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Acts 2008 **CHAPTER 305** AN ACT TO PROMOTE COST CONTAINMENT, TRANSPARENCY AND EFFICIENCY IN THE DELIVERY OF QUALITY HEALTH CARE.

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

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

SECTION 1. Subsection (d) of section 38C of chapter 3 of the General Laws, as appearing in the 2006 Official Edition, is hereby amended by striking out the third sentence and inserting in place thereof the following sentence:- The division shall enter into interagency agreements as necessary with the office of Medicaid, the group insurance commission, the department of public health, the division of insurance, the health care quality and cost council, and other state agencies holding utilization, cost or claims data relevant to the division's review under this section.

SECTION 2. Section 16J of chapter 6A, as so appearing, is hereby amended by inserting after the definition of "Physician Group Practice" the following definition:—

"Third party administrator", an entity that administers payments for health care services on behalf of a client plan in exchange for an administrative fee.

SECTION 3. Chapter 6A of the General Laws is hereby amended by striking out sections 16K, as so appearing, and 16L, as amended by section 1 of chapter 205 of the acts of 2007, and inserting in place thereof the following 2 sections:-

Section 16K. (a) There shall be established a health care quality and cost council within, but not subject to control of, the executive office of health and human services. The council shall promote public transparency of the quality and cost of health care in the commonwealth, and shall seek to improve health care quality, reduce racial and ethnic health disparities and contain health care costs by: (i) disseminating health care quality and cost data to consumers, health care providers and insurers via a consumer health information website pursuant to subsection (e) and (g); (ii) establishing quality improvement and cost containment goals pursuant to subsection (h); and (iii) establishing standard performance measures, quality performance benchmarks and statewide

health information technology adoption goals for health care providers and insurers pursuant to subsection (i).

(b) The council shall consist of 16 members and shall be comprised of: (i) 9 ex-officio members, including the secretary of health and human services, who shall serve as the chair, the secretary of administration and finance, the state auditor, the inspector general, the attorney general, the commissioner of insurance, the commissioner of health care finance and policy, the commissioner of public health, and the executive director of the group insurance commission, or their designees; and (ii) 7 representatives of nongovernmental organizations be appointed by the governor, including 1 representative of a health care quality improvement organization recognized by the federal Centers for Medicare and Medicaid Services, 1 representative of the Institute for Healthcare Improvement recommended by the organization's board of directors, 1 representative of the Massachusetts Chapter of the National Association of Insurance and Financial Advisors, 1 representative of the Massachusetts Association of Health Underwriters, Inc., 1 representative of the Massachusetts Medicaid Policy Institute, Inc., 1 expert in health care policy from a foundation or academic institution, and 1 representative of a non-governmental purchaser of health insurance. At least 1 member of the council shall be a clinician licensed to practice in the commonwealth. Members of the council shall be appointed for terms of 3 years or until a successor is appointed. Members shall be eligible to be reappointed and shall serve without compensation, but may be reimbursed for actual and necessary expenses reasonably incurred in the performance of their duties which may include reimbursement for reasonable travel and living expenses while engaged in council business. Chapter 268A shall apply to all council members; provided, however, that the council may purchase from, sell to, borrow from, contract with or otherwise deal with any organization in which any council member is in anyway interested or involved; provided further that such interest or involvement is disclosed in advance to the council and recorded in the minutes of the proceedings of the council; and provided further, that no council member having such interest or involvement may participate in any decision relating to such organization.

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

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

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

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

(d) The council shall disseminate the data it collects under this section to consumers, health care providers and insurers through: (i) a publicly-accessible consumer health information website; (ii)

reports on performance provided to health care providers; and (iii) any other analysis and reporting the council deems appropriate.

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

The council may, subject to chapter 30B, contract with an independent health care organization for data collection, analysis or technical assistance related to its duties; provided, however, that the organization has a history of demonstrating the skill and expertise necessary to: (i) collect, analyze and aggregate data related to quality and cost across the health care system; (ii) identify quality improvement areas through data analysis; (iii) work with Medicare, MassHealth, and other insurers' data; (iv) collaborate in the design and implementation of quality improvement and clinical performance measures; (v) establish and maintain security measures necessary to maintain confidentiality and preserve the integrity of the data; and (vii) identify and, when necessary, develop appropriate measures of quality and cost for public reporting of quality and cost information.

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

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

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

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

The council shall, in consultation with its advisory committee, develop and adopt, on an annual basis, a reporting plan specifying the quality and cost measures to be included on the consumer

health information website and the security measures used to maintain confidentiality and preserve the integrity of the data. In developing the reporting plan, the council, to the extent possible, shall collaborate with other organizations or state or federal agencies that develop, collect and publicly report health care quality and cost measures and the council shall give priority to those measures that are already available in the public domain. As part of the reporting plan, the council shall determine for each service the comparative information to be included on the consumer health information website, including whether to: (i) list services separately or as part of a group of related services; or (ii) combine the cost information for each facility and its affiliated clinicians and physician practices or to list facility and professional costs separately.

The council shall, after due consideration and public hearing, adopt or reject the reporting plan or any revisions. If the council rejects the reporting plan or any revisions, the council shall state its reasons for the rejection. The reporting plan and any revisions adopted by the council shall be promulgated by the council. The council shall submit the reporting plan and any periodic revisions to the chairs of the house and senate committees on ways and means and the chairs of the joint committee on health care financing and the clerks of the house and senate.

The website shall provide updated information on a regular basis, at least annually, and additional comparative quality and cost information shall be published as determined by the council, in consultation with the advisory committee. To the extent possible, the website shall include: (i) comparative quality information by facility, clinician or physician group practice for each service or category of service for which comparative cost information is provided; (ii) general information related to each service or category of service for which comparative information is provided; (iii) comparative quality information by facility, clinician or physician practice that is not service-specific, including information related to patient safety and satisfaction; and (iv) data concerning healthcare-acquired infections and serious reportable events reported under section 51H of chapter 111.

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

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

The council shall, through interagency service agreements, allow the use of its data by other state

agencies, including division of health care finance and policy, for review and evaluation of mandated health benefit proposals as required by section 38C of chapter 3.
(g) The council, in consultation with its advisory committee, shall disseminate to health care providers their individualized de-identified data, including comparisons with other health care providers on the quality, cost and other data to be published on the consumer health information website.
(h) The council, in consultation with its advisory committee, shall develop annual health care quality improvement and cost containment goals. The goals shall be designed to promote high-quality, safe, effective, timely, efficient, equitable and patient centered health care. The council shall also establish goals that are intended to reduce racial and ethnic health care disparities and in so doing shall seek to incorporate the recommendations of the health disparities council and the office of health equity. For each goal, the council shall: identify the steps needed to achieve the goal; estimate the cost of implementation; project the anticipated short-term or long-term financial savings achievable by the health care providers, insurers or the commonwealth: and estimate the expected improvements in the health status of health care consumers in the commonwealth. The council may recommend legislation or regulatory changes to achieve these goals.
(i) The council, in consultation with its advisory committee, relevant state agencies, and public and private health care organizations, shall develop and annually publish: (i) standard performance measures, including, common and consistent reporting of quality measures and common use of measures used for pay-for-performance reimbursement; (ii) quality performance benchmarks for health care providers and insurers that: (1) are clinically important, evidence-based, standardized and timely; (2) include both process and outcome measures; (3) encourage health care providers and insurers to improve health care quality; and (4) are developed based on the work of national organizations, including the National Quality Forum and the Hospitals Quality Alliance; and (iii) goals for statewide adoption of health information technology.
(k) The council shall conduct annual public hearings at which health care providers, insurers, relevant state agencies, and public and private health care organizations shall report their progress towards achieving the quality improvement and cost containment goals, adopting the standard performance measures and meeting the quality performance benchmarks. The council shall provide health care providers, insurers, state agencies and the general court with the following, at least 60 days prior to the public hearings: (i) recommended action required by each entity to achieve the specified quality and cost containment goals; and (ii) recommendations for adoption of each standard performance measure, quality performance benchmark and health information technology adoption goal established by the council.
(l) The council shall file a report, not less than annually, with the chairs of the house and senate committees on ways and means and the chairs of the joint committee on health care financing and the clerks of the house and senate on its progress in achieving the goals of improving quality and containing or reducing health care costs data provided pursuant to chapter 111N. The report shall include, at a minimum, a review of the progress towards achieving the quality improvement and cost

containment goals, adoption of standard performance measures, meeting the quality performance benchmarks, and achieving the health information technology adoption goals.
The council shall provide its advisory committee with reasonable opportunity to review and comment on all reports before their public release.
Reports of the council shall be published on the consumer health information website.

Section 16L. (a) There shall be established an advisory committee to the health care quality and cost council, established by section 16K, to allow the broadest possible involvement of the health care industry and others concerned about health care quality and cost.
(b) The advisory committee shall consist of at least 29 members to be appointed by the governor, 1 of whom shall be a representative of the Massachusetts Medical Society, 1 of whom shall be a representative of the Massachusetts Hospital Association, Inc., 1 of whom shall be a representative of the Massachusetts Association of Health Plans, Inc., 1 of whom shall be a representative of Blue Cross Blue Shield of Massachusetts, Inc., 1 of whom shall be a representative of the Massachusetts AFL-CIO Council, Inc., 1 of whom shall be a representative of the Massachusetts League of Community Health Centers, Inc., 1 of whom shall be a representative of Health Care For All, Inc., 1 of whom shall be a representative of the Massachusetts Public Health Association, 1 of whom shall be a representative of the Massachusetts Association of Behavioral Health Systems, Inc., 1 of whom shall be a representative of the Massachusetts Extended Care Federation, Inc., 1 of whom shall be a representative of the Massachusetts Council of Human Service Providers, Inc., 1 of whom shall be a representative of the Home Care Alliance of Massachusetts, Inc., 1 of whom shall be a representative of Associated Industries of Massachusetts, Inc., 1 of whom shall be a representative of the Massachusetts Business Roundtable, Inc., 1 of whom shall be a representative of the Massachusetts Taxpayers Foundation, 1 of whom shall be a representative of the Massachusetts chapter of the National Federation of Independent Business, 1 of whom shall be a representative of the Retailers Association of Massachusetts, 1 of whom shall be a representative of the Massachusetts Biotechnology Council, Inc., 1 of whom shall be a representative of the Blue Cross Blue Shield of Massachusetts Foundation, Inc., 1 of whom shall be a representative of the Massachusetts chapter of the American Association of Retired Persons, 1 of whom shall be a representative of the Massachusetts Coalition of Taft-Hartley Trust Funds, Inc., and additional members including, but not limited to, a representative of the mental health field, a representative of pediatric health care, a representative of primary health care, a representative of medical education, a representative of racial or ethnic minority groups concerned with health care, a representative of hospice care, a representative of the nursing profession and a representative of the pharmaceutical field. Members of the advisory committee shall be appointed for terms of 3 years or until a successor is appointed. Members shall be eligible to be reappointed and shall serve without compensation.
(c) The members of the advisory committee shall annually elect a chair, vice chair and secretary and may adopt by-laws governing the affairs of the advisory committee.

(d) The advisory committee shall have the following duties: (i) advise the council on the consumer health information website and health care provider and insurer reports; (ii) advise the council on the annual health care quality improvement and cost containment goals, transparency standards and quality performance benchmarks; and (iii) review and comment on all reports of the council before public release, including the annual reporting plan and any revisions and the annual report to the general court.
(e) A written record of all meetings of the committee shall be maintained by the secretary and a copy filed within 15 days after each meeting with the council.

SECTION 4. Chapter 40J of the General Laws is hereby amended by inserting after section 6C the following 2 sections:-

Section 6D. (a) There shall be established an institute for health care innovation, technology and competitiveness, to be known as the Massachusetts e-Health Institute. The executive director of the corporation shall appoint a qualified individual to serve as the director of the institute, who shall be an employee of the corporation, report to the executive director and manage the affairs of the institute. The institute shall advance the dissemination of health information technology across the commonwealth, including the deployment of electronic health records systems in all health care provider settings that are networked through a statewide health information exchange.
(b) There shall be established a health information technology council within the corporation. The council shall advise the institute on the dissemination of health information technology across commonwealth, including the deployment of electronic health records systems in all health care provider settings that are networked through a statewide health information exchange.
The council shall consist of 9 members, as follows: 1 shall be the secretary of health and human services, who shall serve as the chair; 1 shall be the secretary of administration and finance, or a designee; 1 shall be the executive director of the health care quality and cost council; 1 shall be the director of the office of Medicaid; 5 shall be appointed by the governor, of whom at least 1 shall be an expert in health information technology, 1 shall be an expert in law and health policy, and 1 shall be an expert in health information privacy and security. The council may consult with such parties, public or private, as it deems desirable in exercising its duties under this section, including persons with expertise and experience the development and dissemination of electronic health records systems, and the implementation of electronic health record systems by small physician groups or ambulatory care providers, as well as persons representing organizations within the commonwealth interested in and affected by the development of networks and electronic health records systems, including, but not limited to, persons representing local public health agencies, licensed hospitals and other licensed facilities and providers, private purchasers, the medical and nursing professions, physicians, health insurers and health plans, the state quality improvement organization, academic and research institutions, consumer advisory organizations with expertise in health information

technology and other stakeholders as identified by the secretary of health and human services. Appointive members of the council shall serve for terms of 2 years or until a successor is appointed. Members shall be eligible to be reappointed and shall serve without compensation.

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

(c) The institute, in consultation with the council, shall advance the dissemination of health information technology by: (i) facilitating the implementation and use of electronic health records systems by health care providers in order to improve health care delivery and coordination, reduce unwarranted treatment variation, eliminate wasteful paper-based processes, help facilitate chronic disease management initiatives and establish transparency; (ii) facilitating the creation and maintenance of a statewide interoperable electronic health records network that allows individual health care providers in all health care settings to exchange patient health information with other providers; and (iii) identifying and promoting an accelerated dissemination in the commonwealth of emerging health care technologies that have been developed and employed and that are expected to improve health care quality and lower health care costs, but that have not been widely implemented in the commonwealth.

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

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

Each plan as updated shall: (i) allow seamless, secure electronic exchange of health information among health care providers, health plans and other authorized users; (ii) provide consumers with secure, electronic access to their own health information; (iii) meet all applicable federal and state

privacy and security requirements, including requirements imposed by 45 C.F.R. §§160, 162 and 164; (iv) meet standards for interoperability adopted by the institute with the approval of the council; (v) give patients the option of allowing only designated health care providers to disseminate their individually identifiable information; (vi) provide public health reporting capability as required under state law; and (vii) allow reporting of health information other than identifiable patient health information for purposes of such activities as the secretary of health and human services may from time to time consider necessary.

(e) The corporation may contract with implementing organizations to: (i) facilitate a public-private partnership that includes representation from hospitals, physicians and other health care professionals, health insurers, employers and other health care purchasers, health data and service organizations, and consumer organizations; (ii) provide resources and support to recipients of grants awarded under subsection (f) to implement each program within the designated community pursuant to the implementation plan; (iii) certify and disburse funds to subcontractors, when necessary; (iv) provide technical assistance to facilitate successful practice redesign, adoption of electronic health records, and utilization of care management strategies; (v) ensure that electronic health records systems are fully interoperable and secure and that sensitive patient information is kept confidential by exclusively utilizing electronic health records products that are certified by the Certification Commission for Healthcare Information Technology; and (vi) certify, with approval of the corporation and the council, a group of subcontractors who shall provide the necessary hardware and software for system implementation. Prior to the institute's issuing requests for proposals for contracts to be entered into pursuant to this section, the institute's director shall consult with the council with respect to the content of all such proposals. All contracts with implementing organizations entered into by the corporation must first be approved by the council.

(f) Funding for the institute and council's activities shall be through the E-Health Institute Fund, established in section 6E. The institute, in consultation with the council, shall develop mechanisms for funding health information technology, including a grant program to assist health care providers with costs associated with health information technologies, including electronic health records systems, and coordinated with other electronic health records projects seeking federal reimbursement.

The institute shall consult with the office of Medicaid to maximize all opportunities to qualify any expenditures for federal financial participation. Applications for funding shall be in the form and manner determined by the institute director and the council, and shall include the information and assurances required by the institute director and the council. The institute director and the council may consider, as a condition for awarding grants, the grantee's financial participation and any other factors it deems relevant.

All grants shall be recommended by the institute director and subsequently approved by both the executive director and the council. The institute director shall work with implementation organizations to oversee the grant-making process as it relates to an implementing organization's responsibilities under its contract with the corporation. Each recipient of monies from this program

shall: (i) capture and report certain quality improvement data, as determined by the institute in consultation with the health care quality and cost council; (ii) implement the system fully, including all clinical features, not later than the second year of the grant; and (iii) make use of the system's full range of features.
(g) The council shall receive staff assistance from the corporation.
(h) The institute shall file an annual report, not later than January 30, with the joint committee on health care financing, the joint committee on economic development and emerging technologies, and the house and senate committees on ways and means concerning the activities of the council in general and, in particular, describing the progress to date in implementing a statewide electronic health records system and recommending such further legislative action as it deems appropriate.

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

Section 6F. Any plan approved by the board and every grantee and implementing organization that receives monies for the adoption of health information technology shall:
(1) establish a mechanism to allow patients to opt-in to the health information network and to opt-out at any time;
(2) maintain identifiable health information in physically and technologically secure environments by means including, but not limited to: prohibiting the storage or transfer of unencrypted and non-password protected identifiable health information on portable data storage devices; requiring data encryption, unique alpha-numerical identifiers and password protection; and other methods to

prevent unauthorized access to identifiable health information;
(3) provide individuals the option of, upon request, obtaining a list of individuals and entities that have accessed their identifiable health information; and
(4) develop and distribute to authorized users of the health information network and to prospective network participants, written guidelines addressing privacy, confidentiality and security of health information and inform individuals of what information about them is available, who may access their information, and the purposes for which their information may be accessed.

Section 6G. In the event of an unauthorized access to or disclosure of individually identifiable patient health information by or through the statewide health information network or by or through any technology grantees or implementing organizations funded in whole or in part from the E-Health Institute Fund established pursuant to section 6E, the operator of such network or grantee or contractor shall: (i) report the conditions of such unauthorized access or disclosure as required by the Massachusetts e-Health Institute; and (ii) provide notice, as defined in section 1 of chapter 93H, as soon as practicable, but not later than 10 business days after such unauthorized access or disclosure, to any person whose patient health information may have been compromised as a result of such unauthorized access or disclosure, and shall report the conditions of such unauthorized access or disclosure.

SECTION 5. Chapter 111 of the General Laws is hereby amended by inserting after section 4M the following section:—

Section 4N. (a) The department shall, in cooperation with Commonwealth Medicine at the University of Massachusetts medical school, develop, implement and promote an evidence-based outreach and education program about the therapeutic and cost-effective utilization of prescription drugs for physicians, pharmacists and other health care professionals authorized to prescribe and dispense prescription drugs. In developing the program, the department shall consult with physicians, pharmacists, private insurers, hospitals, pharmacy benefit managers, the MassHealth drug utilization review board and the University of Massachusetts medical school.
(b) The program shall arrange for physicians, pharmacists and nurses under contract with the department to conduct face-to-face visits with prescribers, utilizing evidence-based materials and borrowing methods from behavioral science, educational theory and, where appropriate, pharmaceutical industry data and outreach techniques; provided, however, that to the extent possible, the program shall inform prescribers about drug marketing that is intended to circumvent competition from generic or other therapeutically-equivalent pharmaceutical alternatives or other evidence-based treatment options.
The program shall include outreach to: physicians and other health care practitioners who participate in MassHealth, the subsidized catastrophic prescription drug insurance program authorized in section 39 of chapter 19A or the commonwealth care health insurance program; other

publicly-funded, contracted or subsidized health care programs; academic medical centers; and other prescribers.
The department shall, to the extent possible, utilize or incorporate into its program other independent educational resources or models proven effective in promoting high quality, evidenced-based, cost-effective information regarding the effectiveness and safety of prescription drugs, including, but not limited to: (i) the Pennsylvania PACE/Harvard University Independent Drug Information Service; (ii) the Academic Detailing Program of the University of Vermont College of Medicine Area Health Education Centers; (iii) the Oregon Health and Science University Evidence-based Practice Center's Drug Effectiveness Review project; and (iv) the North Carolina evidence-based peer-to-peer education program outreach program.
(c) The department may establish and collect fees for subscriptions and contracts with private payers. The department may seek funding from nongovernmental health access foundations and undesignated drug litigation settlement funds associated with pharmaceutical marketing and pricing practices.

SECTION 6. Section 25B of said chapter 111, as appearing in the 2006 Official Edition, is hereby amended by striking out the definition of "Expenditure minimum with respect to substantial capital expenditures."

SECTION 7. Said section 25B of said chapter 111, as so appearing, is hereby further amended by inserting after the definition of "Department" the following definitions: -

"Expenditure minimum with respect to substantial capital expenditures", with respect to expenditures and acquisitions made by or for: (1) acute care hospitals and comprehensive cancer centers as defined in section 1 of chapter 118G, only, $7,500,000, except that expenditures for, or the acquisition of, major movable equipment not otherwise defined by the department as new technology or innovative services shall not require a determination of need and shall not be included in the calculation of the expenditure minimum; and (2) health care facilities, other than acute care hospitals, and facilities subject to licensing under chapter 111B, with respect to: (a) expenditures for, or the acquisition of, medical, diagnostic or therapeutic equipment, $400,000; and (b) all other expenditures and acquisitions, $800,000; provided, however, that expenditures for, or the acquisition of, any replacement of medical, diagnostic or therapeutic equipment defined as new technology or innovative services for which a determination of need has issued or which was exempt from determination of need, shall not require a determination of need and shall not be included in the calculation of the expenditure minimum; provided further, that expenditures and acquisitions concerned solely with outpatient services other than ambulatory surgery, not otherwise defined as new technology or innovative services by the department, shall not require a determination of need and shall not be included in the calculation of the expenditure minimum, unless the expenditures and acquisitions are at least $25,000,000, in which case a determination of

need shall be required. Notwithstanding the above limitations, acute care hospitals only may elect at their option to apply for determination of need for expenditures and acquisitions less than the expenditure minimum.

SECTION 8. Said chapter 111 is hereby further amended by inserting after section 25K the following 3 sections:—

Section 25L. (a) There shall be in the department a health care workforce center to improve access to health care services. The center, in consultation with the health care workforce advisory council established by section 25M and the commissioner of labor and workforce development, shall: (i) coordinate the department's health care workforce activities with other state agencies and public and private entities involved in health care workforce training, recruitment and retention; (ii) monitor trends in access to primary care providers, nurse practitioners practicing as primary care providers, and other physician and nursing providers, through activities including: (1) review of existing data and collection of new data as needed to assess the capacity of the health care workforce to serve patients, including patient access and regional disparities in access to physicians or nurses and to examine physician and nursing satisfaction; (2) review existing laws, regulations, policies, contracting or reimbursement practices, and other factors that influence recruitment and retention of physicians and nurses; (3) making projections on the ability of the workforce to meet the needs of patients over time; (4) identifying strategies currently being employed to address workforce needs, shortages, recruitment and retention; (5) studying the capacity of public and private medical and nursing schools in the commonwealth to expand the supply of primary care physicians and nurse practitioners practicing as primary care providers; (iii) establish criteria to identify underserved areas in the commonwealth for administering the loan repayment program established under section 25N and for determining statewide target areas for health care provider placement based on the level of access; and (iv) address health care workforce shortages through the following activities, including: (1) coordinating state and federal loan repayment and incentive programs for health care providers; (2) providing assistance and support to communities, physician groups, community health centers and community hospitals in developing cost-effective and comprehensive recruitment initiatives; (3) maximizing all sources of public and private funds for recruitment initiatives; (4) designing pilot programs and make regulatory and legislative proposals to address workforce needs, shortages, recruitment and retention; and (5) making short-term and long-term programmatic and policy recommendations to improve workforce performance, address identified workforce shortages and recruit and retain physicians and nurses.

(c) The center shall maintain ongoing communication and coordination with the health care quality and cost council, established by section 16K of chapter 6A, and the health disparities council, established by section 16O of said chapter 6A.

(d) The center shall annually submit a report, not later than March 1, to the governor; the health care

quality and cost council established by section 16K of chapter 6A, the health disparities council established by section 16O of chapter 6A; and the general court, by filing the report with the clerk of the house of representatives, the clerk of the senate, the joint committee on labor and workforce development, the joint committee on health care financing, and the joint committee on public health. The report shall include: (i) data on patient access and regional disparities in access to physicians, by specialty and sub-specialty, and nurses; (ii) data on factors influencing recruitment and retention of physicians and nurses; (iii) short and long-term projections of physician and nurse supply and demand; (iv) strategies being employed by the council or other entities to address workforce needs, shortages, recruitment and retention; (v) recommendations for designing, implementing and improving programs or policies to address workforce needs, shortages, recruitment and retention; and (vi) proposals for statutory or regulatory changes to address workforce needs, shortages, recruitment and retention.

Section 25M. (a) There shall be a healthcare workforce advisory council within, but not subject to the control of, the health care workforce center established by section 25L. The council shall advise the center on the capacity of the healthcare workforce to provide timely, effective, culturally competent, quality physician and nursing services.
(b) The council shall consist of 16 members who shall be appointed by the governor: 1 of whom shall be a representative of the Massachusetts Extended Care Federation; 1 of whom shall be a physician with a primary care specialty designation who practices in a rural area; 1 of whom shall be a physician with a primary care specialty who practices in an urban area; 1 of whom shall be a physician with a medical subspecialty; 1 of whom shall be an advanced practice nurse, authorized under section 80B of said chapter 112, who practices in a rural area; 1 of whom shall be an advanced practice nurse, authorized under said section 80B of said chapter 112, who practices in an urban area; 1 of whom shall be a representative of the Massachusetts Organization of Nurse Executives; 1 of whom shall be a representative of the Massachusetts Academy of Family Physicians; 1 of whom shall be a representative of the Massachusetts Workforce Board Association; 1 of whom shall be a representative of the Massachusetts League of Community Health Centers, Inc.; 1 of whom shall be a representative of the Massachusetts Medical Society; 1 of whom shall be a representative of the Massachusetts Center for Nursing, Inc.; 1 of whom shall be a representative of the Massachusetts Nurses Association; 1 of whom shall be a representative of the Massachusetts Association of Registered Nurses; 1 of whom shall be a representative of the Massachusetts Hospital Association, Inc.; and 1 of whom shall be a representative of Health Care For All, Inc. Members of the council shall be appointed for terms of 3 years or until a successor is appointed. Members shall be eligible to be reappointed and shall serve without compensation, but may be reimbursed for actual and necessary expenses reasonably incurred in the performance of their duties. Vacancies of unexpired terms shall be filled within 60 days by the appropriate appointing authority.
The members of the council shall annually elect a chair, vice chair and secretary and may adopt by-

laws governing the affairs of the council.
The council shall meet at least bimonthly, at other times as determined by its rules, and when requested by any 8 members.
(c) The council shall advise the center on: (i) trends in access to primary care and physician subspecialties and nursing services; (ii) the development and administration of the loan repayment program, established under section 25N, including criteria to identify underserved areas in the commonwealth; (iii) solutions to address identified health care workforces shortages; and (iv) the center's annual report to the general court.

Section 25N. (a) There shall be a health care workforce loan repayment program, administered by the health care workforce center established by section 25L. The program shall provide repayment assistance for medical school loans to participants who: (i) are graduates of medical or nursing schools; (ii) specialize in family health or medicine, internal medicine, pediatrics, psychiatry, or obstetrics/gynecology; (iii) demonstrate competency in health information technology, including use of electronic medical records, computerized physician order entry and e-prescribing; and (iv) meet other eligibility criteria, including service requirements, established by the board. Each recipient shall be required to enter into a contract with the commonwealth which shall obligate the recipient to perform a term of service of no less than 2 years in medically underserved areas as determined by the center.
(b) The center shall promulgate regulations for the administration and enforcement of this section which shall include penalties and repayment procedures if a participant fails to comply with the service contract.
The center shall, in consultation with the health care workforce advisory council and the public health council, establish criteria to identify medically underserved areas within the commonwealth. These criteria shall consist of quantifiable measures, which may include the availability of primary care medical services within reasonable traveling distance, poverty levels, and disparities in health care access or health outcomes.
(c) The center shall evaluate the program annually, including exit interviews of participants to determine their post-program service plans and to solicit program improvement recommendations.
(d) The center shall, not later than July 1, file an annual report with the governor, the clerk of the house of representatives, the clerk of the senate, the house committee on ways and means, the senate committee on ways and means, the joint committee on health care financing, the joint committee on mental health and substance abuse and the joint committee on public health. The report shall include annual data and historical trends of: (i) the number of applicants, the number accepted, and the number of participants by race, gender, medical or nursing specialty, medical or nursing school, residence prior to medical or nursing school, and where they plan to practice after program completion; (ii) the service placement locations and length of service commitments by participants; (iii) the number of participants who fail to fulfill the program requirements and the reason for the failures; (iv) the number of former participants who continue to serve in underserved

areas; and (v) program expenditures.

SECTION 9. Said chapter 111 is hereby further amended by inserting after section 51G the following section:-

Section 51H. (a) As used in this section the following words shall, unless the context clearly requires otherwise, have the following meanings:-
“Facility”, a hospital, institution for the care of unwed mothers or clinic providing ambulatory surgery as defined by section 25.
“Healthcare-associated infection”, a localized or systemic condition that results from an adverse reaction to the presence of an infectious agent or its toxins that: (i) occurs in a patient in a facility, (ii) was not present or incubating at the time of the admission during which the reaction occurs, and (iii) if occurring in a hospital, meets the criteria for a specific infection site as defined by the federal Centers for Disease Control and Prevention and its national health care safety network.
“Serious reportable event”, an event that results in a serious adverse patient outcome that is clearly identifiable and measurable, reasonably preventable, and that meets any other criteria established by the department in regulations.
(b) A facility shall report data and information about healthcare-associated infections and serious reportable events. A serious reportable event shall be reported by a facility no later than 15 working days after its discovery. Reports shall be made in the manner and form established by the department in its regulations. The department may require facilities to register in and report to nationally recognized quality and safety organizations.
(c) The department shall, through interagency service agreements, transmit data collected under this section to the Betsy Lehman center for patient safety and medical error reduction and to the health care quality and cost council for publication on its consumer health information website. Any facility failing to comply with this section may: (i) be fined up to $1,000 per day per violation; (ii) have its license revoked or suspended by the department; or (iii) be fined up to $1,000 per day per violation and have its license revoked or suspended by the department.
(d) The department shall promulgate regulations prohibiting a health care facility from charging or seeking reimbursement for services provided as a result of the occurrence of a serious reportable event. A health care facility shall not charge or seek reimbursement for a serious reportable event that the facility has determined, through a documented review process, and under regulations promulgated by the department, was (i) preventable; (ii) within its control; and (iii) unambiguously the result of a system failure based on the health care provider’s policies and procedures.

SECTION 10. Said chapter 111 is hereby further amended by inserting after section 51G the following section:-

Section 51H. (a) As used in this section the following words shall, unless the context clearly requires

otherwise, have the following meanings:
“Facility”, a hospital, institution for the care of unwed mothers or clinic providing ambulatory surgery as defined by section 25.
“Healthcare-associated infection”, a localized or systemic condition that results from an adverse reaction to the presence of an infectious agent or its toxins that: (i) occurs in a patient in a facility, (ii) was not present or incubating at the time of the admission during which the reaction occurs, and (iii) if occurring in a hospital, meets the criteria for a specific infection site as defined by the federal Centers for Disease Control and Prevention and its national health care safety network.
“Serious adverse drug event”, any preventable event that causes inappropriate medication use in a hospital or ambulatory surgical center that leads to harm to a patient, as further defined in regulations of the department.
“Serious reportable event”, an event that results in a serious adverse patient outcome that is clearly identifiable and measurable, reasonably preventable, and that meets any other criteria established by the department in regulations.
(b) A facility shall report data and information about healthcare-associated infections, serious reportable events, and serious adverse drug events. A serious reportable event shall be reported by a facility no later than 15 working days after its discovery. Reports shall be made in the manner and form established by the department in its regulations. The department may require facilities to register in and report to nationally recognized quality and safety organizations.
(c) The department, through interagency service agreements, shall transmit data collected under this section to the Betsy Lehman center for patient safety and medical error reduction and to the health care quality and cost council for publication on its consumer health information website. Any facility failing to comply with this section may: (i) be fined up to $1,000 per day per violation; (ii) have its license revoked or suspended by the department; or (iii) be fined up to $1,000 per day per violation and have its license revoked or suspended by the department.
(d) The department shall promulgate regulations prohibiting a health care facility from charging or seeking reimbursement for services provided as a result of the occurrence of a serious reportable event. A health care facility shall not charge or seek reimbursement for a serious reportable event that the facility has determined, through a documented review process, and under regulations promulgated by the department, was (i) preventable; (ii) within its control; and (iii) unambiguously the result of a system failure based on the health care provider’s policies and procedures.

SECTION 11. Said chapter 111 is hereby further amended by inserting after section 53D the following 3 sections:-

Section 53E. The department shall promulgate regulations for the establishment of a patient and family advisory council at each hospital in the commonwealth. The council shall advise the hospital on matters including, but not limited to, patient and provider relationships, institutional review boards, quality improvement initiatives and patient education on safety and quality matters.

Members of a council may act as reviewers of publicly reported quality information, members of task forces, members of awards committees for patient safety activities, members of advisory boards, participants on search committees and in the hiring of new staff, and may act as co-trainers for clinical and nonclinical staff, in-service programs, and health professional trainees or as participants in reward and recognition programs.

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

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

SECTION 12. The first paragraph of section 70 of said chapter 111, as appearing in the 2006 Official Edition, is hereby amended by striking out the second and third sentences and inserting in place thereof the following 4 sentences:- These records may be handwritten, printed, typed or in electronic digital media or converted to electronic digital media as originally created by such hospital or clinic, by the photographic or microphotographic process, or any combination thereof. The hospital or clinic may destroy records only after the applicable retention period has elapsed and after notifying the department of public health, in accordance with its regulations, that the records will be destroyed. The department, through its regulations, shall establish an appropriate notification process. On the notice of privacy practices distributed to its patients, a hospital or clinic shall provide: (i) information concerning the provisions of this section and (ii) the hospital or clinic's records termination policy.

SECTION 13. Said section 70 of said chapter 111, as so appearing, is hereby further amended by

striking out, in line 66, the word “thirty” and inserting in place thereof the following figure:- 20.

SECTION 14. The General Laws are hereby amended by inserting after Chapter 111M the following chapter:-

CHAPTER 111N
PHARMACEUTICAL AND MEDICAL DEVICE MANUFACTURER CONDUCT

Section 1. As used in this chapter, the following words shall have the following meanings:-
“Department”, the department of public health.
“Health care practitioner”, a person who prescribes prescription drugs for any person and is licensed to provide health care, or a partnership or corporation comprised of such persons, or an officer, employee, agent or contractor of such person acting in the course and scope of his employment, agency or contract related to or in support of the provision of health care to individuals.
“Marketing code of conduct” practices and standards that govern the marketing and sale of prescription drugs or medical devices by a pharmaceutical or medical device manufacturing company to health care practitioners.
“Medical device”, an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent or other similar or related article, including any component, part or accessory, which is: (1) recognized in the official National Formulary or the United States Pharmacopeia or any supplement thereto; (2) intended for use in the diagnosis of disease or other conditions or in the cure, mitigation, treatment or prevention of disease, in persons or animals; or (3) intended to affect the structure or function of the body of a person or animal, and which does not achieve its primary intended purposes through chemical action within or on such body and which is not dependent upon being metabolized for the achievement of its primary intended purposes.
“Person”, a business, individual, corporation, union, association, firm, partnership, committee or other organization.
“Pharmaceutical or medical device manufacturer agent”, a pharmaceutical or medical device marketer or any other person who for compensation or reward does any act to promote, oppose or influence the prescribing of a particular prescription drug, medical device, or category of prescription drugs or medical devices; provided, however, that “pharmaceutical or medical device manufacturer agent” shall not include a licensed pharmacist, licensed physician or any other licensed health care practitioner with authority to prescribe prescription drugs who is acting within the ordinary scope of the practice for which he is licensed.
“Pharmaceutical or medical device manufacturing company”, any entity that participates in a commonwealth health care program and which is engaged in the production, preparation, propagation, compounding, conversion or processing of prescription drugs or medical devices, either directly or indirectly, by extraction from substances of natural origin, or independently by means of chemical synthesis or by a combination of extraction and chemical synthesis, or any entity

engaged in the packaging, repackaging, labeling, relabeling or distribution of prescription drugs; provided, however, that “pharmaceutical or medical device manufacturing company” shall not include a wholesale drug distributor licensed under section 36A of chapter 112 or a retail pharmacist registered under section 37 of said chapter 112.

“Pharmaceutical or medical device marketer”, a person who, while employed by or under contract with a pharmaceutical or medical device manufacturing company that participates in a commonwealth health care program, engages in detailing, promotional activities or other marketing of prescription drugs or medical devices in the commonwealth to any physician, hospital, nursing home, pharmacist, health benefits plan administrator, other health care practitioner or person authorized to prescribe, dispense or purchase prescription drugs; provided, however, that the “pharmaceutical or medical device marketer” shall not include a wholesale drug distributor licensed under section 36A of chapter 112, a representative of such a distributor who promotes or otherwise markets the services of the wholesale drug distributor in connection with a prescription drug or a retail pharmacist registered under section 37 of said chapter 112 if such person is not engaging in such practices under contract with a manufacturing company.

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

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

Section 2. Notwithstanding any general or special law to the contrary, the department shall adopt a standard marketing code of conduct for all pharmaceutical or medical device manufacturing companies that employ a person to sell or market prescription drugs or medical devices in the commonwealth. The marketing code of conduct shall be based on applicable legal standards and incorporate principles of health care including, without limitation, requirements that the activities of the pharmaceutical or medical device manufacturer agents be intended to benefit patients, enhance the practice of medicine and not interfere with the independent judgment of health care practitioners. In promulgating regulations for a marketing code of conduct, the department adopt regulations that shall be no less restrictive than the most recent version of the Code on Interactions with Healthcare Professionals developed by the Pharmaceutical Research and Manufacturers of America and the Code on Interactions with Healthcare Professionals developed by the Advanced Medical Technology Association.

The marketing code of conduct adopted by the department shall not allow:

(1) the provision of or payment for meals for health care practitioners that:

(a) are part of an entertainment or recreational event;

(b) are offered without an informational presentation made by pharmaceutical marketing agent or without the pharmaceutical marketing agent being present;

(c) are offered, consumed, or provided outside of the health care practitioner’s office or hospital

setting; or
(d) are provided to a healthcare practitioner's spouse or other guest;
(2) the provision or payment of entertainment or recreational items of any value, including, but not limited to, tickets to the theater or sporting events, sporting equipment, or leisure or vacation trips, to any health care practitioner who is not a salaried employee of the company;
(3) sponsorship or payment for continuing medical education, in this section referred to as CME, also known as independent medical education, that does not meet the Accreditation Council for Continuing Medical Education Standards For Commercial Support, or that provides payment directly to a health care practitioner;
(4) financial support for the costs of travel, lodging or other personal expenses of non-faculty healthcare practitioners attending any CME event, third-party scientific or educational conference, or professional meetings, either directly to the individuals participating in the event or indirectly to the event's sponsor, except in cases as determined by the department.
(5) funding to compensate for the time spent by health care practitioners participating in any CME event, third-party scientific or educational conferences, or professional meetings;
(6) the provision of or payment for meals directly at any CME event, third-party scientific or educational conferences, or professional meetings;
(7) payments in cash or cash equivalents to healthcare practitioners either directly or indirectly, except as compensation for bona fide services;
(8) any grants, scholarships, subsidies, support, consulting contracts, or educational or practice related items to a healthcare practitioner in exchange for prescribing prescription drugs or using medical devices or for a commitment to continue prescribing prescription drugs or using medical devices.
The marketing code of conduct adopted by the department shall allow:

(1) the provision, distribution, dissemination or receipt of peer reviewed academic, scientific or clinical information;
(2) the purchase of advertising in peer reviewed academic, scientific or clinical journals;
(3) prescription drugs provided to a health care practitioner solely and exclusively for use by the health care practitioner's patients;
(4) compensation for the substantial professional or consulting services of a health care practitioner in connection with a genuine research project or a clinical trial;
(5) payment for reasonable expenses necessary for technical training on the use of a medical device if that expense is part of the vendor's purchase contract for the device.
The department shall update the marketing code of conduct no less than every two years. The department may promulgate regulations or other guidelines as necessary to implement this section.

Section 3. No pharmaceutical or medical device manufacturer company or pharmaceutical or medical device manufacturer agent shall knowingly and willfully violate the marketing code of

conduct as adopted by the department.

Section 4. (a) A pharmaceutical or medical device manufacturing company that employs a person to sell or market a drug, medicine, or medical device in the commonwealth shall adopt and comply with the most recent marketing code of conduct as adopted by the department.
(b) A pharmaceutical or medical device manufacturing company that employs a person to sell or market prescription drugs or medical devices in the commonwealth shall adopt a training program to provide regular training to appropriate employees including, without limitation, all sales and marketing staff, on the marketing code of conduct.
(c) A pharmaceutical or medical device manufacturing company that employs a person to sell or market prescription drugs or medical devices in the commonwealth shall conduct annual audits to monitor compliance with the marketing code of conduct.
(d) A pharmaceutical or medical device manufacturing company that employs a person to sell or market a prescription drugs or medical devices in the commonwealth shall adopt policies and procedures for investigating instances of noncompliance with the marketing code of conduct and take corrective action in response to noncompliance and the reporting of instances of noncompliance to the appropriate state authorities.
(e) A pharmaceutical or medical device manufacturing company that employs a person to sell or market prescription drugs or medical devices in the commonwealth shall identify a compliance officer responsible for operating and monitoring the marketing code of conduct.

Section 5. A pharmaceutical or medical device manufacturing company that employs a person to sell or market prescription drugs or medical devices in the commonwealth shall annually submit to the department: (i) a description of its training program; (ii) a description of its investigation policies; (iii) the name, title, address, telephone number and electronic mail address of its compliance officer; and (iv) certification that it has conducted its annual audit and is in compliance with the marketing code of conduct.

Section 6. (1) By July 1 of each year, every pharmaceutical or medical device manufacturing company that employs a person to sell or market a drug, medicine, chemical, device or appliance in the commonwealth shall disclose to the department of public health the value, nature, purpose and particular recipient of any fee, payment, subsidy or other economic benefit with a value of at least $50, which the company provides, directly or through its agents, to any physician, hospital, nursing home, pharmacist, health benefit plan administrator, health care practitioner or other person in the commonwealth authorized to prescribe, dispense, or purchase prescription drugs or medical devices in the commonwealth. The disclosure shall be accompanied by the payment of a fee, to be determined by the department, to pay the costs of administering this section.
(2) The department of public health shall make all disclosed data publicly available and easily searchable on its website.

(3) The department of public health shall report to the attorney general any payment, entertainment, meals, travel, honorarium, subscription, advance, services or anything of value provided in violation of the market code of conduct as adopted by the department of public health.

Section 7. This chapter shall be enforced by the attorney general, the district attorney with jurisdiction over a violation or the department of public health. A person that violates this chapter shall be punished by a fine of not more than $5,000 for each transaction, occurrence or event that violates this chapter.

SECTION 15. The first paragraph of section 2 of chapter 112 of the General Laws, as appearing in the 2006 Official Edition, is hereby amended by inserting the following after the second sentence of the first paragraph:- The board shall require, as a standard of eligibility for licensure, that applicants show a predetermined level of competency in the use of computerized physician order entry, e-prescribing, electronic health records and other forms of health information technology, as determined by the board.

SECTION 16. Section 9E of said chapter 112, as so appearing, is hereby amended by striking out, in line 6, the word “two” and inserting in place thereof the following figure:- 4.

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

Section 39E. Stores or pharmacies engaged in the drug business, as defined in section 37, shall inform the department of public health of any improper dispensing of prescription drugs that results in serious injury or death, as defined by the department in regulations, as soon as is reasonably and practically possible, but not later than 15 working days after discovery of the improper dispensing. The department of public health shall promulgate regulations for the administration and enforcement of this section.

SECTION 18. Chapter 118E of the General Laws is hereby amended by adding the following section:-

Section 55. (a) Subject to subsection (c), for the purposes of processing claims for health care services submitted by a health care provider and to provide uniformity and consistency in the reporting of patient diagnostic information, patient care service and procedure information as it relates to the submission and processing of health care claims, the executive office of health and human services and its subcontractors shall, without local customization, accept and recognize patient diagnostic information and patient care service and procedure information submitted

pursuant to, and consistent with, the current Health Insurance Portability and Accountability Act compliant code sets as adopted by the Centers for Medicare and Medicaid Services; the International Classification of Diseases; the American Medical Association's Current Procedural Terminology codes, reporting guidelines and conventions; and the Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding System. The executive office and its subcontractors shall adopt the aforementioned coding standards and guidelines, and all changes thereto, in their entirety, which shall be effective on the same date as the national implementation date established by the entity implementing the coding standards.
(b) Subject to subsection (c), the executive office and its subcontractors shall, without local customization, use the standardized claim formats for processing health care claims as adopted by the National Uniform Claim Committee and the National Uniform Billing Committee and implemented pursuant to the federal Health Insurance Portability and Accountability Act. The executive office and its subcontractors shall, without local customization, adopt and routinely process all changes to such formats which shall be effective on the same date as the implementation date established by the entity implementing the formats.
(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 modify or supersede 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.
(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.

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

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

SECTION 20. Section 1 of chapter 118G of the General Laws is hereby amended by inserting after the definition of “Pediatric specialty unit”, as appearing in the 2006 Official Edition, the following definition:-

“Private health care payer”, a carrier authorized to transact accident and health insurance under chapter 175, a nonprofit hospital service corporation licensed under chapter 176A, a nonprofit medical service corporation licensed under chapter 176B, a dental service corporation organized under chapter 176E, an optometric service corporation organized under chapter 176F, a self-insured plan, to the extent allowable under federal law governing health care provided by employers to employees, or a health maintenance organization licensed under chapter 176G.

SECTION 21. Said section 1 of said chapter 118G, as so appearing, is hereby further amended by inserting after the definition of “Provider” the following definition:-

“Public health care payer”, the Medicaid program established in chapter 118E; any carrier or other entity that contracts with the office of Medicaid or the commonwealth health insurance connector to pay for or arrange the purchase of health care services on behalf of individuals enrolled in health coverage programs under Titles XIX or XXI, or under the commonwealth care health insurance program, including prepaid health plans subject to the provisions of section 28 of chapter 47 of the acts of 1997; the group insurance commission established under chapter 32A; and any city or town with a population of more than 60,000 that has adopted chapter 32B.

SECTION 22. Section 2 of said chapter 118G, as so appearing, is hereby amended by striking out the second paragraph, as most recently amended by section 38 of chapter 58 of the acts of 2006, and inserting in place thereof the following paragraph:-

The commissioner shall appoint and may remove such agents and subordinate officers as the commissioner may deem necessary and may establish such subdivisions within the division as he deems appropriate to fulfill the following duties: (i) to collect, analyze and disseminate health care data to assist in the formulation of health care policy and in the provision and purchase of health care services; (ii) to work with other state agencies including, but not limited to, the department of public health and the department of mental health, the health care quality and cost council, the division of medical assistance and the division of insurance to collect and publish data concerning the cost of health insurance in the commonwealth and the health status of individuals; (iii) to hold annual hearings concerning health care provider and payer costs and cost trends, and to provide an analysis of health care spending trends with recommendations for strategies to promote an efficient health delivery system; and (iv) to administer the health safety net office and trust fund established under sections 35 and 36.

SECTION 23. Section 6 of said chapter 118G, as so appearing, is hereby amended by striking out the third paragraph and inserting in place thereof the following 4 paragraphs:-

The division may promulgate regulations necessary to ensure the uniform reporting of information from private and public health care payers that enables the division to analyze: (i) changes over time in health insurance premium levels; (ii) changes in the benefit and cost-sharing design of plans offered by these payers; and (iii) changes in measures of plan cost and utilization; provided that this analysis shall facilitate comparison among plans and between public and private payers.
The division shall require the submission of data and other information from each private health care payer offering small or large group health plans including, without limitation: (i) average annual

individual and family plan premiums for each payer's most popular plans for a representative range of group sizes, as further determined in regulations, and average annual individual and family plan premiums for the lowest cost plan in each group size that meets the minimum standards and guidelines established by the division of insurance under section 8H of chapter 26; (ii) information concerning the actuarial assumptions that underlie the premiums for each plan; (iii) summaries of the plan designs for each plan; (iv) information concerning the medical and administrative expenses, including medical loss ratios for each plan; (v) information concerning the payer's current level of reserves and surpluses; and (vi) information on provider payment methods and levels.

The division shall require the submission of data and other information from public health care payers including, without limitation: (i) average premium rates for health insurance plans offered by public payers and information concerning the actuarial assumptions that underlie these premiums; (ii) average annual per-member per-month payments for enrollees in MassHealth primary care clinician and fee for service programs; (iii) summaries of plan designs for each plan or program; (iv) information concerning the medical and administrative expenses, including medical loss ratios for each plan or program; (v) where appropriate, information concerning the payer's current level of reserves and surpluses; and (vi) information on provider payment methods and levels, including information concerning payment levels to each hospital for the 25 most common medical procedures provided to enrollees in these programs, in a form that allows payment comparisons between Medicaid programs and managed care organizations under contract to the office of Medicaid.

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

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

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

(b) The attorney general may review and analyze any information submitted to the division under section 6 and 6A. The attorney general may require that any provider or payer produce documents

and testimony under oath related to health care costs and cost trends or documents that the attorney general deems necessary to evaluate factors that contribute to cost growth within the commonwealth's health care system and to the relationship between provider costs and payer premium rates. The attorney general shall keep confidential all nonpublic information and documents obtained under this section and shall not disclose such information or documents to any person without the consent of the provider or payer that produced the information or documents except in a public hearing under this section, a rate hearing before the division of insurance, or in a case brought by the attorney general, if the attorney general believes that such disclosure will promote the health care cost containment goals of the commonwealth and that such disclosure should be made in the public interest after taking into account any privacy, trade secret or anti-competitive considerations. Such confidential information and documents shall not be public records and shall be exempt from disclosure under section 10 of chapter 66.

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

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

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

(f) Witnesses shall provide testimony under oath and subject to examination and cross examination by the division and the attorney general at the public hearing in a manner and form to be determined by the division, including without limitation: (i) in the case of providers, testimony concerning payment systems, payer mix, cost structures, administrative and labor costs, capital and technology costs, adequacy of public payer reimbursement levels, reserve levels, utilization trends, and cost-containment strategies, the relation of private payer reimbursement levels to public payer reimbursements for similar services, efforts to improve the efficiency of the delivery system, efforts to reduce the inappropriate or duplicative use of technology; and (ii) in the case of private and public

payers, testimony concerning factors underlying premium cost and rate increases, the relation of reserves to premium costs, the payer's efforts to develop benefit design and payment policies that enhance product affordability and encourage efficient use of health resources and technology, efforts by the payer to increase consumer access to health care information, and efforts by the payer to promote the standardization of administrative practices, and any other matters as determined by the division.

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

SECTION 25. Section 36 of chapter 123 of the General Laws, as appearing in the 2006 Official Edition, is hereby amended by adding the following 4 sentences:-

Each facility, subject to this chapter and section 19 of chapter 19, that provides mental health care and treatment shall maintain patient records, as defined in the first paragraph of section 70 of chapter 111, for at least 20 years after the closing of the record due to discharge, death or last date of service. A facility shall not destroy such records until after the retention period has elapsed and only upon notifying the department of public health that the records will be destroyed, provided that the department shall promulgate regulations further defining an appropriate notification process. On the notice of privacy practices distributed to its patients, each facility shall provide: (i) information concerning the provisions of this section; and (ii) the hospital or clinic's records termination policy.

SECTION 26. Chapter 176O of the General Laws is hereby amended by inserting after section 5 the following 2 sections:-

Section 5A. (a) Subject to subsection (c), for the purposes of processing claims for health care services submitted by a health care provider and to provide uniformity and consistency in the reporting of patient diagnostic information, patient care service and procedure information as it relates to the submission and processing of health care claims, a carrier and its subcontractors shall, without local customization, accept and recognize patient diagnostic information and patient care service and procedure information submitted pursuant to, and consistent with the current Health Insurance Portability and Accountability Act compliant code sets: the International

Classification of Diseases; the American Medical Association's Current Procedural Terminology codes, reporting guidelines and conventions; and the Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding System. A carrier and its subcontractors shall adopt the aforementioned coding standards and guidelines, and all changes thereto, in their entirety, which shall be effective on the same date as the national implementation date established by the entity implementing the coding standards.

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

(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 modify or supersede a carrier’s or its subcontractor’s payment policy, utilization review policy or benefits under a health benefit plan. Nothing in this section shall further preclude a carrier or a subcontractor thereof from adjudicating a claim pursuant to its billing guidelines, payment policies, provider contracts or health benefit plans.

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

Section 5B. To ensure uniformity and consistency in the submission and processing of claims for health care services pursuant to section 5A, the bureau of managed care within the division of insurance, after consultation with a statewide advisory committee including, but not limited to, representatives of the Massachusetts Hospital Association, the Massachusetts Medical Society, the Massachusetts Association of Health Plans, the Blue Cross and Blue Shield of Massachusetts, the Massachusetts Health Information Management Association, the Massachusetts Health Data Consortium, a representative of America's Health Insurance Plans, a representative of a MassHealth contracted managed care organization, the executive office of health and human services, the division of health care finance and policy, the health care quality and cost council, the house of representatives and the senate, shall adopt policies and procedures to enforce said section 5A. The policies and procedures shall include a system for reporting inconsistencies related to a carrier’s compliance with said section 5A. The bureau shall work jointly with the executive office of health and human services to resolve reports of noncompliance with the requirements of section 61 of chapter 118E. The bureau shall convene the advisory committee annually to review and discuss issues reported by health care providers pursuant to this section and to discuss further recommendations to improve the uniformity and consistency of the reporting of patient diagnostic information and patient care service and procedure information as it relates to the submission and

processing of health care claims.

SECTION 27. Section 5A of said chapter 176O, as appearing in section 23, is hereby amended by striking out subsection (d) and inserting in place thereof the following subsection:-

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

SECTION 28. The General Laws are hereby amended by inserting after chapter 176Q the following chapter:-

CHAPTER 176R
CONSUMER CHOICE OF NURSE PRACTITIONER SERVICES

Section 1. As used in this chapter, the following words shall have the following meanings unless the context clearly requires otherwise:
“Carrier”, an insurer licensed or otherwise authorized to transact accident or health insurance under chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a nonprofit medical service corporation organized under chapter 176B; a health maintenance organization organized under chapter 176G; an organization entering into a preferred provider arrangement under chapter 176I; a contributory group general or blanket insurance for persons in the service of the commonwealth under chapter 32A; a contributory group general or blanket insurance for persons in the service of counties, cities, towns and districts, and their dependents under chapter 32B; the medical assistance program administered by the division of medical assistance pursuant to chapter 118E and in accordance with Title XIX of the Social Security Act or any successor statute; and any other medical assistance program operated by a governmental unit for persons categorically eligible for such program.
“Commissioner”, the commissioner of insurance.
“Insured”, an enrollee, covered person, insured, member, policyholder or subscriber of a carrier.
“Nondiscriminatory basis”, a carrier shall be deemed to be providing coverage on a non-discriminatory basis if its plan does not contain any annual or lifetime dollar or unit of service limitation imposed on coverage for the care provided by a nurse practitioner which is less than any annual or lifetime dollar or unit of service limitation imposed on coverage for the same services by other participating providers.
“Nurse practitioner”, a registered nurse who holds authorization in advanced nursing practice as a nurse practitioner under section 80B of chapter 112 and regulations promulgated thereunder.
“Participating provider”, a provider who, under the terms and conditions of a contract with the carrier or with its contractor or subcontractor, has agreed to provide health care services to an insured with an expectation of receiving payment, other than coinsurance, co-payments or deductibles, directly

or indirectly from the carrier.
“Primary care provider”, a health care professional qualified to provide general medical care for common health care problems, supervises, coordinates, prescribes, or otherwise provides or proposes health care services, initiates referrals for specialist care, and maintains continuity of care within the scope of practice.

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

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

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

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

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

SECTION 29. Notwithstanding any general or special law to the contrary, the first report of the health care workforce center required by section 25L of chapter 111 of the General Laws shall be filed on or before December 31, 2009 and shall focus on the primary care workforce, defined as physicians with a medical specialty in family medicine, internal medicine, pediatrics, and

obstetrics/gynecology or nurse practitioners practicing as primary care providers.

SECTION 30. Notwithstanding any general or special law to the contrary, the office of Medicaid, subject to appropriation and the availability of federal financial participation, and in consultation with the MassHealth payment policy advisory board, shall establish a medical home demonstration project. Within the demonstration project the office of Medicaid shall restructure its payment system to support primary care practices that use a medical home model and shall develop a program to support primary care providers in developing an organizational structure necessary to provide a medical home. The office of Medicaid shall work with Medicaid managed care organizations to develop and implement the project.

The office shall consider payment methodologies that support care-coordination through multi-disciplinary teams, including payment for care of patients with chronic diseases and the elderly, and that encourage services such as: (i) patient or family education for patients with chronic diseases; (ii) home-based services; (iii) telephonic communication; (iv) group care; and (v) culturally and linguistically appropriate care. Payment shall reward quality and improved patient outcomes.

The office shall identify practices, for participation in the project, that provide care to its patients using a medical home model, which at minimum shall include primary care practices with a multi-specialty team that provides patient-centered care coordination through the use of health information technology and chronic disease registries, across the patient's life-span and across all domains of the health care system and the patient's community.

The office shall promulgate regulations for the phase-in and implementation of this demonstration project.

The office, subject to appropriation and in coordination with the health care workforce center and the Massachusetts Academy of Family Physicians, shall develop a program to provide support to practices interested in developing an organizational structure necessary to provide a medical home.

The office shall conduct an annual project evaluation including documentation of cost savings achieved through implementation; health care screening rates, outcomes and hospitalization rates for patients with chronic illnesses such as pediatric asthma, diabetes, heart disease, hospitalization and readmission rates for the frail elderly. The office shall submit a report of the evaluation to the senate and house chairs of the joint committee on health care financing and the chairs of the senate and house committees on ways and means.

SECTION 31. Notwithstanding any general or special law to the contrary, the trustees of the University of Massachusetts shall expand the entering class at its medical school and increase residencies for medical school graduates for students committed to entering the primary care field and to working in underserved regions of the commonwealth. The trustees shall develop a master plan for expanding medical student enrollment and increasing internships and residencies for medical school graduates who are committed to primary care and work in underserved regions without reducing academic quality, together with a financial plan to support such expansion, and

shall report that plan to the clerk of the house of representatives who shall forward the same to the joint committee on health care financing and the house and senate committees on ways and means on or before January 1, 2009.

SECTION 32. Notwithstanding any general or special law to the contrary, the trustees of the University of Massachusetts, in conjunction with the state health education center at the University of Massachusetts medical center, shall establish and maintain an enhanced learning contract program available to medical students every academic year. The program shall provide full waivers of tuition and fees at the University of Massachusetts medical school. In exchange for the waivers, the contract shall require at least 4 years of service within the commonwealth in areas of primary care, public or community service or underserved areas, as determined by the health care workforce center established under section 25L of chapter 111 of the General Laws and the learning contract committee, in coordination with the area health education center and state and regional health planning agencies. If a student fails to perform the service required by an enhanced learning contract, that student shall pay the difference between the tuition paid and double the amount of the tuition charged together with an origination fee, interest per annum at prime rate as reported at the time of origination by the Federal Reserve, a margin and repayment fee as established by the board. No service or tuition loan repayment shall be required prior to the termination of any internship and residency requirements. Interest shall begin to accrue upon completion of the requirements for the degree. The commonwealth shall bear the cost of such tuition and fee waivers for enhanced learning contracts. The dean of the medical school shall report annually the number of students participating in enhanced learning contracts, the area of medicine within which payback is to be performed and the number of students utilizing the repayment option. The report shall also outline the effects of payback in the underserved areas of the commonwealth.

SECTION 33. (a) Notwithstanding any general or special law to the contrary, there shall be established and set up on the books of the commonwealth a separate fund to be known as the Massachusetts Nursing and Allied Health Workforce Development Trust Fund to which shall be credited any appropriations, bond proceeds or other monies authorized by the general court and specifically designated to be credited thereto, and additional funds, including federal grants or loans or private donations made available to the commissioner of higher education for this purpose. The department of higher education shall hold the fund in an account separate and apart from other funds or accounts. Amounts credited to the fund shall be expended by the commissioner of higher education to carry out subsection (b). Any balance in the fund at the close of a fiscal year shall be available for expenditure in subsequent fiscal years and shall not revert to the General Fund.
(b) the fund shall be used to develop and support, in consultation with the Massachusetts Nursing and Allied Health Workforce Development Advisory Committee, short-term and long-term strategies to increase the number of public and private higher education faculty and students who participate in programs that support careers in fields related to nursing and allied health. The commissioner of

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

SECTION 34. Notwithstanding any general or special law to the contrary, the department of housing and community development, in consultation with the executive office of health and human services, the department of workforce development and the Massachusetts housing finance agency, shall establish a pilot grant or loan program to assist hospitals, community health centers, and physician practices in providing housing grants or loans for health care professionals who commit to practicing in underserved areas, identified by the health care workforce center, established under section 25L of chapter 111, and who meet income eligibility guidelines established by the department. Grants and loans may be used for: (i) purchasing a principal residence, including cooperative housing, that falls within price guidelines established by the department, including costs for down payments, mortgage interest rate buy-downs, closing costs and other costs determined to be eligible by the department; and (ii) payments for security deposits and advance payments for rental housing. The department, to the extent possible shall seek matching funds from hospitals and other private entities.

The department shall promulgate rules and regulations for the administration and enforcement of this section including, establishing provisions for eligibility, specifying the expenses for which grants and loans may be made, and determining the procedures necessary to qualify for assistance.

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

SECTION 35. (a) Notwithstanding any general or special laws to the contrary, the division of health care finance and policy, in conjunction with the division of insurance, shall examine options and alternatives available to the commonwealth to provide regulation, oversight and disposition of the reserves, endowments and surpluses of health insurers and hospitals.
(b) The division shall conduct a study relative to health insurers, including health maintenance organizations and acute care and non-acute care hospitals. The study shall include, but not be limited to: (1) an analysis of the laws, regulations and other measures currently in effect in the commonwealth which regulate the amount, nature and disposition of surpluses held by or for the benefit of health insurers in excess of amounts reasonably anticipated to be required to pay claims, taking into account the level of such reserves and surpluses necessary to safeguard the solvency of health insurers against unanticipated events and other circumstances which may cause extraordinary medical losses; (2) an analysis of federal and state law, regulations and other measures currently in effect which regulate the amount, nature and disposition of surpluses and endowments held by or for the benefit of hospitals in excess of amounts reasonably anticipated to be required to perform and support services provided by the hospital and to guard against unanticipated events and other circumstances; (3) a review of recent fiscal practices and financial reporting by health insurers relative to reserves and surpluses and of hospital fiscal practices and financial reporting required by general or special law; (4) a comparison of the commonwealth's current statutes and regulations with those of other states which the commission deems to be reasonably comparable to those of the commonwealth; (5) a review and assessment of model acts and regulations and any other information which the commission finds to be relevant to its inquiry; and (6) a review of the method by which health insurers and hospitals fund community benefit programs including, but not limited to, the manner by which funding is regulated by other states as to the appropriate amount, monitoring and direction of such funding. In compiling this report, the division shall seek input from health plans and hospitals operating in the commonwealth, the attorney general, the executive office of health and human services, and the health care quality and cost council, established in section 16K of section 6A of the General Laws. In conducting its examination, the division shall, to the extent possible, obtain and use actual health plan and hospital data and such data shall be confidential and shall not be a public record under clause twenty-sixth of section 7 of chapter 4 of the General Laws or section 10 of chapter 66 of the General Laws.
(c) The division may contract with another entity with the requisite objective financial and actuarial expertise to assist the division in conducting its study.
(d) The division shall file a report of its findings and recommendations with the clerks of the senate and house of representatives, the house and senate committees on ways and means and the joint

committee on health care financing not later than July 1, 2009.

SECTION 36. Notwithstanding any general or special law to the contrary, on or before October 1, 2012, the department of public health shall adopt regulations requiring hospitals and community health centers, as a standard of eligibility for original licensure and renewal of licensure, to implement computerized physician order entry systems as defined by the department. The systems shall be certified by the Certification Commission for Healthcare Information Technology or a successor agency or organization established for the purpose of certifying that health information technology meets national interoperability standards.

SECTION 37. Notwithstanding any general or special law to the contrary, on or before October 1, 2015, the department of public health shall adopt regulations requiring hospitals and community health centers, as a standard of eligibility for original licensure and renewal of licensure, to implement interoperable electronic health records systems, as defined by the department. The system shall be certified by the Certification Commission for Healthcare Information Technology or a successor agency or organization established for the purpose of certifying that health information technology meets national interoperability standards.

SECTION 38. Notwithstanding any general or special law to the contrary, the executive office of health and human services shall maximize enrollment of eligible persons in the MassHealth Senior Care Options program, the Program of All Inclusive Care for the Elderly, the Enhanced Community Options Program and the Community Choices program, or comparable successor programs, and shall develop dual eligible plans. For the purposes of this section, “dual eligible plans” shall be plans that offer similar coverage to Medicaid and Medicare-eligible disabled persons under age 65.
Not later than 6 months after the effective date of this act, the executive office of health and human services shall prepare a report identifying clinical, administrative and financial barriers to expanded dual eligible plans, and shall recommend steps to remove the barriers and implement the plans. Before finalizing the report, the executive office shall hold a public consultative session that shall include organizations representing seniors, organizations representing disabled persons, organizations representing health care consumers, organizations representing racial and ethnic minorities, health delivery systems and health care providers. The report shall include consideration of changes in procurement standards and MassHealth payment methodologies to promote enrollment in dual eligible plans. The report shall include estimates of the costs and benefits of implementing steps to remove barriers to expanded enrollment in dual eligible plans, including financial savings and improved quality of care.
The report shall be provided to the committee on health care financing and the house and senate committees on ways and means. Subject to appropriation, the executive office of health and human services shall implement any steps recommended by the report. Not later than 1 year after the filing

of the report, the executive office shall issue a progress statement on expanded enrollment in dual eligible plans.

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

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

SECTION 41. Notwithstanding any general or special law to the contrary, the executive office of health and human services, in consultation with the health care quality and cost council, commission on end-of-life care established by section 480 of chapter 159 of the Acts of 2000, and the Betsy Lehman Center for Patient Safety and the Reduction of Medical Errors, shall convene an expert panel on end-of-life care for patients with serious chronic illnesses. The panel shall investigate and

study health care delivery for these patients and the variations in delivery of such care among health care providers in the commonwealth. For the purposes of this investigation and study, “health care providers” shall mean facilities and health care professionals licensed to provide acute inpatient hospital care, outpatient services, skilled nursing, rehabilitation and long-term hospital care, home health care and hospice services. The panel shall identify best practices for end-of-life care, including those that minimize disparities in care delivery and variations in practice or spending among geographic regions and hospitals, and shall present recommendations for any legislative, regulatory, or other policy changes necessary to implement its recommendations.

SECTION 42. Notwithstanding any general or special law to the contrary, on or before January 1, 2009, the executive office of health and human services, in consultation with the commission on end–of-life care established by section 480 of chapter 159 of the acts of 2000, shall initiate a public awareness campaign to highlight the importance of end-of-life care planning. The campaign shall include, but not be limited to, dissemination of information and other activities that educate the public about existing options for care at the end of life and how to communicate their end-of-life care wishes to family members and health care providers.

SECTION 43. Notwithstanding any general or special law to the contrary, the executive office of health and human services, in consultation with the commission on end-of-life care established by section 480 of chapter 159 of the acts of 2000, shall establish a pilot program to test the implementation of the physician order for life-sustaining treatment paradigm program to assist individuals in communicating end-of-life care directives across care settings in at least 1 region of the commonwealth. The pilot program shall include educational outreach to patients, families, caregivers and health care providers regarding the physician order for life-sustaining treatment paradigm program. The executive office of health and human services, in conjunction with the end-of-life commission, shall develop measures to test the success of the pilot program and make recommendations for the establishment of a state-wide program.

SECTION 44. (a) Notwithstanding any general or special law to the contrary, there shall be a special commission on the health care payment system that shall investigate reforming and restructuring the system to provide incentives for efficient and effective patient-centered care and to reduce variations in the quality and cost of care.
(b) The commission shall consist of the secretary of administration and finance and the commissioner of health care finance and policy, who shall serve as co-chairs, the executive director of the group insurance commission, 1 person to be appointed by the senate president, 1 person to be appointed by the speaker of the house, and 5 members to be appointed by the Governor, 1 of whom shall be a representative of the Massachusetts Association of Health Plans, Inc., 1 of whom shall be a representative of Blue Cross and Blue Shield of Massachusetts, Inc., 1 of whom shall be a representative of the Massachusetts Hospital Association, Inc., 1 of whom shall be a

representative of the Massachusetts Medical Society, and 1 of whom shall be a health economist or expert in the area of payment methodology.

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

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

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

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

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

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

The commission shall hold its first meeting no later than September 15, 2008 and shall file the report of its findings and recommendations together with legislation, if any, with the clerks of the senate and the house of representatives and with the governor no later than April 1, 2009.
Any person or entity acting under the authority of any rule, regulation or guideline adopted pursuant to this section shall be engaged in action under state policy and shall be immune from antitrust liability to the same degree and extent as the Commonwealth.

SECTION 45. Any entity providing ambulatory surgical center services which is in operation or under construction, as determined by the department of public health, on the effective date of this act shall be exempt from the determination of need requirement of section 53G of chapter 111 of the General Laws and shall be eligible, pursuant to said section 53G of said chapter 111, to make application to the department for a clinic license for up to 6 months after the effective date of regulations adopted by the department pursuant to said section 53G of said chapter 111.

SECTION 46. Section 7 shall apply to any project seeking written approval of final architectural plans, pursuant to section 51 of chapter 111 of the General Laws 6 months or more after the effective day of this act.

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

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

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

SECTION 50. Notwithstanding any general or special law to the contrary, the secretary of administration and finance and the secretary of health and human services shall prepare and submit a report to the general court about the allocation for and use of state funds by acute care hospitals,

non-acute care hospitals, Medicaid managed care organizations, other managed care organizations, community health centers and carriers contracting with the commonwealth health insurance connector authority to provide coverage under chapter 118H or any other publicly funded program. The report shall include: (1) a comprehensive review of the current manner, amount and purposes of annual state funding received by those entities, including a description of the source of the funding; (2) an assessment of the change in total state funding for those entities over the past 5 years, with particular attention paid to the impact of chapter 58 of the acts of 2006; (3) an assessment of how those entities use state funds; (4) an assessment of whether the current payment structure assures the delivery of quality health care in the most cost-effective way; (5) an analysis of financial and management practices of those entities by benchmarking performance with respect to quality and cost effectiveness against national performance levels and similar health care providers in the commonwealth; (6) identification of common factors that may contribute to the fiscal instability of those entities; (7) recommendations for the development of performance and operational benchmarks; (8) recommendations for ensuring that the entities are spending state and other funds in a fiscally-responsible manner and providing quality care; (9) recommendations for legislative and other action necessary to strengthen state oversight and ensure greater accountability of state resources; (10) an assessment of the manner in which hospitals seek payment from consumers, including an analysis of the impact that court filing fees have on their ability to collect payment; and (11) recommendations for regulations regarding the due diligence that facilities shall exercise in seeking to collect payment from consumers before seeking reimbursement from the commonwealth.

SECTION 51. Notwithstanding any general or special law to the contrary, on or before July 31, 2012, the e-Health institute, in consultation with the health information technology council established by section 6D of chapter 40J, shall submit a report to the joint committee on health care financing and the senate and house committees on ways and means on the status of health information technology in the commonwealth. The report shall include the status of: (i) the implementation and use of electronic health records systems, such as rate of provider participation; (ii) the statewide interoperable electronic health records network and its capacity to exchange health information between and among components of the health system, with special focus on ambulatory care providers; (iii) the security and privacy of health information technology developed and disseminated through activities of the council; and (iv) the impact of health information technology on health care quality, health outcomes of patients, and health care costs.

SECTION 52. Notwithstanding any general or special law to the contrary, the health e-Health institute and the health information technology oversight council, established by section 6D of chapter 40J of the General Laws, shall have as its goal full implementation of electronic health records systems and the statewide interoperable electronic health records network by January 1, 2015.

SECTION 53. Notwithstanding any general or special law to the contrary, the secretary of health and human services, in consultation with the health care quality and cost council, shall: (i) examine the feasibility of the commonwealth entering into an interstate compact with 1 or more states to establish an independent entity to research the comparative effectiveness of medical procedures, drugs, devices, and biologics, so that research results can be used as a basis for health care purchasing and payment decisions, and (ii) make recommendations concerning the entity's design. The secretary shall consider existing state and country models, including, but not limited to, the Washington State Health Care Authority's Health Technology Assessment program, the National Institute for Health and Clinical Excellence in Britain, and the Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen in Germany. The secretary shall file a report with the results of the study together with legislation, if any, with the clerk of the senate and the clerk of the house of representatives on or before March 30, 2009.

SECTION 54. Item 1599-2008 of chapter 182 of the acts of 2008 is hereby amended by striking the following words:- , inspector general's office.

SECTION 55. Chapter 182 of the acts of 2008 is hereby amended by striking out section 10.

SECTION 56. Chapter 182 of the acts of 2008 is hereby amended in section 87 by striking out the words:- "established in section 10 of this act".

SECTION 57. Section 10 shall take effect on October 1, 2012.

SECTION 58. Section 15 shall take effect on January 1, 2015.

SECTION 59. Subsection (d) of section 61 of chapter 118E of the General Laws, as appearing in section 18 shall take effect on January 1, 2011.

SECTION 60. Sections 19 and 27 shall take effect on July 1, 2012.

SECTION 61. Subsection (d) of section 5A of chapter 176O of the General Laws, as appearing in section 26 shall take effect on January 1, 2011.

SECTION 62. Sections 14, 28 and 42 shall take effect on January 1, 2009.

Approved August 10, 2008