Report Title:
Prescription Drug Cost Containment; Disclosure of Gifts

Description:
Requires the director of human services to establish a pharmacy best practices and cost control program including medicaid and other state public assistance health benefits plans, in which any public and private health plan may participate. Includes a prescription drug preferred list and prior authorization review process. Requires drug manufacturers to disclose economic benefits of $25 or more provided to persons who prescribe, dispense, or purchase prescription drugs.

THE SENATE
TWENTY-FOURTH LEGISLATURE, 2007
STATE OF HAWAII

S.B. NO. 816

A BILL FOR AN ACT

relating to prescription drug cost containment and affordable access.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. The purpose of this Act is to reduce the cost of providing prescription drugs while maintaining the high quality of prescription drug therapies available to Hawaii's residents.

SECTION 2. The Hawaii Revised Statutes is amended by adding a new chapter to be appropriately designated and to read as follows:

"**Chapter**

PRESCRIPTION DRUG COST CONTAINMENT

§ -1 Definitions. As used in this chapter, unless the context clearly requires otherwise:

"Board" or "drug utilization review board" means the drug utilization review board established pursuant to section -3 in connection with the state medicaid program.

"Department" means the department of human services.

"Director" means the director of human services.

"Health benefits plan" means a health benefits plan with prescription drug coverage offered or administered by a health insurer and the out-of-state counterparts to such a plan. The term includes:

(1) Any state public assistance program with a health benefits plan that provides coverage for prescription drugs;

(2) Any health benefits plan offered by or on behalf of the State or any instrumentality of the State providing coverage for government employees and their dependents that agrees to participate in the program; and

(3) Any insured or self-insured health benefits plan that agrees to participate in the program.

"Health insurer" means any health insurance company, nonprofit hospital, medical service corporation, managed care organization, or, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health benefits plan offered by public or private entities.

"Participating health benefits plan" means a health benefits plan that has agreed to participate in one or more components of the program.

"Program" means the pharmacy best practices and cost control program established by this chapter.

"State public assistance program" includes the state medicaid program, including QUEST and the state children's health insurance

program, and the out-of-state counterparts to these programs.

§ -2 Pharmacy best practices and cost control program; established. (a) The director shall establish a pharmacy best practices and cost control program designed to reduce the cost of providing prescription drugs while maintaining high quality in prescription drug therapies. The program shall include:

(1) A preferred list of covered prescription drugs that identifies preferred choices within therapeutic classes for particular diseases and conditions, including generic alternatives; provided that:

(A) The directors of human services and health shall implement the preferred drug list as a uniform, statewide preferred drug list by encouraging all health benefits plans in this State to participate in the program;

(B) The board of trustees of the Hawaii employer-union health benefits trust fund shall use the preferred drug list in the health benefits plan or plans established by that board under section 87A-16 only if participation in the program will provide economic and health benefits to those health benefits plans and to beneficiaries of those plans, and only if agreed to through the collective bargaining process between the State and the authorized representatives of the employees of the State. This subparagraph does not authorize the actuarial pooling of the health benefits plans established by the board of trustees with any other health benefits plan, unless

otherwise agreed to through the collective bargaining process between the State and the authorized representatives of the employees of the State; and

(C) The director shall encourage all health benefits plans to implement the preferred drug list as a uniform, statewide preferred drug list by inviting the representatives of each health benefits plan providing prescription drug coverage to residents of this State to participate as observers or nonvoting members in the proceedings of the drug utilization review board pursuant to section -3(e), and inviting those plans to use the preferred drug list in connection with the plans' prescription drug coverage;

(2) Utilization review procedures, including a prior authorization review process;

(3) Any strategy designed to negotiate with pharmaceutical manufacturers to lower the cost of prescription drugs for program participants, including a supplemental rebate program;

(4) Educational programs, including a counter-detailing program that provides information and education on the therapeutic and cost-effective utilization of prescription drugs to physicians, pharmacists, and other health care professionals authorized to prescribe and dispense prescription drugs;

(5) Alternative pricing mechanisms, including consideration of using maximum allowable cost pricing for

generic and other prescription drugs;

(6) Alternative coverage terms, including consideration of providing coverage of over-the-counter drugs where cost-effective in comparison to prescription drugs, and authorizing coverage of dosages capable of permitting the consumer to split each pill if cost-effective and medically appropriate for the consumer;

(7) A simple, uniform prescription form designed to implement the preferred drug list and to enable prescribers and consumers to request an exception to the preferred drug list with a minimum of cost and time to prescribers, pharmacists, and consumers; and

(8) Any other cost containment activity adopted by the director by rule pursuant to chapter 91 that is designed to reduce the cost of providing prescription drugs while maintaining high quality in prescription drug therapies.

(b) The director shall implement the program for medicaid and all other state public assistance program health benefits plans to the extent permitted by federal law.

(c) The director may implement the program for any other health benefits plan within or outside this State that agrees to participate in the program.

(d) The director shall take all steps necessary to enable participation in joint prescription drug purchasing agreements with any other health benefits plan or organization within or outside this State that agrees to participate in a joint purchasing agreement. The

director shall:

(1) Execute any joint purchasing agreements or other contracts with any participating health benefits plan or organization within or outside the State that the director determines will lower the cost of prescription drugs for residents of this State while maintaining high quality in prescription drug therapies;

(2) With regard to participation by a health benefits plan established by the board of trustees of the Hawaii employer-union health benefits trust fund, execute any joint purchasing agreements or other contracts with any health benefits plan or organization within or outside the State that the director determines will lower the cost of prescription drugs and provide overall quality of integrated health care services to that health benefits plan and the beneficiaries of the plan, and that is negotiated through the collective bargaining process between the State and the authorized representatives of the employees of the State;

(3) Renegotiate and amend existing contracts to which the department is a party if renegotiation and amendment will be of economic benefit to the health benefits plans subject to those contracts and to the beneficiaries of those plans. Any renegotiated or substituted contract shall be designed to improve the overall quality of integrated health care services provided to beneficiaries of those plans; and

(4) Report annually to the governor and the legislature on progress in securing Hawaii's participation in joint

purchasing agreements.

(e) The directors of human services and health shall collaborate with physicians, pharmacists, health insurers, consumers, employer organizations and other health benefits plan sponsors, pharmaceutical manufacturer organizations, and other interested parties to consider and make recommendations to reduce the cost of prescription drugs for all Hawaii residents.

(f) A participating health benefits plan other than a state public assistance program may agree with the director to limit the plan's participation to one or more program components. The director may include such insured or self-insured health benefits plans that agree to use the preferred drug list or otherwise participate in one or more program components in any hearing, deliberation, or other proceeding required by this chapter.

(g) The director shall develop procedures for the coordination of state public assistance program health benefits plan drug benefits with pharmaceutical manufacturer patient assistance programs offering free or low-cost prescription drugs, including the development of a single application form for participation in those programs. The director may contract with a nongovernmental organization to develop the single application form.

§ -3 Drug utilization review board; establishment. (a) The drug utilization review board is established within the department of human services for administrative purposes and shall consist of the following members who shall be appointed by the governor pursuant to section 26-34:

(1) members of executive branch agencies;

(2) members of the private sector;

(3) members to be appointed from a list of nominees submitted by the president of the senate, at least one of whom shall be a member of the private sector; and

(4) members to be appointed from a list of nominees submitted by the speaker of the house of representatives, at least one of whom shall be a member of the private sector.

(b) The board shall meet at least quarterly and shall comply with the requirements of chapter 92.

(c) In carrying out its duties under this chapter, the board may request staff assistance from the department of human services and other appropriate state agencies. The board may also employ, without regard to chapter 76, persons it finds necessary for the performance of its functions and fix their compensation.

(d) The members of the board shall serve without compensation, but shall be reimbursed for expenses, including travel expenses, necessary for the performance of their duties.

(e) The board shall:

(1) Make recommendations to the director concerning the adoption of the preferred drug list. The board's recommendations shall be based upon considerations of clinical efficacy, safety, and cost-effectiveness;

(2) To the extent feasible, review all drug classes included in the preferred drug list at least every twelve months, and as appropriate, recommend that the director make additions to or deletions from the preferred drug list; and

(3) Establish procedures for the timely review of prescription drugs newly approved by the federal Food and Drug Administration, including procedures for the review of newly-approved prescription drugs in emergency circumstances.

§ -4 Consumer protection rules; prior authorization. (a) When a patient's health care provider prescribes a prescription drug that is not on the preferred drug list, or that is not the list's preferred choice, the program shall authorize pharmacy benefit coverage if:

(1) The prescriber determines after consultation with the pharmacist or with the participating health benefits plan if required by the terms of the plan that:

(A) The preferred choice has not been effective, or with reasonable certainty is not expected to be effective in treating the patient's condition; or

(B) The preferred choice causes or is reasonably expected to cause an adverse or harmful reaction in the patient;

provided that a prescriber's determination under this paragraph shall be final; and

(2) The patient agrees to pay any additional cost in excess of the benefits provided by the patient's health benefits plan that is participating in the program. This paragraph shall not apply to the extent that it may be inconsistent with any federal medicaid laws and regulations. This paragraph shall not affect implementation by a participating health benefits plan of tiered copayments or

other similar cost sharing systems.

(b) The program or any participating health benefits plan shall provide information on:

(1) How prescribers, pharmacists, beneficiaries, and other interested parties can obtain a copy of the preferred drug list;

(2) Whether any change has been made to the preferred drug list since it was last issued; and

(3) The process by which exceptions to the preferred list may be made.

(c) The program shall include a prior authorization process that shall:

(1) Be designed to minimize administrative burdens on prescribers, pharmacists, and consumers;

(2) Ensure real-time receipt of requests, by telephone, voice mail, facsimile, electronic transmission, or mail on a twenty-four-hour, seven days a week basis;

(3) Provide an in-person response to emergency requests by a prescriber with telephone answering queues that do not exceed ten minutes;

(4) Any request for authorization or approval of a drug that the prescriber indicates is for an emergency or urgent condition shall include the clinical reasons for the request, and be responded to in no more than four hours from the time the program or participating health benefits plan receives the request;

(5) In emergency circumstances, or if the response to a

request for prior authorization is not provided within the time period established in paragraph (4), a seventy-two hour supply of the drug prescribed shall be deemed to be authorized by the program or the participating health benefits plan; provided that:

(A) It is a prescription drug approved by the federal Food and Drug Administration; and

(B) For drugs dispensed to a medicaid beneficiary, it is subject to a rebate agreement with the Centers for Medicare and Medicaid Services; and

(6) The program or participating plan shall provide to participating providers a prior authorization request form for each enrolled beneficiary that:

(A) Permits the prescriber to make prior authorization requests in advance of the need to fill the prescription;

(B) May be completed without unnecessary delay; and

(C) May be stamped with information relating to the participating provider.

If feasible, at least one form capable of being copied shall contain known patient information.

(d) The program's prior authorization process shall allow the prescriber to request a prior authorization exception to the requirements of this section. The program may exempt a prescriber from the need to secure prior authorization for a specific drug category if

the program determines that the prescriber has written a minimum number of prescriptions in that category and the prescriber prescribes prescription drugs on the preferred drug list at or above the minimum threshold for that category.

(e) The program's prior authorization process shall not apply to prescription drugs used in the treatment of serious mental illness, including schizophrenia, major depression, and bipolar disorder.

§ -5 Pharmacy benefit management. (a) The director may implement all or a portion of the program through a contract with a third party with expertise in the management of pharmacy benefits.

(b) The director shall not enter into a contract with a pharmacy benefit manager unless the pharmacy benefit manager has agreed to disclose to the director the terms and the financial impact on the State and on beneficiaries in the state of:

(1) Any agreement with a pharmaceutical manufacturer to favor the manufacturer's products over a competitor's products, to place the manufacturer's drug on the pharmacy benefit manager's preferred list or formulary, or to switch the drug prescribed by the patient's health care provider with a drug agreed to by the pharmacy benefit manager and the manufacturer;

(2) Any agreement with a pharmaceutical manufacturer to share manufacturer rebates and discounts with the pharmacy benefit manager or to pay "soft money" or other economic benefits to the pharmacy benefit manager;

(3) Any agreement or practice to bill state health benefits plans for prescription drugs at a cost higher than the pharmacy benefit manager pays the pharmacy;

(4) Any agreement to share revenue with a mail order or internet pharmacy company;

(5) Any agreement to sell prescription drug data or other information concerning the consumers or participants in the program, or data concerning the prescribing practices of the health care providers participating in the program; and

(6) Any other agreement of the pharmacy benefit manager with a pharmaceutical manufacturer, or with wholesale and retail pharmacies, affecting the cost of pharmacy benefits provided through the program.

(c) The director shall not enter into a contract with a pharmacy benefit manager who has entered into an agreement or engaged in a practice described in subsection (b) unless the director determines and certifies in the fiscal report required by section -6(d)(4) that the agreement or practice furthers the financial interests of the State and does not adversely affect the medical interests of program consumers or participants.

§ -6 Reporting and oversight. (a) The director shall report prior to initial implementation of the program, as well as prior to any subsequent modifications of the program, the following information for review by the auditor:

(1) The preferred drug list and list of drugs subject to prior authorization;

(2) Any utilization review procedures, including any prior authorization procedures; and

(3) The procedures by which drugs will be selected for

placement on the preferred drug list, prior authorization, or for any other utilization review procedure.

(b) The director shall report quarterly to the auditor concerning the following aspects of the pharmacy best practices and cost control program:

(1) The efforts undertaken to educate health care providers about the preferred drug list and the program's utilization review procedures;

(2) The number of prior authorization requests made; and

(3) The number of utilization review events, other than prior authorization requests.

(c) The auditor shall closely monitor implementation of the preferred drug list and utilization review procedures to ensure that the consumer protection standards established in this chapter are not diminished as a result of implementing the preferred drug list and the utilization review procedures, including any unnecessary delay in access to appropriate medications. The auditor shall ensure that all affected parties, including consumers, health care providers, pharmacists, and others with pharmaceutical expertise have an opportunity to comment on the preferred drug list and procedures reviewed under this subsection.

(d) Before January 1, 2008, and before December 31 of each subsequent year for the duration of any pharmacy benefit management contract under section -5, the director shall submit a report to the legislature and the auditor concerning implementation of any pharmacy benefit management contract entered into by the program. The report shall include:

(1) A description of the activities of the pharmacy benefit manager;

(2) An analysis of the success of the pharmacy benefit manager in achieving each of the department's public policy goals, together with the pharmacy benefit manager's report of its activities and achievements;

(3) An assessment of medicaid program administrative costs relating to prescription drug benefits, including any recommendations for increasing the administrative efficiency of the program;

(4) A fiscal report on the costs and savings to the State of the pharmacy benefit management contract, including an accounting of any payments, fees, offsets, savings, and other financial transactions or accountings. The report shall disclose:

(A) Any agreements entered into by the pharmacy benefit manager; and

(B) The financial impact of these agreements on the State, and on beneficiaries in this State;

(5) Any recommendations for enhancing the benefits of the pharmacy benefit management contract, and the identification of, and any recommendations for, minimizing any problems with the contract; and

(6) If the department has not entered into a contract with a pharmacy benefit manager, or if any such contract has been rescinded, any recommendations for pursuing the State's

public policy goals relating to pharmaceutical costs, quality, and access through other means.

§ -7 Supplemental rebates. (a) The director, separately or in concert with the authorized representatives of any participating health benefits plan, shall use the preferred drug list authorized by the pharmacy best practices and cost control program to negotiate with pharmaceutical companies for the payment to the director of supplemental rebates or price discounts for medicaid and for any other state public assistance health benefits plans designated by the director that are in addition to those required by Title XIX of the Social Security Act. The director may also use the preferred drug list to negotiate for the payment of rebates or price discounts in connection with drugs covered under any other participating health benefits plan within or outside this State; provided that these negotiations and any subsequent agreement shall comply with 42 U.S.C. section 1396r•8. The program, or such portions of the program as the director shall designate, shall constitute a state pharmaceutical assistance program under 42 U.S.C. section 1396r-8(c)(1)(C).

(b) The director shall negotiate supplemental rebates, price discounts, and other mechanisms to reduce net prescription drug costs by means of any negotiation strategy that the director determines will result in the maximum economic benefit to the program and to consumers in this State, while maintaining access to high quality prescription drugs. This section does not authorize agreements with pharmaceutical manufacturers whereby financial support for medical services covered by the medicaid program is accepted as consideration for placement of one or more prescription drugs on the preferred drug list. The January 1,

2008, report of the director pursuant to section •6(d) shall include a cost-benefit analysis of alternative negotiation strategies, including:

(1) The strategy used by the State of Florida to secure supplemental rebates;

(2) The strategy used by the State of Michigan to secure supplemental rebates; and

(3) Any other alternative negotiation strategy that might secure lower net prescription drug costs.

(c) The director and the department shall prohibit the public disclosure of information revealing company-identifiable trade secrets (including rebate and supplemental rebate amounts and manufacturer's pricing) obtained by the department and by any officer, employee, or contractor of the department in the course of negotiations conducted pursuant to this section. The confidential information shall be exempt from public disclosure under chapter 92F.

§ -8 Pharmacy discount plan. (a) By July 1, 2008, the director shall implement a pharmacy discount plan for state residents without adequate coverage for prescription drugs. The director may establish an enrollment fee to support the administrative costs of the plan.

(b) The pharmacy discount plan authorized by this section shall include a program implemented as a Section 1115 medicaid waiver, wherein the State makes a payment of at least two per cent of the cost of each prescription or refill, consistent with any appropriation for the program established by this subsection.

(c) The director shall implement the pharmacy discount plan authorized by this section without any financial contribution by the State other than that required by subsection (b), and without federal waiver approval during such time as federal waiver approval has not been secured.

(d) As used in this section:

"Eligible beneficiary" means

(1) A resident who is:

(A) At least sixty-five years of age; or

(B) Disabled; and

(C) Eligible for medicare or social security disability benefits, with a household income equal to or less than four hundred per cent of the federal poverty level; or

(2) A resident with a household income equal to or less than three hundred per cent of the federal poverty level.

"Residents without adequate coverage" includes eligible beneficiaries with no coverage for prescription drugs and eligible beneficiaries whose annual maximum coverage limit under their health benefits plan has been reached.

§ -9 Pharmaceutical marketers. (a) Before December 31 of each year, every pharmaceutical manufacturing company shall disclose to the board of pharmacy the value, nature, and purpose of any gift, fee, payment, subsidy, or other economic benefit provided in connection with detailing, promotional, or other marketing activities by the company, directly or through its pharmaceutical marketers, to any physician, hospital, nursing home, pharmacist, health benefits plan administrator,

or any other person in the State authorized to prescribe, dispense, or sell prescription drugs in this State. Disclosure shall be made in a form and manner prescribed by the board of pharmacy. Initial disclosure shall be made before December 31, 2008, for the twelve-month period ending June 30, 2008. The board of pharmacy shall provide to the attorney general complete access to the information required to be disclosed under this subsection. The attorney general shall report on the disclosures made under this section to the legislature and the governor before March 1 of each year.

(b) Each pharmaceutical manufacturing company subject to this section shall also disclose to the board of pharmacy, before October 1, 2008, and annually thereafter, the name and address of the individual responsible for the company's compliance with this section.

(c) The board of pharmacy and the attorney general shall keep confidential all trade secret information. The disclosure form prescribed by the board of pharmacy shall permit the company to identify any information that is a trade secret.

(d) The following shall be exempt from disclosure:

(1) Free samples of prescription drugs intended to be distributed to patients;

(2) The payment of reasonable compensation and reimbursement of expenses in connection with bona fide clinical trials. As used in this paragraph, "clinical trial" means an approved clinical trial conducted in connection with a research study designed to answer specific questions about vaccines, new therapies, or new ways of using known treatments;

(3) Any gift, fee, payment, subsidy, or other economic benefit the value of which is less than $25; and

(4) Scholarship or other support for medical students, residents, and fellows to attend a significant educational, scientific, or policy-making conference of a national, regional, or specialty medical or other professional association if the recipient of the scholarship or other support is selected by the association.

(e) The attorney general may bring an action for injunctive relief, costs, and attorneys fees and to impose on a pharmaceutical manufacturing company that fails to disclose as required by this section (a), a civil penalty of no more than $10,000 per violation. Each unlawful failure to disclose shall constitute a separate violation.

(f) As used in this section:

"Pharmaceutical manufacturing company" or "company" means any entity that is engaged in the production, preparation, propagation, compounding, conversion, or processing of prescription drugs, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, or any entity engaged in the packaging, repackaging, labeling, relabeling, or distribution of prescription drugs. The term does not include a pharmacist licensed under chapter 461.

"Pharmaceutical marketer" means a person who, while employed by or under contract to represent a pharmaceutical manufacturing company, engages in pharmaceutical detailing, promotional activities, or other marketing of prescription drugs in this State to any physician,

hospital, nursing home, pharmacist, health benefits plan administrator, or any other person authorized to prescribe, dispense, or sell prescription drugs. The term does not include a wholesale drug distributor or the distributor's representative who promotes or otherwise markets the services of the wholesale drug distributor in connection with a prescription drug."

SECTION 3. Section 461-4.5, Hawaii Revised Statutes, is amended by amending subsection (a) to read as follows:

"(a) In addition to any other powers and duties authorized by law, the board:

(1) Shall adopt, amend, and repeal rules pursuant to chapter 91, as it deems proper for the purposes of this chapter, Public Law 100-293, and 21 Code of Federal Regulations part 205;

(2) Shall examine, license, reinstate, and renew the licenses of qualified applicants for registered pharmacists and wholesale prescription drug distributors, and issue and renew permits to operate pharmacies;

(3) May require the inspection of any wholesale prescription drug distributor premises in the State to ensure compliance with this chapter and rules adopted under this chapter, or may require an applicant for a pharmacy license to submit a statement that the premises, including but not limited to security and sanitation, are in conformance with the board's requirements and that the applicant possesses the reference materials and technical clinical equipment and supplies as may

be specified in rules adopted under this chapter; [and]

(4) May fine, suspend, or revoke any license or permit for any cause prescribed by this chapter, or for any violation of the rules adopted under this chapter, and refuse to grant or renew any license or permit for any cause which would be ground for revocation or suspension of a license or permit[.]; and

(5) Shall develop criteria for a standardized tamper-resistant prescription pad that can be used by all health care providers who prescribe drugs. The criteria shall be developed in consultation with pharmacists, hospitals, nursing homes, physicians and other prescribers, and other affected parties."

SECTION 4. **Section 1115 waiver for pharmaceutical programs.** (a) The director of human services shall submit a request for a Section 1115 waiver or waiver amendment to maximize federal financial participation for state pharmaceutical assistance programs and to preserve continued access to the programs, unless the director determines that a waiver or waiver amendment will not provide a financial benefit to the State over the long term. The director shall report to the legislature if the director determines not to apply for a waiver or if the director determines to apply for a waiver that is not consistent with the principles established in subsection (b) in whole or in part.

(b) The waiver request shall conform to the following principles except when deviation is necessary to conduct successful negotiations with the Centers for Medicare and Medicaid Services:

(1) The waiver request shall propose a financially sustainable program designed to provide access to medically

necessary prescription drugs for low-income, elderly, and disabled residents;

(2) The waiver request shall consolidate and streamline program administration of and eligibility for pharmaceutical assistance programs; and

(3) The benefit plan and cost sharing provisions shall be designed to provide financial assistance and benefits based on the beneficiary's household income.

SECTION 5. **Application of preferred drug list to nursing home patients.** During fiscal year 2007-2008, the preferred drug list of the department of human services shall not apply to medicaid coverage of prescriptions for beneficiaries residing in a nursing home until the department proposes and the auditor approves a plan to notify and educate nursing home patients, their prescribers, and their pharmacy concerning the preferred drug list and the prior authorization process, and ensure that medicaid is securing the best price for covered drugs prescribed for nursing home residents. The department shall propose a plan by July 1, 2008.

SECTION 6. **Outcomes-based assessment and treatment.** (a) The State's health care policies shall promote outcomes-based assessment and treatment through the development of a statewide quality assurance system and an effective quality improvement process that integrates best practices research, functional status assessment, patient satisfaction measurements, and cost containment goals, and that is established and implemented by nongovernmental organizations of health care providers and patients. The State shall recognize and support

efforts of nongovernmental organizations to collaboratively establish and implement outcomes-based assessment and treatment.

(b) Statewide quality assurance inventory. Subject to the availability of grants from federal government agencies and nongovernmental organizations to support the costs of the contract authorized by this subsection, the director of health shall contract with a qualified nongovernmental organization to conduct an inventory of existing quality assurance measurements used in this State by:

(1) Public and private health plans;

(2) Hospitals serving residents; and

(3) Other state government entities.

The director's contractor shall report to the director with the results of the inventory and with an analysis and identification of any other information necessary to establish a statewide quality assurance system.

(c) Evaluation of inventory. The directors of human services and health shall convene a working group to develop a quality assurance measurement of statewide applicability. The working group shall include representatives from private and public health plans and any other members deemed appropriate by the directors. The working group shall:

(1) Evaluate the results of the statewide quality assurance inventory;

(2) Identify measurements common to all;

(3) Identify areas lacking measurements; and

(4) Make recommendations for change.

The working group may also propose the continuation or addition of outcomes-based assessments to identify areas of health care that need

improvement, compare the quality of health care provided under public and private health benefits plans, identify ways to focus resources and programs to improve the health of beneficiary populations or discrete portions thereof, and develop additional means of expanding access to, improving the quality of, and lowering the cost of the State's health care system.

(d) Report to the legislature. The directors of human services and health shall submit a joint report of the findings and recommendations of the working group, including any proposed implementing legislation, to the legislature no later than twenty days before the convening of the regular session of 2008. The report shall include:

(1) A summary of the activities of the directors under this section; and

(2) A description of any proposals to implement outcomes-based assessment projects.

SECTION 7. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 8. This Act shall take effect upon its approval.

INTRODUCED BY:_____