HOUSE DOCKET, NO. 3111 FILED ON: 1/20/2017

HOUSE . . . . . No. 3235

The Commonwealth of Massachusetts

PRESENTED BY:

Michael J. Finn

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act ensuring safe and equitable ambulatory care.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Michael J. Finn	*6th Hampden*
Gerard Cassidy	*9th Plymouth*

HOUSE DOCKET, NO. 3111 FILED ON: 1/20/2017

HOUSE . . . . . No. 3235

By Mr. Finn of West Springfield, a petition (accompanied by bill, House, No. 3235) of Michael J. Finn and Gerard Cassidy relative to the health care delivery and payment system and ensuring safe and equitable ambulatory care. Public Health.

The Commonwealth of Massachusetts

In the One Hundred and Ninetieth General Court
(2017-2018)

An Act ensuring safe and equitable ambulatory care.

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. Chapter 6D of the General Laws, is hereby amended by striking out section 5, as appearing in the 2014 Official Edition, and inserting in place thereof the following section:-

The commission shall monitor the reform of the health care delivery and payment system in the commonwealth under this chapter. The commission shall: (i) set health care cost growth goals for the commonwealth; (ii) enhance the transparency of provider organizations and clinics as defined by section 52 of chapter 111 of the General Laws; (iii) monitor the development of ACOs and patient-centered medical homes; (iv) monitor the adoption of alternative payment methodologies; (v) foster innovative health care delivery and payment models that lower health care cost growth while improving the quality of patient care; (vi) monitor and review the impact of changes within the health care marketplace and (vii) protect patient access to necessary health care services.

SECTION 2. Section 8 of said chapter 6D, as so appearing, is hereby amended by striking out paragraphs (d) and (e) and inserting in place thereof the following paragraphs:-

(d) The commission shall identify as witnesses for the public hearing a representative sample of providers, provider organizations, payers and others, 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 commonwealth; (iv) freestanding ambulatory surgical centers from at least 3 separate regions of the commonwealth; (v) at least 1 urgent care clinic as defined in section 52 of chapter 111 of the General Laws; (vi) at least 1 limited services clinic as defined in section 52 of chapter 111 of the General Laws; (vii) community health centers from at least 3 separate regions of the commonwealth; (viii) the 5 private health care payers with the highest enrollments in the commonwealth; (ix) any managed care organization that provides health benefits under Title XIX; (x) the group insurance commission; (xi) at least 3 municipalities that have adopted chapter 32B; (xii) at least 4 provider organizations, at least 2 of which shall be certified as accountable care organizations, 1 of which has been certified as a model ACO, which shall be from diverse geographic regions of the commonwealth; and (xii) any witness identified by the attorney general or the center.

(e) Witnesses shall provide testimony under oath and subject to examination and cross examination by the commission, the executive director of the center and the attorney general at the public hearing in a manner and form to be determined by the commission, including, but not limited to: (i) in the case of providers and provider organizations; testimony concerning payment systems; care delivery models; payer mix; the payer mix of ambulatory surgical centers, urgent care clinics as defined in section 52 of chapter 111 of the General Laws, and limited services clinics as defined in section 52 of chapter 111 of the General Laws, as compared to hospitals in the same primary service area; cost structures; administrative and labor costs; capital and technology cost; adequacy of public payer reimbursement levels; reserve levels; utilization trends; relative price; quality improvement and care-coordination strategies; investments in health information technology; 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 the impact of price transparency on prices; 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, efforts by the payer to reduce the use of fee-for-service payment mechanisms, the payer's efforts to develop benefit design, network design and payment policies that enhance product affordability and encourage efficient use of health resources and technology including utilization of alternative payment methodologies, efforts by the payer to increase consumer access to health care information, efforts by the payer to promote the standardization of administrative practices, the impact of price transparency on prices and any other matters as determined by the commission. The commission shall solicit testimony from any payer which has been identified by the center's annual report under subsection (a) of section 16 of chapter 12C as (1) paying

providers more than 10 per cent above or more than 10 per cent below the average relative price or (2) entering into alternative payment contracts that vary by more than 10 per cent. Any payer identified by the center's report shall explain the extent of price variation between the payer's participating providers and describe any efforts to reduce such price variation.

SECTION 3. Subsection (a) of section 8 of chapter 12C of the General Laws, as so appearing, is hereby amended by striking out the second sentence and inserting in place thereof the following sentence:-

Such uniform reporting shall enable the center to identify, on a patient-centered and provider-specific basis, statewide and regional trends in the cost, price, availability, utilization, and public payer mix of medical, surgical, diagnostic and ancillary services provided by acute hospitals, nursing homes, chronic care and rehabilitation hospitals, other specialty hospitals, clinics, including mental health clinics, ambulatory surgical centers, urgent care clinics as defined in section 52 of chapter 111 of the General Laws, limited services clinics as defined by section 52 of chapter 111 of the General Laws, and other ambulatory care providers as the center may specify.

SECTION 4. Said section 8 of chapter 12C, as so appearing, is hereby further amended by inserting after paragraph (c) the following paragraph:-

(c ½) The center shall also collect and analyze such data as it considers necessary in order to better protect the public's interest in monitoring the financial conditions of ambulatory care providers, including ambulatory surgical centers, urgent care clinics as defined in section 52 of chapter 111 of the General Laws, and limited services clinics as defined by section 52 of chapter 111 of the General Laws. The information shall be analyzed on an industry-wide and ambulatory care provider-specific basis and shall include, but not be limited to: (1) gross and net patient service revenues; (2) sources of revenue; (3) private sector charges; (4) trends in outpatient case mix and payer mix, including public payer mix; (5) total payroll as a per cent of operating expenses, as well as the salary and benefits of the top 3 highest compensated employees, identified by position description and specialty; and (6) other relevant measures of financial health or distress.

The center shall publish annual reports and establish a continuing program of investigation and study of financial trends in the ambulatory care provider industry, including an analysis of systemic inefficiencies and payer mix that contribute to financial distress in the acute hospital industry.

SECTION 5. Paragraph (d) of section 15 of said chapter 12C, as so appearing, is hereby amended by striking out the first sentence and inserting in place thereof the following sentence:-

The Lehman center shall develop and administer a patient safety and medical error reduction education and research program to assist health care professionals, health care facilities, urgent care clinics as defined in section 52 of chapter 111 of the General Laws, and agencies and the general public regarding issues related to the causes and consequences of medical error and practices and procedures to promote the highest standard for patient safety in the commonwealth.

SECTION 6. Subsection (a) of section 16 of said chapter 12C, as so appearing, is hereby amended by striking out the first paragraph and inserting in place thereof the following paragraph:-

The center shall publish an annual report based on the information submitted under sections 8, 9 and 10 concerning health care provider, provider organization and private and public health care payer costs and cost trends, section 13 of chapter 6D relative to market power reviews and section 15 relative to quality data. The center shall compare the costs and cost trends with the health care cost growth benchmark established by the health policy commission under section 9 of chapter 6D, analyzed by regions of the commonwealth, and shall detail: (1) baseline information about cost, price, quality, utilization and market power in the commonwealth's health care system; (2) cost growth trends for care provided within and outside of accountable care organizations and patient-centered medical homes; (3) cost growth trends by provider sector, including but not limited to, hospitals, hospital systems, non-acute providers, ambulatory surgical centers, urgent care clinics as defined in section 52 of chapter 111 of the General Laws,

limited services clinics as defined in section 52 of chapter 111 of the General Laws, pharmaceuticals, medical devices and durable medical equipment; provided, however, that any detailed cost growth trend in the pharmaceutical sector shall consider the effect of drug rebates and other price concessions in the aggregate without disclosure of any product or manufacturer-specific rebate or price concession information, and without limiting or otherwise affecting the confidential or proprietary nature of any rebate or price concession agreement; (4) factors that contribute to cost growth within the commonwealth's health care system and to the relationship between provider costs and payer premium rates; (5) the proportion of health care expenditures reimbursed under fee-for-service and alternative payment methodologies; (6) the impact of health care payment and delivery reform efforts on health care costs including, but not limited to, the development of limited and tiered networks, increased price transparency, increased utilization of electronic medical records and other health technology; (7) the impact of any assessments including, but not limited to, the health system benefit surcharge collected under section 68 of chapter 118E, on health insurance premiums; (8) trends in utilization of unnecessary or duplicative services, with particular emphasis on imaging and other high-cost services; (9) the prevalence and trends in adoption of alternative payment methodologies and impact of alternative payment methodologies on overall health care spending, insurance premiums and provider rates; (10) the development and status of provider organizations in the commonwealth including, but not limited to, acquisitions, mergers, consolidations and any evidence of excess consolidation or anti-competitive behavior by provider organizations; (11) the impact of health care payment and delivery reform on the quality of care delivered in the commonwealth; and (12) the impact of the public payer mix of ambulatory surgical centers, urgent care clinics as defined in section 52 of chapter 111 of the General Laws, and limited

services clinics as defined in section 52 of chapter 111 of the General Laws on acute care hospitals.

SECTION 7. Said chapter 111 is hereby amended by striking out section 51D, as so appearing, and inserting in place thereof the following section:--

No acute hospital, ambulatory surgical center, urgent care clinic, or limited services clinic shall impose any discriminatory restrictions or conditions relating to admission, availability of services, treatment, transfer or discharge with respect to any patient because that patient is a medicare beneficiary. Prohibited practices include, but are not limited to, any such discrimination based on the diagnostically related group classification of such a beneficiary or any other criteria, including cost of treatment, severity of illness, and average length of stay, which are not equally applied to all patients with comparable medical needs seeking or receiving the services of the hospital, ambulatory surgical center, urgent care clinic, or limited services clinic. For medicare patients, admission and discharge shall be consistent with Public Laws 97-248, 98-21 and 09-369 and any other applicable federal statutes and regulations.

The department shall establish an advocacy office for the receipt of complaints of alleged violations of the provisions of this section. Said advocacy office shall investigate such alleged violations and if the advocacy office finds cause for crediting the allegations of a complaint, it will seek to resolve such complaint through negotiation. Hospitals, ambulatory surgical centers,

urgent care clinics, or limited services clinics shall cooperate with said advocacy office in the investigation and resolution of an alleged violation. Such cooperation shall include, but not be limited to, the provisions of nonconfidential information reasonably related to the alleged violation, and the provision of patient records with the consent of the patient.

If the advocacy office cannot promptly negotiate a resolution to a complaint, the department may forward the complaint and any information obtained to the attorney general. The attorney general may bring a civil action for injunctive or other equitable relief to enforce the provisions of this section.

If the advocacy office cannot negotiate a resolution to the complaint and has cause to believe there exists a practice or pattern of violations of this section at any hospital, ambulatory surgical center, urgent care clinics, or limited services clinic, the department may also forward the complaints to the regional office of the health care financing administration for appropriate action.

Any information supplied by a hospital, ambulatory surgical center, urgent care clinics, or limited services clinic to the department which is provided to the attorney general shall not, unless otherwise ordered by a court for good cause shown, be disclosed to any person other than the patient, the authorized agent of the patient or representative of the attorney general, unless

with the consent of the hospital, ambulatory surgical center, urgent care clinics, or limited services clinic providing the same.

The department shall have the authority to promulgate such regulation as may be necessary to implement the provisions of this section.

The attorney general may bring a civil action for injunctive or other equitable relief to enforce the provisions of this section.

In any action brought by the attorney general under this section, the court may also award a civil penalty of not more than five thousand dollars for each violation unless the peer review organization of said health care financing administration has formally commenced sanction proceedings against an institution as provided in 42 CFR 474.30.

Hospitals, ambulatory surgical centers, urgent care clinics, and limited services clinics shall provide written notice of the rights established by this section to every medicare eligible person seeking services in the facility. In addition, notice of such rights shall be conspicuously posted in the facility.

Each acute care hospital is hereby required, in accordance with applicable federal and state regulations, to create for each medicare patient determined to need assistance with post-hospital care, a written comprehensive, individualized, discharge plan consistent with medical discharge orders and identified patient needs. Said plan shall be developed with the participation of appropriate health care professionals, the medicare patient and, as appropriate, the patient's family or representative. The patient's representative shall be selected in accordance with department regulations. The discharge plan shall be given to the patient or the patient's representative at least twenty-four hours prior to discharge, except where such a requirement is not feasible due to a short length of stay. If said plan is revised due to the medical needs of the patient or due to a space becoming available in an appropriate institutional setting, the twenty-four hour requirement shall not apply to the amended plan, except insofar as such timing relates to the filing of a request for review with the advocacy office as hereinafter provided.

The discharge plan shall include at least the following information:

(1) identification of the post-hospital services needed by the patient, including home health and homemaker services, and of the post-hospital social needs of the patient, as determined in accordance with procedures set forth by the department;

(2) the services that have been arranged for the patient;

(3) the names, addresses, and telephone numbers of service providers;

(4) the service schedule as requested by the hospital;

(5) medications prescribed and instructions for their use or verification that such information was provided separately;

(6) scheduled follow-up medical appointments or verification that such information was provided separately; and

(7) such other information as the department may require.

Each hospital shall have a clear, concise front page on the discharge plan, which front page shall be written in large print and understandable language. The front page shall contain at least the following:

(1) the name and telephone number of the hospital discharge planning coordinator to be contacted in the event the patient has any problems with post-hospital services after said patient leaves the hospital;

(2) a notice that, in the event the patient or the patient's representative does not agree with the discharge plan, the discharge planning coordinator and the patient's physician shall meet with the patient or the patient's representative in an effort to develop a plan that is acceptable to the patient;

(3) a notice, including the advocacy office telephone number, that, if an acceptable resolution is not reached as a result of the meeting provided for in clause (2), the patient or the patient's representative may file a request for review of the discharge plan with the advocacy office, as hereinafter provided;

(4) a notice that signing the discharge plan does not necessarily indicate approval of the plan and does not preclude the right to request a meeting or a review pursuant to clauses (2) and (3); and

(5) a signature line for the patient or the patient's representative acknowledging participation in the development of the discharge plan and receipt of a copy of said plan.

If the patient or the patient's representative does not sign the plan, the reason for not signing shall be noted on the plan. A signed or noted copy of the plan shall be retained in the patient's medical record. The patient's medical record shall also document that said plan was communicated orally to the patient or to the patient's representative.

No hospital may discharge a medicare patient without the patient or patient's representative having received, read and signed the front page of the discharge plan or upon decision of the advocacy office.

If a discharge plan cannot be agreed upon as a result of the meeting of the patient or the patient's representative, the discharge planning coordinator and the patient's physician, as provided for in this section, the patient or the patient's representative shall have the right to file a request for a review of said discharge plan with the department's advocacy office. The hospital also shall have the right to file a request for a review of said discharge. A request for review shall be made with the advocacy office not later than noon of the first working day after the date the

patient or the patient's representative receives the written discharge plan. The hospital shall deliver to the advocacy office the records required to review the discharge plan by the close of such working day. The advocacy office shall either approve or disapprove the discharge plan within one working day of receiving the request for review and the hospital records. Said discharge plan shall not be approved unless the requirements set forth herein have been satisfied.

If the advocacy office approves the discharge plan, discharge shall occur pursuant to the approved plan by noon of the day following notification of the advocacy office's decision, unless hospital and patient agree otherwise. If the advocacy office does not approve the discharge plan, said office shall state the problems needing correction, and the hospital shall not charge the medicare patient for inpatient hospital services until an alternative plan is developed to resolve the problems set forth by the advocacy office. The requirements of this section relating to the initial discharge also shall apply to the alternative plan.

If a timely request for review has been filed with the advocacy office, the hospital shall not charge the medicare patient for inpatient hospital services furnished before noon of the day after said patient is notified by telephone or otherwise of the advocacy office's decision. If notice is made by telephone, the notice shall be made to both parties to the review and shall be followed by written notice as soon as possible.

No patient shall be discharged or transferred without a physician's order, except where such patient leaves against medical advice. No patient shall be discharged until the hospital has made all appropriate contacts to initiate the provisions for aftercare services.

A medicare patient treated at the emergency room of an acute care hospital or at an ambulatory surgical center, urgent care clinic, or limited services clinic shall be provided with a discharge plan in accordance with the requirements of this section, with the exception of the right to request a review of such discharge plan by the advocacy office prior to such discharge.

Nothing in this section shall be construed to prevent a hospital, ambulatory surgical center, urgent care clinic, or limited services clinic from implementing a decision relating to patient care which is in the best interest of a patient and in conformity with good medical and hospital practice.

Nothing in this section shall be construed as limiting any other rights or remedies provided by law to medicare patients. Nothing in this section shall be construed to limit the applicability of section sixty B of chapter two hundred and thirty-one. Nothing in this section shall give rise to or limit an otherwise available cause of action in negligence or medical malpractice.

The department shall conduct an evaluation as to whether the introduction of the medicare prospective payment system has affected the delivery of quality care to medicare beneficiaries including the appropriateness of admissions and discharges to acute care hospitals. Said department shall submit an interim report of its findings to the clerk of the house of representatives to the general court no later than March first, nineteen hundred and eighty-seven, and a final report not later than March first, nineteen hundred and eighty-eight, including any applicable recommendations for legislation arrived after consultation with the Massachusetts Hospital Association, the Massachusetts Medical Society, and others. Acute hospitals are hereby required to submit to the department relevant data reasonably necessary to conduct this evaluation. The department shall not seek information directly from hospitals when such information is available from other sources. The department shall protect the confidentiality of patient information provided by the hospitals. No data, findings, conclusions or reports developed by the department during or as a result of such evaluation from hospital/practitioner data shall be released without thirty days prior notice to such hospital. Comments by the hospital shall accompany the release of the data, findings, conclusions or reports.

SECTION 8. Said chapter 111 is hereby amended by striking out section 51G, as so appearing, and inserting in place thereof the following section:--

(1) No original license shall be granted to establish or maintain an acute-care hospital, as defined by section 25B; an ambulatory surgical center that is not otherwise owned by, a joint venture with, or affiliated with an existing acute care hospital in said hospital's primary service

area; an urgent care clinic that is not otherwise owned by, a joint venture with, or affiliated with an existing acute care hospital in said hospital’s primary service area; or a limited services clinic that is not otherwise owned by, a joint venture with, or affiliated with an existing acute care hospital in said hospital’s primary service area unless there is a determination by the department of the suitability and responsibility of the prospective licensee in accordance with regulations of the department.

For purposes of this section, the department's determination of suitability and responsibility shall include the following factors:

(a) the financial capacity of the prospective licensee to operate the hospital, ambulatory surgical center, urgent care clinic, or limited services clinic in accordance with applicable laws;

(b) the history of the prospective licensee in providing acute care, including in states other than the commonwealth, if any, measured by compliance with the applicable statutes and regulations governing the operation of hospitals, ambulatory surgical centers, urgent care clinic, or limited services clinics in such states;

(c) the participation of persons residing in the non-profit entity's primary service area in oversight of the resulting hospital, ambulatory surgical center, urgent care clinic, or limited services clinic; and

(d) whether the transaction will create a significant effect on the availability or accessibility of health care services to the affected communities.

(2) No original license shall be granted to establish or maintain an acute care hospital as defined in section 25B; ambulatory surgical center that is not otherwise owned by, a joint venture with, or affiliated with an existing acute care hospital in said hospital's primary service area; an urgent care clinic that is not otherwise owned by, a joint venture with, or affiliated with an existing acute care hospital in said hospital's primary service area; or limited services clinic that is not otherwise owned by, a joint venture with, or affiliated with an existing acute care hospital in said hospital's primary service area unless all financial transactions, including remuneration of all officers of hospitals, ambulatory surgical centers, urgent care clinics, or limited services clinics affected by the transaction, are disclosed as part of the licensure process, and unless a public hearing is held, according to procedures established in regulation by the department, prior to the granting of the license.

(3) No original license shall be granted to establish or maintain an acute-care hospital, as defined by section 25B, any subsequent successor or acquirer, or to any ambulatory surgical center that is not otherwise owned by, a joint venture with, or affiliated with an existing acute care hospital in said hospital's primary service area; urgent care clinic that is not otherwise owned by, a joint venture with, or affiliated with an existing acute care hospital in said hospital's primary service area; or limited services clinic that is not otherwise owned by, a joint venture

with, or affiliated with an existing acute care hospital in said hospital’s primary service area unless the applicant agrees to maintain or increase the percentage of gross patient service revenues allocated to free care. The department may permit the applicant to reduce said percentage if the department determines that demographic or other changes in the hospital's, ambulatory surgical center’s, urgent care clinic’s, or limited services clinic’s service area justify a reduction in said percentage. The department shall promulgate regulations to enforce this paragraph and any agreement made by an applicant concerning free care.

(4) Any hospital shall inform the department 90 days prior to the closing of the hospital, ambulatory surgical center, urgent care clinic, or limited services clinic or the discontinuance of any essential health service provided therein. The department shall by regulation define "essential health service" for the purposes of this section. The department shall, in the event that a hospital, ambulatory surgical center, urgent care clinic, or limited services clinic proposes to discontinue an essential health service or services, conduct a public hearing on the closure of said essential services or of the hospital, ambulatory surgical center, urgent care clinic, or limited services clinic. The department shall determine whether any such discontinued services are necessary for preserving access and health status in the hospital's, ambulatory surgical center’s, urgent care clinic’s, or limited services clinic’s service area and shall require hospitals, ambulatory surgical centers, urgent care clinics, or limited services clinics to submit a plan for assuring access to such necessary services following the hospital's, ambulatory surgical center’s, urgent care clinic’s, or limited services clinic’s closure of the service, and assure continuing access to such services in the event that the department determines that their closure will significantly reduce access to necessary services. The department shall conduct a public hearing

prior to a determination on the closure of said essential services or of the hospital, ambulatory surgical center, urgent care clinic, or limited services clinic. No original license shall be granted to establish or maintain an acute-care hospital, ambulatory surgical center, urgent care clinic, or limited services clinic as defined by section 25B, unless the applicant submits a plan, to be approved by the department, for the provision of community benefits, including the identification and provision of essential health services. In approving the plan, the department may take into account the applicant's existing commitment to primary and preventive health care services and community contributions as well as the primary and preventive health care services and community contributions of the predecessor hospital, ambulatory surgical center, urgent care clinic, or limited services clinic. The department may waive this requirement, in whole or in part, at the request of the applicant which has provided or at the time the application is filed, is providing, substantial primary and preventive health care services and community contributions in its service area.

(5) No original license shall be granted to establish or maintain an acute care hospital; ambulatory surgical center that is not otherwise owned by, a joint venture with, or affiliated with an existing acute care hospital in said hospital’s primary service area; urgent care clinic that is not otherwise owned by, a joint venture with, or affiliated with an existing acute care hospital in said hospital’s primary service area; or limited services clinic that is not otherwise owned by, a joint venture with, or affiliated with an existing acute care hospital in said hospital’s primary service area as defined by section 25B which results from the merger or acquisition of the hospital, ambulatory surgical center, urgent care clinic, or limited services clinic, unless the board of trustees of the hospital, ambulatory surgical center, urgent care clinic, or limited

services clinic publicly presents and evaluates all proposals for such a merger or acquisition according to rules and regulations promulgated by the department.

(6) Whenever the department finds upon inspection, or through information in its possession, that a licensee is not in compliance with a requirement established under this section, the department may order the licensee to correct such deficiency. Every such correction order shall include a statement of the deficiencies found, the period prescribed within which the deficiency must be corrected, and the provisions of law relied upon. The department may assess the licensee ordered to correct deficiencies no less than $1,000 and not more than $10,000 per deficiency for each day the deficiency continues to exist beyond the date prescribed for correction. Within seven days of receipt, the affected licensee may file a written request with the department for administrative reconsideration of the order or any portion thereof.

SECTION 9. Section 51H of said chapter 11, as so appearing, is hereby amended by striking the definition of “facility” and replacing it with the following definition:-

"Facility", a hospital, institution for the care of unwed mothers, clinic providing ambulatory surgery as defined by section 25B, urgent care clinic as defined by section 52, or a limited services clinic as defined by section 52.

SECTION 10. Section 51I of said chapter 11, as so appearing, is hereby amended by striking the definition of “facility” and replacing it with the following definition:-

"Facility," a hospital, an institution maintaining an Intensive Care Unit, an institution providing surgical services, clinic providing ambulatory surgery, urgent care clinic as defined by section 52, or a limited services clinic as defined by section 52.

SECTION 11. The definition of “Clinic” in section 52 of said chapter 111, as so appearing, is hereby amended by inserting after the word “rehabilitation,” in both instances in which it appears, the following words:-

urgent care, limited services,

SECTION 12. Said section 52, as so appearing, is hereby further amended by adding the following two definitions:-

“Urgent care”, a model of episodic care delivery that is primarily the immediate diagnosis, treatment, management or monitoring of acute and chronic disease, generally provided on a walk-in basis, and not intended as the patient’s primary care provider.

"Urgent care clinic", a clinic that provides urgent care as defined by this section.

SECTION 13. Said chapter 111is hereby amended by striking out section 53D, as so appearing, and inserting in place thereof the following section:-

(a) Any acute hospital, non-acute hospital, ambulatory surgical center, urgent care clinic, or limited services clinic licensed under this chapter shall ensure the provision of services to individuals through the use of hollow-bore needle devices or other technology that minimize the risk of injury to health care workers from hypodermic syringes or needles, in accordance with rules and regulations promulgated pursuant to subsection (b).

(b) The department shall promulgate rules and regulations requiring the use, at all acute hospitals, non-acute hospitals, ambulatory surgical centers, urgent care clinics, and limited services clinics, of only such devices which minimize the risk of injury to health care workers from needlestick and sharps, so-called. Such rules and regulations promulgated by the department shall include the following requirements:

(1) Written exposure control plans shall be developed by each acute hospital, non-acute hospital, ambulatory surgical center, urgent care clinic, or limited services clinic that include an

effective procedure for identifying and selecting existing sharps prevention technology, so-called, of the types specified by the department.

(2) Sharps injury prevention technology shall be included as engineering or work practice controls, except in cases where the employer or other appropriate party can demonstrate circumstances in which the technology does not promote employee or patient safety or interferes with a medical procedure. Those circumstances shall be specified by the employer and shall include, but not be limited to, circumstances where the technology is medically contraindicated or not more effective than alternative measures used by the employer to prevent exposure incidents. In all cases the department shall make the final determination as to whether an employer or other appropriate party has demonstrated in a satisfactory manner circumstances which warrant an exemption from the inclusion of sharps injury prevention technology.

(3) Information concerning exposure incidents shall be recorded in a sharps injury log to be kept within such acute hospitals, non-acute hospitals, ambulatory surgical centers, urgent care clinics, or limited services clinics and reported annually to the department, including but not limited to, the type and brand of device involved in the incident. Such logs shall be used as the basis for continuing quality improvement in reducing sharps injuries through the provision of education and the procurement of improved products. Such logs shall be kept confidential and shall be used only for the intended purposes of this section.

(4) Written exposure control plans shall be updated when necessary to reflect progress in sharps prevention technology as determined by the department.

(c) The department shall promulgate all rules and regulations pursuant to this section in consultation with an advisory committee composed of, but not limited to: the department's director of infectious disease, a consumer to be selected by the commissioner, a technical expert to be selected by the commissioner, and a representative from the Massachusetts Nurses Association, the Massachusetts Association of Occupational and Environmental Medicine, the Massachusetts Medical Society and the Massachusetts Hospital Association.

The department, in consultation with the advisory committee, shall compile and maintain a list of needleless systems, needles and sharps, so-called, with engineered injury protections meeting the purposes of this section. The list shall be available to assist employers in complying with rules and regulations promulgated in accordance with this section.

SECTION 14. Said chapter 111 is hereby amended by striking out section 53E, as so appearing, and inserting in place thereof the following section:-

The department shall promulgate regulations for the establishment of a patient and family advisory council at each hospital and ambulatory surgical center in the commonwealth. The council shall advise the hospital or ambulatory surgical center 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 15. Said chapter 111 is hereby amended by striking out section 53F, as so appearing, and inserting in place thereof the following section:-

The department shall require acute care hospitals, ambulatory surgical centers, urgent care clinics, and limited services clinics 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, ambulatory surgical center, urgent care clinic, or limited services clinic shall have an early recognition and response method most suitable for the hospital's, ambulatory surgical center’s, urgent care clinic’s, or limited services clinic’s needs and resources, such as a rapid response team. The method shall be available 24 hours per day.

SECTION 16. Section 203 of said chapter 111, as so appearing, is hereby amended by striking out paragraphs (a) through (d), inclusive, and inserting in place thereof the following four paragraphs:-

(a) The by-laws of every licensed or public hospital, the by-laws of all medical staffs, and the by-laws of all ambulatory surgical centers and urgent care clinics shall contain provisions for reporting conduct by a health care provider that indicates incompetency in his specialty or conduct that might be inconsistent with or harmful to good patient care or safety. Said by-laws shall direct a procedure for investigation, review and resolutions of such reports.

(b) Whenever, following review by a medical peer review committee of a licensed or public hospital, ambulatory surgical center, or urgent care clinic determination is reached that a health care provider's privileges should be suspended in the best interests of patient care, such committee shall immediately forward the recommendation to the executive committee of the medical staff and the institution's board of trustees for action. A provider whose privileges are suspended shall be entitled to notice and a prompt hearing following suspension, in accordance with the institution's medical staff by-laws.

(c) An individual or institution, including a licensed or public hospital, ambulatory surgical center, urgent care clinic, physician credentialing verification service operated by a society or organization of medical professionals for the purpose of providing credentialing

information to health care entities, or licensed nursing home reporting, providing information, opinion, counsel or services to a medical peer review committee, or participation in the procedures required by this section, shall not be liable in a suit for damages by reason of having furnished such information, opinion, counsel or services or by reason of such participation, provided, that such individual or institution acted in good faith and with a reasonable belief that said actions were warranted in connection with or in furtherance of the function of said committee or the procedures required by this section.

(d) Every licensed hospital, ambulatory surgical center, and urgent care clinic, as a condition of licensure, and every public hospital shall be required to participate in risk management programs established by the board of registration in medicine pursuant to section five of chapter one hundred and twelve; provided, however, that licensed or public hospitals, ambulatory surgical centers, and urgent care clinics which participate in pre-existing risk management programs may be exempted by regulations of the board from the requirements of this paragraph.