S. 2650

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

04/15/08 S Reported from the committee on Senate Ways and Means
04/15/08 S Reported on a part of S2526
04/15/08 S Read -SJ 1454
04/15/08 S Order relative to subject adopted -SJs 1454-1455
04/15/08 S Placed in the Orders of the Day for the next session -SJs 1454-1455

04/17/08 S Amendment (1) (Tisei) rejected - 6 YEAS to 33 NAYS (see Senate Roll Call, No. 203)
04/17/08 S Amendment (2) (Tisei) rejected - 5 YEAS to 34 NAYS (see Senate Roll Call, No. 204)
04/17/08 S Amendment (5) (Tisei) rejected
04/17/08 S Amendment (8) (Jehlen) rejected
04/17/08 S Amendment (9) (Tolman) adopted
04/17/08 S Amendment (10) (Tisei) rejected
04/17/08 S Amendment (13) (Jehlen) rejected
04/17/08 S Amendment (14) (Buonicont) rejected
04/17/08 S Amendment (16) (Tarr) rejected
04/17/08 S Amendment (17) (Downing) rejected
04/17/08 S Amendment (18) (Morrissey) rejected
04/17/08 S Amendment (20) (Tucker) adopted
04/17/08 S Amendment (21) (Galluccio) rejected
04/17/08 S Amendment (23) (Galluccio) rejected
04/17/08 S Amendment (24) (O'Leary) rejected
04/17/08 S Amendment (25) (Chandler) rejected
04/17/08 S Amendment (27) (Baddour) adopted
04/17/08 S Amendment (30) (Chandler) rejected
04/17/08 S Amendment (32) (Chandler) rejected
04/17/08 S Amendment (33) (Fargo) rejected
04/17/08 S Amendment (34) (Chandler) adopted
04/17/08 S Amendment (35) (Jehlen) rejected
04/17/08 S Amendment (36) (Jehlen) rejected
04/17/08 S Amendment (40) (Baddour) rejected
04/17/08 S Amendment (41) (Brown) rejected
04/17/08 S Amendment (42) (O'Leary) rejected
04/17/08 S Amendment (43) (O'Leary) rejected - 6 YEAS to 32 NAYS (see Senate Roll Call, No. 205
04/17/08 S Amendment (28) (Chandler) adopted
04/17/08 S Amendment (46) (Buonicontti) adopted
04/17/08 S Amendment (48) (Tarr) rejected
04/17/08 S Amendment (49) (Moore) adopted
04/17/08 S Amendment (50) (Tarr) rejected

04/17/08 S Amendment (51) (Moore) adopted
04/17/08 S Amendment (26) (Baddour) adopted
04/17/08 S Amendment (38) (Baddour) adopted
04/17/08 S Amendment (44) (Antonioni) adopted
04/17/08 S Amendment (4) (Tisei) adopted
04/17/08 S Amendment (11) (Tisei) adopted -SJs 1461-1481
04/17/08 S Amendment (7) (Tisei) rejected
04/17/08 S Amendment (12) (Morrissey) rejected
04/17/08 S Amendment (37) (O'Leary) rejected
04/17/08 S Amendment (39) (O'Leary) rejected
04/17/08 S Amendment (45) (Creem) rejected
04/17/08 S Amendment (3) (Montigny) adopted
04/17/08 S Amendment (54) (Panagiotakos) adopted
04/17/08 S Ordered to a third reading
04/17/08 S Read third
04/17/08 S Passed to be engrossed - 36 YEAS to 0 NAYS (see Senate Roll Call, No. 206) -SJs 1483-1493
04/17/08 S Reprinted as amended, **see S2660**

SENATE, NO. 2650

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

The Commonwealth of Massachusetts

IN THE YEAR OF TWO THOUSAND AND EIGHT

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

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

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

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

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

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

"Associated with", that it is reasonable to initially assume that the adverse event was directly due to the referenced course of care.

SECTION 3. Said section 16J of said chapter 6A, as so appearing, is hereby further amended by adding the following 2 definitions:-

"Preventable", an event that could have been reasonably anticipated and prepared for but which occurred because of an error or other system failure.

"Serious disability", an event that results in death, loss of a body part, physical disability or loss of bodily function lasting at least 7 days or occurring at the time of discharge from an inpatient health care facility.

SECTION 4. Said chapter 6A is hereby further amended by striking out section 16K, as so appearing, and inserting in place thereof the following section:-

Section 16K. There shall be a health care quality and cost council within, but not subject to the control of, the executive office of health and human services. The council shall promote public transparency of the quality and cost of health care in the commonwealth and shall establish health care quality improvement and cost containment goals. The goals shall be designed to promote high-quality, safe, effective, timely, efficient, equitable and patient-centered health care. The council shall receive staff assistance from the executive office of health and human services and may, subject to appropriation, employ such additional staff or consultants as it may deem necessary. The council shall consist of the secretary of health and human services, the auditor of the commonwealth or his designee, the inspector general or his designee, the attorney general or his designee, the commissioner of insurance, the executive director of the group insurance commission, the executive director of the commonwealth connector, the secretary of administration and finance or his designee, and 7 persons to be

appointed by the governor, 1 of whom shall be a representative of a health care quality improvement organization recognized by the federal Centers for Medicare and Medicaid services, 1 of whom shall be a representative of the Institute for Healthcare Improvement, Inc. recommended by the organization's board of directors, 1 of whom shall be a representative of the Massachusetts Chapter of the National Association of Insurance and Financial Advisors, 1 of whom shall be a representative of the Massachusetts Association of Health Underwriters, 1 of whom shall be a representative of the Massachusetts Medicaid Policy Institute, 1 of whom shall be an expert in health care policy from a foundation or academic institution and 1 of whom shall represent a nongovernmental purchaser of health insurance. The representatives of nongovernmental organizations shall serve staggered 3-year terms. The council shall be chaired by the secretary of health and human services.

SECTION 5. Section 16L of said chapter 6A, as so appearing, is hereby amended by adding the following 2 subsections:-

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

developing a "medical home" payment model that emphasizes a comprehensive approach to patient care; (vi) reducing waste and duplication in clinical care; (vii) investing in and accelerating the adoption of health information technology, specifically computerized physician order entry systems, e-prescribing, and electronic health records; (viii) aligning incentives with federal Medicare payment policies; (ix) promoting health wellness programs; and (x) empowering consumers with access to health care information. The subcommittee members shall be determined by the chair of the council, and shall consult with an advisory committee consisting of 1 member representing the Massachusetts Association of Health Plans, 1 member representing Blue Cross Blue Shield of Massachusetts, 1 member representing Associated Industries of Massachusetts, 1 member representing the Massachusetts Municipal Association, and 4 members to be appointed by the Governor, including 1 health economist, 1 expert in federal Medicare payment policy, 1 representative of a self-insured labor union, and 1 health care consumer advocate. The council shall provide the subcommittee with staff as necessary to complete needed research and analysis. The subcommittee shall meet at least once every 2 months, and at other times as determined by its rules. The subcommittee shall submit a report annually by July 1 to the governor, the health care cost and quality council and the general court, by filing the same with the clerks of the senate and house of representatives, the joint committee on health care financing and the joint committee on public health on the subcommittee's progress and activities, and may recommend legislation or regulatory changes.

(s) The council shall establish goals for adoption of health information technology including, but not limited to, electronic prescription transactions for new prescriptions, prescription renewals, cancellations, changes between prescribers and dispensers, ancillary messages and administrative transactions known as e-prescribing, the process of electronic entry

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

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

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

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

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

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

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

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

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

Section 8K. (a) As used in this section, an insurer shall be defined as a carrier authorized to transact accident and health insurance under chapter 175, a nonprofit hospital service corporation licensed under chapter 176A, a nonprofit medical service corporation licensed under chapter 176B, a dental service corporation organized under chapter 176E, an optometric service corporation organized under chapter 176F and a health maintenance organization licensed under chapter 176G.

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

(c) On or before July 1 of each year, the division of insurance and the division of health care finance and policy shall annually make available the massachusetts health insurance transparency report for consumer and employer use. The report shall be compiled using data collected under this section in the preceding year and shall include the average premium cost results from subsection (b) by insurer, employer size category and by insurer's prototype or alternative prototype plan, as defined in section 1 of chapter 176S.

SECTION 9. Chapter 40J of the General Laws is hereby amended by inserting after section 6C the following section:-

Section 6D. (a) The corporation shall establish an institute for health care innovation, technology and competitiveness, to be known as the e-health institute, and a fund to be known as the e-Health Institute Fund, to be held by the corporation separate and apart from its other funds, to finance the activities of the institute. The institute shall transform care delivery and the utilization of care process redesign supported by a statewide, interoperable electronic health records system in order to improve patient safety and quality, and to lower costs in the state's health care system, with a particular emphasis on the deployment of quality improvement efforts and health information technology in discrete and underserved regions by harnessing local support and involvement in such development activities and by improving the health information technology infrastructure for such clusters. In furtherance of these public purposes, the institute shall endeavor to identify regions where compelling opportunities to make strategic investments appear to be present and develop strategies therefore. The institute may also provide development support more generally to organizations to assist in quality improvement activities and the formation and growth of emerging health technology sectors in those regions and may provide support to departments, agencies and quasi-public entities of the commonwealth for activities that are consistent with the purposes of the institute.

The executive director of the corporation shall appoint a qualified individual as director to manage the affairs of the institute, who shall be an employee of the corporation, report to the executive director and manage the affairs of the institute. The corporation shall establish a governing board to assist it in matters related to the institute. The governing board shall be comprised of not less than 9 individuals, including the executive director of the corporation and

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

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

Shield of Massachusetts, the Massachusetts Association of Health Plans, the Mental Health and Substance Abuse Corporations of Massachusetts, and other quasi-public agencies and not-for-profit organizations. The institute may make grants in support of Massachusetts-based public and private enterprises developing and deploying new technologies to significantly increase the efficiency, safety and quality of the health care system. Successful grants should incorporate regional involvement through alliances among municipalities, colleges, hospitals, health centers, skilled nursing facilities, business and industry, community based organizations, community-based behavioral health care providers, non-profit organizations and labor unions. The governing board may apply the provisions of this chapter that apply to centers and to the center fund to the institute and to the e-health institute fund. Without limiting the generality of the foregoing, the corporation may apply moneys in said fund to pay for start-up expenses, project costs and current expenses associated with said institute and related activities, grants or loans to nonprofit or other organizations to promote its purposes as consistent with the purposes of this section. The institute shall file a report, by no later than January 31 of each year, with the joint committee on health care financing and the house and senate committees on ways and means addressing the activities of the institute, in general, and describing progress to date in implementation of a statewide electronic health records system and recommendations for any further legislative action that it may deem necessary or appropriate.

(b) There shall be an e-health advisory committee to advise the institute and the governing board relative to the electronic health records plan and implementing the institute's purposes and responsibilities under this section. The advisory committee shall review and offer guidance on the establishment and implementation of the statewide electronic health records system, as well as the financing and technical assistance required to allow all health care

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

fourth paragraph of section 3; provided, however, that notwithstanding said section 3 and sections 5, 6 and 7 of chapter 268A, no member of the advisory committee shall be precluded from participating in matters before the committee because he, or a related party within the scope of said section 6 of said chapter 268A has a financial interest in a matter being considered by the committee, provided that such interest or involvement shall have been disclosed in advance to the advisory committee and recorded in the minutes of the advisory committee's proceedings.

(c) Each electronic health records plan developed and approved pursuant to subsection (a) shall address the development, implementation and dissemination of systems of electronic health records among ambulatory care providers in the commonwealth, with a particular focus on those ambulatory care providers, such as community health centers, that care for a significant number of persons in underserved populations. Each plan shall also address the establishment and implementation throughout the commonwealth of one or more networks that: (i) allow the seamless, secure, electronic sharing of health information among health care providers, health plans, and other authorized users; (ii) provide consumers with secure, electronic access to their own health information; (iii) meet standards for interoperability adopted from time to time by the institute; (iv) meet all applicable federal and state-specific privacy and security requirements; (v) give patients the option of allowing only designated health care providers to access their individually identifiable information concerning diagnosis and treatment of sexually transmitted diseases, addiction, mental illnesses, and termination of pregnancy; (vi) provide such public health reporting capability as the secretary of health and human services may determine; (vii) allow for reporting of, and access to, health information, other than PHI (identifiable personal health information), for purposes of such research activities as the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 12. Said chapter 111 hereby further amended by inserting after section 25K the following section:-

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

The center shall: (i) coordinate the department's primary care workforce activities with other state agencies and public and private entities involved in health care workforce training, recruitment and retention; (ii) monitor trends in access to primary care and primary care workforce capacity, including regional disparities; (iii) determine statewide target areas for provider placement based on level of access to primary care; (iv) maintain a public web-based statewide primary care job database; (v) conduct outreach and marketing to recruit primary care providers, regionally and nationally, to practice in the commonwealth; (vi) coordinate state and federal loan repayment and incentive programs for primary care providers; (vii) assist and support communities, physician groups, community health centers and community hospitals in developing cost-effective and comprehensive recruitment initiatives; (viii) act as a career

service center to assist and support primary care professsionals and provide job placement assistance; and (ix) maximize all sources of public and private funds for recruitment initiatives.

The center shall submit an annual report, not later than October 1, to the joint committee on public health, the joint committee on health care financing, and the house and senate committees on ways and means regarding the center's activities in recruiting and retaining health care providers for underserved populations and areas throughout the commonwealth. The annual report shall include, but shall not be limited to, information about: (i) the activities and accomplishments of the center during the report period; (ii) planned activities for the next year; (iii) the number and type of providers who have been recruited to work in the commonwealth as a result of center activities; (iv) the retention rate of providers who have located in target areas as a result of center activities; (v) the utilization rate of the scholarship and loan repayment programs and other programs or activities authorized for provider recruitment and retention; and (vi) recommendations for pilot programs and regulatory or legislative proposals to address workforce needs, shortages, recruitment and retention.

SECTION 13. Section 51 of said chapter 111, as appearing in the 2006 Official Edition, is hereby amended by inserting after the fourth paragraph the following paragraph:-

A hospital licensed under this chapter shall report each serious reportable event listed in regulations promulgated under subsection (a) of section 16P of chapter 6A to the Betsy Lehman center for patient safety and medical error reduction and the department of public health as soon as is reasonably and practically possible, but not later than 15 working days after the discovery of the serious reportable event. Any licensed hospital that fails to comply with this section and the rules and regulation set forth by the department may have its license revoked or suspended by the department, be fined up to $1,000 per day per violation, or both.

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

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

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

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

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

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

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

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

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

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

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

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

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

preventive and ongoing health services and is respectful of, and responsive to, individual patient preference, needs, and values.

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

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

(d) The program shall operate for 3 years in urban, rural and underserved areas in up to 10 communities and shall include physician practices with less than 3 full-time equivalent physicians, as well as larger practices, particularly in rural and underserved areas.

(e) Personal physicians who provide first contact and continuous care for their patients shall be board certified. Such personal physicians must also have a staff and resources to manage the comprehensive and coordinated care of each of their patients. Participating

providers may be specialists or sub-specialists for patients requiring ongoing care for specific conditions, multiple chronic conditions such as severe asthma, complex diabetes, cardiovascular disease, and rheumatologic disorder, or for those with a prolonged illness.

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

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

(h) The office of Medicaid may also establish a system of supplemental payment for a medical home to physician group practices through the establishment of a medical home fee, and shall establish a medical home fee code and a value for these payments.

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

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

Section 61. (a) Subject to subsection (c), for the purposes of processing claims for health care services submitted by a health care provider, the executive office of health and human services and its subcontractors shall, without local customization, accept and recognize patient diagnostic information and patient care service and procedure information submitted pursuant to, and consistent with, the current Health Insurance Portability and Accountability Act compliant code sets as adopted by: the Centers for Medicare and Medicaid Services; the International Classification of Diseases; the American Medical Association's Current Procedural Terminology codes, reporting guidelines and conventions; and the Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding System. The executive office and its subcontractors shall adopt the foregoing coding standards and guidelines and changes thereto effective on the same date as the national implementation date established by the entity implementing said coding standards.

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

(c) Other than requirements for consistency and uniformity in coding patient diagnostic information and patient care service and procedure information, this section shall not modify

575 nor supersede the executive office's or its subcontractor's payment policy or utilization review
576 policy. Nothing in this section shall further preclude the executive office or a subcontractor
577 thereof from adjudicating a claim pursuant to its billing guidelines, payment policies or provider
578 contracts.
579 (d) The executive office and its subcontractors shall accept and recognize at least 85 per
580 cent of all claims submitted by health care providers pursuant to this section.
581 SECTION 20. Said section 61 of said chapter 118E, as appearing in section 19, is hereby
582 amended by striking out subsection (d) and inserting the following:- (d) The executive office
583 and its subcontractors shall accept and recognize all claims submitted by health care providers
584 pursuant to and consistent with this section.
585 SECTION 21. Chapter 118G of the General Laws, as appearing in the 2006 Official
586 Edition, is hereby amended by adding the following section:-
587 Section 40. (a) The division shall hold an annual public hearing to examine the factors
588 that contribute to the cost increases of the health care delivery system and strategies employed
589 by the provider community to reduce cost growth. While considering size, payor mix,
590 geographic representation and specialty, the division shall identify a broad representative
591 sample of providers in each of the following categories: integrated delivery systems; acute care
592 hospitals; community health centers; freestanding ambulatory surgical centers; physician group
593 practices; rehabilitation hospitals; and skilled nursing facilities. Each identified provider shall
594 be required to provide oral and written testimony at the hearing in a format determined by the
595 division. The division shall require providers to provide testimony relative to: payment
596 systems; utilization trends, including volume of services and intensity of services; demographics
597 of populations served; labor and supply costs; community benefits programs; endowment

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

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

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

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

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

Section 5A. (a) Subject to subsection (c), for the purposes of processing claims for health care services submitted by a health care provider, a carrier and its subcontractors shall, without local customization, accept and recognize patient diagnostic information and patient care service and procedure information submitted pursuant to, and consistent with, the current Health Insurance Portability and Accountability Act compliant code sets as adopted by: the International Classification of Diseases; the American Medical Association's Current Procedural Terminology codes, reporting guidelines and conventions; and the Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding System. A carrier and its subcontractors shall adopt the foregoing coding standards and guidelines, and changes thereto, effective on the same date as the national implementation date established by the entity implementing said coding standards.

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

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

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

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

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

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

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

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

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

CHAPTER 176R

CONSUMER CHOICE OF NURSE PRACTITIONER SERVICES

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

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

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

"Commissioner", the commissioner of insurance.

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

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

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

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

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

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

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

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

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

Section 6. Complaints of noncompliance against carriers shall be filed with and investigated by the commissioner or the group insurance commission, whichever shall have regulatory authority over the carrier. The commissioner and the group insurance commission shall promulgate regulations to enforce this chapter.

CHAPTER 176S

HEALTH INSURANCE RATE HEARINGS

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

"Actual loss ratio", the ratio between provider claims incurred by a carrier and premiums earned by that carrier under a health plan, to be calculated in a manner established by the commissioner pursuant to regulation.

"Adjusted weighted average market premium price", the arithmetic mean of all premium rates for a given prototype plan sold to eligible insureds with similar rate basis type by all

carriers selling prototype plans or alternative prototype plans in the commonwealth, weighted pursuant to regulations promulgated by the commissioner.

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

"Carrier", an insurer licensed or otherwise authorized to transact accident and health insurance under chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a non-profit medical service corporation organized under chapter 176B; or a health maintenance organization organized under chapter 176G.

"Commissioner", the commissioner of insurance.

"Health plan", any individual, general, blanket or group policy of health, accident or sickness insurance issued by an insurer licensed under chapter 175 or the laws of any other jurisdiction; a hospital service plan issued by a nonprofit hospital service corporation under chapter 176A or the laws of any other jurisdiction; a medical service plan issued by a nonprofit hospital service corporation under chapter 176B or the laws of any other jurisdiction; a health maintenance contract issued by a health maintenance organization under chapter 176G or the laws of any other jurisdiction; and an insured health benefit plan that includes a preferred provider arrangement issued under chapter 176I or the laws of any other jurisdiction. "Health plan" shall not include accident only, credit-only, limited scope dental or vision benefits if offered separately, hospital indemnity insurance policies if offered as independent, noncoordinated benefits which for the purposes of this chapter shall mean policies issued pursuant to chapter 175 which provide a benefit not to exceed $500 per day, as adjusted on an annual basis by the amount of increase in the average weekly wages in the commonwealth as

defined in section 1 of chapter 152, to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent, disability income insurance, coverage issued as a supplement to liability insurance, specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meets any requirements the commissioner by regulation may set, insurance arising out of a workers' compensation law or similar law, automobile medical payment insurance, insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self insurance, long-term care if offered separately, coverage supplemental to the coverage provided under 10 U.S.C. 55 if offered as a separate insurance policy, or any policy subject to the provisions of chapter 176K. The commissioner may by regulation define other health coverage as a health plan for the purposes of this chapter.

"Prototype plan", a health plan which meets the criteria established by the commissioner.

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

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

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

Section 4. A carrier shall annually report to the commissioner and to the health care quality and cost council, established under section 16K of chapter 6A, not later than May 1, the actual loss ratio calculated for each health plan for the previous calendar year.

Section 5. The commissioner shall initiate a hearing conducted pursuant to chapter 30A on any filing under section 2 prior to its effective date on at least 10 days' notice. The commissioner may consolidate hearings for more than 1 carrier and may consolidate hearings for multiple health plans filed by 1 carrier. The carrier shall provide information on the reasons for the proposed premium change, and members of the public may testify. All testimony and evidence received shall be public records. The commissioner may promulgate guidelines to safeguard the confidentiality of contracts that establish rates between insurers and institutional providers licensed under section 51 of chapter 111 which shall apply when the commissioner obtains such contracts pursuant to section 8A of chapter 175 for purposes of a hearing under this section.

The attorney general shall have the authority to intervene in any hearing called for under this section and may require that a party to such a hearing produce any documents related to the proposed premium change or documents that the attorney general deems necessary to enable him or the commissioner to evaluate the merits of the proposed premium change. The attorney general shall keep all information and documents obtained under this section confidential and shall not disclose such information or documents to any person except as necessary in a case

brought by the attorney general under this chapter. Such information and documents shall not be public records and shall be exempt from disclosure under section 10 of chapter 66.

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

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

Within 90 days after the conclusion of any hearing initiated under this section, the commissioner shall issue a report containing findings of fact from the evidence presented in the carrier's filing and in the hearing. The findings of fact shall include, but shall not be limited to:

1) the carrier's administrative expenses, including but not limited to the carrier's salary structure, advertising and other marketing expenses, and commissions, brokerage fees and other distribution expenses, as compared to other carriers within and without the commonwealth;
2) the carrier's expenses related to health care contracts, including but not limited to the costs of services rendered by health care providers, the rates at which it pays for such services and the volume of services provided;

3) the carrier's loss experience under the health plan, including evaluations of the carrier's actual loss ratio and of utilization by the carrier's insureds, and of identifiable cost drivers for that health plan, as compared to other carriers within and without the commonwealth;

4) cost-sharing assumptions made in the health plan, including, but not limited to, the use of deductibles, co-payments and coinsurance;

5) the carrier's provisions in the rates for reserves and surplus; and

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

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

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

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

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

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

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

SECTION 26. The General Laws are hereby amended by inserting after chapter 268B the following chapter:-

CHAPTER 268C

PHYSICIAN AND PHARMACEUTICAL MANUFACTURER CONDUCT

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

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

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

"Medical device", an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part, or accessory, which is: (1) recognized in the official National Formulary, or the United States Pharmacopeia, or any supplement to them; (2) intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals; or (3)

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

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

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

"Pharmaceutical manufacturing company", any entity which is engaged in the production, preparation, propagation, compounding, conversion or processing of prescription drugs, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis or by a combination of extraction and chemical

synthesis, or any entity engaged in the packaging, repackaging, labeling, relabeling or distribution of prescription drugs. The term does not include a wholesale drug distributor licensed under section 36A of chapter 112 or a retail pharmacist registered under section 37 of chapter 112.

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

"Physician", a person licensed to practice medicine by the board of medicine under section 2 of chapter 112 who prescribes prescription drugs for any person, or the physician's employees or agents.

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

Section 2. No pharmaceutical manufacturer agent shall knowingly and willfully offer or give to a physician, a member of a physician's immediate family, a physician's employee or agent, a health care facility or employee or agent of a health care facility, a gift of any value.

Nothing in the section shall prohibit the provision, distribution, dissemination, or receipt of peer reviewed academic, scientific or clinical information. Nothing in this section shall prohibit the purchase of advertising in peer reviewed academic, scientific or clinical journals.

Section 3. A person who violates this chapter shall be punished by a fine of not more than $5,000.

SECTION 27. Notwithstanding any general or special law to the contrary, the trustees of the University of Massachusetts shall expand the entering class at its medical school and increase residencies for medical school graduates for students committed to entering the primary care field and to working in underserved regions of the commonwealth. The trustees shall develop a master plan for expanding medical student enrollment and increasing internships and residencies for medical school graduates who are committed to primary care and work in underserved regions without reducing academic quality, together with a financial plan to support such expansion, and shall report that plan to the joint committee on health care financing and the house and senate committees on ways and means not later than January 1, 2009.

SECTION 28. Notwithstanding any general or special law to the contrary, the center for primary care recruitment and placement established under section 12 in consultation with the board of higher education and the executive office of health and human services, shall, subject to appropriation, establish a primary care workforce development and loan forgiveness grant program at community health centers, community hospitals and other facilities in target areas,

as determined by the center pursuant to section 25L of chapter 111 of the General Laws, for the purpose of enhancing the recruitment and retention of primary care physicians and nurse practitioners authorized to practice pursuant to section 80B of chapter 112 of the General Laws. Loan forgiveness programs or zero interest loan programs or other forms of assistance utilizing public funds, in whole or in part, shall require each medical or nursing student recipient to enter into a contract with the commonwealth as a primary care fellow which shall obligate the recipient to perform a term of service determined by the center within the commonwealth in areas of primary care.

SECTION 29. Notwithstanding any general or special law to the contrary, the trustees of the University of Massachusetts, in conjunction with the state health education center at the University of Massachusetts medical center, shall establish and maintain an enhanced learning contract program available to medical students every academic year. The program shall provide full waivers of tuition and fees at the University of Massachusetts medical school. The contract shall require payback service, of at least 4 years of service within the commonwealth in areas of primary care, public or community service, or underserved areas as determined by the center for primary care recruitment and placement and the learning contract committee, in coordination with the area health education center and state and regional health planning agencies. If a student fails to perform payback service as required by an enhanced learning contract, that student shall pay the difference between the tuition paid and double the amount of the tuition charged together with an origination fee, interest per annum at prime rate as reported at the time of origination by the Federal Reserve, a margin and repayment fee as set by the board. No

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

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

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

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

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

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

housing fund. The procedures shall include provisions for eligibility and shall specify the expenses for which grants and loans may be made and determine the documentation and procedures necessary to qualify for the assistance. Two years after the commencement of the pilot program, the department shall report to the house and senate committees on ways and means, the joint committee on housing and the joint committee on health care financing, the results of the pilot program and shall recommend it for expansion, continuation or discontinuation.

SECTION 32. Notwithstanding any special or general law to the contrary, the center for primary care recruitment and placement, in conjunction with the University of Massachusetts medical school and area health education centers, shall study the efforts of Massachusetts-based public and private graduate medical education institutions to foster and expand the supply of primary care physicians in the commonwealth. The study shall include, but shall not be limited to, a survey of institutional efforts to both increase the percentage of medical residents who choose a primary care specialty and the overall enrollment of medical students committed to entering the primary care field. The study shall recommend innovative primary care educational programs and strategies that foster a culture within graduate medical education which embraces primary care. The center shall report its findings and recommendations to the house and senate committee on ways and means and the joint committee on health care financing not later than January 1, 2009.

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

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

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

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

(f) The commission may contract with an another entity with the requisite financial expertise to assist the commission in conducting its study.

(g) The commission shall meet not later than October 1, 2008 and shall hold at least 2 public hearings. The commission shall file a report of its findings and recommendations with the clerks of the senate and house of representatives, the house and senate committee on ways and means and the joint committee on health care financing not later than July 1, 2009.

SECTION 34. Notwithstanding any general or special law to the contrary, the department of public health, in consultation with the health care quality and cost council, shall adopt regulations requiring hospitals, as a standard of eligibility for original licensure and renewal of licensure, to register with the National Healthcare Safety Network. Each hospital that registers with the National Healthcare Safety Network shall grant access to the department and the Betsy Lehman center for patient safety and medical error reduction, in accordance with guidelines of the department to: (1) health care-associated infection data elements reportable to the National Healthcare Safety Network; and (2) hospital-specific reports generated by the National Healthcare Safety Network. Each registered hospital shall collect and submit to the National Healthcare Safety Network health care-associated infection data elements in accordance with guidelines of the department.

SECTION 35. Notwithstanding any general or special law to the contrary, not later than October 1, 2012, the department of public health, in consultation with the health care quality and cost council, shall adopt regulations requiring hospitals and community health centers, as a standard of eligibility for original licensure and renewal of licensure, to implement computerized physician order entry systems as defined by the department. The systems shall be certified by the Certification Commission for Healthcare Information Technology or any

successor agency or organization established for the purpose of certifying that health information technology shall meet national interoperability standards.

SECTION 36. Notwithstanding any general or special law to the contrary, not later than October 1, 2015, the department of public health, in consultation with the health care quality and cost council, shall adopt regulations requiring hospitals and community health centers, as a standard of eligibility for original licensure and renewal of licensure, to implement interoperable electronic health records systems, as defined by the department. The system shall be certified by the Certification Commission for Healthcare Information Technology or any successor agency or organization established for the purpose of certifying that health information technology shall meet national interoperability standards.

SECTION 37. Notwithstanding any general or special law to the contrary, the executive office of health and human services shall maximize enrollment of eligible persons in the MassHealth Senior Care Options program, the Program of All Inclusive Care for the Elderly, the Enhanced Community Options Program and the Community Choices program, or comparable successor programs, and shall develop a plan to offer similar coverage to Medicaid and Medicare-eligible disabled persons under age 65, which shall be referred to in this section, as dual eligible plans.

Not later than 6 months after the effective date of this act, the executive office of health and human services shall prepare a report identifying clinical, administrative and financial barriers to expanded dual eligible plan, and shall recommend steps to remove the barriers and implement the plans. Before finalizing the report, the executive office shall hold a public consultative session that shall include organizations representing seniors, organizations representing disabled persons, organizations representing health care consumers, organizations

representing racial and ethnic minorities, health delivery systems and health care providers. The report shall include consideration of changes in procurement standards and MassHealth payment methodologies to promote enrollment in dual eligible plans. The report shall include estimates of the costs and benefits of implementing steps to remove barriers to expanded enrollment in dual eligible plans, including financial savings and improved quality of care.

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

SECTION 38. The department of public health shall, not later than July 1, 2009, establish a registry of exemptions granted by the department pursuant to section 6 of chapter 350 of the acts of 1993 and the department's regulations to any person who filed with the department by December 23, 1993, a notice of intent to acquire medical, diagnostic or therapeutic equipment used to provide an innovative service or which is a new technology, as defined in section 25B of chapter 111 of the General Laws. Registered exemptions shall be nontransferable. After July 1, 2009, all exemptions qualifying for this registry that have not been registered with the department shall be void. Holders of registered exemptions for medical, diagnostic or therapeutic equipment not placed in regular service by July 1, 2009, shall, upon application, be eligible for an expedited determination of need process, as determined by the department. Exemptions granted by the department under said section 6 of said chapter 350 and the department's regulations to any person who filed with the department, by December 23, 1993, a notice of intent to acquire medical, diagnostic or therapeutic

equipment used to provide an innovative service or which is a new technology shall expire on July 1, 2010, if the equipment for which the exemption was granted was not placed in regular service by July 1, 2009 and if no determination of need was granted by the department.

SECTION 39. The division of insurance shall conduct an investigation and study of the costs of medical malpractice coverage for health care providers, as defined in section 193U of chapter 175 of the General Laws. The investigation and study shall include, but shall not be limited to, examination and analysis of the following: (1) the availability and affordability of medical malpractice insurance; (2) the factors considered by medical malpractice insurers when increasing premiums; (3) options for decreasing premiums including, but not limited to, establishing a reinsurance pool with additional stop loss coverage, subsidizing premium payments of providers practicing in certain high-risk specialties or in specialties for which the cost of premiums represents a disproportionately high proportion of a health care provider's income, subsidizing premium payments of providers who do not qualify for group coverage rates and pay higher premiums for commercial market insurance and prorating premiums for providers who practice less than full-time; and (4) funding mechanisms that would facilitate the implementation of recommendations arising out of the study which may include, but which shall not be limited to, charges borne by the health care industry or other entities. The division shall hold at least 2 public hearings to take testimony relating to the investigation and study, 1 of which shall be held outside the metropolitan Boston area. The division shall report its findings and recommendations to the house and senate committee on ways and means and the joint committee on health care financing not later than January 1, 2009.

SECTION 40. Notwithstanding any general or special law to the contrary, the masshealth payment advisory board, established pursuant to section 16M of chapter 6Aof the

General Laws, shall conduct a study of the need for an increase in Medicaid rates or bonuses for primary care physicians, nurse practitioners and subspecialists who provide primary care services, such as preventive care, certain evaluation and management procedures, early periodic screening, diagnosis and treatment, and scheduled weekend and holiday services, in order to focus on prevention and wellness and delivery of primary care to identify illness earlier, to better manage chronic disease and to avoid costs associated with emergency room visits and hospitalizations. The committee shall report its findings, including recommendations for the amount of funding and the sources of funding, to the joint committee on health care financing, and the house and senate committees on ways and means not later than January 1, 2009.

SECTION 41. There shall be a community benefits taskforce, which shall include the attorney general, the commissioner of public health and other members as determined by the attorney general which shall conduct a study of the community benefits contributions by nonprofit health care providers and insurers. The study shall include, but not be limited to, examination and analysis of the following: (1) current community benefits programs including, but not limited to, plans filed with the attorney general's voluntary community benefits program; (2) methods used to identify and define communities to be served by community benefit programs; (3) the process hospitals and insurers use to assess community needs, define target populations for programs and to make resource allocation decisions; (4) methods used to measure and evaluate the contributions by non-profit healthcare providers and insurers to various communities; (5) the administrative and technological needs of non-profit healthcare providers; (6) potential collaborations between providers to fund improved administrative and technological support systems and information infrastructures as part of a statewide community benefits program including, but not limited to, the creation of a statewide electronic medical

records database and computerized physician order entry to improve access and the portability of health information; and (7) whether the commonwealth ought to mandate standards and amounts of community benefits spending and, if so, what standards ought to apply. The task force shall hold at least 2 public hearings to hear testimony relating to the investigation and study, 1 of which shall be held outside the metropolitan Boston area. The task force shall report its findings and recommendations to the house and senate committee on ways and means and the joint committee on health care financing not later than January 1, 2009.

SECTION 42. Notwithstanding any general or special law to the contrary, the attorney general shall adopt rules, regulations or guidelines that permit 2 or more health insurers, health maintenance organizations, hospitals and other providers in the health care market to: (1) discuss methods to standardize or simplify administrative standards, protocols or practices in order to reduce health care costs, improve access to health care services, improve the quality of care or reduce health care disparities; and (2) negotiate and enter into agreements to implements such standards, protocols or practices, but, no rule, regulation or guideline shall permit rate setting or price fixing, for insurance premiums or payments to providers.

Any person or entity acting under the authority of any rule, regulation or guideline adopted pursuant to this section shall be engaged in action under state policy and shall be immune from antitrust liability to the same degree and extent as the commonwealth.

SECTION 43. The enhanced learning contract program at the University of Massachusetts Medical Center required under section 29 shall be established by the commencement of the 2008 academic year.

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

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

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

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

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

SECTION 49. The bureau of managed care within the division of insurance shall convene the first advisory committee required under section 5B of chapter 176O of the General Laws on January 1, 2009.

SECTION 49A. Notwithstanding any general or special law to the contrary, the secretary of administration and finance and the secretary of health and human services shall prepare and submit a report to the general court about the allocation and use of state funds to acute care and non-acute care hospitals, Medicaid managed care organizations and other managed care organizations, community health centers and carriers contracting with the commonwealth health insurance connector authority. The report shall include: (1) a comprehensive review of the current manner, amount and purposes of annual state funding received by these entities, including a description of the source of the funding; (2) an assessment of the change in total state funding for these entities over the past 5 years, with particular attention paid to the impact of provisions of chapter 58 of the acts of 2006; (3) an assessment of how these entities use state funds; (4) an assessment of whether the current payment structure assures the delivery of quality health care in the most cost-effective way; (5) an analysis of financial and management practices of these entities by benchmarking performance with respect to quality and cost effectiveness against national performance levels and against the performance of similar healthcare providers in the commonwealth; (6) identification of common factors that may contribute to the fiscal instability of these entities; (7) recommendations for the development of performance and operational benchmarks; (8) recommendations for ensuring that these entities are spending state and other funds in a fiscally responsible manner and providing quality care; and (9) recommendations for legislative and

other action necessary to strengthen state oversight and ensure greater accountability of state resources.

The secretaries shall have access to all documents of acute care and non-acute care hospitals, Medicaid managed care organizations and other managed care organizations, community health centers, carriers contracting with the commonwealth health insurance connector authority and any related entities that relate to that organization's use of state funds. The secretaries shall keep all information and documents obtained under this section confidential and shall not disclose such information or documents to any person except as necessary in a case brought by the attorney general under this chapter. Such information and documents shall not be public records and shall be exempt from disclosure under section 10 of chapter 66.

For the purpose of conducting their duties under this section, the secretaries may contract with an outside organization with the requisite financial expertise to enable the secretaries to prepare the report. The secretaries shall submit the report, along with any recommendations for legislative or other action, to the clerks of the house of representatives and of the senate on or before December 31, 2008.

SECTION 50. Not later than 4 years after the effective date of this act, the e-health institute, established in section 6D of chapter 40J of the General Laws, shall submit a report to the joint committee on health care financing and the senate and house committees on ways and means on the progress in realizing the purposes of this act, with particular attention to the following: (i) the capacity to exchange health information between and among components of the health system; (ii) rates of provider participation in electronic health records; (iii) rates of provider participation in practice resdesign; (iv) quality measurement and improvement; (v)

healthcare cost reduction; (vi) participation in advanced programs such as medical home and P4P programs; and (vii) the security and privacy of health information technology supported by this section.

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

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

SECTION 53. Subsection (d) of section 61 of chapter 118E of the General Laws, as appearing in section 19, shall take effect on January 1, 2011.

SECTION 54. Subsection (d) of section 5a of chapter 176O of the General Law, as appearing section 23, shall take effect on January 1, 2011.

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

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