physician’s patients.

899

900 "Immediate family", a spouse and any dependent children residing in the reporting

901 person's household.

902

903 “Medical device”, an instrument, apparatus, implement, machine, contrivance, implant,

904 in vitro reagent, or other similar or related article, including any component, part, or accessory,

905 which is: (1) recognized in the official National Formulary, or the United States Pharmacopeia,

906 or any supplement to them; (2) intended for use in the diagnosis of disease or other conditions,

907 or in the cure, mitigation, treatment, or prevention of disease, in man or other animals; or (3)

908 intended to affect the structure or any function of the body of man or other animals, and which

909 does not achieve its primary intended purposes through chemical action within or on the body of

910 man or other animals and which is not dependent upon being metabolized for the achievement

911 of its primary intended purposes.

912

913 "Person", a business, individual, corporation, union, association, firm, partnership,

914 committee, or other organization or group of persons.

915

916 "Pharmaceutical marketer", a person who, while employed by or under contract to

917 represent a pharmaceutical manufacturing company, engages in pharmaceutical detailing,

918 promotional activities or other marketing of prescription drugs in this state to any physician,

919 hospital, nursing home, pharmacist, health benefit plan administrator or any other person

920 authorized to prescribe, dispense, or purchase prescription drugs. The term does not include a

921 wholesale drug distributor licensed under section 36A of chapter 112, a representative of such a

922 distributor who promotes or otherwise markets the services of the wholesale drug distributor in

923 connection with a prescription drug, a licensed medical device distributor, or a retail pharmacist

924 registered under section 37 of chapter 112 if such person is not engaging in such practices under

925 contract with a manufacturing company.

926

927 "Pharmaceutical manufacturing company", any entity which is engaged in the

928 production, preparation, propagation, compounding, conversion or processing of prescription

929 drugs, either directly or indirectly by extraction from substances of natural origin, or

930 independently by means of chemical synthesis or by a combination of extraction and chemical

931 synthesis, or any entity engaged in the packaging, repackaging, labeling, relabeling or
932 distribution of prescription drugs. The term does not include a wholesale drug distributor
933 licensed under section 36A of chapter 112 or a retail pharmacist registered under section 37 of
934 chapter 112.
935
936 "Pharmaceutical manufacturer agent", a pharmaceutical marketer or any other person
937 who for compensation or reward does any act to promote, oppose or influence the prescribing of
938 a particular prescription drug or medical device or category of prescription drugs or medical
939 devices. The term shall not include a licensed pharmacist, licensed physician or any other
940 licensed health care professional with authority to prescribe prescription drugs who is acting
941 within the ordinary scope of the practice for which he is licensed.
942
943 "Physician", a person licensed to practice medicine by the board of medicine
944 under section 2 of chapter 112 who prescribes prescription drugs for any person, or the
945 physician's employees or agents.
946
947 "Prescription drugs", any and all drugs upon which the manufacturer or distributor has
948 placed or is required by federal law and regulations to place the following or a comparable
949 warning: "Caution federal law prohibits dispensing without prescription."
950
951 Section 2. No pharmaceutical manufacturer agent shall knowingly and willfully offer or
952 give to a physician, a member of a physician's immediate family, a physician's employee or
953 agent, a health care facility or employee or agent of a health care facility, a gift of any value.

954 Nothing in the section shall prohibit the provision, distribution, dissemination, or receipt of peer
955 reviewed academic, scientific or clinical information. Nothing in this section shall prohibit the
956 purchase of advertising in peer reviewed academic, scientific or clinical journals.
957 Section 3. A person who violates this chapter shall be punished by a fine of not more
958 than $5,000.
959
960 SECTION 27. Notwithstanding any general or special law to the contrary, the trustees of
961 the University of Massachusetts shall expand the entering class at its medical school and
962 increase residencies for medical school graduates for students committed to entering the
963 primary care field and to working in underserved regions of the commonwealth. The trustees
964 shall develop a master plan for expanding medical student enrollment and increasing internships
965 and residencies for medical school graduates who are committed to primary care and work in
966 underserved regions without reducing academic quality, together with a financial plan to
967 support such expansion, and shall report that plan to the joint committee on health care
968 financing and the house and senate committees on ways and means not later than January 1,
969 2009.
970
971
972 SECTION 28. Notwithstanding any general or special law to the contrary, the center for
973 primary care recruitment and placement established under section 12 in consultation with the
974 board of higher education and the executive office of health and human services, shall, subject
975 to appropriation, establish a primary care workforce development and loan forgiveness grant
976 program at community health centers, community hospitals and other facilities in target areas,

977 as determined by the center pursuant to section 25L of chapter 111 of the General Laws, for the
978 purpose of enhancing the recruitment and retention of primary care physicians and nurse
979 practitioners authorized to practice pursuant to section 80B of chapter 112 of the General Laws.
980 Loan forgiveness programs or zero interest loan programs or other forms of assistance utilizing
981 public funds, in whole or in part, shall require each medical or nursing student recipient to enter
982 into a contract with the commonwealth as a primary care fellow which shall obligate the
983 recipient to perform a term of service determined by the center within the commonwealth in
984 areas of primary care.
985
986
987 SECTION 29. Notwithstanding any general or special law to the contrary, the trustees
988 of the University of Massachusetts, in conjunction with the state health education center at the
989 University of Massachusetts medical center, shall establish and maintain an enhanced learning
990 contract program available to medical students every academic year. The program shall provide
991 full waivers of tuition and fees at the University of Massachusetts medical school. The contract
992 shall require payback service, of at least 4 years of service within the commonwealth in areas of
993 primary care, public or community service, or underserved areas as determined by the center for
994 primary care recruitment and placement and the learning contract committee, in coordination
995 with the area health education center and state and regional health planning agencies. If a
996 student fails to perform payback service as required by an enhanced learning contract, that
997 student shall pay the difference between the tuition paid and double the amount of the tuition
998 charged together with an origination fee, interest per annum at prime rate as reported at the time
999 of origination by the Federal Reserve, a margin and repayment fee as set by the board. No

1000 payback service or tuition loan repayment shall be required prior to the termination of any
1001 internship and residency requirements. Interest shall begin to accrue upon completion of the
1002 requirements for the degree. The commonwealth shall bear the cost of such tuition and fee
1003 waivers for enhanced learning contracts. The dean of the medical school shall report annually
1004 the number of students participating in enhanced learning contracts, the area of medicine within
1005 which payback is to be performed, and the number of students utilizing the repayment option.
1006 The report shall also outline the effects of payback in the underserved areas of the
1007 commonwealth.
1008

1009 SECTION 30. (a) Notwithstanding any general or special law to the contrary, there is
1010 hereby established and set up on the books of the commonwealth a separate fund to be known as
1011 the Massachusetts Nursing and Allied Health Workforce Development Trust Fund, hereinafter
1012 referred to as the health care workforce trust fund, to which shall be credited any appropriations,
1013 bond proceeds or other monies authorized by the general court and specifically designated to be
1014 credited thereto, and additional funds including federal grants or loans, or private donations
1015 made available to the commissioner of higher education for this purpose. The department of
1016 higher education shall hold the fund in an account separate and apart from other funds or
1017 accounts. Amounts credited to the fund shall be expended by the commissioner of higher
1018 education to carry out subsection (b). Any balance in the fund at the close of a fiscal year shall
1019 be available for expenditure in subsequent fiscal years and shall not revert to the General Fund.

1020 (b) The public purposes of the Massachusetts Nursing and Allied Health Workforce
1021 Development Trust Fund shall be to develop and support, in consultation with the

1022 Massachusetts Nursing and Allied Health Workforce Development Advisory Committee, short-
1023 term and long-term strategies to increase the number of Massachusetts public and private higher
1024 education faculty and students who participate in programs that support careers in fields related
1025 to nursing and allied health. The commissioner of higher education may expend from the health
1026 care workforce trust fund such administrative monies as may be necessary for the administration
1027 of the Massachusetts Nursing and Allied Health Workforce Development Initiative. In
1028 furtherance of these public purposes, the commissioner of higher education shall expend the
1029 health care workforce trust fund monies on activities that are calculated to increase the number
1030 of qualified nursing and allied health faculty and students in the commonwealth and improve
1031 the nursing and allied health educational offerings available in public higher education
1032 institutions. Grants and other disbursements and activities may involve, without limitation, the
1033 University of Massachusetts, state and community colleges, private higher education institutions
1034 in partnership with public higher education institutions, business and industry partnerships,
1035 regional alliances, workforce investment boards, organizations granted tax-exempt status under
1036 section 501(c)(3) of the Internal Revenue Code and other community groups which promote the
1037 nursing profession. Grants and other disbursements and activities may support, without
1038 limitation: (i) the goal of rapidly increasing the number of nurses and allied health workers; (ii)
1039 enhancing the role of the system of public higher education, as institutions and in partnerships
1040 with other stakeholders, in meeting the short-term and long-term workforce challenges in the
1041 nursing and allied health professions; (iii) the development and use of innovative curricula,
1042 courses, programs and modes of delivering education in nursing and allied health professions
1043 for faculty and students in these fields; (iv) activities with the growing network of stakeholders
1044 in the nursing and allied health professions to create, implement, share and make broadly and

1045 publicly available best practices and innovative programs relative to instruction, development of
1046 partnerships and expanding and maintaining faculty and student involvement in careers in these
1047 fields; and (v) strengthening the institutional capacity to develop and implement long-term
1048 programs and policies to respond effectively to these challenges.

1049

1050 SECTION 31. Notwithstanding any general or special law to the contrary, the
1051 department of housing and community development, in consultation with the executive office of
1052 health and human services and the department of workforce development, shall establish a pilot
1053 program to assist hospitals, community health centers, and physician practices in providing
1054 housing grants or loans for health care professionals in underserved areas. The department of
1055 housing and community development shall establish an Assisted Housing Fund to provide
1056 grants or loans for health care professionals who contract to provide care in underserved regions
1057 of the commonwealth and whose incomes do not exceed certain benchmarks, as established by
1058 said department. Grants and loans from the fund shall be made available for expenditure in the
1059 commonwealth and may be used for: (i) the cost to purchase housing that is to be a principal
1060 residence, including cooperative housing, and that falls within price guidelines established by
1061 the department, including costs for down payments, mortgage interest rate buy-downs, closing
1062 costs and other costs determined to be eligible by the department; and (ii) payments for security
1063 deposits and advance payments for rental housing. The department, subject to appropriation,
1064 shall contribute $1 to the assisted housing fund for every $2 expended by the hospital,
1065 community health center or physician practice from the assisted housing fund as provided in
1066 this act. The assistance granted pursuant to this act shall be determined by the department. The
1067 department shall adopt written procedures for the establishment and operation of the assisted

1068 housing fund. The procedures shall include provisions for eligibility and shall specify the
1069 expenses for which grants and loans may be made and determine the documentation and
1070 procedures necessary to qualify for the assistance. Two years after the commencement of the
1071 pilot program, the department shall report to the house and senate committees on ways and
1072 means, the joint committee on housing and the joint committee on health care financing, the
1073 results of the pilot program and shall recommend it for expansion, continuation or
1074 discontinuation.
1075
1076
1077 SECTION 32. Notwithstanding any special or general law to the contrary, the center for
1078 primary care recruitment and placement, in conjunction with the University of Massachusetts
1079 medical school and area health education centers, shall study the efforts of Massachusetts-based
1080 public and private graduate medical education institutions to foster and expand the supply of
1081 primary care physicians in the commonwealth. The study shall include, but shall not be limited
1082 to, a survey of institutional efforts to both increase the percentage of medical residents who
1083 choose a primary care specialty and the overall enrollment of medical students committed to
1084 entering the primary care field. The study shall recommend innovative primary care
1085 educational programs and strategies that foster a culture within graduate medical education
1086 which embraces primary care. The center shall report its findings and recommendations to the
1087 house and senate committee on ways and means and the joint committee on health care
1088 financing not later than January 1, 2009.
1089
1090

1091 SECTION 33. (a) Notwithstanding any general or special laws to the contrary, there
1092 shall be a special commission to examine options and alternatives available to the
1093 commonwealth to provide regulation, oversight and disposition of the reserves, endowments
1094 and surpluses of health insurers and hospitals.

1095 (b) The commission shall consist of the inspector general, who shall serve as the chair,
1096 the commissioner of insurance or his designee, the commissioner of health care finance and
1097 policy or his designee, the secretary of administration and finance or his designee, the attorney
1098 general or his designee, the commissioner of public health or his designee and 3 members to be
1099 appointed by the governor, which shall include a health care consumer advocate and a health
1100 economist.

1101 (c) The commission shall conduct a study relative to health insurers, including health
1102 maintenance organizations and acute care and non-acute care hospitals including, but not
1103 limited to: (1) an analysis of the laws, regulations and other measures currently in effect in the
1104 commonwealth which regulate the amount, nature and disposition of surpluses held by or for the
1105 benefit of health insurers in excess of amounts reasonably anticipated to be required to pay
1106 claims, taking into account the level of such reserves and surpluses necessary to safeguard the
1107 solvency of health insurers against unanticipated events and other circumstances which may
1108 cause extraordinary medical losses; (2) an analysis of the federal and state statutes, regulations
1109 and other measures currently in effect which regulate the amount, nature and disposition of
1110 surpluses and endowments held by or for the benefit of hospitals in excess of amounts
1111 reasonably anticipated to be required to perform and support services provided by the hospital
1112 and to guard against unanticipated events and other circumstances; (3) a review of recent fiscal
1113 practices and financial reporting by health insurers relative to reserves and surpluses under the

1114 laws of the commonwealth, and of hospital fiscal practices and financial reporting required
1115 under the laws of the commonwealth; (4) a comparison of the commonwealth's current statutes
1116 and regulations with those of other states which the commission deems to be reasonably
1117 comparable to those of the commonwealth; (5) a review and assessment of model acts and
1118 regulations and any other information which the commission finds to be relevant to its inquiry;
1119 (6) a summary of alternative approaches to regulation of reserves and surpluses, including the
1120 disposition of amounts held by or on behalf of health insurers, with particular consideration of
1121 alternatives that would govern the use of those amounts to reduce premiums or to delay or to
1122 moderate premium increases; (7) a summary of approaches to regulation of surpluses and
1123 endowments held by or on behalf of hospitals, with particular consideration of alternatives that
1124 would govern the use of those amounts to reduce the cost of care; and (8) a review of the
1125 method by which health insurers and hospitals fund community benefit programs including, but
1126 not limited to, the manner by which funding is regulated by other states as to the appropriate
1127 amount, monitoring and direction of such funding, In compiling this report, the commission
1128 shall seek input from health plans and hospitals operating in the commonwealth, the attorney
1129 general, the executive office of health and human services, and the health care quality and cost
1130 council, established under section 16K of section 6A of the General Laws. In conducting its
1131 examination, the commission shall, to the extent possible, obtain and use actual health plan and
1132 hospital data and such data shall be confidential and shall not be a public record under clause
1133 twenty-sixth of section 2 of chapter 4 of the General Laws or section 10 of chapter 66 of the
1134 General Laws..
1135 (f) The commission may contract with an another entity with the requisite financial
1136 expertise to assist the commission in conducting its study.

1137 (g) The commission shall meet not later than October 1, 2008 and shall hold at least 2
1138 public hearings. The commission shall file a report of its findings and recommendations with
1139 the clerks of the senate and house of representatives, the house and senate committee on ways
1140 and means and the joint committee on health care financing not later than July 1, 2009.
1141
1142
1143 SECTION 34. Notwithstanding any general or special law to the contrary, the
1144 department of public health, in consultation with the health care quality and cost council, shall
1145 adopt regulations requiring hospitals, as a standard of eligibility for original licensure and
1146 renewal of licensure, to register with the National Healthcare Safety Network. Each hospital
1147 that registers with the National Healthcare Safety Network shall grant access to the department
1148 and the Betsy Lehman center for patient safety and medical error reduction, in accordance with
1149 guidelines of the department to: (1) health care-associated infection data elements reportable to
1150 the National Healthcare Safety Network; and (2) hospital-specific reports generated by the
1151 National Healthcare Safety Network. Each registered hospital shall collect and submit to the
1152 National Healthcare Safety Network health care-associated infection data elements in
1153 accordance with guidelines of the department.
1154 SECTION 35. Notwithstanding any general or special law to the contrary, not later than
1155 October 1, 2012, the department of public health, in consultation with the health care quality
1156 and cost council, shall adopt regulations requiring hospitals and community health centers, as a
1157 standard of eligibility for original licensure and renewal of licensure, to implement
1158 computerized physician order entry systems as defined by the department. The systems shall be
1159 certified by the Certification Commission for Healthcare Information Technology or any

1160 successor agency or organization established for the purpose of certifying that health
1161 information technology shall meet national interoperability standards.
1162 SECTION 36. Notwithstanding any general or special law to the contrary, not later than
1163 October 1, 2015, the department of public health, in consultation with the health care quality
1164 and cost council, shall adopt regulations requiring hospitals and community health centers, as a
1165 standard of eligibility for original licensure and renewal of licensure, to implement interoperable
1166 electronic health records systems, as defined by the department. The system shall be certified by
1167 the Certification Commission for Healthcare Information Technology or any successor agency
1168 or organization established for the purpose of certifying that health information technology shall
1169 meet national interoperability standards.
1170 SECTION 37. Notwithstanding any general or special law to the contrary, the executive
1171 office of health and human services shall maximize enrollment of eligible persons in the
1172 MassHealth Senior Care Options program, the Program of All Inclusive Care for the Elderly,
1173 the Enhanced Community Options Program and the Community Choices program, or
1174 comparable successor programs, and shall develop a plan to offer similar coverage to Medicaid
1175 and Medicare-eligible disabled persons under age 65, which shall be referred to in this section,
1176 as dual eligible plans.
1177 Not later than 6 months after the effective date of this act, the executive office of health
1178 and human services shall prepare a report identifying clinical, administrative and financial
1179 barriers to expanded dual eligible plan, and shall recommend steps to remove the barriers and
1180 implement the plans. Before finalizing the report, the executive office shall hold a public
1181 consultative session that shall include organizations representing seniors, organizations
1182 representing disabled persons, organizations representing health care consumers, organizations

1183 representing racial and ethnic minorities, health delivery systems and health care providers. The
1184 report shall include consideration of changes in procurement standards and_MassHealth
1185 payment methodologies to promote enrollment in dual eligible plans. The report shall include
1186 estimates of the costs and benefits of implementing steps to remove barriers to expanded
1187 enrollment in dual eligible plans, including financial savings and improved quality of care.
1188 The report shall be provided to the committee on health care financing and the house and
1189 senate committees on ways and means. Subject to appropriation, the executive office of health
1190 and human services shall implement any steps recommended by the report. Not later than 1
1191 year after the filing of the report, the executive office shall issue a progress statement on
1192 expanded enrollment in dual eligible plans
1193 SECTION 38. The department of public health shall, not later than July 1, 2009,
1194 establish a registry of exemptions granted by the department pursuant to section 6 of chapter
1195 350 of the acts of 1993 and the department's regulations to any person who filed with the
1196 department by December 23, 1993, a notice of intent to acquire medical, diagnostic or
1197 therapeutic equipment used to provide an innovative service or which is a new technology, as
1198 defined in section 25B of chapter 111 of the General Laws. Registered exemptions shall be
1199 nontransferable. After July 1, 2009, all exemptions qualifying for this registry that have not
1200 been registered with the department shall be void. Holders of registered exemptions for
1201 medical, diagnostic or therapeutic equipment not placed in regular service by July 1, 2009,
1202 shall, upon application, be eligible for an expedited determination of need process, as
1203 determined by the department. Exemptions granted by the department under said section 6 of
1204 said chapter 350 and the department's regulations to any person who filed with the department,
1205 by December 23, 1993, a notice of intent to acquire medical, diagnostic or therapeutic

1206 equipment used to provide an innovative service or which is a new technology shall expire on
1207 July 1, 2010, if the equipment for which the exemption was granted was not placed in regular
1208 service by July 1, 2009 and if no determination of need was granted by the department.
1209 SECTION 39. The division of insurance shall conduct an investigation and study of the
1210 costs of medical malpractice coverage for health care providers, as defined in section 193U of
1211 chapter 175 of the General Laws. The investigation and study shall include, but shall not be
1212 limited to, examination and analysis of the following: (1) the availability and affordability of
1213 medical malpractice insurance; (2) the factors considered by medical malpractice insurers when
1214 increasing premiums; (3) options for decreasing premiums including, but not limited to,
1215 establishing a reinsurance pool with additional stop loss coverage, subsidizing premium
1216 payments of providers practicing in certain high-risk specialties or in specialties for which the
1217 cost of premiums represents a disproportionately high proportion of a health care provider's
1218 income, subsidizing premium payments of providers who do not qualify for group coverage
1219 rates and pay higher premiums for commercial market insurance and prorating premiums for
1220 providers who practice less than full-time; and (4) funding mechanisms that would facilitate the
1221 implementation of recommendations arising out of the study which may include, but which
1222 shall not be limited to, charges borne by the health care industry or other entities. The division
1223 shall hold at least 2 public hearings to take testimony relating to the investigation and study, 1
1224 of which shall be held outside the metropolitan Boston area. The division shall report its
1225 findings and recommendations to the house and senate committee on ways and means and the
1226 joint committee on health care financing not later than January 1, 2009.
1227 SECTION 40. Notwithstanding any general or special law to the contrary, the
1228 masshealth payment advisory board, established pursuant to section 16M of chapter 6Aof the

1229 General Laws, shall conduct a study of the need for an increase in Medicaid rates or bonuses for
1230 primary care physicians, nurse practitioners and subspecialists who provide primary care
1231 services, such as preventive care, certain evaluation and management procedures, early periodic
1232 screening, diagnosis and treatment, and scheduled weekend and holiday services, in order to
1233 focus on prevention and wellness and delivery of primary care to identify illness earlier, to
1234 better manage chronic disease and to avoid costs associated with emergency room visits and
1235 hospitalizations. The committee shall report its findings, including recommendations for the
1236 amount of funding and the sources of funding, to the joint committee on health care financing,
1237 and the house and senate committees on ways and means not later than January 1, 2009.
1238 SECTION 41. There shall be a community benefits taskforce, which shall include the
1239 attorney general, the commissioner of public health and other members as determined by the
1240 attorney general which shall conduct a study of the community benefits contributions by
1241 nonprofit health care providers and insurers. The study shall include, but not be limited to,
1242 examination and analysis of the following: (1) current community benefits programs including,
1243 but not limited to, plans filed with the attorney general's voluntary community benefits
1244 program; (2) methods used to identify and define communities to be served by community
1245 benefit programs; (3) the process hospitals and insurers use to assess community needs, define
1246 target populations for programs and to make resource allocation decisions; (4) methods used to
1247 measure and evaluate the contributions by non-profit healthcare providers and insurers to
1248 various communities; (5) the administrative and technological needs of non-profit healthcare
1249 providers; (6) potential collaborations between providers to fund improved administrative and
1250 technological support systems and information infrastructures as part of a statewide community
1251 benefits program including, but not limited to, the creation of a statewide electronic medical

1252 records database and computerized physician order entry to improve access and the portability
1253 of health information; and (7) whether the commonwealth ought to mandate standards and
1254 amounts of community benefits spending and, if so, what standards ought to apply. The task
1255 force shall hold at least 2 public hearings to hear testimony relating to the investigation and
1256 study, 1 of which shall be held outside the metropolitan Boston area. The task force shall report
1257 its findings and recommendations to the house and senate committee on ways and means and
1258 the joint committee on health care financing not later than January 1, 2009.
1259 SECTION 42. Notwithstanding any general or special law to the contrary, the attorney
1260 general shall adopt rules, regulations or guidelines that permit 2 or more health insurers, health
1261 maintenance organizations, hospitals and other providers in the health care market to: (1)
1262 discuss methods to standardize or simplify administrative standards, protocols or practices in
1263 order to reduce health care costs, improve access to health care services, improve the quality of
1264 care or reduce health care disparities; and (2) negotiate and enter into agreements to implements
1265 such standards, protocols or practices, but, no rule, regulation or guideline shall permit rate
1266 setting or price fixing, for insurance premiums or payments to providers.
1267
1268 Any person or entity acting under the authority of any rule, regulation or guideline adopted
1269 pursuant to this section shall be engaged in action under state policy and shall be immune from
1270 antitrust liability to the same degree and extent as the commonwealth.
1271 SECTION 43. The enhanced learning contract program at the University of
1272 Massachusetts Medical Center required under section 29 shall be established by the
1273 commencement of the 2008 academic year.

1274 SECTION 44. Any entity providing ambulatory surgical center services which is in
1275 operation or under construction, as determined by the department of public health, on the
1276 effective date of this act shall be exempt from the determination of need requirement of said
1277 section 53G of said chapter 111 and shall be eligible, pursuant to said section 53G of said
1278 chapter 111, to make application to the department for a clinic license for up to 6 months after
1279 the effective date of regulations adopted by the department pursuant to said section 53G of said
1280 chapter 111.

1281 SECTION 45. Section 11 shall apply to any project seeking written approval of final
1282 architectural plans, pursuant to section 51 of Chapter 111 of the General Laws, on or after 6
1283 months from the effective day of this act.

1284 SECTION 46 . The secretary of health and human services shall promulgate the
1285 regulations required under subsection (a) of section 16P of chapter 6A of the General Laws not
1286 later than October 1, 2009.

1287 SECTION 47. The health care quality and cost council shall publish the serious
1288 reportable event occurrences as required under subsection (a) of section 16P of chapter 6A of
1289 the General Laws on its consumer health information website not later than 1 year after the
1290 effective date of this act.

1291 SECTION 48. The department of public health shall promulgate regulations as
1292 necessary to implement section 4N of chapter 111 of the General Laws in accordance with
1293 chapter 30A not later than October 1, 2008. The department of public health shall begin
1294 implementing the outreach and education program established under said section 4N of said
1295 chapter 111 not later than January 1, 2009.

1296 SECTION 49. The bureau of managed care within the division of insurance shall
1297 convene the first advisory committee required under section 5B of chapter 176O of the General
1298 Laws on January 1, 2009.
1299 SECTION 49A. Notwithstanding any general or special law to the contrary, the
1300 secretary of administration and finance and the secretary of health and human services shall
1301 prepare and submit a report to the general court about the allocation and use of state funds to
1302 acute care and non-acute care hospitals, Medicaid managed care organizations and other
1303 managed care organizations, community health centers and carriers contracting with the
1304 commonwealth health insurance connector authority. The report shall include: (1) a
1305 comprehensive review of the current manner, amount and purposes of annual state funding
1306 received by these entities, including a description of the source of the funding; (2) an
1307 assessment of the change in total state funding for these entities over the past 5 years, with
1308 particular attention paid to the impact of provisions of chapter 58 of the acts of 2006; (3) an
1309 assessment of how these entities use state funds; (4) an assessment of whether the current
1310 payment structure assures the delivery of quality health care in the most cost-effective way; (5)
1311 an analysis of financial and management practices of these entities by benchmarking
1312 performance with respect to quality and cost effectiveness against national performance levels
1313 and against the performance of similar healthcare providers in the commonwealth; (6)
1314 identification of common factors that may contribute to the fiscal instability of these entities; (7)
1315 recommendations for the development of performance and operational benchmarks; (8)
1316 recommendations for ensuring that these entities are spending state and other funds in a fiscally
1317 responsible manner and providing quality care; and (9) recommendations for legislative and

1318 other action necessary to strengthen state oversight and ensure greater accountability of state
1319 resources.
1320 The secretaries shall have access to all documents of acute care and non-acute care
1321 hospitals, Medicaid managed care organizations and other managed care organizations,
1322 community health centers, carriers contracting with the commonwealth health insurance
1323 connector authority and any related entities that relate to that organization's use of state funds.
1324 The secretaries shall keep all information and documents obtained under this section
1325 confidential and shall not disclose such information or documents to any person except as
1326 necessary in a case brought by the attorney general under this chapter. Such information and
1327 documents shall not be public records and shall be exempt from disclosure under section 10 of
1328 chapter 66.
1329 For the purpose of conducting their duties under this section, the secretaries may
1330 contract with an outside organization with the requisite financial expertise to enable the
1331 secretaries to prepare the report. The secretaries shall submit the report, along with any
1332 recommendations for legislative or other action, to the clerks of the house of representatives and
1333 of the senate on or before December 31, 2008.
1334 SECTION 50. Not later than 4 years after the effective date of this act, the e-health
1335 institute, established in section 6D of chapter 40J of the General Laws, shall submit a report to
1336 the joint committee on health care financing and the senate and house committees on ways and
1337 means on the progress in realizing the purposes of this act, with particular attention to the
1338 following: (i) the capacity to exchange health information between and among components of
1339 the health system; (ii) rates of provider participation in electronic health records; (iii) rates of
1340 provider participation in practice resdesign; (iv) quality measurement and improvement; (v)

1341 healthcare cost reduction; (vi) participation in advanced programs such as medical home and

1342 P4P programs; and (vii) the security and privacy of health information technology supported by

1343 this section.

1344 SECTION 51. Section 7 shall take effect on January 1, 2015.

1345 SECTION 52. Sections 20 and 24 shall take effect on July 1, 2012.

1346 SECTION 53. Subsection (d) of section 61 of chapter 118E of the General Laws, as

1347 appearing in section 19, shall take effect on January 1, 2011.

1348 SECTION 54. Subsection (d) of section 5a of chapter 176O of the General Law, as

1349 appearing section 23, shall take effect on January 1, 2011.

1350 SECTION 55. Section 25 shall take effect on January 1, 2009.

1351 SECTION 56. Section 34 shall take effect on October 1, 2008.