S. 2660

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

04/17/08 S New draft of S2650, printed as amended
04/17/08 S Passed to be engrossed - 36 YEAS to 0 NAYS (see Senate Roll Call, No. 206) -SJs 1483-1493

04/24/08 H Read; and referred to the committee on House Ways and Means -HJ 1287

07/15/08 H Committee recommended ought to pass with an amendment, substituting therefor the text contained in H4974
07/15/08 H Referred to the committee on House Steering, Policy and Scheduling with the amendment pending
07/15/08 H Committee reported that the matter be placed in the Orders of the Day for the next sitting for a second reading with the amendment pending -HJ 1715

07/16/08 H Read second, amended (as recommended by the committee on Ways and Means) and ordered to a third reading
07/16/08 H Rules suspended
07/16/08 H Read third
07/16/08 H Amendment adopted
07/16/08 H Amendment adopted
07/16/08 H Amendment adopted
07/16/08 H Amendment adopted
07/16/08 H Amendment rejected
07/16/08 H Amendment rejected
07/16/08 H Amendment rejected
07/16/08 H Amendment rejected
07/16/08 H Amendment rejected
07/16/08 H Amendment adopted
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07/16/08 H Amendment adopted
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07/16/08 H Amendment adopted
07/16/08 H Amendment adopted
07/16/08 H Amendment adopted
07/16/08 H Amendment adopted
07/16/08 H Amendment adopted
07/16/08 H Amendment adopted
07/16/08 H For text, see House, No. 4974, printed as amended
07/16/08 H Passed to be engrossed - 154 YEAS to 0 NAYS (See Yea and Nay in Supplement, No. 432) -HJs 1730-1741

07/30/08 S Senate NON-concurred in the House amendments

07/30/08 S Committee of conference appointed (Moore-Panagiotakos-Tisei) -SJ 2221
07/30/08 H *House insisted on its amendments*
07/30/08 H Committee of conference appointed (Walrath-Bosley-Hargraves) -HJ 1881

07/31/08 S Reported by committee of conference
07/31/08 S **See S2863** -SJs 2419-2420

SENATE, NO. 2660, printed as amended

[Senate, April 17, 2008 – Substituted by amendment by the Senate as a new draft of Senate, No. 2650]

The Commonwealth of Massachusetts

IN THE YEAR OF TWO THOUSAND AND EIGHT

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

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

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

1 SECTION 1. Section 16J of chapter 6A of the General Laws, as appearing in the 2006
2 Official Edition, is hereby amended by striking out the words "and 16L", in line 1, and inserting
3 in place thereof the following words:- ,16L and 16P.
4 SECTION 2. Said section 16J of said chapter 6A, as so appearing, is hereby further
5 amended by inserting before the definition of "Clinician" the following 2 definitions:-
6 "Adverse", a negative consequence of care that results in an unintended injury or illness,
7 which may or may not have been preventable.

8 "Associated with", that it is reasonable to initially assume that the adverse event was

9 directly due to the referenced course of care.

10 SECTION 3. Said section 16J of said chapter 6A, as so appearing, is hereby further

11 amended by adding the following definition:-

12 "Preventable", an event that could have been reasonably anticipated and prepared for but

13 which occurred because of an error or other system failure.

14 SECTION 4. Said chapter 6A is hereby further amended by striking out section 16K, as

15 so appearing, and inserting in place thereof the following section:-

16 Section 16K. There shall be a health care quality and cost council within, but not subject

17 to the control of, the executive office of health and human services. The council shall promote

18 public transparency of the quality and cost of health care in the commonwealth by establishing

19 health care quality improvement and cost containment goals. The goals shall be designed to

20 promote high-quality, safe, effective, timely, efficient, equitable and patient-centered health

21 care. The council shall receive staff assistance from the executive office of health and human

22 services and may, subject to appropriation, employ such additional staff or consultants as it may

23 deem necessary. The council shall consist of the secretary of health and human services who

24 shall be the chairperson, the auditor of the commonwealth or his designee, the inspector general

25 or his designee, the attorney general or his designee, the commissioner of insurance, the

26 executive director of the group insurance commission, the executive director of the

27 commonwealth health insurance connector authority, the secretary of administration and finance

28 or his designee and 7 persons to be appointed by the governor, 1 of whom shall be a

29 representative of a health care quality improvement organization recognized by the Centers for

30 Medicare and Medicaid Services, 1 of whom shall be a representative of the Institute for

31 Healthcare Improvement, Inc. recommended by the organization's board of directors, 1 of
32 whom shall be a representative of the Massachusetts Chapter of the National Association of
33 Insurance and Financial Advisors, 1 of whom shall be a representative of the Massachusetts
34 Association of Health Underwriters, 1 of whom shall be a representative of the Massachusetts
35 Medicaid Policy Institute, 1 of whom shall be an expert in health care policy from a foundation
36 or academic institution and 1 of whom shall represent a nongovernmental purchaser of health
37 insurance. The representatives of nongovernmental organizations shall serve staggered 3-year
38 terms.

39 SECTION 4A. Section 16L of said chapter 6A, as so appearing, is hereby amended by
40 inserting after the word "Business", in lines 144 and 145, the following words:- ,1 member
41 representing the Retailers Association of Massachusetts.

42 SECTION 4B. Section 16L of chapter 6A of the General Laws is hereby amended, in
43 subsection (l), by inserting after the words "Trust Funds", the following words:-
44 "geographically representative Independent Practice Association medical directors coordinated
45 through the Massachusetts Medical Society,".
46

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

49 (r) A subcommittee of the council shall be established to pursue public and private
50 reform of health care purchasing. The subcommittee shall convene public and private health
51 care purchasers for the purpose of collaborating on common purchasing principles and
52 strategies for promoting and rewarding higher value health care. The subcommittee shall
53 identify and develop nonbinding payment guidelines and best practices that will align

54 purchasing incentives around shared quality goals. The subcommittee shall focus on, but shall
55 not be limited to: (i) encouraging quality, coordinated and effective care as opposed to volume
56 of care; (ii) emphasizing chronic disease management programs; (iii) developing appropriate
57 and feasible measures of quality performance and rewarding providers for improving quality
58 performance; (iv) improving compensation and support for primary care providers; (v)
59 developing a medical home payment model that emphasizes a comprehensive approach to
60 patient care; (vi) reducing waste and duplication in clinical care; (vii) investing in and
61 accelerating the adoption of health information technology, specifically computerized physician
62 order entry systems, e-prescribing and electronic health records; (viii) aligning incentives with
63 Medicare payment policies; (ix) promoting health and wellness programs; and (x) empowering
64 consumers with access to health care information. The subcommittee members shall be
65 determined by the chair of the council and shall consult with an advisory committee consisting
66 of 1 person representing the Massachusetts Association of Health Plans, Inc., 1 person
67 representing Blue Cross and Blue Shield of Massachusetts, Inc., 1 person representing
68 Associated Industries of Massachusetts, 1 person representing the Massachusetts Municipal
69 Association and 4 persons to be appointed by the governor, 1 of whom shall be a health
70 economist, 1 of whom shall be an expert in Medicare payment policy, 1 of whom shall be a
71 representative of a self-insured labor union and 1 of whom shall be a health care consumer
72 advocate. The council shall provide the subcommittee with staff as necessary to complete its
73 research and analysis. The subcommittee shall meet at least once every 2 months and at such
74 other times as required by its rules. The subcommittee shall submit an annual report of its
75 progress and activities and its recommendations, if any, together with drafts of legislation or
76 regulations necessary to carry those recommendations into effect, by filing the same with the

77 governor, the health care cost and quality council, the clerks of the senate and house of

78 representatives, the joint committee on health care financing and the joint committee on public

79 health not later than July 1.

80 (s) The council shall establish goals for the adoption of health information technology

81 including, but not limited to, electronic prescription transactions for new prescriptions,

82 prescription renewals, cancellations, changes between prescribers and dispensers, ancillary

83 messages and administrative transactions, hereinafter referred to as e-prescribing, the process of

84 electronic entry of physician instructions for the treatment of patients, whether inpatient or

85 outpatient, under the care of that physician, hereinafter referred to as computerized physician

86 order entry, and individual patient records in digital format or electronic health records;

87 provided, however, that any system, network, software or equipment utilized in the attainment

88 of those goals shall be certified by the certification commission for health care information

89 technology, an independent, nonprofit organization designated by the federal government as the

90 recognized certification body for health information technology products and networks; and

91 provided further, that the goals shall state the percentage adoption by providers expected by a

92 given year, any incentives or other provisions for attainment of the goals and any penalties for

93 failure to attain the goals.

94 SECTION 6. Said chapter 6A is hereby further amended by inserting after section 16O

95 the following section:-

96 Section 16P. (a) The secretary of health and human services shall adopt regulations to

97 create a list of serious reportable events consistent with the list established by the National

98 Quality Forum. The executive office of health and human services, its agencies and the health

99 care quality and cost council shall utilize the list created by the secretary's regulations for all

100 standardized reporting of serious reportable events. Each serious reportable event shall be
101 reported on the consumer health information website created by subsection (h) of section 16L.
102 The website shall identify each serious reportable event and the facility at which it occurred but
103 shall not include any other identifying information, including, but not limited to, the identities of
104 any of the health care professionals, facility employees or patients involved.

105 (b) The secretary shall adopt regulations prohibiting a health care facility from charging
106 or seeking reimbursement for services associated with a serious reportable event. In adopting
107 the regulations, the secretary shall consider that the list of serious reportable events established
108 under subsection (a) is intended to facilitate public reporting and was not designed to serve as a
109 basis for determining whether reimbursement shall be sought or forgone. A health care facility
110 shall not charge or seek reimbursement for a serious reportable event that the health care facility
111 has determined, through a documented review process, was: (i) preventable; (ii) within its
112 control; and (iii) unambiguously the result of a system failure based on the health care
113 provider's policies and procedures.

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

118 (d) Notwithstanding any general or special law to the contrary, all communications and
119 documentation regarding whether reimbursement for health care services that are directly
120 associated with an occurrence of a serious reportable event shall be sought or forgone shall be
121 privileged and confidential, shall be exempt from the disclosure of public records under section

122 10 of chapter 66 and shall not be subject to subpoena or discovery or introduced into evidence
123 in any judicial or administrative proceeding.

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

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

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

138 (b) Notwithstanding any general or special law to the contrary, all insurers marketing
139 small group or large group plans shall annually submit to the division of insurance, on or before
140 April 1, the following information: current average individual and family plan premiums for the
141 insurer's prototype or alternative prototype plan, as defined in section 1 of chapter 176S, for
142 groups of 1 to 5 employees, 6 to 10 employees, 11 to 25 employees, 26 to 50 employees, 51 to
143 100 employees, 101 to 500 employees, 501 to 1000 employees, 1001 to 2500 employees, 2501
144 to 5000 employees and 5001 or more employees. Public employer plans shall be similarly

145 aggregated and reported separately. All reports shall include plan design summaries, including
146 average benefits and co-pays.
147 (c) On or before April 1 of each year, the division of insurance shall compile, through
148 confidential surveys, division filings and other means, average individual and family plan costs
149 for ERISA exempt self-insured health plans operating in the commonwealth using the most
150 commonly offered plan design.
151 (d) On or before April 1 of each year, the division of insurance and the division of health
152 care finance and policy shall collaborate to compile, through confidential surveys, division
153 filings and other means, a list of all the state-mandated health benefits and the percentages to
154 which ERISA exempt self-insured health plans operating in the commonwealth include each
155 mandated benefit within each health plan offered to or administered on behalf of residents in the
156 commonwealth.
157 (e) On or before July 1 of each year, the division of insurance and the division of health
158 care finance and policy shall make available the Massachusetts health insurance transparency
159 report for consumer and employer use. This report shall be completed using data collected
160 during the preceding year pursuant to this section, and shall include the average premium cost
161 data required to be reported under subsection (b) by insurer, employer size and category and by
162 insurer's prototype or alternative prototype plan, as defined in section 1 of chapter 176S. The
163 data required to be reported under subsection (c) shall be reported in aggregate form.
164 SECTION 9. Chapter 40J of the General Laws is hereby amended by inserting after
165 section 6C the following section:-
166 Section 6D. (a) The corporation shall establish an institute for health care innovation,
167 technology and competitiveness, to be known as the e-health institute, and a fund to be known

168 as the e-Health Institute Fund, to be held by the corporation separate and apart from its other
169 funds, to finance the activities of the institute. The institute shall transform care delivery and the
170 utilization of care process redesign supported by a statewide, secure, interoperable electronic
171 health records system in order to improve patient safety and quality, and to lower costs in the
172 state's health care system, with a particular emphasis on the deployment of quality improvement
173 efforts and health information technology in discrete and underserved regions by harnessing
174 local support and involvement in such development activities and by improving the health
175 information technology infrastructure for those regions. In furtherance of these public purposes,
176 the institute shall endeavor to identify regions where compelling opportunities to make strategic
177 investments appear to be present and develop strategies therefor. The institute may also provide
178 development support more generally to organizations to assist in quality improvement activities
179 and the formation and growth of emerging health technology sectors in those regions and may
180 provide support to departments, agencies and quasi-public entities of the commonwealth for
181 activities that are consistent with the purposes of the institute.
182 The executive director of the corporation shall appoint a qualified individual as director
183 to manage the affairs of the institute, who shall be an employee of the corporation, report to the
184 executive director and manage the affairs of the institute. The corporation shall establish a
185 governing board to assist it in matters related to the institute. The governing board shall be
186 comprised of not less than 9 individuals, including the executive director of the corporation and
187 the secretary of health and human services who shall serve ex-officio. The corporation, on
188 recommendation of the executive director, shall appoint not less than 7 persons to a governing
189 board to assist the corporation in matters related to the institute, 1 of whom shall be a dean of a
190 medical school, 1 of whom shall be a head of an emerging health technology company, 1 of

191 whom shall be a chief information officer of a major teaching hospital, 1 of whom shall be an
192 expert in health information privacy and security and 1 of whom shall be a technology transfer
193 officer or individual qualified in technology commercialization from a university in the
194 commonwealth. Each member of the governing board appointed by the corporation shall serve
195 for such term as the corporation may designate upon such member's appointment, but no term
196 shall be for less than 1 year and nor more than three years. The corporation may appoint a
197 member for an unlimited number of additional terms, the length of each such term being
198 determined by the corporation at the time of appointment to each such additional term. The
199 members of the governing board shall develop and submit to the board, for its review,
200 modification and approval, a detailed plan for the operation of the institute and the
201 administration of the fund. Upon approval of such detailed plan by the board of directors of the
202 corporation, it shall delegate such authority to the governing board as it deems necessary to
203 implement the plan.

204 Upon consultation with the advisory committee established in subsection (b), the
205 governing board shall prepare, and update annually, a statewide electronic health records plan
206 and submit such plan and each update to the board for approval. In developing the plan, the
207 governing board may consult with any individual, agency or organization including, but not
208 limited to, the Massachusetts Technology Collaborative, the New England Healthcare Institute,
209 Masspro, the Massachusetts Health Data Consortium, MA-SHARE, the Institute for Health
210 Improvement, the Massachusetts League of Community Health Centers, Inc., the Massachusetts
211 Hospital Association, the Massachusetts Association of Community Hospitals, Blue Cross and
212 Blue Shield of Massachusetts, Inc., the Massachusetts Association of Health Plans, the Mental
213 Health and Substance Abuse Corporations of Massachusetts and other quasi-public agencies and

214 not-for-profit organizations. The institute may make grants in support of Massachusetts-based
215 public and private enterprises developing and deploying new technologies to significantly
216 increase the efficiency, safety and quality of the health care system. Successful grants shall
217 incorporate regional involvement through alliances among municipalities, colleges, hospitals,
218 health centers, skilled nursing facilities, business and industry; community-based organizations,
219 community-based behavioral health care providers, nonprofit organizations and labor unions.
220 The governing board may apply the provisions of this chapter that apply to centers and to the
221 center fund to the institute and to the e-Health Institute Fund. Without limiting the generality of
222 the foregoing, the corporation may apply moneys in said fund to pay for start-up expenses,
223 project costs and current expenses associated with said institute and related activities, grants or
224 loans to nonprofit or other organizations to promote its purposes consistent with the purposes of
225 this section. The institute shall file a report annually, not later than January 31, with the joint
226 committee on health care financing and the house and senate committees on ways and means
227 addressing the activities of the institute, in general, and describing progress to date in
228 implementation of a statewide electronic health records system and recommendations for any
229 further legislative action that it may deem necessary or appropriate.
230 (b) There shall be an e-health advisory committee to advise the institute and the
231 governing board relative to the electronic health records plan and implementing the institute's
232 purposes and responsibilities under this section. The advisory committee shall review and offer
233 guidance on the establishment and implementation of the statewide electronic health records
234 system, as well as the financing and technical assistance required to enable all health care
235 providers to acquire and implement electronic medical records necessary to participate in the
236 statewide system. The members of the advisory committee shall include the secretary of health

237 and human services, who shall serve as the chair, the secretary of administration and finance or
238 his designee, the executive director of the Massachusetts e-health institute, the executive
239 director of the health care cost and quality council established in section 16K of chapter 6A and
240 such additional members as the secretary may determine; provided, however, that the such
241 appointees shall include persons with expertise and experience in 1 or more of the following
242 areas: health information privacy and security, the development and dissemination of electronic
243 health records systems, implementation of electronic health record systems by small physician
244 groups or ambulatory care providers or the interoperability of systems of electronic health
245 records systems; and provided further, that such appointees shall include persons representing
246 organizations within the commonwealth interested in and affected by the development of
247 networks and electronic health records systems including, but not limited to, persons
248 representing local public health agencies, licensed hospitals and other licensed facilities and
249 providers, private purchasers, the medical and nursing professions, physicians, health insurers
250 and health plans, the state quality improvement organization, academic and research
251 institutions, consumer advisory organizations with expertise in health information technology
252 and other stakeholders as identified by the secretary of health and human services. Each
253 member of the advisory committee appointed by the secretary shall serve for such term as the
254 secretary may designate upon such member's appointment, but no term shall be less than 1 year
255 nor more than 3 years. The secretary may appoint a member for an unlimited number of
256 additional terms, the length of each such term being determined by the secretary at the time of
257 appointment to each such additional term. The members of the advisory committee shall be
258 deemed to be directors for purposes of the fourth paragraph of section 3; provided, however,
259 that notwithstanding said section 3 and sections 5, 6 and 7 of chapter 268A, no member of the

260 advisory committee shall be precluded from participating in matters before the committee
261 because he, or a related party within the scope of said section 6 of said chapter 268A, has a
262 financial interest in a matter being considered by the committee, if such interest or involvement
263 was disclosed in advance to the advisory committee and recorded in the minutes of the advisory
264 committee's proceedings; and provided further, that no member shall be deemed to violate
265 section 4 of said chapter 268A because of his receipt of his usual and regular compensation
266 from his employer during the time in which the member participates in the activities of the
267 advisory committee..

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

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

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

295 (e) In awarding grants, which are to be distributed from the e-Health Institute Fund, not
296 more than $25,000,000 annually shall be allocated to implement the objectives and priorities of
297 this section and of the e-health plan in a manner that is equitable across all geographic regions
298 of the commonwealth, including the central area, the greater Boston area, the northeast area, the
299 southeast area and the western area, based on an allocation plan that the institute will prepare
300 annually and submit, prior to awarding grants under this subsection, for approval of the joint
301 committee on health care financing; provided, however, that if the committee does not act upon
302 such plan within 30 days of its receipt the plan shall be deemed to be approved.

303 (f) In making grants under this section to health services providers or to health plans, the
304 institute shall receive assurances from the grant recipient that the grant shall be used to: (1)
305 redesign care processes; (2) utilize care management techniques; (3) develop and implement an

306 electronic health records system; and (4) begin implementation of the plan not later than the
307 beginning of the second year of the grant.
308 (g) In selecting grant or loan recipients under this section, the institute shall consider:
309 (i) existing technological and organizational infrastructure upon which the health information
310 network can build; (ii) the extent of stakeholder participation; (iii) health care provider
311 participation commitments; (iv) capacity to measure quality and efficiency improvements;
312 (v) replicability; (vi) the extent of the opportunity for a plan to improve health care quality and
313 the health outcomes of patients in the region to be served; (vii) the participation in health
314 information exchange efforts; (viii) care redesign and management efforts; (ix) technological
315 capacity to maintain the security of identifiable health data by means of data segregation,
316 encryption, the use of unique alpha-numerical identifiers to track stored or transferred patient
317 records, and other administrative protections; (x) any history of security and data breaches; and
318 (xi) such other factors as it deems relevant.
319 (h) Any health information network funded in whole or in part under this section shall:
320 (1) be required to establish within the system a mechanism to allow patients to opt-in to the
321 health information network and to opt-out at any time; (2) comply with any applicable
322 regulatory privacy protections; (3) upon request, provide individuals with a list of individuals
323 and entities who have accessed their identifiable health information and what identifiable health
324 information about them is made available through the health information network; (4) develop
325 and distribute to authorized users of the health information network and to prospective network
326 patient participants, written guidelines addressing privacy, confidentiality and security of health
327 information and inform individuals of what information about them is available, who may
328 access their information and the purposes for which their information may be accessed and shall

329 implement a training program regarding such guidelines for all persons who acquire, use,
330 disclose or store identifiable health information to ensure compliance with such policies; and (5)
331 shall undertake continuous review and assessment of security standards and conduct periodic
332 audits of all security systems for potential and actual security breaches.

333 (i) In the event of an unauthorized access to or disclosure of individually identifiable
334 patient health information by or through the statewide health information network or by or
335 through any technology grantees funded in whole or in part under this section, the operator of
336 such network or grantee shall: (i) report the conditions of such unauthorized access or disclosure
337 as required by the Massachusetts Technology Collaborative; and (ii) provide notice, as defined
338 in section 1 of chapter 93H of the General Laws, as soon as practicable, but not later than 10
339 business days, to person whose patient health information may have been compromised as a
340 result of such unauthorized access or disclosure, and shall report the conditions of such
341 unauthorized access or disclosure.

342 (j) To apply for a grant under this section, an applicant shall submit an application to
343 the collaborative in such form and manner, and containing such information and assurances as
344 the collaborative may require. No material containing information received by the
345 Massachusetts Technology Collaborative in connection with the procurement, performance and
346 evaluation of contracts, including grants, under this section shall constitute a public record if
347 such information constitutes a private party's trade secret, proprietary commercial or financial
348 information or strategically sensitive information. Notwithstanding the aforementioned, all
349 materials created or received by the collaborative shall be open to inspection by the state auditor
350 and the inspector general.

351 (k) (1) The Massachusetts Technology Collaborative shall provide to the statewide
352 health information technology network and to individual technology grantees such technical
353 assistance as it deems appropriate to carry out this section, including assistance relating to
354 questions of governance, financing and technological approaches to the creation of health
355 information networks.

356 (2) The institute shall by contract or grant establish and maintain a statewide technical
357 assistance center to provide assistance to physicians to facilitate successful practice redesign,
358 adoption of electronic health records, utilization of care management strategies and participation
359 in advanced programs such as the statewide health information network, medical homes
360 program, pay for performance and other incentive programs by such physicians. The statewide
361 technical assistance center shall assist physicians in all geographical areas served by a health
362 information network. In assisting physicians under this paragraph, the statewide technical
363 assistance centers shall prioritize physicians in small physician groups and, as resources allow,
364 shall assist physicians in larger groups. Technical assistance provided under this paragraph
365 shall, at a minimum, include the following: (i) a clearinghouse of best practices, guidelines and
366 implementation strategies directed at the small medical practices that plan to redesign their
367 practices; (ii) a change management tool kit to enable physicians and their staff to successfully
368 prepare practice workflows for adoption of electronic medical records and electronic
369 prescribing, to receive guidance in the selection of vendors of health information technology
370 products and services that are appropriate within the context of the individual practice and the
371 community setting, to implement health information technology solutions and manage the
372 project at the practice level and to address the ongoing need for upgrades, maintenance and
373 security of office-based health information technologies; and (iii) the capability to provide

374 consultations and advice to small medical practices to facilitate adoption of health information
375 technologies.

376 (l) No databases developed with funds made available under this section and to be used
377 for research or to support reporting provider-specific health information required for the
378 calculation of any voluntary consensus standard endorsed by the National Quality Forum shall
379 contain individually identifiable patient health information.;

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

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

387 Section 4N. (a) The department of public health shall develop, in cooperation with the
388 Division of Commonwealth Medicine at the University of Massachusetts Medical School,
389 implement and promote an evidence-based outreach and education program designed to provide
390 information and education on the therapeutic and cost-effective utilization of prescription drugs
391 to physicians, pharmacists and other health care professionals authorized to prescribe and
392 dispense prescription drugs, subject to appropriation. In developing the program, the department
393 shall consult with physicians, pharmacists, private insurers, hospitals, pharmacy benefit
394 managers, the MassHealth drug utilization review board and the University of Massachusetts
395 Medical School. The program shall include the following elements:

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

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

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

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

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

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

424 "Expenditure minimum with respect to substantial capital expenditures", with respect to
425 expenditures and acquisitions made by or for: (1) acute care hospitals and comprehensive cancer
426 centers as defined in section 31 of chapter 6A, only, $7,500,000, except that expenditures for, or
427 the acquisition of, major movable equipment not otherwise defined by the department as new
428 technology or innovative services shall not require a determination of need and shall not be
429 included in the calculation of the expenditure minimum; and (2) health care facilities, other than
430 acute care hospitals, and facilities subject to licensing under chapter 111B, with respect to: (a)
431 expenditures for, or the acquisition of, medical, diagnostic or therapeutic equipment, $400,000
432 and (b) all other expenditures and acquisitions, eight $800,000; provided, however, that
433 expenditures for, or the acquisition of, any replacement of medical, diagnostic or therapeutic
434 equipment defined as new technology or innovative services for which a determination of need
435 has issued or which was exempt from determination of need, shall not require a determination
436 of need and shall not be included in the calculation of the expenditure minimum; provided
437 further, that expenditures and acquisitions concerned solely with outpatient services other than
438 ambulatory surgery, not otherwise defined as new technology or innovative services by the
439 department, shall not require a determination of need and shall not be included in the calculation

440 of the expenditure minimum, unless the expenditures and acquisitions are at lease $25,000,000,
441 in which case a determination of need shall be required. Notwithstanding the above limitations,
442 acute care hospitals only may elect at their option to apply for determination of need for
443 expenditures and acquisitions less than the expenditure minimum.

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

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

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

460 The center shall submit an annual report, not later than October 1, to the joint committee
461 on public health, the joint committee on health care financing and the house and senate
462 committees on ways and means regarding the center's activities in recruiting and retaining

463 health care providers for underserved populations and areas throughout the commonwealth. The
464 annual report shall include, but not be limited to, information about: (i) the activities and
465 accomplishments of the center during the report period; (ii) planned activities for the next year;
466 (iii) the number and type of providers who have been recruited to work in the commonwealth as
467 a result of center activities; (iv) the retention rate of providers who have located in target areas
468 as a result of center activities; (v) the utilization rate of the scholarship and loan repayment
469 programs and other programs or activities authorized for provider recruitment and retention; and
470 (vi) *recommendations for pilot programs and regulatory or legislative proposals to address*
471 workforce needs, shortages, recruitment and retention.

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

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

481 SECTION 14. Said chapter 111 is hereby further amended by inserting after section
482 53D the following 3 sections:-

483 Section 53E. The department shall promulgate regulations for the establishment of
484 patient and family advisory councils by hospitals. The councils may advise the hospital on

485 matters including, but not limited to, patient and provider relationships, institutional review
486 boards, quality improvement initiatives and patient education on safety and quality matters.
487 Members of a council may act as reviewers of publicly reported quality information, members
488 of task forces, members of awards committees for patient safety activities, members of advisory
489 boards, participants on search committees and hiring of new staff, co-trainers for clinical and
490 nonclinical staff, in-service programs, health professional trainees and participants in reward
491 and recognition programs. The department may require hospitals to report annually on the
492 membership and work of their councils.

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

499 (b) The regulations shall include criteria for calling additional assistance to respond to a
500 change or perception of change in a patient's condition by the staff, patients or families. The
501 regulations shall include criteria for hospitals to educate patients and family members about the
502 methods for recognition and response to changes in patients' conditions, their purposes and how
503 to activate the methods.

504 Section 53G. Notwithstanding any general or special law to the contrary, any entity that
505 is certified or intends to be certified as an Ambulatory Surgical Center by the Centers for
506 Medicare and Services for participation in the Medicare program shall be a clinic for the

507 purposes of licensure under section 51, and shall be deemed to be in compliance with the
508 conditions for licensure as a clinic under said section 51 if it is accredited to provide ambulatory
509 surgery services by the Accreditation Association for Ambulatory Health Care, Inc., the Joint
510 Commission on Accreditation of Healthcare Organizations, the American Association for
511 Accreditation of Ambulatory Surgery Facilities or any other national accrediting body that the
512 department of public health determines provides reasonable assurances that such conditions are
513 met. No original license shall be issued pursuant to said section 51 to establish any such
514 ambulatory surgical clinic unless there is a determination by the department that there is a need
515 for such a facility. For purposes of this section, "clinic" shall not include a clinic conducted by
516 a hospital licensed under said section 51 or by the federal government or the commonwealth.
517 The department shall promulgate regulations to implement this section.

518 SECTION 15. The first paragraph of section 70 of said chapter 111, as appearing in the
519 2006 Official Edition, is hereby amended by striking out the second and third sentences and
520 inserting in place thereof the following 3 sentences- Such records may be handwritten, printed,
521 typed or in electronic digital media or converted to electronic digital media as originally created
522 by such hospital or clinic, by the photographic or microphotographic process, or any
523 combination thereof. Such hospital or clinic, may only destroy records after notifying the
524 department of public health and the patient that the applicable retention period has elapsed and
525 the records will be destroyed. Such notification shall occur through appropriate notice, which
526 may include, but shall not be limited to, the hospital or clinic's privacy notice, that records will
527 be destroyed after the applicable retention period has elapsed. Such hospital or clinic shall
528 further provide information through applicable provisions contained in the hospital or clinic

529 notice of privacy practices that records will be terminated after the applicable retention period
530 has elapsed since the last date of service.

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

534 SECTION 17. Section 9E of chapter 112 of the General Laws, as so appearing, is
535 hereby amended by striking out, in line 6, the word "two" and inserting in place thereof the
536 following figure:- 4.

537 SECTION 17A. Said chapter 112 is hereby further amended by inserting after section
538 39C the following section:-

539 Section 39D. Stores or pharmacies engaged in the drug business, as defined in section
540 37, shall be mandatory reporters required to inform the department of public health of any
541 improper dispensing of prescription drugs resulting in serious injury or death, as soon as is
542 reasonably and practically possible, but not later than 15 working days after discovery of the
543 error.

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

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

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

551 preventive and ongoing health services and is respectful of, and responsive to, individual patient
552 preference, needs and values.
553 (b) Notwithstanding any general or special law to the contrary, the office of Medicaid,
554 subject to appropriation and the availability of federal financial participation, shall establish a
555 medical home demonstration program for the purpose of redesigning the health care delivery
556 system to provide targeted, accessible, continuous and coordinated family-centered care to high
557 need populations including, but not limited to, those with multiple chronic illnesses that require
558 regular monitoring, advising or treatment. The office of Medicaid shall work with Medicaid
559 managed care organizations to develop and implement the program.
560 (c) Under the demonstration program, case management fees shall be paid to personal
561 physicians and incentive payments shall be paid to physicians and providers participating in
562 practices that provide medical home services. Medical homes shall be responsible for: (1)
563 targeting eligible individuals for program participation; (2) providing safe and secure
564 technology to promote patient access to personal health information; (3) developing a health
565 assessment tool for the targeted individuals; and (4) providing training for personnel involved in
566 the coordination of care.
567 (d) The program shall operate for 3 years in urban, rural and underserved areas in up to
568 10 communities and shall include physician practices with less than 3 full-time equivalent
569 physicians, as well as larger practices, particularly in rural and underserved areas.
570 (e) Personal physicians who provide first contact and continuous care for their patients
571 shall be board certified. Such personal physicians shall also have a staff and resources to
572 manage the comprehensive and coordinated care of each of their patients. Participating
573 providers may be specialists or sub-specialists for patients requiring ongoing care for specific

574 conditions, multiple chronic conditions including, but not limited to severe asthma, complex
575 diabetes, cardiovascular disease and rheumatologic disorders or for those with prolonged
576 illnesses.

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

586 (g) The office of Medicaid may establish a system of supplemental payments for care
587 management to personal physicians through the establishment of a care management fee and,
588 for that purpose, shall establish a care management fee code and a value for those payments.

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

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

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

597 Section 61. (a) Subject to subsection (c), for the purposes of processing claims for
598 health care services submitted by a health care provider and to provide uniformity and
599 consistency in the reporting of patient diagnostic information, patient care service and procedure
600 information as it relates to the submission and processing of health care claims, the executive
601 office of health and human services and its subcontractors shall, without local customization,
602 accept and recognize patient diagnostic information and patient care service and procedure
603 information submitted pursuant to, and consistent with, the current Health Insurance Portability
604 and Accountability Act compliant code sets as adopted by: the Centers for Medicare and
605 Medicaid Services; the International Classification of Diseases; the American Medical
606 Association's Current Procedural Terminology codes, reporting guidelines and conventions; and
607 the Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding
608 System. The executive office and its subcontractors shall adopt the aforementioned coding
609 standards and guidelines, and all changes thereto, in their entirety, which shall be effective on
610 the same date as the national implementation date established by the entity implementing the
611 coding standards.

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

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

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

626 SECTION 20. Section 61 of said chapter 118E, as appearing in section 19, is hereby amended by striking out subsection (d) and inserting in place thereof the following section:-

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

630 SECTION 21. Chapter 118G of the General Laws, as appearing in the 2006 Official Edition, is hereby amended by adding the following section:-

632 Section 40. (a) The division shall hold an annual public hearing to examine the factors that contribute to the cost increases of the health care delivery system and strategies employed by the provider community to reduce cost growth. While considering size, payor mix, geographic representation and specialty, the division shall identify a broad representative sample of providers in each of the following categories: integrated delivery systems; acute care hospitals; community health centers; freestanding ambulatory surgical centers; physician group practices; rehabilitation hospitals; and skilled nursing facilities. Each identified provider shall be required to provide oral and written testimony at the hearing in a format determined by the division. The division shall require providers to provide testimony relative to: payment systems; utilization trends, including volume of services and intensity of services; demographics

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

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

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

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

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

673 Section 5A. (a) Subject to subsection (c), for the purposes of processing claims for
674 health care services submitted by a health care provider and to provide uniformity and
675 consistency in the reporting of patient diagnostic information, patient care service and procedure
676 information as it relates to the submission and processing of health care claims, a carrier and its
677 subcontractors shall, without local customization, accept and recognize patient diagnostic
678 information and patient care service and procedure information submitted pursuant to, and
679 consistent with the current Health Insurance Portability and Accountability Act compliant code
680 sets as adopted by the Centers for Medicare and Medicaid Services: the International
681 Classification of Diseases; the American Medical Association's Current Procedural
682 Terminology codes, reporting guidelines and conventions; and the Centers for Medicare and
683 Medicaid Services Healthcare Common Procedure Coding System. A carrier and its
684 subcontractors shall adopt the aforementioned coding standards and guidelines, and all changes
685 thereto, in their entirety, which shall be effective on the same date as the national
686 implementation date established by the entity implementing the coding standards.

687 (b) Subject to subsection (c), a carrier and its subcontractors shall, without local

688 customization, use the standardized claim formats for processing health care claims as adopted

689 by the National Uniform Claim Committee and the National Uniform Billing Committee and

690 implemented pursuant to the Health Insurance Portability and Accountability Act. A carrier and

691 its subcontractors shall, without local customization, adopt and routinely process all changes to

692 such formats which shall be effective on the same date as the implementation date established

693 by the entity implementing the formats.

694 (c) Except for the requirements for consistency and uniformity in coding patient

695 diagnostic information and patient care service and procedure information, this section shall not

696 affect a carrier's or its subcontractor's payment policy, utilization review policy or benefits

697 under a health benefit plan. Nothing in this section shall preclude a carrier or a subcontractor

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

699 contracts or health benefit plans.

700 (d) Carriers and subcontractors thereof shall accept and recognize at least 85 per cent of

701 all claims submitted by health care providers pursuant to this section..

702 Section 5B. To ensure uniformity and consistency in the submission and processing of

703 claims for health care services pursuant to section 5A, the bureau of managed care within the

704 division of insurance, after consultation with a statewide advisory committee including, but not

705 limited to, members of the Massachusetts Hospital Association, the Massachusetts Medical

706 Society, the Massachusetts Association of Health Plans, the Blue Cross and Blue Shield of

707 Massachusetts, the Massachusetts Health Information Management Association, the

708 Massachusetts Health Data Consortium, a representative of America's Health Insurance Plans, a

709 representative of a MassHealth contracted managed care organization, the executive office of

710 health and human services, the division of health care finance and policy, the health care quality
711 and cost council, the house of representatives and the senate, shall adopt policies and procedures
712 to enforce said section 5A. The policies and procedures shall include a system for reporting
713 inconsistencies related to a carrier's compliance with said section 5A. The bureau shall work
714 jointly with the executive office of health and human services to resolve reports of
715 noncompliance with the requirements of section 53 of chapter 118E. The bureau shall convene
716 the advisory committee annually to review and discuss issues reported by health care providers
717 pursuant to this section and to discuss further recommendations to improve the uniformity and
718 consistency of the reporting of patient diagnostic information and patient care service and
719 procedure information as it relates to the submission and processing of health care claims.

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

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

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

726 CHAPTER 176R

727 CONSUMER CHOICE OF NURSE PRACTITIONER SERVICES

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

730 "Carrier", an insurer licensed or otherwise authorized to transact accident or health
731 insurance under chapter 175; a nonprofit hospital service corporation organized under chapter
732 176A; a nonprofit medical service corporation organized under chapter 176B; a health
733 maintenance organization organized under chapter 176G; an organization entering into a
734 preferred provider arrangement under chapter 176I; a contributory group general or blanket
735 insurance for persons in the service of the commonwealth under chapter 32A; a contributory
736 group general or blanket insurance for persons in the service of counties, cities, towns and
737 districts, and their dependents under chapter 32B; the medical assistance program administered
738 by the division of medical assistance pursuant to chapter 118E and in accordance with Title XIX
739 of the Social Security Act or any successor statute; and any other medical assistance program
740 operated by a governmental unit for persons categorically eligible for such program.

741 "Commissioner", the commissioner of insurance.

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

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

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

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

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

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

770 Section 3. A participating nurse practitioner practicing within the scope of his license
771 including all regulations requiring collaboration with a physician under section 80B of chapter
772 112, shall be considered qualified within the carrier's definition of primary care provider to an
773 insured.

774 Section 4. Notwithstanding any general or special law to the contrary, a carrier that
775 requires the designation of a primary care provider shall provide its insured with an opportunity
776 to select a participating provider nurse practitioner as a primary care provider or to change its
777 primary care provider to a participating provider nurse practitioner at any time during their
778 coverage period.

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

782 Section 6. A complaint for noncompliance against a carrier shall be filed with and
783 investigated by the commissioner or the group insurance commission, whichever shall have
784 regulatory authority over the carrier. The commissioner and the group insurance commission
785 shall promulgate regulations to enforce this chapter.

786 CHAPTER 176S

787 HEALTH INSURANCE RATE HEARINGS

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

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

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

797 "Alternative prototype plan", a health plan which meets the criteria established by the
798 commissioner and which is intended for sale under section 4 of chapter 176Q, to eligible
799 individuals and to eligible small groups, as defined in section 1 of said chapter 176Q.
800 "Carrier", an insurer licensed or otherwise authorized to transact accident and health
801 insurance under chapter 175; a nonprofit hospital service corporation organized under chapter
802 176A; a nonprofit medical service corporation organized under chapter 176B; or a health
803 maintenance organization organized under chapter 176G.
804 "Commissioner", the commissioner of insurance.
805 "Health plan", any individual, general, blanket or group policy of health, accident or
806 sickness insurance issued by an insurer licensed under chapter 175 or the laws of any other
807 jurisdiction; a hospital service plan issued by a nonprofit hospital service corporation under
808 chapter 176A or the laws of any other jurisdiction; a medical service plan issued by a nonprofit
809 hospital service corporation under chapter 176B or the laws of any other jurisdiction; a health
810 maintenance contract issued by a health maintenance organization organized under chapter
811 176G or the laws of any other jurisdiction; and an insured health benefit plan that includes a
812 preferred provider arrangement issued under chapter 176I or the laws of any other jurisdiction;
813 provided; however, that "Health plan" shall not include accident only, credit only, limited scope
814 dental or vision benefits if offered separately, hospital indemnity insurance policies if offered as
815 independent, noncoordinated benefits, which for the purposes of this chapter, shall mean
816 policies issued pursuant to chapter 175 which provide a benefit not to exceed $500 per day, as
817 adjusted on an annual basis by the amount of increase in the average weekly wages in the
818 commonwealth as defined in section 1 of chapter 152, to be paid to an insured or a dependent,
819 including the spouse of an insured, on the basis of a hospitalization of the insured or a

820 dependent, disability income insurance, coverage issued as a supplement to liability insurance,
821 specified disease insurance that is purchased as a supplement and not as a substitute for a health
822 plan and meets any requirements the commissioner may set by regulation, insurance arising out
823 of a workers' compensation law or similar law, automobile medical payment insurance,
824 insurance under which benefits are payable with or without regard to fault and which is
825 statutorily required to be contained in a liability insurance policy or equivalent self insurance,
826 long-term care insurance if offered separately, coverage supplemental to the coverage provided
827 under 10 U.S.C. 55 if offered as a separate insurance policy or any policy subject to chapter
828 176K; and provided further, that the commissioner may, by regulation, define other health
829 coverage as a health plan for the purposes of this chapter.

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

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

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

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

841 Section 4. A carrier shall annually report to the commissioner and to the health care
842 quality and cost council, established in section 16K of chapter 6A, not later than May 1, the
843 actual loss ratio calculated for each health plan for the previous calendar year.
844 Section 5. The commissioner shall hold a hearing conducted pursuant to chapter 30A on
845 any filing under section 2 prior to its effective date on at least 10 days' notice. The
846 commissioner may consolidate hearings for more than 1 carrier and may consolidate hearings
847 for multiple health plans filed by 1 carrier. The carrier shall provide information on the reasons
848 for the proposed premium change, and members of the public may testify. All testimony and
849 evidence received shall be public records. The commissioner may promulgate guidelines to
850 safeguard the confidentiality of contracts that establish rates between insurers and institutional
851 providers licensed under section 51 of chapter 111 which shall apply when the commissioner
852 obtains such contracts pursuant to section 8A of chapter 175 for purposes of a hearing under this
853 section.
854 The attorney general may intervene in any hearing called for under this section and may
855 require that a party to such a hearing produce any documents related to the proposed premium
856 change or documents that the attorney general deems necessary to enable him or the
857 commissioner to evaluate the merits of the proposed premium change. The attorney general
858 shall keep all information and documents obtained under this section confidential and shall not
859 disclose such information or documents to any person except as necessary in a case brought by
860 the attorney general under this chapter. Such information and documents shall not be public
861 records and shall be exempt from disclosure under section 10 of chapter 66.
862 Such requested premium change or initial premium request shall be filed at least 90 days
863 before the proposed effective date of such increase, and shall be communicated to the insureds

864 at least 90 days before the proposed effective date of such change, in the manner directed by the
865 commissioner.

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

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

872 (1) the carrier's administrative expenses including, but not limited to, the carrier's salary
873 structure, advertising and other marketing expenses and commissions, brokerage fees and other
874 distribution expenses, as compared to other carriers within and without the commonwealth;

875 (2) the carrier's expenses related to health care contracts, including but not limited to the
876 costs of services rendered by health care providers, the rates at which it pays for such services
877 and the volume of services provided;

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

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

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

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

887 Nothing in this section shall prohibit the attorney general from publishing any report concerning a hearing under this section. Nothing in this section shall affect any procedures for the approval or disapproval of health plan rates provided elsewhere in the General Laws, except as specifically provided herein.

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

894 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.

897 Any person aggrieved by any final action, order, finding or decision of the commissioner under this section may, within 20 days after 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 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 clause (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

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

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

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

917 CHAPTER 268C

918 HEALTH CARE PRACTITIONER AND PHARMACEUTICAL AND MEDICAL DEVICE
919 MANUFACTURER CONDUCT

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

922 "Gift", a payment, entertainment, meals, travel, honorarium, subscription, advance,
923 services or anything of value, unless consideration of equal or greater value is received and for
924 which there is a contract with specific deliverables which are not related to marketing and are
925 restricted to medical or scientific issues; provided, however, that a gift shall not include
926 anything of value received by inheritance, a gift received from a member of the health care
927 practitioner's immediate family or from a relative within the third degree of consanguinity of
928 the health care practitioner or of the health care practitioner's spouse or from the spouse of any
929 such relative, or prescription drugs provided to a health care practitioner solely and exclusively
930 for use by the health care practitioner's patients.

931 "Health care practitioner", a person who prescribes prescription drugs for any person
932 and is licensed to provide health care, or a partnership or corporation comprised of such
933 persons, or an officer, employee, agent or contractor of such person acting in the course and
934 scope of his employment, agency or contract related to or in support of the provision of health
935 care to individuals.

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

938 "Medical device", an instrument, apparatus, implement, machine, contrivance, implant,
939 in vitro reagent or other similar or related article, including any component, part or accessory,
940 which is: (1) recognized in the official National Formulary or the United States Pharmacopeia
941 or any supplement thereto; (2) intended for use in the diagnosis of disease or other conditions or
942 in the cure, mitigation, treatment or prevention of disease, in persons or animals; or (3) intended
943 to affect the structure or function of the body of a person or animal, and which does not achieve
944 its primary intended purposes through chemical action within or on such body and which is not
945 dependent upon being metabolized for the achievement of its primary intended purposes.
946 "Person", a business, individual, corporation, union, association, firm, partnership,
947 committee or other organization.

948 "Pharmaceutical or medical device manufacturer agent", a pharmaceutical or medical
949 device marketer or any other person who for compensation or reward does any act to promote,
950 oppose or influence the prescribing of a particular prescription drug, medical device, or category
951 of prescription drugs or medical devices; provided, however, that "pharmaceutical or medical
952 device manufacturer agent" shall not include a licensed pharmacist, licensed physician or any

953 other licensed health care practitioner with authority to prescribe prescription drugs who is
954 acting within the ordinary scope of the practice for which he is licensed.

955 "Pharmaceutical or medical device manufacturing company", any entity that participates
956 in a commonwealth health care program and which is engaged in the production, preparation,
957 propagation, compounding, conversion or processing of prescription drugs or medical devices,
958 either directly or indirectly, by extraction from substances of natural origin, or independently by
959 means of chemical synthesis or by a combination of extraction and chemical synthesis, or any
960 entity engaged in the packaging, repackaging, labeling, relabeling or distribution of prescription
961 drugs; provided, however, that "pharmaceutical or medical device manufacturing company"
962 shall not include a wholesale drug distributor licensed under section 36A of chapter 112 or a
963 retail pharmacist registered under section 37 of said chapter 112.

964 "Pharmaceutical or medical device marketer", a person who, while employed by or
965 under contract with a pharmaceutical or medical device manufacturing company that
966 participates in a commonwealth health care program, engages in detailing, promotional
967 activities or other marketing of prescription drugs or medical devices in the commonwealth to
968 any physician, hospital, nursing home, pharmacist, health benefits plan administrator, other
969 health care practitioner or person authorized to prescribe, dispense or purchase prescription
970 drugs; provided, however, that the "pharmaceutical or medical device marketer" shall not
971 include a wholesale drug distributor licensed under section 36A of chapter 112, a representative
972 of such a distributor who promotes or otherwise markets the services of the wholesale drug
973 distributor in connection with a prescription drug or a retail pharmacist registered under section

974 37 of said chapter 112 if such person is not engaging in such practices under contract with a
975 manufacturing company.

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

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

982 Section 2. No pharmaceutical or medical device manufacturer agent shall knowingly
983 and willfully offer or give to a health care practitioner, a member of a health care practitioner's
984 immediate family, a health care practitioner's employee or agent, a health care facility or an
985 employee or agent of a health care facility, a gift of any value. Nothing in the section shall
986 prohibit the provision, distribution, dissemination, or receipt of peer reviewed academic,
987 scientific or clinical information. Nothing in this section shall prohibit the purchase of
988 advertising in peer reviewed academic, scientific or clinical journals.
989 Section 3. (a)(1) By July 1 of each year, every pharmaceutical or medical device
990 manufacturing company shall disclose to the department of public health the value, nature,
991 purpose and recipient of any fee, payment, subsidy or other economic benefit not prohibited in
992 Section 2, which the company provides, directly or through its agents, to any physician,
993 hospital, nursing home, pharmacist, health benefit plan administrator, health care practitioner or
994 other person in the commonwealth authorized to prescribe, dispense, or purchase prescription
995 drugs or medical devices in this state. For each expenditure, the company shall identify the

996 recipient and the recipient's address, credentials, institutional affiliation and state board or Drug

997 Enforcement Administration numbers.

998 (2) Each company subject to this section shall disclose to the department of public

999 health the name and address of the individual responsible for the company's compliance with

1000 this section or, if this information has been previously reported to the department, any changes

1001 to the name or address of the individual responsible for such compliance.

1002 (3) The report shall be accompanied by the payment of a fee, to be determined by the

1003 department of public health, to pay the costs of administering this section.

1004 (b)(1) Information submitted to the department of public health pursuant to this section

1005 shall constitute public records except to the extent that it includes information that is protected

1006 by state or federal law as a trade secret.

1007 (2) Notwithstanding any other law to the contrary, the identities of health care

1008 practitioners and other recipients of gifts, payments and materials required by this chapter to be

1009 reported shall not constitute confidential information or trade secrets protected by this section.

1010 (3) The department of public health shall make all disclosed data publicly available and

1011 easily searchable on its website.

1012 (c) The department of public health shall report to the attorney general any payment,

1013 entertainment, meals, travel, honorarium, subscription, advance, services or anything of value

1014 provided in violation of this chapter, including anything of value provided when consideration

1015 of equal or greater value was not received or which was not subject to a contract with specific

1016 deliverables restricted to medical or scientific issues.

1017 Section 4. The department of public health, in consultation with the board of

1018 registration in pharmacy and board of registration in medicine, shall adopt regulations requiring

1019 the licensing of all pharmaceutical and medical device manufacturer agents. As a prerequisite
1020 to such licensing, pharmaceutical and medical device manufacturer agents shall complete such
1021 training as may be deemed appropriate by the department. As a prerequisite to the renewal of
1022 such licenses, pharmaceutical and medical device manufacturer agents shall complete
1023 continuing education as the department deems appropriate. The fee for such licenses shall be
1024 determined by the department of public health, in conjunction with the board of registration in
1025 pharmacy and the board of registration in medicine at a rate sufficient to provide for the
1026 administration and enforcement of this chapter. Revenue generated from this fee shall be
1027 divided in equal shares, with 75 per cent allocated for the use of the department of public health
1028 and 25 per cent allocated for the use of the office of attorney general for the administration of
1029 this chapter.

1030 Section 5. This chapter shall be enforced by the attorney general, the district attorney
1031 with jurisdiction over a violation or the department of public health. A person who violates this
1032 chapter shall be punished by a fine of not more than $5,000 for each transaction, occurrence or
1033 event that violates this chapter.

1034 SECTION 27. Notwithstanding any general or special law to the contrary, the trustees
1035 of the University of Massachusetts shall expand the entering class at its medical school and
1036 increase residencies for medical school graduates for students committed to entering the
1037 primary care field and to working in underserved regions of the commonwealth. The trustees
1038 shall develop a master plan for expanding medical student enrollment and increasing internships
1039 and residencies for medical school graduates who are committed to primary care and work in
1040 underserved regions without reducing academic quality, together with a financial plan to
1041 support such expansion, and shall report that plan to the joint committee on health care
1042 financing and the house and senate committees on ways and means not later than January 1,
1043 2009.

1044 SECTION 28. Notwithstanding any general or special law to the contrary, the center for
1045 primary care recruitment and placement established in section 25L of chapter 111 of the
1046 General Laws, in consultation with the board of higher education and the executive office of
1047 health and human services, shall, subject to appropriation, establish a primary care workforce
1048 development and loan forgiveness grant program at community health centers, community
1049 hospitals, nonprofit community-based primary care providers and other facilities in target areas,
1050 as determined by the center pursuant to said section 25L of said chapter 111, for the purpose of
1051 enhancing the recruitment and retention of primary care physicians and nurse practitioners
1052 authorized to practice pursuant to section 80B of chapter 112 of the General Laws. Recruitment
1053 and placement shall focus on the practice of primary care but, at the discretion of the center,
1054 may also include geriatric health services, obstetrics and gynecology, psychiatry and
1055 neurosurgery. Loan forgiveness programs, zero interest loan programs or other forms of
1056 assistance utilizing public funds, in whole or in part, shall require each medical or nursing
1057 student recipient to enter into a contract with the commonwealth as a primary care fellow which
1058 shall obligate the recipient to perform a term of service, as determined by the center, within the
1059 commonwealth in areas of primary care, geriatric health services, obstetrics and gynecology,
1060 psychiatry or neurosurgery.
1061 SECTION 29. Notwithstanding any general or special law to the contrary, the trustees
1062 of the University of Massachusetts, in conjunction with the state health education center at the
1063 University of Massachusetts Medical Center, shall establish and maintain an enhanced learning
1064 contract program available to medical students every academic year. The program shall provide
1065 full waivers of tuition and fees at the University of Massachusetts Medical School. The contract
1066 shall require payback service, of at least 4 years of service within the commonwealth in areas of

1067 primary care, public or community service or underserved areas, as determined by the center for
1068 primary care recruitment and placement and the learning contract committee, in coordination
1069 with the area health education center and state and regional health planning agencies. If a
1070 student fails to perform payback service as required by an enhanced learning contract, that
1071 student shall pay the difference between the tuition paid and double the amount of the tuition
1072 charged together with an origination fee, interest per annum at prime rate as reported at the time
1073 of origination by the Federal Reserve, a margin and repayment fee as set by the board. No
1074 payback service or tuition loan repayment shall be required prior to the termination of any
1075 internship and residency requirements. Interest shall begin to accrue upon completion of the
1076 requirements for the degree. The commonwealth shall bear the cost of such tuition and fee
1077 waivers for enhanced learning contracts. The dean of the medical school shall report annually
1078 the number of students participating in enhanced learning contracts, the area of medicine within
1079 which payback is to be performed and the number of students utilizing the repayment option.
1080 The report shall also outline the effects of payback in the underserved areas of the
1081 commonwealth.

1082 SECTION 30. (a) Notwithstanding any general or special law to the contrary, there is
1083 hereby established and set up on the books of the commonwealth a separate fund to be known as
1084 the Massachusetts Nursing and Allied Health Workforce Development Trust Fund to which
1085 shall be credited any appropriations, bond proceeds or other monies authorized by the general
1086 court and specifically designated to be credited thereto, and additional funds, including federal
1087 grants or loans or private donations made available to the commissioner of higher education for
1088 this purpose. The department of higher education shall hold the fund in an account separate and
1089 apart from other funds or accounts. Amounts credited to the fund shall be expended by the

1090 commissioner of higher education to carry out subsection (b). Any balance in the fund at the
1091 close of a fiscal year shall be available for expenditure in subsequent fiscal years and shall not
1092 revert to the General Fund.

1093 (b) The Massachusetts Nursing and Allied Health Workforce Development Trust Fund
1094 shall be used to develop and support, in consultation with the Massachusetts Nursing and Allied
1095 Health Workforce Development Advisory Committee, short-term and long-term strategies to
1096 increase the number of public and private higher education faculty and students who participate
1097 in programs that support careers in fields related to nursing and allied health. The
1098 commissioner of higher education may expend such funds as may be necessary for the
1099 administration of the Massachusetts Nursing and Allied Health Workforce Development
1100 Initiative. In furtherance of these public purposes, the commissioner of higher education shall
1101 expend funds in the fund for activities that are calculated to increase the number of qualified
1102 nursing and allied health faculty and students and improve the nursing and allied health
1103 educational offerings available in public higher education institutions. Grants and other
1104 disbursements and activities may involve, without limitation, the University of Massachusetts,
1105 state and community colleges, private institutions of higher education institutions in partnership
1106 with public institutions of higher education, business and industry partnerships, regional
1107 alliances, workforce investment boards, organizations granted tax-exempt status under section
1108 501(c)(3) of the Internal Revenue Code and other community groups which promote the nursing
1109 profession. Grants and other disbursements and activities may support, without limitation: (i)
1110 the goal of rapidly increasing the number of nurses and allied health workers; (ii) enhancing the
1111 role of the system of public higher education, as institutions and in partnerships with other
1112 stakeholders, in meeting the short-term and long-term workforce challenges in the nursing and

1113 allied health professions; (iii) the development and use of innovative curricula, courses,
1114 programs and modes of delivering education in nursing and allied health professions for faculty
1115 and students in these fields; (iv) activities with the growing network of stakeholders in the
1116 nursing and allied health professions to create, implement, share and make broadly and publicly
1117 available best practices and innovative programs relative to instruction, development of
1118 partnerships and expanding and maintaining faculty and student involvement in careers in these
1119 fields; and (v) strengthening the institutional capacity to develop and implement long-term
1120 programs and policies to effectively respond to these challenges.

1121 SECTION 31. Notwithstanding any general or special law to the contrary, the
1122 department of housing and community development, in consultation with the executive office of
1123 health and human services and the department of workforce development, shall establish a pilot
1124 program to assist hospitals, community health centers, and physician practices in providing
1125 housing grants or loans for health care professionals in underserved areas. The department of
1126 housing and community development shall establish an Assisted Housing Fund to provide
1127 grants or loans for health care professionals who contract to provide care in underserved areas
1128 and whose incomes do not exceed certain benchmarks, as established by said department.
1129 Grants and loans from the fund shall be made available for expenditure in the commonwealth
1130 and may be used for: (i) the cost to purchase housing that is to be a principal residence,
1131 including cooperative housing, and that falls within price guidelines established by the
1132 department, including costs for down payments, mortgage interest rate buy-downs, closing costs
1133 and other costs determined to be eligible by the department; and (ii) payments for security
1134 deposits and advance payments for rental housing. The department shall, subject to
1135 appropriation, contribute $1 to the fund for every $2 expended by the hospital, community

1136 health center or physician practice from the fund. The assistance granted pursuant to this
1137 section shall be determined by the department. The department shall adopt written procedures
1138 for the establishment and operation of the assisted fund. The procedures shall include
1139 provisions for eligibility and shall specify the expenses for which grants and loans may be made
1140 and shall determine the documentation and procedures necessary to qualify for the assistance.
1141 Two years after the commencement of the pilot program, the department shall report to the
1142 house and senate committees on ways and means, the joint committee on housing and the joint
1143 committee on health care financing, the results of the pilot program and shall recommend it for
1144 expansion, continuation or discontinuation.

1145 SECTION 32. Notwithstanding any special or general law to the contrary, the center for
1146 primary care recruitment and placement, in conjunction with the University of Massachusetts
1147 Medical School and area health education centers, shall study the efforts of Massachusetts-
1148 based public and private graduate medical education institutions to foster and expand the supply
1149 of primary care physicians. The study shall include, but shall not be limited to, a survey of
1150 institutional efforts to increase the percentage of medical residents who choose a primary care
1151 specialty and the overall enrollment of medical students committed to entering the primary care
1152 field. The study shall recommend innovative primary care educational programs and strategies
1153 that foster a culture within graduate medical education which embraces primary care. The center
1154 shall report its findings and recommendations to the house and senate committee on ways and
1155 means and the joint committee on health care financing not later than January 1, 2009.

1156 SECTION 33. (a) Notwithstanding any general or special laws to the contrary, there
1157 shall be a special commission to examine options and alternatives available to the

1158 commonwealth to provide regulation, oversight and disposition of the reserves, endowments
1159 and surpluses of health insurers and hospitals.

1160 (b) The commission shall consist of the inspector general, who shall serve as the chair,
1161 the commissioner of insurance or his designee, the commissioner of health care finance and
1162 policy or his designee, the secretary of administration and finance or his designee, the attorney
1163 general or his designee, the commissioner of public health or his designee and 3 persons to be
1164 appointed by the governor, 1 of whom shall be a health care consumer advocate and 1 of whom
1165 shall be a health economist.

1166 (c) The commission shall conduct a study relative to health insurers, including health
1167 maintenance organizations and acute care and non-acute care hospitals. The study shall include,
1168 but not be limited to: (1) an analysis of the laws, regulations and other measures currently in
1169 effect in the commonwealth which regulate the amount, nature and disposition of surpluses held
1170 by or for the benefit of health insurers in excess of amounts reasonably anticipated to be
1171 required to pay claims, taking into account the level of such reserves and surpluses necessary to
1172 safeguard the solvency of health insurers against unanticipated events and other circumstances
1173 which may cause extraordinary medical losses; (2) an analysis of federal and state law,
1174 regulations and other measures currently in effect which regulate the amount, nature and
1175 disposition of surpluses and endowments held by or for the benefit of hospitals in excess of
1176 amounts reasonably anticipated to be required to perform and support services provided by the
1177 hospital and to guard against unanticipated events and other circumstances; (3) a review of
1178 recent fiscal practices and financial reporting by health insurers relative to reserves and
1179 surpluses and of hospital fiscal practices and financial reporting required by general or special
1180 law; (4) a comparison of the commonwealth's current statutes and regulations with those of

1181 other states which the commission deems to be reasonably comparable to those of the
1182 commonwealth; (5) a review and assessment of model acts and regulations and any other
1183 information which the commission finds to be relevant to its inquiry; (6) a summary of
1184 alternative approaches to regulation of reserves and surpluses, including the disposition of
1185 amounts held by or on behalf of health insurers, with particular consideration of alternatives that
1186 would govern the use of those amounts to reduce premiums or to delay or to moderate premium
1187 increases; (7) a summary of approaches to regulation of surpluses and endowments held by or
1188 on behalf of hospitals, with particular consideration of alternatives that would govern the use of
1189 those amounts to reduce the cost of care; and (8) a review of the method by which health
1190 insurers and hospitals fund community benefit programs including, but not limited to, the
1191 manner by which funding is regulated by other states as to the appropriate amount, monitoring
1192 and direction of such funding. In compiling this report, the commission shall seek input from
1193 health plans and hospitals operating in the commonwealth, the attorney general, the executive
1194 office of health and human services, and the health care quality and cost council, established in
1195 section 16K of section 6A of the General Laws. In conducting its examination, the commission
1196 shall, to the extent possible, obtain and use actual health plan and hospital data and such data
1197 shall be confidential and shall not be a public record under clause twenty-sixth of section 7 of
1198 chapter 4 of the General Laws or section 10 of chapter 66 of the General Laws.
1199 (f) The commission may contract with another entity with the requisite financial
1200 expertise to assist the commission in conducting its study.
1201 (g) The commission shall meet not later than October 1, 2008 and shall hold at least 2
1202 public hearings. The commission shall file a report of its findings and recommendations with

1203 the clerks of the senate and house of representatives, the house and senate committees on ways
1204 and means and the joint committee on health care financing not later than July 1, 2009.

1205 SECTION 34. Notwithstanding any general or special law to the contrary, the
1206 department of public health, in consultation with the health care quality and cost council, shall
1207 adopt regulations requiring hospitals, as a standard of eligibility for original licensure and
1208 renewal of licensure, to register with the National Healthcare Safety Network. Each hospital
1209 that registers with the network shall grant access to the department and the Betsy Lehman center
1210 for patient safety and medical error reduction, in accordance with guidelines of the department
1211 to: (1) health care-associated infection data elements reportable to the network; and (2) hospital-
1212 specific reports generated by the network. Each registered hospital shall collect and submit to
1213 the network health care-associated infection data elements in accordance with guidelines of the
1214 department.

1215 SECTION 35. Notwithstanding any general or special law to the contrary and not later
1216 than October 1, 2012, the department of public health, in consultation with the health care
1217 quality and cost council, shall adopt regulations requiring hospitals and community health
1218 centers, as a standard of eligibility for original licensure and renewal of licensure, to implement
1219 computerized physician order entry systems as defined by the department. The systems shall be
1220 certified by the Certification Commission for Healthcare Information Technology or a successor
1221 agency or organization established for the purpose of certifying that health information
1222 technology meets national interoperability standards.

1223 SECTION 36. Notwithstanding any general or special law to the contrary and not later
1224 than October 1, 2015, the department of public health, in consultation with the health care
1225 quality and cost council, shall adopt regulations requiring hospitals and community health

1226 centers, as a standard of eligibility for original licensure and renewal of licensure, to implement
1227 interoperable electronic health records systems, as defined by the department. The system shall
1228 be certified by the Certification Commission for Healthcare Information Technology or a
1229 successor agency or organization established for the purpose of certifying that health
1230 information technology meets national interoperability standards.

1231 SECTION 37. Notwithstanding any general or special law to the contrary, the executive
1232 office of health and human services shall maximize enrollment of eligible persons in the
1233 MassHealth Senior Care Options program, the Program of All Inclusive Care for the Elderly,
1234 the Enhanced Community Options Program and the Community Choices program, or
1235 comparable successor programs, and shall develop dual eligible plans. For the purposes of this
1236 section, "dual eligible plans" shall be plans that offer similar coverage to Medicaid and
1237 Medicare-eligible disabled persons under age 65.

1238 Not later than 6 months after the effective date of this act, the executive office of health
1239 and human services shall prepare a report identifying clinical, administrative and financial
1240 barriers to expanded dual eligible plans, and shall recommend steps to remove the barriers and
1241 implement the plans. Before finalizing the report, the executive office shall hold a public
1242 consultative session that shall include organizations representing seniors, organizations
1243 representing disabled persons, organizations representing health care consumers, organizations
1244 representing racial and ethnic minorities, health delivery systems and health care providers. The
1245 report shall include consideration of changes in procurement standards and MassHealth
1246 payment methodologies to promote enrollment in dual eligible plans. The report shall include
1247 estimates of the costs and benefits of implementing steps to remove barriers to expanded
1248 enrollment in dual eligible plans, including financial savings and improved quality of care.

1249 The report shall be provided to the committee on health care financing and the house and
1250 senate committees on ways and means. Subject to appropriation, the executive office of health
1251 and human services shall implement any steps recommended by the report. Not later than 1
1252 year after the filing of the report, the executive office shall issue a progress statement on
1253 expanded enrollment in dual eligible plans

1254 SECTION 38. The department of public health shall, not later than July 1, 2009,
1255 establish a registry of exemptions granted by the department pursuant to section 6 of chapter
1256 350 of the acts of 1993 and the department's regulations to any person who filed with the
1257 department by December 23, 1993, a notice of intent to acquire medical, diagnostic or
1258 therapeutic equipment used to provide an innovative service or which is a new technology, as
1259 defined in section 25B of chapter 111 of the General Laws. Registered exemptions shall be
1260 nontransferable. After July 1, 2009, all exemptions qualifying for this registry that have not
1261 been registered with the department shall be void. Holders of registered exemptions for
1262 medical, diagnostic or therapeutic equipment not placed in regular service by July 1, 2009,
1263 shall, upon application, be eligible for an expedited determination of need process, as
1264 determined by the department. Exemptions granted by the department under said section 6 of
1265 said chapter 350 and the department's regulations to any person who filed with the department,
1266 by December 23, 1993, a notice of intent to acquire medical, diagnostic or therapeutic
1267 equipment used to provide an innovative service or which is a new technology shall expire on
1268 July 1, 2010, if the equipment for which the exemption was granted was not placed in regular
1269 service by July 1, 2009 and if no determination of need was granted by the department.

1270 SECTION 39. The division of insurance shall conduct an investigation and study of the
1271 costs of medical malpractice coverage for health care providers, as defined in section 193U of

1272 chapter 175 of the General Laws. The investigation and study shall include, but not be limited
1273 to, an examination and analysis of the following: (1) the availability and affordability of medical
1274 malpractice insurance; (2) the factors considered by medical malpractice insurers when
1275 increasing premiums; (3) options for decreasing premiums including, but not limited to,
1276 establishing a reinsurance pool with additional stop loss coverage, subsidizing premium
1277 payments of providers practicing in certain high-risk specialties or in specialties for which the
1278 cost of premiums represents a disproportionately high proportion of a health care provider's
1279 income, subsidizing premium payments of providers who do not qualify for group coverage
1280 rates and pay higher premiums for commercial market insurance and prorating premiums for
1281 providers who practice less than full-time; and (4) funding mechanisms that would facilitate the
1282 implementation of recommendations arising out of the study which may include, but shall not
1283 be limited to, charges borne by the health care industry or other entities. The division shall hold
1284 at least 2 public hearings to take testimony relating to the investigation and study, 1 of which
1285 shall be held outside the metropolitan Boston area. The division shall report its findings and
1286 recommendations to the house and senate committee on ways and means and the joint
1287 committee on health care financing not later than January 1, 2009.
1288 SECTION 40. Notwithstanding any general or special law to the contrary, the
1289 MassHealth payment advisory board, established in section 16M of chapter 6A of the General
1290 Laws, shall conduct a study of the need for an increase in Medicaid rates or bonuses for primary
1291 care physicians, nurse practitioners and subspecialists who provide primary care services, such
1292 as preventive care, certain evaluation and management procedures, early periodic screening,
1293 diagnosis and treatment and scheduled weekend and holiday services, in order to focus on
1294 prevention and wellness and delivery of primary care to identify illness earlier, to better manage

1295 chronic disease and to avoid costs associated with emergency room visits and hospitalizations.
1296 The committee shall report its findings, including recommendations for the amount of funding
1297 and the sources of funding, to the joint committee on health care financing, and the house and
1298 senate committees on ways and means not later than January 1, 2009.

1299 SECTION 41. There shall be a community benefits taskforce, which shall include the
1300 attorney general, the commissioner of public health and other members as determined by the
1301 attorney general, which shall conduct a study of the community benefits contributions by
1302 nonprofit health care providers and insurers. The study shall include, but not be limited to,
1303 examination and analysis of the following: (1) current community benefits programs including,
1304 but not limited to, plans filed with the attorney general's voluntary community benefits
1305 program; (2) methods used to identify and define communities to be served by community
1306 benefit programs; (3) the process hospitals and insurers use to assess community needs, define
1307 target populations for programs and to make resource allocation decisions; (4) methods used to
1308 measure and evaluate the contributions by nonprofit health care providers and insurers to
1309 various communities; (5) the administrative and technological needs of nonprofit health care
1310 providers; (6) potential collaborations between providers to fund improved administrative and
1311 technological support systems and information infrastructures as part of a statewide community
1312 benefits program including, but not limited to, the creation of a statewide electronic medical
1313 records database and computerized physician order entry to improve access and the portability
1314 of health information; and (7) whether the commonwealth ought to mandate standards and
1315 amounts of community benefits spending and, if so, what standards ought to apply. The task
1316 force shall hold at least 2 public hearings to hear testimony relating to the investigation and
1317 study, 1 of which shall be held outside the metropolitan Boston area. The task force shall report

1318 its findings and recommendations to the house and senate committee on ways and means and
1319 the joint committee on health care financing not later than January 1, 2009.
1320 SECTION 42. Notwithstanding any general or special law to the contrary, the attorney
1321 general shall adopt rules, regulations or guidelines that permit 2 or more health insurers, health
1322 maintenance organizations, hospitals or other providers in the health care market to: (1) discuss
1323 methods to standardize or simplify administrative standards, protocols or practices in order to
1324 reduce health care costs, improve access to health care services, improve the quality of care or
1325 reduce health care disparities; and (2) negotiate and enter into agreements to implements such
1326 standards, protocols or practices; provided, however, that no rule, regulation or guideline shall
1327 permit rate setting or price fixing, for insurance premiums or payments to providers.
1328 Any person or entity acting under the authority of any rule, regulation or guideline adopted
1329 pursuant to this section shall be engaged in action under state policy and shall be immune from
1330 antitrust liability to the same degree and extent as the commonwealth.
1331 SECTION 42A. Notwithstanding any general or special law to the contrary, the division of
1332 health care finance and policy within the executive office of health and human services, in
1333 cooperation with the Betsy Lehman Center for Patient Safety and the Reduction of Medical
1334 Errors and the Massachusetts Commission on End of Life Care, shall convene an expert panel
1335 on quality and cost of end of life care for patients with serious chronic illness. The panel shall
1336 make an investigation and study of the health care delivery for this population and the variations
1337 in delivery of such care among health care providers in the commonwealth including, but not
1338 limited to, the report and findings of the Dartmouth Atlas of Health Care 2008 entitled
1339 "Tracking the Care of Patients with Severe Chronic Illness." For the purposes of this
1340 investigation and study, "health care providers" shall mean facilities and health care

1341 professionals licensed to provide acute inpatient hospital care, outpatient services, skilled
1342 nursing, rehabilitation and long-term hospital care, home health care and hospice services. The
1343 panel shall present recommendations for legislation, regulation and policies based upon
1344 scientific evidence to identify best practices that ought to constitute the generally accepted
1345 standard of care for end of life care for patients with serious chronic illness and that minimize
1346 the care delivery disparities and chance variations in practice or spending among different
1347 geographic regions and different hospitals that cannot be explained on the basis of illness,
1348 strong scientific evidence or well-informed patient preferences. The panel shall consider the
1349 development of an evidence-based physician education program for treating patients with
1350 serious chronic illness relative to such factors including: how often to see a patient; how to
1351 coordinate care among providers utilizing a single shared electronic health record or
1352 communication standards to ensure complete and reliable sharing of information amongst
1353 physicians and institutional providers; when to refer a patient to a specialist; when to admit a
1354 patient to a licensed health care facility, especially to an intensive care unit; when to order the
1355 use of imaging equipment; and the need for adherence to well-informed patient preference
1356 expressed through advance directive such as do-not-resuscitate orders and designated health
1357 care proxy and living will documents. The panel shall make recommendations relative to: the
1358 adoption by health care providers in the commonwealth of practice patterns observed in those
1359 regions of the United States considered to be the most efficient in delivery of care to those with
1360 serious chronic illness; steps to encourage physician groups and hospitals to be accountable for
1361 the coordination, overall costs and quality of care of patients with serious chronic illness; and
1362 the identification of incentives to organize, finance and promote such adoption. The report shall
1363 address the informational needs of patients and families to make end of life practice patterns

1364 transparent such that they may identify providers whose care patterns correspond more closely
1365 to their preferences.
1366 SECTION 42B. The group insurance commission, in consultation with the division of
1367 insurance, shall investigate and make findings regarding the establishment of a class of health
1368 insurance plans for persons in service of the commonwealth under chapter 32A, in addition to
1369 individual and family plans, to provide coverage to married couples without any additional
1370 dependents. The investigation shall include an analysis of the cost or impact on existing plans,
1371 the anticipated administrative cost of offering such coverage, the anticipated cost to potential
1372 participants and any anticipated savings or reduction in premium costs for the commonwealth
1373 and potential participants. The commission may make recommendations for any legislative
1374 changes necessary to permit the offering of such plans. The commission's findings and
1375 recommendations, if any, shall be submitted to the clerks of the house of representatives and the
1376 senate, the chairs of the joint committee on health care financing and the chairs of the house and
1377 senate committee on ways and means not later than December 31, 2008.
1378 SECTION 43. Any entity providing ambulatory surgical center services which is in
1379 operation or under construction, as determined by the department of public health, on the
1380 effective date of this act shall be exempt from the determination of need requirement of section
1381 53G of chapter 111 of the General Laws and shall be eligible, pursuant to said section 53G of
1382 said chapter 111, to make application to the department for a clinic license for up to 6 months
1383 after the effective date of regulations adopted by the department pursuant to said section 53G of
1384 said chapter 111.
1385 SECTION 43A. Notwithstanding any general or special law or rule or regulation to the
1386 contrary and in recognition of the successful comparative outcomes from the Mass COMM

1387 Percutaneous Coronary Intervention trial between hospitals with cardiac surgery on-site and
1388 community hospitals without cardiac surgery on-site, the department of public health shall move
1389 these community hospitals from the Mass COMM trial to registry oversight, recording outcome
1390 data to the Mass-DAC registry not later than September 1, 2008.

1391 SECTION 44. Section 11 shall apply to any project seeking written approval of final
1392 architectural plans, pursuant to section 51 of chapter 111 of the General Laws 6 months or more
1393 after the effective day of this act.

1394 SECTION 45. The secretary of health and human services shall promulgate the
1395 regulations required under subsection (a) of section 16P of chapter 6A of the General Laws not
1396 later than October 1, 2009.

1397 SECTION 46. The health care quality and cost council shall publish the serious
1398 reportable event occurrences as required under subsection (a) of section 16P of chapter 6A of
1399 the General Laws on its consumer health information website not later than 1 year after the
1400 effective date of this act.

1401 SECTION 47. The department of public health shall promulgate regulations as
1402 necessary to implement section 4N of chapter 111 of the General Laws in accordance with
1403 chapter 30A not later than October 1, 2008. The department of public health shall begin
1404 implementing the outreach and education program established under said section 4N of said
1405 chapter 111 not later than January 1, 2009.

1406 SECTION 48. The bureau of managed care within the division of insurance shall
1407 convene the first advisory committee required under section 5B of chapter 176O of the General
1408 Laws on January 1, 2009.

1409 SECTION 49. Notwithstanding any general or special law to the contrary, the secretary
1410 of administration and finance and the secretary of health and human services shall prepare and
1411 submit a report to the general court about the allocation for and use of state funds by acute care
1412 hospitals, non-acute care hospitals, Medicaid managed care organizations, other managed care
1413 organizations, community health centers and carriers contracting with the commonwealth health
1414 insurance connector authority. The report shall include: (1) a comprehensive review of the
1415 current manner, amount and purposes of annual state funding received by those entities,
1416 including a description of the source of the funding; (2) an assessment of the change in total
1417 state funding for those entities over the past 5 years, with particular attention paid to the impact
1418 of chapter 58 of the acts of 2006; (3) an assessment of how those entities use state funds; (4) an
1419 assessment of whether the current payment structure assures the delivery of quality health care
1420 in the most cost-effective way; (5) an analysis of financial and management practices of those
1421 entities by benchmarking performance with respect to quality and cost effectiveness against
1422 national performance levels and similar health care providers in the commonwealth; (6)
1423 identification of common factors that may contribute to the fiscal instability of those entities; (7)
1424 recommendations for the development of performance and operational benchmarks; (8)
1425 recommendations for ensuring that the entities are spending state and other funds in a fiscally-
1426 responsible manner and providing quality care; (9) recommendations for legislative and other
1427 action necessary to strengthen state oversight and ensure greater accountability of state
1428 resources; (10) an assessment of the manner in which hospitals seek payment from consumers,
1429 including an analysis of the impact that court filing fees have on their ability to collect payment;
1430 and (11) recommendations for regulations regarding the due diligence that facilities shall

1431 exercise in seeking to collect payment from consumers before seeking reimbursement from the
1432 commonwealth.

1433 The secretaries shall have access to all documents of acute care hospitals, non-acute care
1434 hospitals, Medicaid managed care organizations, other managed care organizations, community
1435 health centers, carriers contracting with the commonwealth health insurance connector authority
1436 and any related entities that relate to that organization's use of state funds; provided, however,
1437 that the secretaries shall not request any documents that are in the possession of any agencies of
1438 the executive office of administration and finance or the executive office of health and human
1439 services. The secretaries shall keep all information and documents obtained under this section
1440 confidential and shall not disclose such information or documents to any person except as
1441 necessary in a case brought by the attorney general under this chapter. Such information and
1442 documents shall not be public records and shall be exempt from disclosure under section 10 of
1443 chapter 66.

1444 For the purpose of conducting their duties under this section, the secretaries may
1445 contract with an outside organization with the requisite financial expertise to enable the
1446 secretaries to prepare the report. The secretaries shall submit the report, along with any
1447 recommendations for legislative or other action, to the clerks of the senate and house of
1448 representatives not later than December 31, 2008.

1449 SECTION 50. Not later than 4 years after the effective date of this act, the e-health
1450 institute established in section 6D of chapter 40J of the General Laws, shall submit a report to
1451 the joint committee on health care financing and the senate and house committees on ways and
1452 means on the progress in realizing the purposes of this act, with particular attention to the
1453 following: (i) the capacity to exchange health information between and among components of

1454 the health system; (ii) rates of provider participation in electronic health records; (iii) rates of

1455 provider participation in practice redesign; (iv) quality measurement and improvement; (v)

1456 health care cost reduction; (vi) participation in advanced programs such as medical home and

1457 pay for performance programs; and (vii) the security and privacy of health information

1458 technology supported by this section.

1459 SECTION 51. Section 7 shall take effect on January 1, 2015.

1460 SECTION 52. Subsection (d) of section 61 of chapter 118E of the General Laws, as

1461 appearing in section 19, shall take effect on January 1, 2011.

1462 SECTION 53. Sections 20 and 24 shall take effect on July 1, 2012.

1463 SECTION 54. Subsection (d) of section 5A of chapter 176O of the General Law, as

1464 appearing section 23, shall take effect on January 1, 2011.

1465 SECTION 55. Section 25 shall take effect on January 1, 2009.

1466 SECTION 56. Section 34 shall take effect on October 1, 2008.