S. 2863

Bill to promote cost containment, transparency and efficiency in the delivery of quality health care.

07/31/08 S Reported from the committee of conference on S2660
07/31/08 S Rules suspended
07/31/08 S Committee of conference report accepted - 37 YEAS to 0 NAYS (see Senate Roll Call, No. 404) -SJs 2419-2420
07/31/08 H Committee of conference report accepted -HJ 1934
07/31/08 H Emergency preamble adopted
07/31/08 S Emergency preamble adopted -SJ 2470
07/31/08 H Enacted -HJ 1958
08/01/08 S Enacted - 38 YEAS to 0 NAYS (see Senate Roll Call, No. 438) -SJ 2472
08/01/08 S Laid before the Governor -SJ 2477
08/10/08 G **Signed by the Governor, Chapter 305 of the Acts of 2008**

Senate, No. 2863

[Senate, July 31, 2008 - Report of the committee of conference on the disagreeing votes of the two branches, with reference to the House amendments to the Senate Bill promote cost containment, transparency and efficiency in the delivery of quality health care (Senate, No. 2660) (*amended by the House* by striking out the text and inserting in place thereof the text contained in House document numbered 4974, printed as amended.]

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 purposes, which is to expand forthwith access to health care for residents of the commonwealth, 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. Subsection (d) of section 38C of chapter 3 of the General Laws, as
2 appearing in the 2006 Official Edition, is hereby amended by striking out the third sentence and
3 inserting in place thereof the following sentence:- The division shall enter into interagency
4 agreements as necessary with the office of Medicaid, the group insurance commission, the
5 department of public health, the division of insurance, the health care quality and cost council,
6 and other state agencies holding utilization, cost or claims data relevant to the division's review
7 under this section.
8
9 SECTION 2. Section 16J of chapter 6A, as so appearing, is hereby amended by
inserting after the definition of "Physician Group Practice" the following definition:—

11 "Third party administrator", an entity that administers payments for health care services on
12 behalf of a client plan in exchange for an administrative fee.
13
14 SECTION 3. Chapter 6A of the General Laws is hereby amended by striking out
15 sections 16K, as so appearing, and 16L, as amended by section 1 of chapter 205 of the acts of
16 2007, and inserting in place thereof the following 2 sections:-
17 Section 16K. (a) There shall be established a health care quality and cost council
18 within, but not subject to control of, the executive office of health and human services. The
19 council shall promote public transparency of the quality and cost of health care in the
20 commonwealth, and shall seek to improve health care quality, reduce racial and ethnic health
21 disparities and contain health care costs by: (i) disseminating health care quality and cost data to
22 consumers, health care providers and insurers via a consumer health information website
23 pursuant to subsection (e) and (g); (ii) establishing quality improvement and cost containment
24 goals pursuant to subsection (h); and (iii) establishing standard performance measures, quality
25 performance benchmarks and statewide health information technology adoption goals for health
26 care providers and insurers pursuant to subsection (i).
27 (b) The council shall consist of 16 members and shall be comprised of: (i) 9 ex-officio
28 members, including the secretary of health and human services, who shall serve as the chair, the
29 secretary of administration and finance, the state auditor, the inspector general, the attorney
30 general, the commissioner of insurance, the commissioner of health care finance and policy, the
31 commissioner of public health, and the executive director of the group insurance commission, or
32 their designees; and (ii) 7 representatives of nongovernmental organizations be appointed by the
33 governor, including 1 representative of a health care quality improvement organization
34 recognized by the federal Centers for Medicare and Medicaid Services, 1 representative of the
35 Institute for Healthcare Improvement recommended by the organization's board of directors, 1
36 representative of the Massachusetts Chapter of the National Association of Insurance and
37 Financial Advisors, 1 representative of the Massachusetts Association of Health Underwriters,
38 Inc., 1 representative of the Massachusetts Medicaid Policy Institute, Inc., 1 expert in health
39 care policy from a foundation or academic institution, and 1 representative of a non-
40 governmental purchaser of health insurance. At least 1 member of the council shall be a
41 clinician licensed to practice in the commonwealth. Members of the council shall be appointed

42 for terms of 3 years or until a successor is appointed. Members shall be eligible to be
43 reappointed and shall serve without compensation, but may be reimbursed for actual and
44 necessary expenses reasonably incurred in the performance of their duties which may include
45 reimbursement for reasonable travel and living expenses while engaged in council business.
46 Chapter 268A shall apply to all council members; provided, however, that the council may
47 purchase from, sell to, borrow from, contract with or otherwise deal with any organization in
48 which any council member is in anyway interested or involved; provided further that such
49 interest or involvement is disclosed in advance to the council and recorded in the minutes of the
50 proceedings of the council; and provided further, that no council member having such interest or
51 involvement may participate in any decision relating to such organization.

52 (c) All meetings of the council shall be in compliance with chapter 30A, except that the
53 council, through its by-laws, may provide for executive sessions of the council. No action of
54 the council shall be taken in an executive session.

55 The council may, subject to chapter 30B and subject to appropriation, procure equipment,
56 office space, goods and services.

57 The council shall receive staff assistance from the executive office of health and human
58 services and may, subject to appropriation, appoint an executive director and employ such
59 additional staff or consultants as it deems necessary. The executive office shall provide
60 administrative support to the council as requested.

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

63 (d) The council shall disseminate the data it collects under this section to consumers,
64 health care providers and insurers through: (i) a publicly-accessible consumer health
65 information website; (ii) reports on performance provided to health care providers; and (iii) any
66 other analysis and reporting the council deems appropriate.

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

71 The council may, subject to chapter 30B, contract with an independent health care
72 organization for data collection, analysis or technical assistance related to its duties; provided,

73 however, that the organization has a history of demonstrating the skill and expertise necessary
74 to: (i) collect, analyze and aggregate data related to quality and cost across the health care
75 system; (ii) identify quality improvement areas through data analysis; (iii) work with Medicare,
76 MassHealth, and other insurers' data; (iv) collaborate in the design and implementation of
77 quality improvement and clinical performance measures; (v) establish and maintain security
78 measures necessary to maintain confidentiality and preserve the integrity of the data; and (vii)
79 identify and, when necessary, develop appropriate measures of quality and cost for public
80 reporting of quality and cost information.

81 Insurers and health care providers shall submit data to the council, to an independent
82 health care organization with which the council has contracted, or to the division of health care
83 finance and policy, as required by the council's regulations. The council, through its rules and
84 regulations, may determine what type of data may reasonably be required and the format in
85 which it shall be provided.

86 The council may request that third-party administrators submit data to the council, to an
87 independent health care organization with which the council has contracted, or to the division of
88 health care finance and policy. The council, through its rules and regulations, may determine
89 the format in which the data shall be provided. The council shall publicly post a list of third-
90 party administrators that refuse to submit requested data.

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

97 (e) The council shall, in consultation with the advisory committee established by section
98 16L, establish and maintain a consumer health information website. The website shall contain
99 information comparing the quality and cost of health care services and may also contain general
100 health care information as the council deems appropriate. The website shall be designed to
101 assist consumers in making informed decisions regarding their medical care and informed
102 choices among health care providers. Information shall be presented in a format that is

103 understandable to the average consumer. The council shall take appropriate action to publicize
104 the availability of its website.
105 The council shall, in consultation with its advisory committee, develop and adopt, on an
106 annual basis, a reporting plan specifying the quality and cost measures to be included on the
107 consumer health information website and the security measures used to maintain confidentiality
108 and preserve the integrity of the data. In developing the reporting plan, the council, to the
109 extent possible, shall collaborate with other organizations or state or federal agencies that
110 develop, collect and publicly report health care quality and cost measures and the council shall
111 give priority to those measures that are already available in the public domain. As part of the
112 reporting plan, the council shall determine for each service the comparative information to be
113 included on the consumer health information website, including whether to: (i) list services
114 separately or as part of a group of related services; or (ii) combine the cost information for each
115 facility and its affiliated clinicians and physician practices or to list facility and professional
116 costs separately.
117 The council shall, after due consideration and public hearing, adopt or reject the
118 reporting plan or any revisions. If the council rejects the reporting plan or any revisions, the
119 council shall state its reasons for the rejection. The reporting plan and any revisions adopted by
120 the council shall be promulgated by the council. The council shall submit the reporting plan and
121 any periodic revisions to the chairs of the house and senate committees on ways and means and
122 the chairs of the joint committee on health care financing and the clerks of the house and senate.
123 The website shall provide updated information on a regular basis, at least annually, and
124 additional comparative quality and cost information shall be published as determined by the
125 council, in consultation with the advisory committee. To the extent possible, the website shall
126 include: (i) comparative quality information by facility, clinician or physician group practice for
127 each service or category of service for which comparative cost information is provided; (ii)
128 general information related to each service or category of service for which comparative
129 information is provided; (iii) comparative quality information by facility, clinician or physician
130 practice that is not service-specific, including information related to patient safety and
131 satisfaction; and (iv) data concerning healthcare-acquired infections and serious reportable
132 events reported under section 51H of chapter 111.

133 (f) The council, through its rules and regulations, shall provide access to data it collects
134 pursuant to this section under conditions that: (i) protect patient privacy; (ii) prevent collusion
135 or anti-competitive conduct; and (iii) prevent the release of data that could reasonably be
136 expected to increase the cost of health care. The council may limit access to data based on its
137 proposed use, the credentials of the requesting party, the type of data requested or other criteria
138 required to make a determination regarding the appropriate release of the data. The council
139 shall also limit the requesting party's use and release of any data to which that party has been
140 given access by the council. The council shall provide the division of health care finance and
141 policy with a database of health care claims data submitted pursuant to this section under an
142 interagency service agreement for the purpose of conducting data analysis and preparing reports
143 to assist in the formulation of health care policy and the provision and purchase of health care
144 services.

145 Data collected by the council under this section shall not be a public record under clause
146 twenty-sixth of section 7 of chapter 4 or under chapter 66, except as specifically otherwise
147 provided by the council.

148 The council shall, through interagency service agreements, allow the use of its data by
149 other state agencies, including division of health care finance and policy, for review and
150 evaluation of mandated health benefit proposals as required by section 38C of chapter 3.

151 (g) The council, in consultation with its advisory committee, shall disseminate to health
152 care providers their individualized de-identified data, including comparisons with other health
153 care providers on the quality, cost and other data to be published on the consumer health
154 information website.

155 (h) The council, in consultation with its advisory committee, shall develop annual health
156 care quality improvement and cost containment goals. The goals shall be designed to promote
157 high-quality, safe, effective, timely, efficient, equitable and patient centered health care. The
158 council shall also establish goals that are intended to reduce racial and ethnic health care
159 disparities and in so doing shall seek to incorporate the recommendations of the health
160 disparities council and the office of health equity. For each goal, the council shall: identify the
161 steps needed to achieve the goal; estimate the cost of implementation; project the anticipated
162 short-term or long-term financial savings achievable by the health care providers, insurers or the
163 commonwealth: and estimate the expected improvements in the health status of health care

164 consumers in the commonwealth. The council may recommend legislation or regulatory
165 changes to achieve these goals.

166 (j) The council, in consultation with its advisory committee, relevant state agencies, and
167 public and private health care organizations, shall develop and annually publish: (i) standard
168 performance measures, including, common and consistent reporting of quality measures and
169 common use of measures used for pay-for-performance reimbursement; (ii) quality performance
170 benchmarks for health care providers and insurers that: (1) are clinically important, evidence-
171 based, standardized and timely; (2) include both process and outcome measures; (3) encourage
172 health care providers and insurers to improve health care quality; and (4) are developed based
173 on the work of national organizations, including the National Quality Forum and the Hospitals
174 Quality Alliance; and (iii) goals for statewide adoption of health information technology.

175 (k) The council shall conduct annual public hearings at which health care providers,
176 insurers, relevant state agencies, and public and private health care organizations shall report
177 their progress towards achieving the quality improvement and cost containment goals, adopting
178 the standard performance measures and meeting the quality performance benchmarks. The
179 council shall provide health care providers, insurers, state agencies and the general court with
180 the following, at least 60 days prior to the public hearings: (i) recommended action required by
181 each entity to achieve the specified quality and cost containment goals; and (ii)
182 recommendations for adoption of each standard performance measure, quality performance
183 benchmark and health information technology adoption goal established by the council.

184 (l) The council shall file a report, not less than annually, with the chairs of the house
185 and senate committees on ways and means and the chairs of the joint committee on health care
186 financing and the clerks of the house and senate on its progress in achieving the goals of
187 improving quality and containing or reducing health care costs data provided pursuant to
188 chapter 111N. The report shall include, at a minimum, a review of the progress towards
189 achieving the quality improvement and cost containment goals, adoption of standard
190 performance measures, meeting the quality performance benchmarks, and achieving the health
191 information technology adoption goals.

192 The council shall provide its advisory committee with reasonable opportunity to review
193 and comment on all reports before their public release.

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

195 Section 16L. (a) There shall be established an advisory committee to the health care
196 quality and cost council, established by section 16K, to allow the broadest possible involvement
197 of the health care industry and others concerned about health care quality and cost.
198 (b) The advisory committee shall consist of at least 29 members to be appointed by the
199 governor, 1 of whom shall be a representative of the Massachusetts Medical Society, 1 of whom
200 shall be a representative of the Massachusetts Hospital Association, Inc., 1 of whom shall be a
201 representative of the Massachusetts Association of Health Plans, Inc., 1 of whom shall be a
202 representative of Blue Cross Blue Shield of Massachusetts, Inc., 1 of whom shall be a
203 representative of the Massachusetts AFL-CIO Council, Inc., 1 of whom shall be a representative
204 of the Massachusetts League of Community Health Centers, Inc., 1 of whom shall be a
205 representative of Health Care For All, Inc., 1 of whom shall be a representative of the
206 Massachusetts Public Health Association, 1 of whom shall be a representative of the
207 Massachusetts Association of Behavioral Health Systems, Inc., 1 of whom shall be a
208 representative of the Massachusetts Extended Care Federation, Inc., 1 of whom shall be a
209 representative of the Massachusetts Council of Human Service Providers, Inc., 1 of whom shall
210 be a representative of the Home Care Alliance of Massachusetts, Inc., 1 of whom shall be a
211 representative of Associated Industries of Massachusetts, Inc., 1 of whom shall be a
212 representative of the Massachusetts Business Roundtable, Inc., 1 of whom shall be a
213 representative of the Massachusetts Taxpayers Foundation, 1 of whom shall be a representative
214 of the Massachusetts chapter of the National Federation of Independent Business, 1 of whom
215 shall be a representative of the Retailers Association of Massachusetts, 1 of whom shall be a
216 representative of the Massachusetts Biotechnology Council, Inc., 1 of whom shall be a
217 representative of the Blue Cross Blue Shield of Massachusetts Foundation, Inc., 1 of whom
218 shall be a representative of the Massachusetts chapter of the American Association of Retired
219 Persons, 1 of whom shall be a representative of the Massachusetts Coalition of Taft-Hartley
220 Trust Funds, Inc., and additional members including, but not limited to, a representative of the
221 mental health field, a representative of pediatric health care, a representative of primary health
222 care, a representative of medical education, a representative of racial or ethnic minority groups
223 concerned with health care, a representative of hospice care, a representative of the nursing
224 profession and a representative of the pharmaceutical field. Members of the advisory committee

225 shall be appointed for terms of 3 years or until a successor is appointed. Members shall be
226 eligible to be reappointed and shall serve without compensation.
227 (c) The members of the advisory committee shall annually elect a chair, vice chair and
228 secretary and may adopt by-laws governing the affairs of the advisory committee.
229 (d) The advisory committee shall have the following duties: (i) advise the council on the
230 consumer health information website and health care provider and insurer reports; (ii) advise the
231 council on the annual health care quality improvement and cost containment goals, transparency
232 standards and quality performance benchmarks; and (iii) review and comment on all reports of
233 the council before public release, including the annual reporting plan and any revisions and the
234 annual report to the general court.
235 (e) A written record of all meetings of the committee shall be maintained by the secretary
236 and a copy filed within 15 days after each meeting with the council.
237
238 SECTION 4. Chapter 40J of the General Laws is hereby amended by inserting after
239 section 6C the following 2 sections:-
240 Section 6D. (a) There shall be established an institute for health care innovation,
241 technology and competitiveness, to be known as the Massachusetts e-Health Institute. The
242 executive director of the corporation shall appoint a qualified individual to serve as the director
243 of the institute, who shall be an employee of the corporation, report to the executive director and
244 manage the affairs of the institute. The institute shall advance the dissemination of health
245 information technology across the commonwealth, including the deployment of electronic
246 health records systems in all health care provider settings that are networked through a
247 statewide health information exchange.
248 (b) There shall be established a health information technology council within the
249 corporation. The council shall advise the institute on the dissemination of health information
250 technology across commonwealth, including the deployment of electronic health records
251 systems in all health care provider settings that are networked through a statewide health
252 information exchange.
253 The council shall consist of 9 members, as follows: 1 shall be the secretary of health and
254 human services, who shall serve as the chair; 1 shall be the secretary of administration and
255 finance, or a designee; 1 shall be the executive director of the health care quality and cost

256 council; 1 shall be the director of the office of Medicaid; 5 shall be appointed by the governor,
257 of whom at least 1 shall be an expert in health information technology, 1 shall be an expert in
258 law and health policy, and 1 shall be an expert in health information privacy and security. The
259 council may consult with such parties, public or private, as it deems desirable in exercising its
260 duties under this section, including persons with expertise and experience the development and
261 dissemination of electronic health records systems, and the implementation of electronic health
262 record systems by small physician groups or ambulatory care providers, as well as persons
263 representing organizations within the commonwealth interested in and affected by the
264 development of networks and electronic health records systems, including, but not limited to,
265 persons representing local public health agencies, licensed hospitals and other licensed facilities
266 and providers, private purchasers, the medical and nursing professions, physicians, health
267 insurers and health plans, the state quality improvement organization, academic and research
268 institutions, consumer advisory organizations with expertise in health information technology
269 and other stakeholders as identified by the secretary of health and human services. Appointive
270 members of the council shall serve for terms of 2 years or until a successor is appointed.
271 Members shall be eligible to be reappointed and shall serve without compensation.

272 The members of the council shall be deemed to be directors for purposes of the fourth
273 paragraph of section 3. Chapter 268A shall apply to all council members except that the council
274 may purchase from, sell to, borrow from, contract with or otherwise deal with any organization
275 in which any council member is in anyway interested or involved; provided, however, that such
276 interest or involvement shall be disclosed in advance to the council and recorded in the minutes
277 of the proceedings of the council; and provided further, that no member shall be deemed to have
278 violated section 4 of said chapter 268A because of his receipt of his usual and regular
279 compensation from his employer during the time in which the member participates in the
280 activities of the council.

281 (c) The institute, in consultation with the council, shall advance the dissemination of
282 health information technology by: (i) facilitating the implementation and use of electronic
283 health records systems by health care providers in order to improve health care delivery and
284 coordination, reduce unwarranted treatment variation, eliminate wasteful paper-based processes,
285 help facilitate chronic disease management initiatives and establish transparency; (ii) facilitating
286 the creation and maintenance of a statewide interoperable electronic health records network that

287 allows individual health care providers in all health care settings to exchange patient health
288 information with other providers; and (iii) identifying and promoting an accelerated
289 dissemination in the commonwealth of emerging health care technologies that have been
290 developed and employed and that are expected to improve health care quality and lower health
291 care costs, but that have not been widely implemented in the commonwealth.

292 (d) The institute director shall prepare and annually update a statewide electronic health
293 records plan, and an annual update thereto. Each plan shall contain a budget for the application
294 of funds from the E-Health Institute Fund for use in implementing each such plan. The institute
295 director shall submit such plans and updates, and associated budgets, to the council for its
296 approval. Each such plan and the associated budget shall be subject to approval of the board
297 following action on it by the council.

298 Components of each such plan, as updated, shall be community-based implementation
299 plans that assess a municipality's or region's readiness to implement and use electronic health
300 record systems and an interoperable electronic health records network within the referral market
301 for a defined patient population. Each such implementation plan shall address the development,
302 implementation and dissemination of electronic health records systems among health care
303 providers in the community or region, particularly providers, such as community health centers
304 that serve underserved populations, including, but not limited to, racial, ethnic and linguistic
305 minorities, uninsured persons, and areas with a high proportion of public payer care.

306 Each plan as updated shall: (i) allow seamless, secure electronic exchange of health
307 information among health care providers, health plans and other authorized users; (ii) provide
308 consumers with secure, electronic access to their own health information; (iii) meet all
309 applicable federal and state privacy and security requirements, including requirements imposed
310 by 45 C.F.R. §§160, 162 and 164; (iv) meet standards for interoperability adopted by the
311 institute with the approval of the council; (v) give patients the option of allowing only
312 designated health care providers to disseminate their individually identifiable information; (vi)
313 provide public health reporting capability as required under state law; and (vii) allow reporting
314 of health information other than identifiable patient health information for purposes of such
315 activities as the secretary of health and human services may from time to time consider
316 necessary.

317 (e) The corporation may contract with implementing organizations to: (i) facilitate a
318 public-private partnership that includes representation from hospitals, physicians and other
319 health care professionals, health insurers, employers and other health care purchasers, health
320 data and service organizations, and consumer organizations; (ii) provide resources and support
321 to recipients of grants awarded under subsection (f) to implement each program within the
322 designated community pursuant to the implementation plan; (iii) certify and disburse funds to
323 subcontractors, when necessary; (iv) provide technical assistance to facilitate successful practice
324 redesign, adoption of electronic health records, and utilization of care management strategies;
325 (v) ensure that electronic health records systems are fully interoperable and secure and that
326 sensitive patient information is kept confidential by exclusively utilizing electronic health
327 records products that are certified by the Certification Commission for Healthcare Information
328 Technology; and (vi) certify, with approval of the corporation and the council, a group of
329 subcontractors who shall provide the necessary hardware and software for system
330 implementation. Prior to the institute's issuing requests for proposals for contracts to be entered
331 into pursuant to this section, the institute's director shall consult with the council with respect to
332 the content of all such proposals. All contracts with implementing organizations entered into by
333 the corporation must first be approved by the council.
334 (f) Funding for the institute and council's activities shall be through the E-Health
335 Institute Fund, established in section 6E. The institute, in consultation with the council, shall
336 develop mechanisms for funding health information technology, including a grant program to
337 assist health care providers with costs associated with health information technologies,
338 including electronic health records systems, and coordinated with other electronic health records
339 projects seeking federal reimbursement.
340 The institute shall consult with the office of Medicaid to maximize all opportunities to
341 qualify any expenditures for federal financial participation. Applications for funding shall be in
342 the form and manner determined by the institute director and the council, and shall include the
343 information and assurances required by the institute director and the council. The institute
344 director and the council may consider, as a condition for awarding grants, the grantee's financial
345 participation and any other factors it deems relevant.
346 All grants shall be recommended by the institute director and subsequently approved by both
347 the executive director and the council. The institute director shall work with implementation

348 organizations to oversee the grant-making process as it relates to an implementing
349 organization's responsibilities under its contract with the corporation. Each recipient of monies
350 from this program shall: (i) capture and report certain quality improvement data, as determined
351 by the institute in consultation with the health care quality and cost council; (ii) implement the
352 system fully, including all clinical features, not later than the second year of the grant; and (iii)
353 make use of the system's full range of features.

354 (g) The council shall receive staff assistance from the corporation.

355 (h) The institute shall file an annual report, not later than January 30, with the joint
356 committee on health care financing, the joint committee on economic development and
357 emerging technologies, and the house and senate committees on ways and means concerning the
358 activities of the council in general and, in particular, describing the progress to date in
359 implementing a statewide electronic health records system and recommending such further
360 legislative action as it deems appropriate.

361 Section 6E. There shall be established and set up on the books of the corporation the E-
362 Health Institute Fund, hereinafter referred to as the fund, for the purpose of supporting the
363 advancement of health information technology in the commonwealth, including, but not limited
364 to, the full deployment of electronic health records. There shall be credited to the fund any
365 appropriations, proceeds of any bonds or notes of the commonwealth issued for the purpose, or
366 other monies authorized by the general court and designated thereto; any federal grants or loans;
367 any private gifts, grants or donations made available; and any income derived from the
368 investment of amounts credited to the fund. The director of the institute shall seek, to the
369 greatest extent possible, private gifts, grants and donations to the fund. The corporation shall
370 hold the fund in an account or accounts separate from other funds. The fund shall be
371 administered by the executive director without further appropriation; provided, however, that
372 any disbursement or expenditure from the fund for grants or for contracts with implementing
373 organizations, as provided in section 6D, shall be approved by the health information
374 technology council established under said section 6D. Amounts credited to the fund shall be
375 available for reasonable expenditure by the corporation, subject to the approval of the health
376 information technology council where such approval is required under this chapter, for such
377 purposes as the corporation determines are necessary to support the dissemination and
378 development of health information technology in the commonwealth, including, but not limited

379 to, for the grant program established in said section 6D and for contracts with implementing
380 organizations provided for in said section 6D. .
381 Section 6F. Any plan approved by the board and every grantee and implementing
382 organization that receives monies for the adoption of health information technology shall:
383 (1) establish a mechanism to allow patients to opt-in to the health information network
384 and to opt-out at any time;
385 (2) maintain identifiable health information in physically and technologically secure
386 environments by means including, but not limited to: prohibiting the storage or transfer of
387 unencrypted and non-password protected identifiable health information on portable data
388 storage devices; requiring data encryption, unique alpha-numerical identifiers and password
389 protection; and other methods to prevent unauthorized access to identifiable health information;
390 (3) provide individuals the option of, upon request, obtaining a list of individuals and entities
391 that have accessed their identifiable health information; and
392 (4) develop and distribute to authorized users of the health information network and to
393 prospective network participants, written guidelines addressing privacy, confidentiality and
394 security of health information and inform individuals of what information about them is
395 available, who may access their information, and the purposes for which their information may
396 be accessed.
397 Section 6G. In the event of an unauthorized access to or disclosure of individually
398 identifiable patient health information by or through the statewide health information network
399 or by or through any technology grantees or implementing organizations funded in whole or in
400 part from the E-Health Institute Fund established pursuant to section 6E, the operator of such
401 network or grantee or contractor shall: (i) report the conditions of such unauthorized access or
402 disclosure as required by the Massachusetts e-Health Institute; and (ii) provide notice, as
403 defined in section 1 of chapter 93H, as soon as practicable, but not later than 10 business days
404 after such unauthorized access or disclosure, to any person whose patient health information
405 may have been compromised as a result of such unauthorized access or disclosure, and shall
406 report the conditions of such unauthorized access or disclosure.
407
408 SECTION 5 Chapter 111 of the General Laws is hereby amended by inserting after
409 section 4M the following section:—

410 Section 4N. (a) The department shall, in cooperation with Commonwealth Medicine at
411 the University of Massachusetts medical school, develop, implement and promote an evidence-
412 based outreach and education program about the therapeutic and cost-effective utilization of
413 prescription drugs for physicians, pharmacists and other health care professionals authorized to
414 prescribe and dispense prescription drugs. In developing the program, the department shall
415 consult with physicians, pharmacists, private insurers, hospitals, pharmacy benefit managers,
416 the MassHealth drug utilization review board and the University of Massachusetts medical
417 school.
418 (b) The program shall arrange for physicians, pharmacists and nurses under contract
419 with the department to conduct face-to-face visits with prescribers, utilizing evidence-based
420 materials and borrowing methods from behavioral science, educational theory and, where
421 appropriate, pharmaceutical industry data and outreach techniques; provided, however, that to
422 the extent possible, the program shall inform prescribers about drug marketing that is intended
423 to circumvent competition from generic or other therapeutically-equivalent pharmaceutical
424 alternatives or other evidence-based treatment options.
425 The program shall include outreach to: physicians and other health care practitioners
426 who participate in MassHealth, the subsidized catastrophic prescription drug insurance program
427 authorized in section 39 of chapter 19A or the commonwealth care health insurance program;
428 other publicly-funded, contracted or subsidized health care programs; academic medical centers;
429 and other prescribers.
430 The department shall, to the extent possible, utilize or incorporate into its program other
431 independent educational resources or models proven effective in promoting high quality,
432 evidenced-based, cost-effective information regarding the effectiveness and safety of
433 prescription drugs, including, but not limited to: (i) the Pennsylvania PACE/Harvard University
434 Independent Drug Information Service; (ii) the Academic Detailing Program of the University
435 of Vermont College of Medicine Area Health Education Centers; (iii) the Oregon Health and
436 Science University Evidence-based Practice Center's Drug Effectiveness Review project; and
437 (iv) the North Carolina evidence-based peer-to-peer education program outreach program.
438 (c) The department may establish and collect fees for subscriptions and contracts with
439 private payers. The department may seek funding from nongovernmental health access

440 foundations and undesignated drug litigation settlement funds associated with pharmaceutical
441 marketing and pricing practices.
442
443 SECTION 6. Section 25B of said chapter 111, as appearing in the 2006 Official Edition,
444 is hereby amended by striking out the definition of "Expenditure minimum with respect to
445 substantial capital expenditures."
446
447 SECTION 7. Said section 25B of said chapter 111, as so appearing, is hereby further
448 amended by inserting after the definition of "Department" the following definitions:
449 "Expenditure minimum with respect to substantial capital expenditures", with respect to
450 expenditures and acquisitions made by or for: (1) acute care hospitals and comprehensive cancer
451 centers as defined in section 1 of chapter 118G, only, $7,500,000, except that expenditures for,
452 or the acquisition of, major movable equipment not otherwise defined by the department as new
453 technology or innovative services shall not require a determination of need and shall not be
454 included in the calculation of the expenditure minimum; and (2) health care facilities, other than
455 acute care hospitals, and facilities subject to licensing under chapter 111B, with respect to: (a)
456 expenditures for, or the acquisition of, medical, diagnostic or therapeutic equipment, $400,000;
457 and (b) all other expenditures and acquisitions, eight $800,000; provided, however, that
458 expenditures for, or the acquisition of, any replacement of medical, diagnostic or therapeutic
459 equipment defined as new technology or innovative services for which a determination of need
460 has issued or which was exempt from determination of need, shall not require a determination
461 of need and shall not be included in the calculation of the expenditure minimum; provided
462 further, that expenditures and acquisitions concerned solely with outpatient services other than
463 ambulatory surgery, not otherwise defined as new technology or innovative services by the
464 department, shall not require a determination of need and shall not be included in the calculation
465 of the expenditure minimum, unless the expenditures and acquisitions are at lease $25,000,000,
466 in which case a determination of need shall be required. Notwithstanding the above limitations,
467 acute care hospitals only may elect at their option to apply for determination of need for
468 expenditures and acquisitions less than the expenditure minimum.
469

470 SECTION 8 Said chapter 111 is hereby further amended by inserting after section 25K
471 the following 3 sections:—
472 Section 25L. (a) There shall be in the department a health care workforce center to
473 improve access to health care services. The center, in consultation with the health care
474 workforce advisory council established by section 25M and the commissioner of labor and
475 workforce development, shall: (i) coordinate the department's health care workforce activities
476 with other state agencies and public and private entities involved in health care workforce
477 training, recruitment and retention; (ii) monitor trends in access to primary care providers, nurse
478 practitioners practicing as primary care providers, and other physician and nursing providers,
479 through activities including: (1) review of existing data and collection of new data as needed to
480 assess the capacity of the health care workforce to serve patients, including patient access and
481 regional disparities in access to physicians or nurses and to examine physician and nursing
482 satisfaction; (2) review existing laws, regulations, policies, contracting or reimbursement
483 practices, and other factors that influence recruitment and retention of physicians and nurses; (3)
484 making projections on the ability of the workforce to meet the needs of patients over time; (4)
485 identifying strategies currently being employed to address workforce needs, shortages,
486 recruitment and retention; (5) studying the capacity of public and private medical and nursing
487 schools in the commonwealth to expand the supply of primary care physicians and nurse
488 practitioners practicing as primary care providers; (iii) establish criteria to identify underserved
489 areas in the commonwealth for administering the loan repayment program established under
490 section 25N and for determining statewide target areas for health care provider placement based
491 on the level of access; and (iv) address health care workforce shortages through the following
492 activities, including: (1) coordinating state and federal loan repayment and incentive programs
493 for health care providers; (2) providing assistance and support to communities, physician
494 groups, community health centers and community hospitals in developing cost-effective and
495 comprehensive recruitment initiatives; (3) maximizing all sources of public and private funds
496 for recruitment initiatives; (4) designing pilot programs and make regulatory and legislative
497 proposals to address workforce needs, shortages, recruitment and retention; and (5) making
498 short-term and long-term programmatic and policy recommendations to improve workforce
499 performance, address identified workforce shortages and recruit and retain physicians and
500 nurses.

501 (c) The center shall maintain ongoing communication and coordination with the health
502 care quality and cost council, established by section 16K of chapter 6A, and the health
503 disparities council, established by section 16O of said chapter 6A.
504 (d) The center shall annually submit a report, not later than March 1, to the governor; the
505 health care quality and cost council established by section 16K of chapter 6A, the health
506 disparities council established by section 16O of chapter 6A; and the general court, by filing the
507 report with the clerk of the house of representatives, the clerk of the senate, the joint committee
508 on labor and workforce development, the joint committee on health care financing, and the joint
509 committee on public health. The report shall include: (i) data on patient access and regional
510 disparities in access to physicians, by specialty and sub-specialty, and nurses; (ii) data on factors
511 influencing recruitment and retention of physicians and nurses; (iii) short and long-term
512 projections of physician and nurse supply and demand; (iv) strategies being employed by the
513 council or other entities to address workforce needs, shortages, recruitment and retention; (v)
514 recommendations for designing, implementing and improving programs or policies to address
515 workforce needs, shortages, recruitment and retention; and (vi) proposals for statutory or
516 regulatory changes to address workforce needs, shortages, recruitment and retention.
517 Section 25M. (a) There shall be a healthcare workforce advisory council within, but not
518 subject to the control of, the health care workforce center established by section 25L. The
519 council shall advise the center on the capacity of the healthcare workforce to provide timely,
520 effective, culturally competent, quality physician and nursing services.
521 (b) The council shall consist of 16 members who shall be appointed by the governor: 1
522 of whom shall be a representative of the Massachusetts Extended Care Federation; 1 of whom
523 shall be a physician with a primary care specialty designation who practices in a rural area; 1 of
524 whom shall be a physician with a primary care specialty who practices in an urban area; 1 of
525 whom shall be a physician with a medical subspecialty; 1 of whom shall be an advanced
526 practice nurse, authorized under section 80B of said chapter 112, who practices in a rural area; 1
527 of whom shall be an advanced practice nurse, authorized under section said 80B of said chapter
528 112, who practices in an urban area; 1 of whom shall be a representative of the Massachusetts
529 Organization of Nurse Executives; 1 of whom shall be a representative of the Massachusetts
530 Academy of Family Physicians; 1 of whom shall be a representative of the Massachusetts
531 Workforce Board Association; 1 of whom shall be a representative of the Massachusetts League

532 of Community Health Centers, Inc.; 1 of whom shall be a representative of the Massachusetts
533 Medical Society; 1 of whom shall be a representative of the Massachusetts Center for Nursing,
534 Inc.; 1 of whom shall be a representative of the Massachusetts Nurses Association; 1 of whom
535 shall be a representative of the Massachusetts Association of Registered Nurses; 1 of whom
536 shall be a representative of the Massachusetts Hospital Association, Inc.; and 1 of whom shall
537 be a representative of Health Care For All, Inc. Members of the council shall be appointed for
538 terms of 3 years or until a successor is appointed. Members shall be eligible to be reappointed
539 and shall serve without compensation, but may be reimbursed for actual and necessary expenses
540 reasonably incurred in the performance of their duties. Vacancies of unexpired terms shall be
541 filled within 60 days by the appropriate appointing authority.

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

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

546 (c) The council shall advise the center on: (i) trends in access to primary care and
547 physician subspecialties and nursing services; (ii) the development and administration of the
548 loan repayment program, established under section 25N, including criteria to identify
549 underserved areas in the commonwealth; (iii) solutions to address identified health care
550 workforces shortages; and (iv) the center's annual report to the general court.

551 Section 25N. (a) There shall be a health care workforce loan repayment program,
552 administered by the health care workforce center established by section 25L. The program shall
553 provide repayment assistance for medical school loans to participants who: (i) are graduates of
554 medical or nursing schools; (ii) specialize in family health or medicine, internal medicine,
555 pediatrics, psychiatry, or obstetrics/gynecology; (iii) demonstrate competency in health
556 information technology, including use of electronic medical records, computerized physician
557 order entry and e-prescribing; and (iv) meet other eligibility criteria, including service
558 requirements, established by the board. Each recipient shall be required to enter into a contract
559 with the commonwealth which shall obligate the recipient to perform a term of service of no
560 less than 2 years in medically underserved areas as determined by the center.

561 (b) The center shall promulgate regulations for the administration and enforcement of this
562 section which shall include penalties and repayment procedures if a participant fails to comply
563 with the service contract.
564 The center shall, in consultation with the health care workforce advisory council and the
565 public health council, establish criteria to identify medically underserved areas within the
566 commonwealth. These criteria shall consist of quantifiable measures, which may include the
567 availability of primary care medical services within reasonable traveling distance, poverty
568 levels, and disparities in health care access or health outcomes.
569 (c) The center shall evaluate the program annually, including exit interviews of participants
570 to determine their post-program service plans and to solicit program improvement
571 recommendations.
572 (d) The center shall, not later than July 1, file an annual report with the governor, the clerk of
573 the house of representatives, the clerk of the senate, the house committee on ways and means,
574 the senate committee ways and means, the joint committee on health care financing, the joint
575 committee on mental health and substance abuse and the joint committee on public health. The
576 report shall include annual data and historical trends of: (i) the number of applicants, the
577 number accepted, and the number of participants by race, gender, medical or nursing specialty,
578 medical or nursing school, residence prior to medical or nursing school, and where they plan to
579 practice after program completion; (ii) the service placement locations and length of service
580 commitments by participants; (iii) the number of participants who fail to fulfill the program
581 requirements and the reason for the failures; (iv) the number of former participants who
582 continue to serve in underserved areas; and (v) program expenditures.
583
584 SECTION 9 Said chapter 111 is hereby further amended by inserting after section 51G
585 the following section:
586 Section 51H. (a) As used in this section the following words shall, unless the context
587 clearly requires otherwise, have the following meanings:-
588 "Facility", a hospital, institution for the care of unwed mothers or clinic providing
589 ambulatory surgery as defined by section 25.
590 "Healthcare-associated infection", a localized or systemic condition that results from an
591 adverse reaction to the presence of an infectious agent or its toxins that: (i) occurs in a patient in

592 a facility, (ii) was not present or incubating at the time of the admission during which the
593 reaction occurs, and (iii) if occurring in a hospital, meets the criteria for a specific infection site
594 as defined by the federal Centers for Disease Control and Prevention and its national health care
595 safety network.
596 "Serious reportable event", an event that results in a serious adverse patient outcome that
597 is clearly identifiable and measurable, reasonably preventable, and that meets any other criteria
598 established by the department in regulations.
599 (b) A facility shall report data and information about healthcare-associated infections and
600 serious reportable events. A serious reportable event shall be reported by a facility no later than
601 15 working days after its discovery. Reports shall be made in the manner and form established
602 by the department in its regulations. The department may require facilities to register in and
603 report to nationally recognized quality and safety organizations.
604 (c) The department shall, through interagency service agreements, transmit data
605 collected under this section to the Betsy Lehman center for patient safety and medical error
606 reduction and to the health care quality and cost council for publication on its consumer health
607 information website. Any facility failing to comply with this section may: (i) be fined up to
608 $1,000 per day per violation; (ii) have its license revoked or suspended by the department; or
609 (iii) be fined up to $1,000 per day per violation and have its license revoked or suspended by the
610 department.
611 (d) The department shall promulgate regulations prohibiting a health care facility from
612 charging or seeking reimbursement for services provided as a result of the occurrence of a
613 serious reportable event. A health care facility shall not charge or seek reimbursement for a
614 serious reportable event that the facility has determined, through a documented review process,
615 and under regulations promulgated by the department, was (i) preventable; (ii) within its
616 control; and (iii) unambiguously the result of a system failure based on the health care
617 provider's policies and procedures.
618
619 SECTION 10 Said chapter 111 is hereby further amended by inserting after section 51G
620 the following section:-
621 Section 51H. (a) As used in this section the following words shall, unless the context
622 clearly requires otherwise, have the following meanings:

623 "Facility", a hospital, institution for the care of unwed mothers or clinic providing
624 ambulatory surgery as defined by section 25.
625 "Healthcare-associated infection", a localized or systemic condition that results from an
626 adverse reaction to the presence of an infectious agent or its toxins that: (i) occurs in a patient in
627 a facility, (ii) was not present or incubating at the time of the admission during which the
628 reaction occurs, and (iii) if occurring in a hospital, meets the criteria for a specific infection site
629 as defined by the federal Centers for Disease Control and Prevention and its national health care
630 safety network.
631 "Serious adverse drug event", any preventable event that causes inappropriate
632 medication use in a hospital or ambulatory surgical center that leads to harm to a patient, as
633 further defined in regulations of the department.
634 "Serious reportable event", an event that results in a serious adverse patient outcome that is
635 clearly identifiable and measurable, reasonably preventable, and that meets any other criteria
636 established by the department in regulations.
637 (b) A facility shall report data and information about healthcare-associated infections,
638 serious reportable events, and serious adverse drug events. A serious reportable event shall be
639 reported by a facility no later than 15 working days after its discovery. Reports shall be made in
640 the manner and form established by the department in its regulations. The department may
641 require facilities to register in and report to nationally recognized quality and safety
642 organizations.
643 (c) The department, through interagency service agreements, shall transmit data
644 collected under this section to the Betsy Lehman center for patient safety and medical error
645 reduction and to the health care quality and cost council for publication on its consumer health
646 information website. Any facility failing to comply with this section may: (i) be fined up to
647 $1,000 per day per violation; (ii) have its license revoked or suspended by the department; or
648 (iii) be fined up to $1,000 per day per violation and have its license revoked or suspended by the
649 department.
650 (d) The department shall promulgate regulations prohibiting a health care facility from
651 charging or seeking reimbursement for services provided as a result of the occurrence of a
652 serious reportable event. A health care facility shall not charge or seek reimbursement for a
653 serious reportable event that the facility has determined, through a documented review process,

654 and under regulations promulgated by the department, was (i) preventable; (ii) within its
655 control; and (iii) unambiguously the result of a system failure based on the health care
656 provider's policies and procedures.
657
658 SECTION 11 Said chapter 111 is hereby further amended by inserting after section 53D
659 the following 3 sections:-
660 Section 53E. The department shall promulgate regulations for the establishment of a
661 patient and family advisory council at each hospital in the commonwealth. The council shall
662 advise the hospital on matters including, but not limited to, patient and provider relationships,
663 institutional review boards, quality improvement initiatives and patient education on safety and
664 quality matters. Members of a council may act as reviewers of publicly reported quality
665 information, members of task forces, members of awards committees for patient safety
666 activities, members of advisory boards, participants on search committees and in the hiring of
667 new staff, and may act as co-trainers for clinical and nonclinical staff, in-service programs, and
668 health professional trainees or as participants in reward and recognition programs.
669 Section 53F. The department shall require acute care hospitals to have a suitable method
670 for health care staff members, patients and families to request additional assistance directly
671 from a specially-trained individual if the patient's condition appears to be deteriorating. The
672 acute care hospital shall have an early recognition and response method most suitable for the
673 hospital's needs and resources, such as a rapid response team. The method shall be available 24
674 hours per day.
675 Section 53G. Any entity that is certified or seeking certification as an ambulatory
676 surgical center by the Centers for Medicare and Medicaid Services for participation in the
677 Medicare program shall be a clinic for the purpose of licensure under section 51, and shall be
678 deemed to be in compliance with the conditions for licensure as a clinic under said section 51 if
679 it is accredited to provide ambulatory surgery services by the Accreditation Association for
680 Ambulatory Health Care, Inc., the Joint Commission on Accreditation of Healthcare
681 Organizations, the American Association for Accreditation of Ambulatory Surgery Facilities or
682 any other national accrediting body that the department determines provides reasonable
683 assurances that such conditions are met. No original license shall be issued pursuant to said
684 section 51 to establish any such ambulatory surgical clinic unless there is a determination by the

685 department that there is a need for such a facility. For purposes of this section, "clinic" shall not
686 include a clinic conducted by a hospital licensed under said section 51 or by the federal
687 government or the commonwealth. The department shall promulgate regulations to implement
688 this section.
689
690 SECTION 12 The first paragraph of section 70 of said chapter 111, as appearing in the
691 2006 Official Edition, is hereby amended by striking out the second and third sentences and
692 inserting in place thereof the following 4 sentences:- These records may be handwritten,
693 printed, typed or in electronic digital media or converted to electronic digital media as originally
694 created by such hospital or clinic, by the photographic or microphotographic process, or any
695 combination thereof. The hospital or clinic may destroy records only after the applicable
696 retention period has elapsed and after notifying the department of public health, in accordance
697 with its regulations, that the records will be destroyed. The department, through its regulations,
698 shall establish an appropriate notification process. On the notice of privacy practices distributed
699 to its patients, a hospital or clinic shall provide: (i) information concerning the provisions of this
700 section and (ii) the hospital or clinic's records termination policy.
701
702 SECTION 13 Said section 70 of said chapter 111, as so appearing, is hereby further
703 amended by striking out, in line 66, the word "thirty" and inserting in place thereof the
704 following figure:- 20
705
706 SECTION 14 The General Laws are hereby amended by inserting after Chapter 111M
707 the following chapter:--
708
709 CHAPTER 111N
710 PHARMACEUTICAL AND MEDICAL DEVICE MANUFACTURER CONDUCT
711
712 Section 1. As used in this chapter, the following words shall have the following
713 meanings:-
714 "Department", the department of public health.

715 "Health care practitioner", a person who prescribes prescription drugs for any person
716 and is licensed to provide health care, or a partnership or corporation comprised of such
717 persons, or an officer, employee, agent or contractor of such person acting in the course and
718 scope of his employment, agency or contract related to or in support of the provision of health
719 care to individuals.
720 "Marketing code of conduct" practices and standards that govern the marketing and sale
721 of prescription drugs or medical devices by a pharmaceutical or medical device manufacturing
722 company to health care practitioners.
723 "Medical device", an instrument, apparatus, implement, machine, contrivance, implant,
724 in vitro reagent or other similar or related article, including any component, part or accessory,
725 which is: (1) recognized in the official National Formulary or the United States Pharmacopeia
726 or any supplement thereto; (2) intended for use in the diagnosis of disease or other conditions or
727 in the cure, mitigation, treatment or prevention of disease, in persons or animals; or (3) intended
728 to affect the structure or function of the body of a person or animal, and which does not achieve
729 its primary intended purposes through chemical action within or on such body and which is not
730 dependent upon being metabolized for the achievement of its primary intended purposes.
731 "Person", a business, individual, corporation, union, association, firm, partnership,
732 committee or other organization.
733 "Pharmaceutical or medical device manufacturer agent", a pharmaceutical or medical
734 device marketer or any other person who for compensation or reward does any act to promote,
735 oppose or influence the prescribing of a particular prescription drug, medical device, or category
736 of prescription drugs or medical devices; provided, however, that "pharmaceutical or medical
737 device manufacturer agent" shall not include a licensed pharmacist, licensed physician or any
738 other licensed health care practitioner with authority to prescribe prescription drugs who is
739 acting within the ordinary scope of the practice for which he is licensed.
740 "Pharmaceutical or medical device manufacturing company", any entity that
741 participates in a commonwealth health care program and which is engaged in the production,
742 preparation, propagation, compounding, conversion or processing of prescription drugs or
743 medical devices, either directly or indirectly, by extraction from substances of natural origin, or
744 independently by means of chemical synthesis or by a combination of extraction and chemical
745 synthesis, or any entity engaged in the packaging, repackaging, labeling, relabeling or

746 distribution of prescription drugs; provided, however, that "pharmaceutical or medical device
747 manufacturing company" shall not include a wholesale drug distributor licensed under section
748 36A of chapter 112 or a retail pharmacist registered under section 37 of said chapter 112.
749 "Pharmaceutical or medical device marketer", a person who, while employed by or
750 under contract with a pharmaceutical or medical device manufacturing company that
751 participates in a commonwealth health care program, engages in detailing, promotional
752 activities or other marketing of prescription drugs or medical devices in the commonwealth to
753 any physician, hospital, nursing home, pharmacist, health benefits plan administrator, other
754 health care practitioner or person authorized to prescribe, dispense or purchase prescription
755 drugs; provided, however, that the "pharmaceutical or medical device marketer" shall not
756 include a wholesale drug distributor licensed under section 36A of chapter 112, a representative
757 of such a distributor who promotes or otherwise markets the services of the wholesale drug
758 distributor in connection with a prescription drug or a retail pharmacist registered under section
759 37 of said chapter 112 if such person is not engaging in such practices under contract with a
760 manufacturing company.
761 "Physician", a person licensed to practice medicine by the board of registration in
762 medicine under section 2 of chapter 112 who prescribes prescription drugs, or the physician's
763 employees or agents.
764 "Prescription drugs", drugs upon which the manufacturer or distributor has placed or is
765 required by federal law and regulations to place the following or a comparable warning:
766 "Caution federal law prohibits dispensing without prescription".
767 Section 2. Notwithstanding any general or special law to the contrary, the department
768 shall adopt a standard marketing code of conduct for all pharmaceutical or medical device
769 manufacturing companies that employ a person to sell or market prescription drugs or medical
770 devices in the commonwealth. The marketing code of conduct shall be based on applicable
771 legal standards and incorporate principles of health care including, without limitation,
772 requirements that the activities of the pharmaceutical or medical device manufacturer agents be
773 intended to benefit patients, enhance the practice of medicine and not interfere with the
774 independent judgment of health care practitioners. In promulgating regulations for a marketing
775 code of conduct, the department adopt regulations that shall be no less restrictive than the most
776 recent version of the Code on Interactions with Healthcare Professionals developed by the

777 Pharmaceutical Research and Manufacturers of America and the Code on Interactions with
778 Healthcare Professionals developed by the Advanced Medical Technology Association.
779 The marketing code of conduct adopted by the department shall not allow:
780 (1) the provision of or payment for meals for health care practitioners that:
781 (a) are part of an entertainment or recreational event;
782 (b) are offered without an informational presentation made by pharmaceutical marketing
783 agent or without the pharmaceutical marketing agent being present;
784 (c) are offered, consumed, or provided outside of the health care practitioner's office or
785 hospital setting; or
786 (d) are provided to a healthcare practitioner's spouse or other guest;
787 (2) the provision or payment of entertainment or recreational items of any value,
788 including, but not limited to, tickets to the theater or sporting events, sporting equipment, or
789 leisure or vacation trips, to any health care practitioner who is not a salaried employee of the
790 company;
791 (3) sponsorship or payment for continuing medical education, in this section referred to
792 as CME, also known as independent medical education, that does not meet the Accreditation
793 Council for Continuing Medical Education Standards For Commercial Support, or that provides
794 payment directly to a health care practitioner;
795 (4) financial support for the costs of travel, lodging or other personal expenses of non-
796 faculty healthcare practitioners attending any CME event, third-party scientific or educational
797 conference, or professional meetings, either directly to the individuals participating in the event
798 or indirectly to the event's sponsor, except in cases as determined by the department.
799 (5) funding to compensate for the time spent by health care practitioners participating in
800 any CME event, third-party scientific or educational conferences, or professional meetings;
801 (6) the provision of or payment for meals directly at any CME event, third-party
802 scientific or educational conferences, or professional meetings;
803 (7) payments in cash or cash equivalents to healthcare practitioners either directly or
804 indirectly, except as compensation for bona fide services;
805 (8) any grants, scholarships, subsidies, support, consulting contracts, or educational or
806 practice related items to a healthcare practitioner in exchange for prescribing prescription drugs

807 or using medical devices or for a commitment to continue prescribing prescription drugs or
808 using medical devices.
809 The marketing code of conduct adopted by the department shall allow:
810 (1) the provision, distribution, dissemination or receipt of peer reviewed academic,
811 scientific or clinical information;
812 (2) the purchase of advertising in peer reviewed academic, scientific or clinical journals;
813 (3) prescription drugs provided to a health care practitioner solely and exclusively for
814 use by the health care practitioner's patients;
815 (4) compensation for the substantial professional or consulting services of a health care
816 practitioner in connection with a genuine research project or a clinical trial;
817 (5) payment for reasonable expenses necessary for technical training on the use of a
818 medical device if that expense is part of the vendor's purchase contract for the device.
819 The department shall update the marketing code of conduct no less than every two years.
820 The department may promulgate regulations or other guidelines as necessary to implement this
821 section.
822 Section 3. No pharmaceutical or medical device manufacturer company or
823 pharmaceutical or medical device manufacturer agent shall knowingly and willfully violate the
824 marketing code of conduct as adopted by the department.
825 Section 4. (a) A pharmaceutical or medical device manufacturing company that
826 employs a person to sell or market a drug, medicine, or medical device in the commonwealth
827 shall adopt and comply with the most recent marketing code of conduct as adopted by the
828 department.
829 (b) A pharmaceutical or medical device manufacturing company that employs a person
830 to sell or market prescription drugs or medical devices in the commonwealth shall adopt a
831 training program to provide regular training to appropriate employees including, without
832 limitation, all sales and marketing staff, on the marketing code of conduct.
833 (c) A pharmaceutical or medical device manufacturing company that employs a person
834 to sell or market prescription drugs or medical devices in the commonwealth shall conduct
835 annual audits to monitor compliance with the marketing code of conduct.
836 (d) A pharmaceutical or medical device manufacturing company that employs a person
837 to sell or market a prescription drugs or medical devices in the commonwealth shall adopt

838 policies and procedures for investigating instances of noncompliance with the marketing code
839 of conduct and take corrective action in response to noncompliance and the reporting of
840 instances of noncompliance to the appropriate state authorities.
841 (e) A pharmaceutical or medical device manufacturing company that employs a person
842 to sell or market prescription drugs or medical devices in the commonwealth shall identify a
843 compliance officer responsible for operating and monitoring the marketing code of conduct.
844 Section 5. A pharmaceutical or medical device manufacturing company that employs a
845 person to sell or market prescription drugs or medical devices in the commonwealth shall
846 annually submit to the department: (i) a description of its training program; (ii) a description of
847 its investigation policies; (iii) the name, title, address, telephone number and electronic mail
848 address of its compliance officer; and (iv) certification that it has conducted its annual audit and
849 is in compliance with the marketing code of conduct.
850 Section 6. (1) By July 1 of each year, every pharmaceutical or medical device
851 manufacturing company that employs a person to sell or market a drug, medicine, chemical,
852 device or appliance in the commonwealth shall disclose to the department of public health the
853 value, nature, purpose and particular recipient of any fee, payment, subsidy or other economic
854 benefit with a value of at least $50, which the company provides, directly or through its agents,
855 to any physician, hospital, nursing home, pharmacist, health benefit plan administrator, health
856 care practitioner or other person in the commonwealth authorized to prescribe, dispense, or
857 purchase prescription drugs or medical devices in the commonwealth. The disclosure shall be
858 accompanied by the payment of a fee, to be determined by the department, to pay the costs of
859 administering this section.
860 (2) The department of public health shall make all disclosed data publicly available and
861 easily searchable on its website.
862 (3) The department of public health shall report to the attorney general any payment,
863 entertainment, meals, travel, honorarium, subscription, advance, services or anything of value
864 provided in violation of the market code of conduct as adopted by the department of public
865 health.
866 Section 7. This chapter shall be enforced by the attorney general, the district attorney
867 with jurisdiction over a violation or the department of public health. A person that violates this

868 chapter shall be punished by a fine of not more than $5,000 for each transaction, occurrence or
869 event that violates this chapter.
870
871 SECTION 15 The first paragraph of section 2 of chapter 112 of the General Laws, as
872 appearing in the 2006 Official Edition, is hereby amended by inserting the following after the
873 second sentence of the first paragraph:- The board shall require, as a standard of eligibility for
874 licensure, that applicants show a predetermined level of competency in the use of computerized
875 physician order entry, e-prescribing, electronic health records and other forms of health
876 information technology, as determined by the board.
877
878 SECTION 16. Section 9E of said chapter 112, as so appearing, is hereby amended by
879 striking out, in line 6, the word "two" and inserting in place thereof the following figure:- 4
880
881 SECTION 17. Said chapter 112 is hereby further amended by inserting after section
882 39C the following section:-
883 Section 39E. Stores or pharmacies engaged in the drug business, as defined in section
884 37, shall inform the department of public health of any improper dispensing of prescription
885 drugs that results in serious injury or death, as defined by the department in regulations, as soon
886 as is reasonably and practically possible, but not later than 15 working days after discovery of
887 the improper dispensing. The department of public health shall promulgate regulations for the
888 administration and enforcement of this section.
889
890 SECTION 18. Chapter 118E of the General Laws is hereby amended by adding the
891 following section:-
892 Section 55. (a) Subject to subsection (c), for the purposes of processing claims for
893 health care services submitted by a health care provider and to provide uniformity and
894 consistency in the reporting of patient diagnostic information, patient care service and procedure
895 information as it relates to the submission and processing of health care claims, the executive
896 office of health and human services and its subcontractors shall, without local customization,
897 accept and recognize patient diagnostic information and patient care service and procedure
898 information submitted pursuant to, and consistent with, the current Health Insurance Portability

899 and Accountability Act compliant code sets as adopted by the Centers for Medicare and
900 Medicaid Services; the International Classification of Diseases; the American Medical
901 Association's Current Procedural Terminology codes, reporting guidelines and conventions; and
902 the Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding
903 System. The executive office and its subcontractors shall adopt the aforementioned coding
904 standards and guidelines, and all changes thereto, in their entirety, which shall be effective on
905 the same date as the national implementation date established by the entity implementing the
906 coding standards.

907 (b) Subject to subsection (c), the executive office and its subcontractors shall, without
908 local customization, use the standardized claim formats for processing health care claims as
909 adopted by the National Uniform Claim Committee and the National Uniform Billing
910 Committee and implemented pursuant to the federal Health Insurance Portability and
911 Accountability Act. The executive office and its subcontractors shall, without local
912 customization, adopt and routinely process all changes to such formats which shall be effective
913 on the same date as the implementation date established by the entity implementing the formats.

914 (c) Except for the requirements for consistency and uniformity in coding patient
915 diagnostic information and patient care service and procedure information, this section shall not
916 modify or supersede the executive office's or its subcontractor's payment policy or utilization
917 review policy. Nothing in this section shall preclude the executive office or a subcontractor
918 thereof from adjudicating a claim pursuant to its billing guidelines, payment policies or provider
919 contracts.

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

922

923 SECTION 19. Section 55 of said chapter 118E, as inserted by section 19, is hereby
924 amended by striking out subsection (d) and inserting in place thereof the following subsection:-

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

927

928 SECTION 20. Section 1 of chapter 118G of the General Laws is hereby amended by
929 inserting after the definition of "Pediatric specialty unit", as appearing in the 2006 Official
930 Edition, the following definition:-
931 "Private health care payer", a carrier authorized to transact accident and health insurance
932 under chapter 175, a nonprofit hospital service corporation licensed under chapter 176A, a
933 nonprofit medical service corporation licensed under chapter 176B, a dental service corporation
934 organized under chapter 176E, an optometric service corporation organized under chapter 176F;
935 a self-insured plan, to the extent allowable under federal law governing health care provided by
936 employers to employees, or a health maintenance organization licensed under chapter 176G.
937
938 SECTION 21. Said section 1 of said chapter 118G, as so appearing, is hereby further
939 amended by inserting after the definition of "Provider" the following definition:-
940 "Public health care payer", the Medicaid program established in chapter 118E; any
941 carrier or other entity that contracts with the office of Medicaid or the commonwealth health
942 insurance connector to pay for or arrange the purchase of health care services on behalf of
943 individuals enrolled in health coverage programs under Titles XIX or XXI, or under the
944 commonwealth care health insurance program, including prepaid health plans subject to the
945 provisions of section 28 of chapter 47 of the acts of 1997; the group insurance commission
946 established under chapter 32A; and any city or town with a population of more than 60,000 that
947 has adopted chapter 32B.
948
949 SECTION 22. Section 2 of said chapter 118G, as so appearing, is hereby amended by
950 striking out the second paragraph, as most recently amended by section 38 of chapter 58 of the
951 acts of 2006, and inserting in place thereof the following paragraph:-
952 The commissioner shall appoint and may remove such agents and subordinate officers as
953 the commissioner may deem necessary and may establish such subdivisions within the division
954 as he deems appropriate to fulfill the following duties: (i) to collect, analyze and disseminate
955 health care data to assist in the formulation of health care policy and in the provision and
956 purchase of health care services; (ii) to work with other state agencies including, but not limited
957 to, the department of public health and the department of mental health, the health care quality
958 and cost council, the division of medical assistance and the division of insurance to collect and

959 publish data concerning the cost of health insurance in the commonwealth and the health status
960 of individuals; (iii) to hold annual hearings concerning health care provider and payer costs and
961 cost trends, and to provide an analysis of health care spending trends with recommendations for
962 strategies to promote an efficient health delivery system; and (iv) to administer the health safety
963 net office and trust fund established under sections 35 and 36.
964
965 SECTION 23. Section 6 of said chapter 118G, as so appearing, is hereby amended by
966 striking out the third paragraph and inserting in place thereof the following 4 paragraphs:-
967 The division may promulgate regulations necessary to ensure the uniform reporting of
968 information from private and public health care payers that enables the division to analyze: (i)
969 changes over time in health insurance premium levels; (ii) changes in the benefit and cost-
970 sharing design of plans offered by these payers; and (iii) changes in measures of plan cost and
971 utilization; provided that this analysis shall facilitate comparison among plans and between
972 public and private payers.
973 The division shall require the submission of data and other information from each
974 private health care payer offering small or large group health plans including, without
975 limitation: (i) average annual individual and family plan premiums for each payer's most
976 popular plans for a representative range of group sizes, as further determined in regulations, and
977 average annual individual and family plan premiums for the lowest cost plan in each group size
978 that meets the minimum standards and guidelines established by the division of insurance under
979 section 8H of chapter 26; (ii) information concerning the actuarial assumptions that underlie the
980 premiums for each plan; (iii) summaries of the plan designs for each plan; (iv) information
981 concerning the medical and administrative expenses, including medical loss ratios for each plan;
982 (v) information concerning the payer's current level of reserves and surpluses; and (vi)
983 information on provider payment methods and levels.
984 The division shall require the submission of data and other information from public
985 health care payers including, without limitation: (i) average premium rates for health insurance
986 plans offered by public payers and information concerning the actuarial assumptions that
987 underlie these premiums; (ii) average annual per-member per-month payments for enrollees in
988 MassHealth primary care clinician and fee for service programs; (iii) summaries of plan designs
989 for each plan or program; (iv) information concerning the medical and administrative expenses,

990 including medical loss ratios for each plan or program; (v) where appropriate, information
991 concerning the payer's current level of reserves and surpluses; and (vi) information on provider
992 payment methods and levels, including information concerning payment levels to each hospital
993 for the 25 most common medical procedures provided to enrollees in these programs, in a form
994 that allows payment comparisons between Medicaid programs and managed care organizations
995 under contract to the office of Medicaid.

996 The division shall, before adopting regulations under this section, consult with other
997 agencies of the commonwealth and the federal government, affected providers, and affected
998 payers, as applicable, to ensure that the reporting requirements imposed under the regulations
999 are not duplicative or excessive. If reporting requirements imposed by the division result in
1000 additional costs for the reporting providers, these costs may be included in any rates
1001 promulgated by the division for these providers. The division may specify categories of
1002 information which may be furnished under an assurance of confidentiality to the provider;
1003 provided that such assurance shall only be furnished if the information is not to be used for
1004 setting rates.
1005

1006 SECTION 24. Said chapter 118G is hereby further amended by inserting after section 6
1007 the following section:—

1008 Section 6½. (a) The division shall hold annual public hearings based on the information
1009 submitted under sections 6 and 6A concerning health care provider and private and public
1010 health care payer costs and cost trends, with particular attention to factors that contribute to cost
1011 growth within the commonwealth's health care system and to the relationship between provider
1012 costs and payer premium rates. The attorney general may intervene in such hearings.

1013 (b) The attorney general may review and analyze any information submitted to the
1014 division under section 6 and 6A. The attorney general may require that any provider or payer
1015 produce documents and testimony under oath related to health care costs and cost trends or
1016 documents that the attorney general deems necessary to evaluate factors that contribute to cost
1017 growth within the commonwealth's health care system and to the relationship between provider
1018 costs and payer premium rates. The attorney general shall keep confidential all nonpublic
1019 information and documents obtained under this section and shall not disclose such information
1020 or documents to any person without the consent of the provider or payer that produced the

1021 information or documents except in a public hearing under this section, a rate hearing before the
1022 division of insurance, or in a case brought by the attorney general, if the attorney general
1023 believes that such disclosure will promote the health care cost containment goals of the
1024 commonwealth and that such disclosure should be made in the public interest after taking into
1025 account any privacy, trade secret or anti-competitive considerations. Such confidential
1026 information and documents shall not be public records and shall be exempt from disclosure
1027 under section 10 of chapter 66.

1028 (c) Hearings shall be held by the commissioner or a designee, or a hearings officer, if
1029 authorized by the commissioner. Public notice of any hearing shall be provided at least 60 days
1030 in advance.

1031 (d) The division shall, 30 days before the date of any hearing, publish a preliminary
1032 report of its findings based on information provided under section 6. The division may contract
1033 with an outside organization with expertise in issues related to the topics of the hearings to
1034 produce this preliminary report. The division shall use this preliminary report as a basis for
1035 designing the format and content of the hearing.

1036 (e) The division shall identify as witnesses for the public hearing a representative sample
1037 of providers and payers, including: (i) at least 3 academic medical centers, including the 2 acute
1038 hospitals with the highest level of net patient service revenue; (ii) at least 3 disproportionate
1039 share hospitals, including the 2 hospitals whose largest per cent of gross patient service revenue
1040 is attributable to Title XVIII and XIX of the federal Social Security Act or other governmental
1041 payers; (iii) community hospitals from at least 3 separate regions of the state; (iv) freestanding
1042 ambulatory surgical centers from at least 3 separate regions of the state; (v) community health
1043 centers from at least 3 separate regions of the state; (vi) the 5 private health care payers with the
1044 highest enrollments in the state; (vii) any managed care organization that provides health
1045 benefits under Title XIX or under the commonwealth care health insurance program; (viii) the
1046 group insurance commission; (ix) at least 3 municipalities that have adopted chapter 32B; and
1047 (x) any witness identified by the attorney general

1048 (f) Witnesses shall provide testimony under oath and subject to examination and cross
1049 examination by the division and the attorney general at the public hearing in a manner and form
1050 to be determined by the division, including without limitation: (i) in the case of providers,
1051 testimony concerning payment systems, payer mix, cost structures, administrative and labor

1052 costs, capital and technology costs, adequacy of public payer reimbursement levels, reserve
1053 levels, utilization trends, and cost-containment strategies, the relation of private payer
1054 reimbursement levels to public payer reimbursements for similar services, efforts to improve the
1055 efficiency of the delivery system, efforts to reduce the inappropriate or duplicative use of
1056 technology; and (ii) in the case of private and public payers, testimony concerning factors
1057 underlying premium cost and rate increases, the relation of reserves to premium costs, the
1058 payer's efforts to develop benefit design and payment policies that enhance product
1059 affordability and encourage efficient use of health resources and technology, efforts by the
1060 payer to increase consumer access to health care information, and efforts by the payer to
1061 promote the standardization of administrative practices, and any other matters as determined by
1062 the division.

1063 (g) The division shall compile an annual report concerning spending trends and
1064 underlying factors, along with any recommendations for strategies to increase the efficiency of
1065 the health care system. The report shall be based on the division's analysis of information
1066 provided at the hearings by providers and insurers, data collected by the division under sections
1067 6 and 6A of this chapter, and any other information the division considers necessary to fulfill its
1068 duties under this section, as further defined in regulations promulgated by the division. The
1069 division shall consult with the health care quality and cost council when developing any
1070 measures or criteria to be used in its analysis. The report shall be submitted to the chairs of the
1071 house and senate committees on ways and means, the chairs of the joint committee on health
1072 care financing and shall be published and available to the public no later than December 31st.
1073

1074 SECTION 25. Section 36 of chapter 123 of the General Laws, as appearing in the 2006
1075 Official Edition, is hereby amended by adding the following 4 sentences:- Each facility, subject
1076 to this chapter and section 19 of chapter 19, that provides mental health care and treatment shall
1077 maintain patient records, as defined in the first paragraph of section 70 of chapter 111, for at
1078 least 20 years after the closing of the record due to discharge, death or last date of service. A
1079 facility shall not destroy such records until after the retention period has elapsed and only upon
1080 notifying the department of public health that the records will be destroyed; provided that the
1081 department shall promulgate regulations further defining an appropriate notification process. On
1082 the notice of privacy practices distributed to its patients, each facility shall provide: (i)

1083 information concerning the provisions of this section; and (ii) the hospital or clinic's records
1084 termination policy.
1085
1086 SECTION 26. Chapter 176O of the General Laws is hereby amended by inserting after
1087 section 5 the following 2 sections:-
1088 Section 5A. (a) Subject to subsection (c), for the purposes of processing claims for
1089 health care services submitted by a health care provider and to provide uniformity and
1090 consistency in the reporting of patient diagnostic information, patient care service and procedure
1091 information as it relates to the submission and processing of health care claims, a carrier and its
1092 subcontractors shall, without local customization, accept and recognize patient diagnostic
1093 information and patient care service and procedure information submitted pursuant to, and
1094 consistent with the current Health Insurance Portability and Accountability Act compliant code
1095 sets: the International Classification of Diseases; the American Medical Association's Current
1096 Procedural Terminology codes, reporting guidelines and conventions; and the Centers for
1097 Medicare and Medicaid Services Healthcare Common Procedure Coding System. A carrier and
1098 its subcontractors shall adopt the aforementioned coding standards and guidelines, and all
1099 changes thereto, in their entirety, which shall be effective on the same date as the national
1100 implementation date established by the entity implementing the coding standards.
1101 (b) Subject to subsection (c), a carrier and its subcontractors shall, without local
1102 customization, use the standardized claim formats for processing health care claims as adopted
1103 by the National Uniform Claim Committee and the National Uniform Billing Committee and
1104 implemented pursuant to the Health Insurance Portability and Accountability Act. A carrier and
1105 its subcontractors shall, without local customization, adopt and routinely process all changes to
1106 such formats which shall be effective on the same date as the implementation date established
1107 by the entity implementing the formats.
1108 (c) Except for the requirements for consistency and uniformity in coding patient
1109 diagnostic information and patient care service and procedure information, this section shall not
1110 modify or supersede a carrier's or its subcontractor's payment policy, utilization review policy
1111 or benefits under a health benefit plan. Nothing in this section shall further preclude a carrier or
1112 a subcontractor thereof from adjudicating a claim pursuant to its billing guidelines, payment
1113 policies, provider contracts or health benefit plans.

1114 (d) Carriers and subcontractors thereof shall accept and recognize at least 85 per cent of
1115 all claims submitted by health care providers pursuant to this section.
1116 Section 5B. To ensure uniformity and consistency in the submission and processing of
1117 claims for health care services pursuant to section 5A, the bureau of managed care within the
1118 division of insurance, after consultation with a statewide advisory committee including, but not
1119 limited to, representatives of the Massachusetts Hospital Association, the Massachusetts
1120 Medical Society, the Massachusetts Association of Health Plans, the Blue Cross and Blue
1121 Shield of Massachusetts, the Massachusetts Health Information Management Association, the
1122 Massachusetts Health Data Consortium, a representative of America's Health Insurance Plans, a
1123 representative of a MassHealth contracted managed care organization, the executive office of
1124 health and human services, the division of health care finance and policy, the health care quality
1125 and cost council, the house of representatives and the senate, shall adopt policies and procedures
1126 to enforce said section 5A. The policies and procedures shall include a system for reporting
1127 inconsistencies related to a carrier's compliance with said section 5A. The bureau shall work
1128 jointly with the executive office of health and human services to resolve reports of
1129 noncompliance with the requirements of section 61 of chapter 118E. The bureau shall convene
1130 the advisory committee annually to review and discuss issues reported by health care providers
1131 pursuant to this section and to discuss further recommendations to improve the uniformity and
1132 consistency of the reporting of patient diagnostic information and patient care service and
1133 procedure information as it relates to the submission and processing of health care claims.
1134
1135 SECTION 27. Section 5A of said chapter 176O, as appearing in section 23, is hereby
1136 amended by striking out subsection (d) and inserting in place thereof the following subsection:-
1137 (d) Carriers and their subcontractors shall accept and recognize all claims submitted by
1138 health care providers pursuant to this section.
1139
1140 SECTION 28. The General Laws are hereby amended by inserting after chapter 176Q
1141 the following chapter:-
1142
1143 CHAPTER 176R
1144 CONSUMER CHOICE OF NURSE PRACTITIONER SERVICES

1145
1146 Section 1. As used in this chapter, the following words shall have the following
1147 meanings unless the context clearly requires otherwise:
1148 "Carrier", an insurer licensed or otherwise authorized to transact accident or health
1149 insurance under chapter 175; a nonprofit hospital service corporation organized under chapter
1150 176A; a nonprofit medical service corporation organized under chapter 176B; a health
1151 maintenance organization organized under chapter 176G; an organization entering into a
1152 preferred provider arrangement under chapter 176I; a contributory group general or blanket
1153 insurance for persons in the service of the commonwealth under chapter 32A; a contributory
1154 group general or blanket insurance for persons in the service of counties, cities, towns and
1155 districts, and their dependents under chapter 32B; the medical assistance program administered
1156 by the division of medical assistance pursuant to chapter 118E and in accordance with Title XIX
1157 of the Social Security Act or any successor statute; and any other medical assistance program
1158 operated by a governmental unit for persons categorically eligible for such program.
1159 "Commissioner", the commissioner of insurance.
1160 "Insured", an enrollee, covered person, insured, member, policyholder or subscriber of a
1161 carrier.
1162 "Nondiscriminatory basis", a carrier shall be deemed to be providing coverage on a non-
1163 discriminatory basis if its plan does not contain any annual or lifetime dollar or unit of service
1164 limitation imposed on coverage for the care provided by a nurse practitioner which is less than
1165 any annual or lifetime dollar or unit of service limitation imposed on coverage for the same
1166 services by other participating providers.
1167 "Nurse practitioner", a registered nurse who holds authorization in advanced nursing
1168 practice as a nurse practitioner under section 80B of chapter 112 and regulations promulgated
1169 thereunder.
1170 "Participating provider", a provider who, under the terms and conditions of a contract
1171 with the carrier or with its contractor or subcontractor, has agreed to provide health care
1172 services to an insured with an expectation of receiving payment, other than coinsurance, co-
1173 payments or deductibles, directly or indirectly from the carrier.
1174 "Primary care provider", a health care professional qualified to provide general medical
1175 care for common health care problems, supervises, coordinates, prescribes, or otherwise

1176 provides or proposes health care services, initiates referrals for specialist care, and maintains
1177 continuity of care within the scope of practice.
1178 Section 2. The commissioner and the group insurance commission shall require that all
1179 carriers recognize nurse practitioners as participating providers subject to section 3 and shall
1180 include coverage on a nondiscriminatory basis to their insureds for care provided by nurse
1181 practitioners for the purposes of health maintenance, diagnosis and treatment. Such coverage
1182 shall include benefits for primary care, intermediate care and inpatient care, including care
1183 provided in a hospital, clinic, professional office, home care setting, long-term care setting,
1184 mental health or substance abuse program, or any other setting when rendered by a nurse
1185 practitioner who is a participating provider and is practicing within the scope of his professional
1186 license to the extent that such policy or contract currently provides benefits for identical
1187 services rendered by a provider of health care licensed by the commonwealth.
1188 Section 3. A participating provider nurse practitioner practicing within the scope of his
1189 license including all regulations requiring collaboration with a physician under section 80B of
1190 chapter 112, shall be considered qualified within the carrier's definition of primary care
1191 provider to an insured.
1192 Section 4. Notwithstanding any general or special law to the contrary, a carrier that
1193 requires the designation of a primary care provider shall provide its insured with an opportunity
1194 to select a participating provider nurse practitioner as a primary care provider or to change its
1195 primary care provider to a participating provider nurse practitioner at any time during their
1196 coverage period.
1197 Section 5. Notwithstanding any general or special law to the contrary, a carrier shall
1198 ensure that all participating provider nurse practitioners are included on any publicly accessible
1199 list of participating providers for the carrier.
1200 Section 6. A complaint for noncompliance against a carrier shall be filed with and
1201 investigated by the commissioner or the group insurance commission, whichever shall have
1202 regulatory authority over the carrier. The commissioner and the group insurance commission
1203 shall promulgate regulations to enforce this chapter.
1204
1205 SECTION 29. Notwithstanding any general or special law to the contrary, the first
1206 report of the health care workforce center required by section 25L of chapter 111 of the General

1207 Laws shall be filed on or before December 31, 2009 and shall focus on the primary care
1208 workforce, defined as physicians with a medical specialty in family medicine, internal medicine,
1209 pediatrics, and obstetrics/gynecology or nurse practitioners practicing as primary care providers.
1210
1211 SECTION 30. Notwithstanding any general or special law to the contrary, the office of
1212 Medicaid, subject to appropriation and the availability of federal financial participation, and in
1213 consultation with the MassHealth payment policy advisory board, shall establish a medical
1214 home demonstration project. Within the demonstration project the office of Medicaid shall
1215 restructure its payment system to support primary care practices that use a medical home model
1216 and shall develop a program to support primary care providers in developing an organizational
1217 structure necessary to provide a medical home. The office of Medicaid shall work with
1218 Medicaid managed care organizations to develop and implement the project.
1219 The office shall consider payment methodologies that support care-coordination through
1220 multi-disciplinary teams, including payment for care of patients with chronic diseases and the
1221 elderly, and that encourage services such as: (i) patient or family education for patients with
1222 chronic diseases; (ii) home-based services; (iii) telephonic communication; (iv) group care; and
1223 (v) culturally and linguistically appropriate care. Payment shall reward quality and improved
1224 patient outcomes.
1225 The office shall identify practices, for participation in the project, that provide care to its
1226 patients using a medical home model, which at minimum shall include primary care practices
1227 with a multi-specialty team that provides patient-centered care coordination through the use of
1228 health information technology and chronic disease registries, across the patient's life-span and
1229 across all domains of the health care system and the patient's community.
1230 The office shall promulgate regulations for the phase-in and implementation of this
1231 demonstration project.
1232 The office, subject to appropriation and in coordination with the health care workforce
1233 center and the Massachusetts Academy of Family Physicians, shall develop a program to
1234 provide support to practices interested in developing an organizational structure necessary to
1235 provide a medical home.
1236 The office shall conduct an annual project evaluation including documentation of cost
1237 savings achieved through implementation; health care screening rates, outcomes and

1238 hospitalization rates for patients with chronic illnesses such as pediatric asthma, diabetes, heart
1239 disease, hospitalization and readmission rates for the frail elderly. The office shall submit a
1240 report of the evaluation to the senate and house chairs of the joint committee on health care
1241 financing and the chairs of the senate and house committees on ways and means.
1242
1243 SECTION 31. Notwithstanding any general or special law to the contrary, the trustees
1244 of the University of Massachusetts shall expand the entering class at its medical school and
1245 increase residencies for medical school graduates for students committed to entering the
1246 primary care field and to working in underserved regions of the commonwealth. The trustees
1247 shall develop a master plan for expanding medical student enrollment and increasing internships
1248 and residencies for medical school graduates who are committed to primary care and work in
1249 underserved regions without reducing academic quality, together with a financial plan to
1250 support such expansion, and shall report that plan to the clerk of the house of representatives
1251 who shall forward the same to the joint committee on health care financing and the house and
1252 senate committees on ways and means on or before January 1, 2009.
1253
1254 SECTION 32. Notwithstanding any general or special law to the contrary, the trustees
1255 of the University of Massachusetts, in conjunction with the state health education center at the
1256 University of Massachusetts medical center, shall establish and maintain an enhanced learning
1257 contract program available to medical students every academic year. The program shall provide
1258 full waivers of tuition and fees at the University of Massachusetts medical school. In exchange
1259 for the waivers, the contract shall require at least 4 years of service within the commonwealth in
1260 areas of primary care, public or community service or underserved areas, as determined by the
1261 health care workforce center established under section 25L of chapter 111 of the General Laws
1262 and the learning contract committee, in coordination with the area health education center and
1263 state and regional health planning agencies. If a student fails to perform the service required by
1264 an enhanced learning contract, that student shall pay the difference between the tuition paid and
1265 double the amount of the tuition charged together with an origination fee, interest per annum at
1266 prime rate as reported at the time of origination by the Federal Reserve, a margin and repayment
1267 fee as established by the board. No service or tuition loan repayment shall be required prior to
1268 the termination of any internship and residency requirements. Interest shall begin to accrue upon

1269 completion of the requirements for the degree. The commonwealth shall bear the cost of such
1270 tuition and fee waivers for enhanced learning contracts. The dean of the medical school shall
1271 report annually the number of students participating in enhanced learning contracts, the area of
1272 medicine within which payback is to be performed and the number of students utilizing the
1273 repayment option. The report shall also outline the effects of payback in the underserved areas
1274 of the commonwealth.
1275
1276 SECTION 33. (a) Notwithstanding any general or special law to the contrary, there
1277 shall be established and set up on the books of the commonwealth a separate fund to be known
1278 as the Massachusetts Nursing and Allied Health Workforce Development Trust Fund to which
1279 shall be credited any appropriations, bond proceeds or other monies authorized by the general
1280 court and specifically designated to be credited thereto, and additional funds, including federal
1281 grants or loans or private donations made available to the commissioner of higher education for
1282 this purpose. The department of higher education shall hold the fund in an account separate and
1283 apart from other funds or accounts. Amounts credited to the fund shall be expended by the
1284 commissioner of higher education to carry out subsection (b). Any balance in the fund at the
1285 close of a fiscal year shall be available for expenditure in subsequent fiscal years and shall not
1286 revert to the General Fund.
1287 (b) the fund shall be used to develop and support, in consultation with the Massachusetts
1288 Nursing and Allied Health Workforce Development Advisory Committee, short-term and long-
1289 term strategies to increase the number of public and private higher education faculty and
1290 students who participate in programs that support careers in fields related to nursing and allied
1291 health. The commissioner of higher education may expend such funds as may be necessary for
1292 the administration of the Massachusetts Nursing and Allied Health Workforce Development
1293 Initiative. In furtherance of these public purposes, the commissioner of higher education shall
1294 expend funds in the fund for activities that are calculated to increase the number of qualified
1295 nursing and allied health faculty and students and improve the nursing and allied health
1296 educational offerings available in public higher education institutions. Grants and other
1297 disbursements and activities may involve, without limitation, the University of Massachusetts,
1298 state and community colleges, private higher education institutions, private higher education
1299 institutions in partnership with public higher education institutions, business and industry

1300 partnerships, regional alliances, workforce investment boards, organizations granted tax-exempt
1301 status under section 501(c)(3) of the Internal Revenue Code and other community groups which
1302 promote the nursing profession. Grants and other disbursements and activities may support,
1303 without limitation: (i) the goal of rapidly increasing the number of nurses and allied health
1304 workers; (ii) enhancing the role of the system of public and private higher education, as
1305 institutions and in partnerships with other stakeholders, in meeting the short-term and long-term
1306 workforce challenges in the nursing and allied health professions; (iii) the development and use
1307 of innovative curricula, courses, programs and modes of delivering education in nursing and
1308 allied health professions for faculty and students in these fields; (iv) activities with the growing
1309 network of stakeholders in the nursing and allied health professions to create, implement, share
1310 and make broadly and publicly available best practices and innovative programs relative to
1311 instruction, development of partnerships and expanding and maintaining faculty and student
1312 involvement in careers in these fields; and (v) strengthening the institutional capacity to develop
1313 and implement long-term programs and policies to effectively respond to these challenges.
1314
1315 SECTION 34. Notwithstanding any general or special law to the contrary, the
1316 department of housing and community development, in consultation with the executive office of
1317 health and human services, the department of workforce development and the Massachusetts
1318 housing finance agency, shall establish a pilot grant or loan program to assist hospitals,
1319 community health centers, and physician practices in providing housing grants or loans for
1320 health care professionals who commit to practicing in underserved areas, identified by the
1321 health care workforce center, established under section 25L of chapter 111, and who meet
1322 income eligibility guidelines established by the department. Grants and loans may be used for:
1323 (i) purchasing a principal residence, including cooperative housing, that falls within price
1324 guidelines established by the department, including costs for down payments, mortgage interest
1325 rate buy-downs, closing costs and other costs determined to be eligible by the department; and
1326 (ii) payments for security deposits and advance payments for rental housing. The department,
1327 to the extent possible shall seek matching funds from hospitals and other private entities.
1328 The department shall promulgate rules and regulations for the administration and enforcement
1329 of this section including, establishing provisions for eligibility, specifying the expenses for

1330 which grants and loans may be made, and determining the procedures necessary to qualify for
1331 assistance.

1332 Two years after the commencement of the pilot program, the department shall report to
1333 the house and senate committees on ways and means, the joint committee on housing and the
1334 joint committee on health care financing, the results of the pilot program and shall recommend
1335 it for expansion, continuation or discontinuation.
1336

1337 SECTION 35. (a) Notwithstanding any general or special laws to the contrary, the
1338 division of health care finance and policy, in conjunction with the division of insurance, shall
1339 examine options and alternatives available to the commonwealth to provide regulation,
1340 oversight and disposition of the reserves, endowments and surpluses of health insurers and
1341 hospitals.

1342 (b) The division shall conduct a study relative to health insurers, including health
1343 maintenance organizations and acute care and non-acute care hospitals. The study shall include,
1344 but not be limited to: (1) an analysis of the laws, regulations and other measures currently in
1345 effect in the commonwealth which regulate the amount, nature and disposition of surpluses held
1346 by or for the benefit of health insurers in excess of amounts reasonably anticipated to be
1347 required to pay claims, taking into account the level of such reserves and surpluses necessary to
1348 safeguard the solvency of health insurers against unanticipated events and other circumstances
1349 which may cause extraordinary medical losses; (2) an analysis of federal and state law,
1350 regulations and other measures currently in effect which regulate the amount, nature and
1351 disposition of surpluses and endowments held by or for the benefit of hospitals in excess of
1352 amounts reasonably anticipated to be required to perform and support services provided by the
1353 hospital and to guard against unanticipated events and other circumstances; (3) a review of
1354 recent fiscal practices and financial reporting by health insurers relative to reserves and
1355 surpluses and of hospital fiscal practices and financial reporting required by general or special
1356 law; (4) a comparison of the commonwealth's current statutes and regulations with those of
1357 other states which the commission deems to be reasonably comparable to those of the
1358 commonwealth; (5) a review and assessment of model acts and regulations and any other
1359 information which the commission finds to be relevant to its inquiry; and (6) a review of the
1360 method by which health insurers and hospitals fund community benefit programs including, but

1361 not limited to, the manner by which funding is regulated by other states as to the appropriate
1362 amount, monitoring and direction of such funding. In compiling this report, the division shall
1363 seek input from health plans and hospitals operating in the commonwealth, the attorney general,
1364 the executive office of health and human services, and the health care quality and cost council,
1365 established in section 16K of section 6A of the General Laws. In conducting its examination,
1366 the division shall, to the extent possible, obtain and use actual health plan and hospital data and
1367 such data shall be confidential and shall not be a public record under clause twenty-sixth of
1368 section 7 of chapter 4 of the General Laws or section 10 of chapter 66 of the General Laws.
1369 (c) .The division may contract with another entity with the requisite objective financial
1370 and actuarial expertise to assist the division in conducting its study.
1371 (g) The division shall file a report of its findings and recommendations with the clerks
1372 of the senate and house of representatives, the house and senate committees on ways and means
1373 and the joint committee on health care financing not later than July 1, 2009.
1374
1375 SECTION 36. Notwithstanding any general or special law to the contrary, on or before
1376 October 1, 2012, the department of public health shall adopt regulations requiring hospitals and
1377 community health centers, as a standard of eligibility for original licensure and renewal of
1378 licensure, to implement computerized physician order entry systems as defined by the
1379 department. The systems shall be certified by the Certification Commission for Healthcare
1380 Information Technology or a successor agency or organization established for the purpose of
1381 certifying that health information technology meets national interoperability standards.
1382
1383 SECTION 37. Notwithstanding any general or special law to the contrary, on or before
1384 October 1, 2015, the department of public health shall adopt regulations requiring hospitals and
1385 community health centers, as a standard of eligibility for original licensure and renewal of
1386 licensure, to implement interoperable electronic health records systems, as defined by the
1387 department. The system shall be certified by the Certification Commission for Healthcare
1388 Information Technology or a successor agency or organization established for the purpose of
1389 certifying that health information technology meets national interoperability standards.
1390

1391 SECTION 38. Notwithstanding any general or special law to the contrary, the executive
1392 office of health and human services shall maximize enrollment of eligible persons in the
1393 MassHealth Senior Care Options program, the Program of All Inclusive Care for the Elderly,
1394 the Enhanced Community Options Program and the Community Choices program, or
1395 comparable successor programs, and shall develop dual eligible plans. For the purposes of this
1396 section, "dual eligible plans" shall be plans that offer similar coverage to Medicaid and
1397 Medicare-eligible disabled persons under age 65.

1398 Not later than 6 months after the effective date of this act, the executive office of health
1399 and human services shall prepare a report identifying clinical, administrative and financial
1400 barriers to expanded dual eligible plans, and shall recommend steps to remove the barriers and
1401 implement the plans. Before finalizing the report, the executive office shall hold a public
1402 consultative session that shall include organizations representing seniors, organizations
1403 representing disabled persons, organizations representing health care consumers, organizations
1404 representing racial and ethnic minorities, health delivery systems and health care providers. The
1405 report shall include consideration of changes in procurement standards and MassHealth
1406 payment methodologies to promote enrollment in dual eligible plans. The report shall include
1407 estimates of the costs and benefits of implementing steps to remove barriers to expanded
1408 enrollment in dual eligible plans, including financial savings and improved quality of care.

1409 The report shall be provided to the committee on health care financing and the house and
1410 senate committees on ways and means. Subject to appropriation, the executive office of health
1411 and human services shall implement any steps recommended by the report. Not later than 1
1412 year after the filing of the report, the executive office shall issue a progress statement on
1413 expanded enrollment in dual eligible plans.

1414

1415 SECTION 39. Notwithstanding any general or special law to the contrary, the division
1416 of insurance shall conduct an investigation and study of the costs of medical malpractice
1417 coverage for health care providers, as defined in section 193U of chapter 175 of the General
1418 Laws. The investigation and study shall include, but not be limited to, an examination and
1419 analysis of the following: (1) the availability and affordability of medical malpractice insurance;
1420 (2) the factors considered by medical malpractice insurers when increasing premiums; (3)
1421 options for decreasing premiums including, but not limited to, establishing a reinsurance pool

1422 with additional stop loss coverage, subsidizing premium payments of providers practicing in
1423 certain high-risk specialties or in specialties for which the cost of premiums represents a
1424 disproportionately high proportion of a health care provider's income, subsidizing premium
1425 payments of providers who do not qualify for group coverage rates and pay higher premiums for
1426 commercial market insurance and prorating premiums for providers who practice less than full-
1427 time; and (4) funding mechanisms that would facilitate the implementation of recommendations
1428 arising out of the study which may include, but shall not be limited to, charges borne by the
1429 health care industry or other entities. The division shall hold at least 2 public hearings to take
1430 testimony relating to the investigation and study, 1 of which shall be held outside the
1431 metropolitan Boston area. The division shall report its findings and recommendations to the
1432 clerk of the house of representatives who shall forward the same to the house and senate
1433 committee on ways and means and the joint committee on health care financing on or before
1434 January 1, 2009.
1435

1436 SECTION 40. Notwithstanding any general or special law to the contrary, the
1437 MassHealth payment policy advisory board, established in section 16M of chapter 6A of the
1438 General Laws, shall conduct a study of the need for an increase in Medicaid rates or bonuses for
1439 primary care physicians, nurse practitioners and subspecialists who provide primary care
1440 services, such as preventive care, certain evaluation and management procedures, early periodic
1441 screening, diagnosis and treatment and scheduled weekend and holiday services, in order to
1442 focus on prevention and wellness and delivery of primary care to identify illness earlier, to
1443 better manage chronic disease and to avoid costs associated with emergency room visits and
1444 hospitalizations. The committee shall report its findings, including recommendations for the
1445 amount of funding and the sources of funding, to the clerk of the house of representatives who
1446 shall forward the same to the joint committee on health care financing, and the house and senate
1447 committees on ways and means on or before January 1, 2009.
1448

1449 SECTION 41. Notwithstanding any general or special law to the contrary, the executive
1450 office of health and human services, in consultation with the health care quality and cost
1451 council, commission on end-of-life care established by section 480 of chapter 159 of the Acts of
1452 2000, and the Betsy Lehman Center for Patient Safety and the Reduction of Medical Errors,

1453 shall convene an expert panel on end-of-life care for patients with serious chronic illnesses. The
1454 panel shall investigate and study health care delivery for these patients and the variations in
1455 delivery of such care among health care providers in the commonwealth. For the purposes of
1456 this investigation and study, "health care providers" shall mean facilities and health care
1457 professionals licensed to provide acute inpatient hospital care, outpatient services, skilled
1458 nursing, rehabilitation and long-term hospital care, home health care and hospice services. The
1459 panel shall identify best practices for end-of-life care, including those that minimize disparities
1460 in care delivery and variations in practice or spending among geographic regions and hospitals,
1461 and shall present recommendations for any legislative, regulatory, or other policy changes
1462 necessary to implement its recommendations.
1463
1464 SECTION 42. Notwithstanding any general or special law to the contrary, on or before
1465 January 1, 2009, the executive office of health and human services, in consultation with the
1466 commission on end–of-life care established by section 480 of chapter 159 of the acts of 2000,
1467 shall initiate a public awareness campaign to highlight the importance of end-of-life care
1468 planning. The campaign shall include, but not be limited to, dissemination of information and
1469 other activities that educate the public about existing options for care at the end of life and how
1470 to communicate their end-of-life care wishes to family members and health care providers.
1471
1472 SECTION 43. Notwithstanding any general or special law to the contrary, the executive
1473 office of health and human services, in consultation with the commission on end-of-life care
1474 established by section 480 of chapter 159 of the acts of 2000; shall establish a pilot program to
1475 test the implementation of the physician order for life-sustaining treatment paradigm program to
1476 assist individuals in communicating end-of-life care directives across care settings in at least 1
1477 region of the commonwealth. The pilot program shall include educational outreach to patients,
1478 families, caregivers and health care providers regarding the physician order for life-sustaining
1479 treatment paradigm program. The executive office of health and human services, in conjunction
1480 with the end-of-life commission, shall develop measures to test the success of the pilot program
1481 and make recommendations for the establishment of a state-wide program.
1482

1483 SECTION 44. (a) Notwithstanding any general or special law to the contrary, there shall
1484 be a special commission on the health care payment system that shall investigate reforming and
1485 restructuring the system to provide incentives for efficient and effective patient-centered care
1486 and to reduce variations in the quality and cost of care.

1487 (b) The commission shall consist of the secretary of administration and finance and the
1488 commissioner of health care finance and policy, who shall serve as co-chairs, the executive
1489 director of the group insurance commission, 1 person to be appointed by the senate president, 1
1490 person to be appointed by the speaker of the house, and 5 members to be appointed by the
1491 Governor, 1 of whom shall be a representative of the Massachusetts Association of Health
1492 Plans, Inc., 1 of whom shall be a representative of Blue Cross and Blue Shield of
1493 Massachusetts, Inc., 1 of whom shall be a representative of the Massachusetts Hospital
1494 Association, Inc., 1 of whom shall be a representative of the Massachusetts Medical Society,
1495 and 1 of whom shall be a health economist or expert in the area of payment methodology.

1496 The commission shall adopt rules and establish procedures it considers necessary for the
1497 conduct of its business. The commission may expend funds as may be appropriated or made
1498 available for its purposes. No action of the commission shall be considered official unless
1499 approved by a majority vote of the commission.

1500 (c) The commission (i) shall examine payment methodologies and purchasing strategies,
1501 including, but not limited to, alternatives to fee-for-service models such as blended capitation
1502 rates, episodes-of-care payments, medical home models, and global budgets; pay-for-
1503 performance programs; tiering of providers; and evidence-based purchasing strategies, (ii)
1504 recommend a common transparent payment methodology that promotes coordination of care
1505 and chronic disease management; rewards primary care physicians for improving health
1506 outcomes; reduces waste and duplication in clinical care; decreases unnecessary hospitalizations
1507 and use of ancillary services; and provides appropriate reimbursement for investment in health
1508 information technology that reduces medical errors and enables coordination of care, and (iii)
1509 recommend a plan for the implementation of the common payment methodology across all
1510 public and private payers in the commonwealth, including a plan under which the

1511 commonwealth shall seek a waiver from federal Medicare rules to facilitate the implementation
1512 of the common payment system.

1513 (d) In making its investigation, the commission shall consult with the health care quality
1514 and cost council, the division of health care finance and policy, health care economists, and
1515 others individuals or organizations with expertise in state and federal health care payment
1516 methodologies and reforms. The commission shall use data and recommendations gathered in
1517 the course of these consultations as a basis for its findings and recommendations.

1518 (e) The commission shall file a report of its findings and recommendations, including
1519 any proposed legislation needed to implement the recommendations.

1520 (f) The attorney general shall, in consultation with the commissioner of health care
1521 finance and policy, adopt rules, regulations or guidelines necessary and appropriate to provide
1522 active state supervision for the administration of this section. The commissioner of health care
1523 finance and policy may terminate any action taken pursuant to this section that does not support
1524 the purposes of this section or the terms of the regulations promulgated pursuant to this section
1525 that provide oversight for the commission.

1526 Before a final vote on any recommendations, the commission shall consult with a
1527 reasonable variety of parties likely to be affected by its recommendations, including, but not
1528 limited to, the office of Medicaid, the division of health care finance and policy, the
1529 commonwealth health insurance connector, the Massachusetts Council of Community
1530 Hospitals, Inc., the Massachusetts League of Community Health Centers, Inc., 1 or more
1531 academic medical centers, 1 or more hospitals with a high proportion of public payors, 1 or
1532 more Taft-Hartley plans, 1 or more self-insured plans with membership of more than 500, the
1533 Massachusetts Municipal Association, Inc. and organizations representing health care
1534 consumers.

1535 The commission shall hold its first meeting no later than September 15, 2008 and shall
1536 file the report of its findings and recommendations together with legislation, if any, with the
1537 clerks of the senate and the house of representatives and with the governor no later than April 1,
1538 2009.

1539 Any person or entity acting under the authority of any rule, regulation or guideline adopted
1540 pursuant to this section shall be engaged in action under state policy and shall be immune from
1541 antitrust liability to the same degree and extent as the Commonwealth.
1542
1543 SECTION 45. Any entity providing ambulatory surgical center services which is in
1544 operation or under construction, as determined by the department of public health, on the
1545 effective date of this act shall be exempt from the determination of need requirement of section
1546 53G of chapter 111 of the General Laws and shall be eligible, pursuant to said section 53G of
1547 said chapter 111, to make application to the department for a clinic license for up to 6 months
1548 after the effective date of regulations adopted by the department pursuant to said section 53G of
1549 said chapter 111.
1550
1551 SECTION 46. Section 7 shall apply to any project seeking written approval of final
1552 architectural plans, pursuant to section 51 of chapter 111 of the General Laws 6 months or more
1553 after the effective day of this act.

1554 SECTION 47. Notwithstanding any general or special law to the contrary, the
1555 department of public health shall review the Mass COMM Percutaneous Coronary Intervention
1556 trial and shall determine any adjustments or changes the department may enact to accelerate the
1557 trial without jeopardizing the validity of the study. The department shall immediately take
1558 action to implement such changes and shall report its findings and any necessary legislative
1559 recommendations to the joint committee on health care financing and the house and senate
1560 committees on ways and means no later than October 31, 2008.

1561 SECTION 48. Notwithstanding any general or special law to the contrary, the
1562 department of public health shall promulgate regulations necessary to implement, administration
1563 and enforcement of section 4N of chapter 111 of the General Laws in accordance with chapter
1564 30A on or before October 1, 2008, and shall begin implementation of the outreach and
1565 education program established under said section 4N on or before January 1, 2009.
1566

1567 SECTION 49. Notwithstanding any general or special law to the contrary, the bureau of
1568 managed care within the division of insurance shall convene the first advisory committee
1569 required under section 5B of chapter 176O of the General Laws on or before January 1, 2009.
1570

1571 SECTION 50. Notwithstanding any general or special law to the contrary, the secretary
1572 of administration and finance and the secretary of health and human services shall prepare and
1573 submit a report to the general court about the allocation for and use of state funds by acute care
1574 hospitals, non-acute care hospitals, Medicaid managed care organizations, other managed care
1575 organizations, community health centers and carriers contracting with the commonwealth health
1576 insurance connector authority to provide coverage under chapter 118H or any other publicly
1577 funded program. The report shall include: (1) a comprehensive review of the current manner,
1578 amount and purposes of annual state funding received by those entities, including a description
1579 of the source of the funding; (2) an assessment of the change in total state funding for those
1580 entities over the past 5 years, with particular attention paid to the impact of chapter 58 of the
1581 acts of 2006; (3) an assessment of how those entities use state funds; (4) an assessment of
1582 whether the current payment structure assures the delivery of quality health care in the most
1583 cost-effective way; (5) an analysis of financial and management practices of those entities by
1584 benchmarking performance with respect to quality and cost effectiveness against national
1585 performance levels and similar health care providers in the commonwealth; (6) identification of
1586 common factors that may contribute to the fiscal instability of those entities; (7)
1587 recommendations for the development of performance and operational benchmarks; (8)
1588 recommendations for ensuring that the entities are spending state and other funds in a fiscally-
1589 responsible manner and providing quality care; (9) recommendations for legislative and other
1590 action necessary to strengthen state oversight and ensure greater accountability of state
1591 resources; (10) an assessment of the manner in which hospitals seek payment from consumers,
1592 including an analysis of the impact that court filing fees have on their ability to collect payment;
1593 and (11) recommendations for regulations regarding the due diligence that facilities shall
1594 exercise in seeking to collect payment from consumers before seeking reimbursement from the
1595 commonwealth.
1596

1597 SECTION 51. Notwithstanding any general or special law to the contrary, on or before
1598 July 31, 2012, the e-Health institute, in consultation with the health information technology
1599 council established by section 6D of chapter 40J, shall submit a report to the joint committee on
1600 health care financing and the senate and house committees on ways and means on the status of
1601 health information technology in the commonwealth. The report shall include the status of: (i)
1602 the implementation and use of electronic health records systems, such as rate of provider
1603 participation; (ii) the statewide interoperable electronic health records network and its capacity
1604 to exchange health information between and among components of the health system, with
1605 special focus on ambulatory care providers; (iii) the security and privacy of health information
1606 technology developed and disseminated through activities of the council; and (iv) the impact of
1607 health information technology on health care quality, health outcomes of patients, and health
1608 care costs.
1609
1610 SECTION 52. Notwithstanding any general or special law to the contrary, the health e-
1611 Health institute and the health information technology oversight council, established by section
1612 6D of chapter 40J of the General Laws, shall have as its goal full implementation of electronic
1613 health records systems and the statewide interoperable electronic health records network by
1614 January 1, 2015.
1615
1616 SECTION 53. Notwithstanding any general or special law to the contrary, the secretary
1617 of health and human services, in consultation with the health care quality and cost council, shall:
1618 (i) examine the feasibility of the commonwealth entering into an interstate compact with 1 or
1619 more states to establish an independent entity to research the comparative effectiveness of
1620 medical procedures, drugs, devices, and biologics, so that research results can be used as a basis
1621 for health care purchasing and payment decisions, and (ii) make recommendations concerning
1622 the entity's design. The secretary shall consider existing state and country models, including,
1623 but not limited to, the Washington State Health Care Authority's Health Technology
1624 Assessment program, the National Institute for Health and Clinical Excellence in Britain, and
1625 the Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen in Germany. The secretary
1626 shall file a report with the results of the study together with legislation, if any, with the clerk of
1627 the senate and the clerk of the house of representatives on or before March 30, 2009.

1628
1629 SECTION 54. Item 1599-2008 of chapter 182 of the acts of 2008 is hereby amended by
1630 striking the following words:- , inspector general's office.
1631
1632 SECTION 55. Chapter 182 of the acts of 2008 is hereby amended by striking out section
1633 10.
1634 SECTION 56. Chapter 182 of the acts of 2008 is hereby amended in section 87 by
1635 striking out the words:- "established in section 10 of this act".
1636
1637 SECTION 57. Section 10 shall take effect on October 1, 2012.
1638
1639 SECTION 58. Section 15 shall take effect on January 1, 2015.
1640
1641 SECTION 59. Subsection (d) of section 61 of chapter 118E of the General Laws, as
1642 appearing in section 18 shall take effect on January 1, 2011.
1643
1644 SECTION 60. Sections 19 and 27 shall take effect on July 1, 2012.
1645
1646 SECTION 61. Subsection (d) of section 5A of chapter 176O of the General Laws, as
1647 appearing in section 26 shall take effect on January 1, 2011.
1648
1649 SECTION 62. Sections 14, 28 and 42 shall take effect on January 1, 2009.