SENATE, NO. 2526

[SIMILAR MATTER FILED DURING PAST SESSION SEE NO. OF]

The Commonwealth of Massachusetts

IN THE YEAR OF TWO THOUSAND AND EIGHT

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

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

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

Promote Public Transparency of Health Care Quality and Cost

SECTION 1. Chapter 6A of the General Laws, as appearing in the 2006 Official Edition, is hereby amended by striking section 16K and inserting in place thereof the following section:-

Section 16K. There shall be a health care quality and cost council within, but not subject to the control of, the executive office of health and human services. The council shall promote public transparency of the quality and cost of health care in the commonwealth, and establish health care quality improvement and cost containment goals. The goals shall be designed to promote high-quality, safe, effective, timely,

efficient, equitable and patient-centered health care. The council shall receive staff assistance from the executive office of health and human services and may, subject to appropriation, employ such additional staff or consultants as it may deem necessary. The council shall consist of the secretary of health and human services, the auditor of the commonwealth or his designee, the inspector general or his designee, the attorney general or his designee, the commissioner of insurance, the executive director of the group insurance commission, the executive director of the commonwealth connector, the secretary of administration and finance or his designee, and 7 persons to be appointed by the governor, 1 of whom shall be a representative of a health care quality improvement organization recognized by the federal Centers for Medicare and Medicaid services, 1 of whom shall be a representative of the Institute for Healthcare Improvement, Inc. recommended by the organization's board of directors, 1 of whom shall be a representative of the Massachusetts Chapter of the National Association of Insurance and Financial Advisors, 1 of whom shall be a representative of the Massachusetts Association of Health Underwriters, 1 of whom shall be a representative of the Massachusetts Medicaid Policy Institute, 1 of whom shall be an expert in health care policy from a foundation or academic institution and 1 of whom shall represent a non-governmental purchaser of health insurance. The representatives of nongovernmental organizations shall serve staggered 3-year terms. The council shall be chaired by the secretary of health and human services.

Public Reporting and Reimbursement of Serious Reportable Events

SECTION 2. Subsection (e) of section 16L of chapter 6A of the General Laws is hereby amended by adding the following 2 clauses:—

(i) The council shall promulgate regulations that create a list of "never events", so-called, which shall be updated annually, based upon guidelines developed by the National Quality Forum and other patient safety and medical quality experts. Reporting of each never event shall be included in the consumer health information website created by subsection (h). The website shall identify both the never events and the facilities at

which each occurred, but shall not include any other identifying information including but not limited to any of the health care professionals, facility employees or patients involved.

(ii) Notwithstanding any provisions in the General Laws to the contrary, no third party payer, including the commonwealth, an insurer licensed or otherwise authorized to transact accident or health insurance organized 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 and an organization entering into a preferred provider arrangement under chapter 176I, may knowingly reimburse a health care professional or a health care facility for services that resulted in and from any of the never events identified by the council, and no health care professional or health care facility may bill the patient for such services.

Enhancing Transparency of Health Care Provider Cost Increases

SECTION 3. Section 16L of Chapter 6A of the General Laws is hereby amended by adding the following 4 subsections:-

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

and supply costs; community benefits programs; endowment contributions; executive compensation; administrative costs; capital investments; strategies to contain the rate of cost growth, including, but not limited to, provider efforts to minimize medical errors, eliminate waste and duplication in clinical care, manage chronic diseases, reduce the use of ineffective or inappropriate medical technology or devices, prioritize technology investments for computerized physician support systems and electronic health records, determine capital expenditures based on public health needs, and cut administrative costs; and other matters as determined by the council. The council may consolidate this hearing with the hearing called for in subsection (j).

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

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

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

(u) The council shall establish goals for adoption of health information technology including, but not limited to, electronic prescription transactions for new prescriptions, prescription renewals, cancellations, changes between prescribers and dispensers, ancillary messages and administrative transactions known as e-prescribing, the process of electronic entry of physician instructions for the treatment of patients, whether hospitalized or ambulatory, under the care of said physician, known as computerized physician order entry, and individual patient records in digital format or

electronic health records; provided, however, that any system, network, software or equipment utilized in the attainment of said goals shall be certified by the certification commission for healthcare information technology, an independent, non-profit organization that has been officially named by the federal government as the "recognized certification body" for health information technology products and networks; and provided further, that goals shall state the percentage adoption by providers expected by a given year, any incentives or other provisions for attainment of the goals; and any penalties for failure to attain said goals.

Ensuring Physician Health Information Competency

SECTION 4. Subsection (b) of section 11A of chapter 13 of the General Laws, as appearing in the 2006 Official Edition, is hereby amended by adding the following sentence:- The board shall require, as a standard of eligibility for licensure, that applicants show a pre-determined 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.

Enhancing Transparency of Insurer Pricing Structures

SECTION 5. Chapter 26 of the General Laws is hereby amended by inserting after section 8J the following section:

Section 8K. The Massachusetts Health Insurance Transparency Report.

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

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

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

Establishing the Massachusetts e-Health Institute

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

Section 6D. (a) The corporation shall establish an institute for health care innovation, technology and competitiveness, to be known as the Massachusetts e-Health Institute, and a fund to be known as the e-Health Institute Fund, to be held by the corporation separate and apart from its other funds, to finance the activities of the institute. The executive director of the corporation shall appoint a qualified individual as director to manage the affairs of the institute. The corporation, on recommendation of the

executive director, shall appoint not less than 7 qualified individuals to a governing board to assist the corporation in matters related to the institute including a dean of a medical school, head of an emerging health technology company, a chief information officer of a major teaching hospital and a technology transfer officer or individual qualified in technology commercialization from a university in the commonwealth. The executive director, and the secretary of health and human services shall serve as ex-officio members of the governing board. The members of the governing board shall consult with the health care quality and cost council, the Massachusetts health and educational facilities authority, the joint committee on health care financing, the house and senate committees ways and means during the preparation of a detailed plan for the operation of the institute and the matching fund. Upon approval of such detailed plan by the board of directors of the corporation, it shall delegate such authority to the governing board as it deems necessary to implement the plan. The members of the governing board shall be deemed to be directors for purposes of the fourth paragraph of section 3. The purpose of the institute shall be to serve as an agent of the commonwealth to create and maintain a statewide, interoperable electronic health records system to improve patient safety and quality, and to lower costs in the state's health care system, with a particular emphasis on the deployment of health information technology in discrete and underserved regions by harnessing local support and involvement in such development activities and by improving the health information technology infrastructure for such clusters. In furtherance of these public purposes, the institute shall endeavor to identify regions where compelling opportunities to make strategic investments appear to be present and develop strategies therefor. The institute may also provide development support more generally to organizations to assist the formation and growth of emerging health technology sectors in those regions and may provide support to departments, agencies, and quasi-public entities of the commonwealth for activities that are consistent with the purposes of the institute. The institute may make grants in support of Massachusetts-based public and private enterprises developing and deploying new technologies to significantly increase the efficiency, safety and quality of the health care system. The institute may work in collaboration with the Massachusetts technology collaborative, the New England Health Care Institute, the Massachusetts Hospital Association, the

Massachusetts Association of Community Hospitals, Blue Cross/Blue Shield of Massachusetts, the Massachusetts Association of Health Plans, and other quasi-public agencies and not-for-profit organizations. Successful grants should incorporate regional involvement through alliances among municipalities, colleges, hospitals, health centers, skilled nursing facilities, business and industry, community based organizations, non-profit organizations and labor unions. The governing board may apply the provisions of this chapter that apply to centers and to the center fund to the institute and to the e-health institute fund. Without limiting the generality of the foregoing, the corporation may apply moneys in said fund to start-up expenses and project costs of said institute and related activities, grants or loans to nonprofit or other organizations to promote the use of electronic health records. The institute shall also file an annual report of its activities with the joint committee on health care financing, the house and senate committees on ways and means.

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

(c) In making the initial round of grants from the innovation institute fund, not more than $25,000,000 a year shall be distributed over a 3 year period to each of the 5 geographic regions of the state, defined generally as follows: the central area, comprised of the Northern Worcester Service Delivery Area and the Southern Worcester Service Delivery Area as specified in 20 CFR 661.280; the greater Boston area, comprised of the Boston Service Delivery Area, the Metropolitan North Service Delivery Area and the Metropolitan South/West Service Delivery Area as specified in 20 CFR section 661.280; the northeast area, comprised of the Lower Merrimack Valley Service Delivery Area, the

Northern Middlesex Service Delivery Area and the Southern Essex Service Delivery Area as specified in 20 CFR 661.280; the southeast area, comprised of the Bristol Service Delivery Area, the Brockton Service Delivery Area, the Cape and Islands Service Delivery Area, the New Bedford Service Delivery Area and the South Coastal Service Delivery Area as specified in 20 CFR 661.280; and the western area, comprised of the Berkshire Service Delivery Area, Franklin/Hampshire Service Delivery Area and Hampden Service Delivery Area as specified in 20 CFR 661.280.

(d) The Massachusetts e-health institute may not make a grant under this section unless the recipient organization agrees to use the grant: (1) to develop and implement an electronic health records (EHR); and (2) to begin implementation of the plan not later than the beginning of the second year of the grant.

(e) In selecting grant or loan recipients under this section, the Massachusetts e-health institute shall consider: (i) existing technological and organizational infrastructure upon which the health information network can build; (ii) the extent of stakeholder participation; (iii) health care provider participation commitments; (iv) capacity to measure quality and efficiency improvements; (v) replicability; (vi) the extent of the opportunity for a plan to improve health care quality and the health outcomes of patients in the region to be served; and (vii) other factors that the collaborative considers relevant.

(f) Any health information network funded in whole or in part under this section shall comply with any applicable regulatory privacy protections and shall allow patients to exclude their health information from the health information network.

(g) In the event of the unauthorized access to or disclosure of individually identifiable patient health information occurs by or through the statewide health information network, or by or through any technology grantees funded in whole or in part under this section, the operator of such network or grantee shall: (i) report the conditions of such unauthorized access or disclosure as required by the collaborative; and (ii)

provide notice to any individuals whose patient health information may have been compromised as a result of such unauthorized access or disclosure.

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

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

(2) The e-health institute shall by contract or grant establish and maintain a statewide technical assistance center to provide assistance to physicians to facilitate successful adoption of electronic health records and participation in the development and implementation of the statewide health information technology plan by such physicians. The statewide technical assistance center shall assist physicians in all geographical areas served by a health information network. In assisting physicians under this paragraph, the statewide technical assistance centers shall prioritize physicians in small physician groups and, as resources allow, shall assist physicians in larger groups. Technical assistance provided under this paragraph shall, at a minimum, include the following: (i) A clearinghouse of best practices, guidelines and implementation strategies directed at the small medical practices that plan to adopt electronic health records; (ii) a change management tool kit to enable physicians and their staff to successfully prepare practice workflows for adoption of electronic medical records and electronic prescribing, to receive guidance in the selection of vendors of health information technology products and services that are appropriate within the context of the individual practice and the community setting, to implement health information technology solutions and manage the project at the practice level, and to address the ongoing need for upgrades, maintenance and security of office-based health information technologies; and (iii) the

capability to provide consultations and advice to small medical practices to facilitate adoption of health information technologies.

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

(k) Not later than 4 years after the date of the enactment of this Act, the e-health institute shall submit a report to the joint committee on health care financing and the senate and house committees on ways and means on the progress in realizing the purposes of this Act, with particular attention to the following: (i) the capacity to exchange health information between and among components of the health system; (ii) rates of provider participation in electronic health records; (iii) the security and privacy of health information technology supported by this section; and (iv) the impact of health information technology on health care quality, health outcomes of patients, and health care costs.

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

Pharmacy Academic Detailing Program

SECTION 7. Chapter 111 of the General Laws is hereby amended by inserting after section 4M the following section:–

Section 4N. (a) The department of shall develop, in cooperation with the division of Commonwealth Medicine of the University of Massachusetts Medical School, implement and promote an evidence-based outreach and education program designed to provide information and education on the therapeutic and cost-effective utilization of prescription

drugs to physicians, pharmacists and other health care professionals authorized to prescribe and dispense prescription drugs, subject to appropriation. In developing the program the department shall consult with physicians, pharmacists, private insurers, hospitals, pharmacy benefit managers, the MassHealth drug utilization review board and the University of Massachusetts medical school. The program shall include the following elements:

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

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

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

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

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

Establish Massachusetts Center for Primary Care Recruitment and Replacement

SECTION 8. Chapter 111 of the General Laws is hereby amended by inserting after section 25K the following section:-

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

The duties of the center shall consist of the following: (i) coordinate the department's primary care workforce activities with other state agencies and public and private entities involved in health care workforce training, recruitment and retention; (ii) monitor trends in access to primary care and primary care workforce capacity, including regional disparities; (iii) maintain a public web-based statewide primary care job database; (iv) conduct outreach and marketing to recruit primary care providers, regionally and nationally, to practice in Massachusetts; (v) coordinate state and federal loan repayment and incentive programs for primary care providers; (vi) assist and support communities, physician groups, community health centers and community hospitals in developing cost-effective and comprehensive recruitment initiatives; (vii) assist and support primary care professsionals by acting as a career service center and providing job placement assistance; and (vii) maximize all sources of public and private funds for recruitment initiatives.

The center shall submit an annual report to the joint committee on public health, the joint committee on health care financing, and the house and senate committees on ways and means regarding the center's activities in recruiting and retaining health care

providers for underserved populations and areas throughout the commonwealth. The annual report shall include, but shall not be limited to, information about: (i) the activities and accomplishments of the center during the report period; (ii) planned activities for the next year; (iii) the number and type of providers who have been recruited to work in the commonwealth as a result of center activities; (iv) the retention rate of providers who have located in underserved areas as a result of center activities; (v) the utilization rate of the scholarship and loan repayment programs and other programs or activities authorized for provider recruitment and retention; and (vi) recommendations for pilot programs and regulatory or legislative proposals to address workforce needs, shortages, recruitment and retention. The annual report shall be submitted by October 1 of each year.

Prevention of Serious Reportable Events

SECTION 9. Section 51 of chapter 111 of the General Laws is hereby amended by inserting after the fourth paragraph the following paragraph:- A hospital licensed under this chapter shall report each never event occurrence listed in regulations promulgated under clause (i) of subsection (e) of section 16L of chapter 6A to the Betsy Lehman center for patient safety and medical error reduction, the department of public health, the board of registration in medicine's patient care assessment division, and the health care quality and cost council, as soon as is reasonably and practically possible, but not later than 15 working days after discovery of the never event. Any licensed hospital in the commonwealth which does not comply with this section and the rules and regulation set forth by the department may have its license revoked or suspended by the department, be fined up to $1,000 per day per violation, or both.

Establishment of Patient and Family Advisory Councils

SECTION 10. Chapter 111 of the General Laws is hereby amended by inserting after section 52 the following section:-

Section 52A. (a) All hospitals shall establish and convene patient and family advisory councils, referred to in this section as the councils.

(b) The councils shall be composed of current and former patients and members of their immediate families. The minimum size of a council shall be 7 members. The rules and regulations for the councils shall be established by council members.

(c) Each hospital shall appoint an employee to serve as a resource to the councils and to coordinate their activities.

(d) Each hospital shall develop a committee to establish and maintain a council and to empower the council to provide meaningful input into hospital policy and management. The councils shall meet at least 4 times annually. The hospital shall provide a meeting place for the council.

Strengthen Determination of Need Process

SECTION 11. Chapter 111 of the General Laws is hereby amended by inserting after section 53D the following section:-

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

federal government or the commonwealth. The department shall promulgate regulations to implement this section.

Reduction of Medical Storage Requirements I

SECTION 12. Section 70 of chapter 111 of the General Laws, as appearing in the 2006 Official Edition, is hereby amended by striking out the second and third sentences in the first paragraph and inserting in place thereof the following three sentences-

Such records may be made in handwriting, in print, by typewriting, in electronic digital media or conversion to electronic digital media as originally created by such hospital or clinic, by the photographic or microphotographic process, or any combination of the same. Such hospital or clinic, may only destroy said records after the applicable retention period has elapsed upon notifying the department of public health that the applicable retention period has elapsed and the records will be destroyed. Such hospital or clinic shall further provide information through applicable provisions contained in the hospital or clinic notice of privacy practices that records will be terminated after the applicable retention period has elapsed since the last date of service.

Reduction of Medical Storage Requirements II

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:- 15.

Reporting Requirements for Clinical Laboratories

SECTION 14. Chapter 111D of the General Laws is hereby amended by striking out section 6, as appearing in the 2006 Official Edition, and inserting in place thereof the following section:

Section 6. Infectious disease reports; confidential information

The department shall require the reporting of any infectious disease found in the examination of specimens at clinical laboratories whenever, in its opinion, reporting of such disease is necessary to protect or promote the public health. Every person who and every agency which maintains a clinical laboratory shall report evidence of any infectious disease including, but not limited to, hospital acquired infections found in the course of the examination of specimens, as required by the department, in such form, manner and detail and within such time as the department shall prescribe. Reports made under this section shall not be constitute a diagnosis nor shall any person making a report under this section be held liable in a civil proceeding for having violated a trust or confidential relationship. Notwithstanding section 10 of chapter 66, every such report shall be kept confidential by the department and its employees and agents and shall not be subject to the inspection, examination or copying by any other agency of government or by any other person; provided, however, that the department shall make public clinical laboratory reports of hospital acquired infections in a manner that does not identify individual patients. Failure of a clinical laboratory to submit reports in a timely manner required under this section shall be punished by a fine, in accordance with regulations promulgated by the department establishing a schedule of fines or by suspension or revocation of the laboratory license or both.

Expanding Use of Physician Assistants in Underserved Area

SECTION 15. Section 9E of chapter 112 of the General Laws, as appearing in the 2006 Official Edition, is hereby amended by adding at the end of the first paragraph, the following sentence:

Physicians who work in medically underserved areas, as designated by the department of public health, may supervise up to 4 physician assistants.

MassHealth Medical Home Demonstration Project

SECTION 16. Chapter 118E of the General Laws is hereby further amended by inserting after section 10F, the following section:-

Section 10G. MassHealth Medical Home Demonstration Program

(a) As used in this section, the following word shall have the following meanings:-

"Medical home," a primary care practice that utilizes a comprehensive approach to providing patient-centered care that is accessible, continuous, and coordinated so that the relationship between the provider and patient is directed at maintaining a healthy lifestyle with preventive and ongoing health services and is respectful of, and responsive to, individual patient preference, needs, and values.

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

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

The program shall operate for three years in urban, rural, and underserved areas in up to ten communities and would include physician practices with fewer than three full-

time equivalent physicians, as well as larger practices, particularly in rural and underserved areas.

Personal physicians who provide first contact and continuous care for their patients must be board certified. Such personal physicians must also have a staff and resources to manage the comprehensive and coordinated care of each of their patients. Participating physicians may be specialists or sub-specialists for patients requiring ongoing care for specific conditions, multiple chronic conditions such as severe asthma, complex diabetes, cardiovascular disease, and rheumatologic disorder, or for those with a prolonged illness.

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

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

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

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

Standardizing Insurance Coding and Forms I

SECTION 17. Chapter 118E of the General Laws is hereby amended by adding the following section:-

Section 61. This section is intended to provide uniformity and consistency in the reporting of patient diagnostic information as well as patient care service and procedure information as it relates to the processing of health care claims.

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

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

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

(c) Other than requirements for consistency and uniformity in coding patient diagnostic information and patient care service and procedure information, this section shall not modify or supersede the Executive Office's or its subcontractor's payment policy or utilization review policy. Nothing in this section shall further preclude the executive office or its subcontractor from adjudicating a claim pursuant to their billing guidelines, payment policies, or provider contracts.

(d) Effective January 1, 2011, the Executive Office and their subcontractors must accept and recognize at least 85 per cent of all claims submitted by health care providers pursuant to and consistent with the provisions set forth in this section.

Reduction of Medical Storage Requirements III

SECTION 18. Section 36 of chapter 123, as so appearing, is hereby amended by adding the following sentences:- Each facility, subject to this chapter and section 19 of chapter 19, that provides mental health care and treatment shall maintain patient records, as defined in the first paragraph of section 70 of chapter 111, for at least 15 years after closing of the record due to discharge, death or last date of service. Such facility may destroy said records after the applicable retention period has elapsed upon notifying the department that the applicable retention period has elapsed and the records will be destroyed. Said facility shall further provide information through applicable provisions in the hospital or clinic notice of privacy practices that records will be terminated after the applicable retention period has elapsed since the last date of service.

Standardizing Insurance Coding and Forms II

SECTION 19. Chapter 176O of the General Laws is hereby amended by inserting after section 5 the following 2 sections:-

Section 5A. Processing of health care claims. This section is intended to provide uniformity and consistency in 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.

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

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

(c) Other than requirements for consistency and uniformity in coding patient diagnostic information and patient care service and procedure information, this section shall not modify 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 its subcontractor from adjudicating a claim pursuant to their billing guidelines, payment policies, provider contracts or health benefit plans.

(d) Effective January 1, 2011, carriers and their subcontractors must accept and recognize at least 85 per cent of all claims submitted by health care providers pursuant to and consistent with the provisions set forth in this section.

Section 5B. To ensure uniformity and consistency in the submission and processing of claims for health care services pursuant to section 5A of chapter 176O, the bureau of managed care within the division of insurance, after consultation with a statewide advisory committee including but not limited to the Massachusetts Hospital Association, the Massachusetts Medical Society, the Massachusetts Association of Health Plans, the Blue Cross and Blue Shield of Massachusetts, the Massachusetts Health Information Management Association, the Massachusetts Health Data Consortium, a representative of America's Health Insurance Plans, a representative of a MassHealth contracted managed care organization, the executive office of health and human services, the division of health care finance and policy, the health care quality and cost council, the Massachusetts house of representatives, and the Massachusetts senate, shall adopt policies and procedures to enforce section 5A. Said policies and procedures shall include a system for reporting of inconsistencies related to a carrier's compliance with section 5A. The bureau shall work jointly with the executive office of health and human services in connection with resolving reports of noncompliance with the requirements of section 53 of chapter 118E. The bureau shall convene the advisory committee annually starting on January 1, 2009, and as otherwise necessary, to review and discuss issues reported by health care providers under the section as well as to discuss further recommendations to improve the uniformity and consistency in 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.

Expanding Consumer Choice of Nurse Practitioner Services

SECTION 20. 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:

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

"Commissioner", the commissioner of insurance.

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

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

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

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

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

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

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

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

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

Section 6. Complaints of noncompliance against carriers shall be filed with and investigated by the commissioner or the group insurance commission, whichever shall have regulatory authority over the carrier. The commissioner and the group insurance commission shall promulgate regulations to enforce sections 2, 3, 4 and 5.

Enhancing Transparency of Health Care Insurance Cost Increases

SECTION 21. The General Laws are hereby amended by inserting after chapter 176R the following chapter:-

CHAPTER 176S

HEALTH INSURANCE RATE HEARINGS

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

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

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

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

under chapter 176A; a non-profit medical service corporation organized under chapter 176B; or a health maintenance organization organized under chapter 176G.

"Health plan", any individual, general, blanket or group policy of health, accident or sickness insurance issued by an insurer licensed under chapter 175 or the laws of any other jurisdiction; a hospital service plan issued by a nonprofit hospital service corporation under chapter 176A or the laws of any other jurisdiction; a medical service plan issued by a nonprofit hospital service corporation under chapter 176B or the laws of any other jurisdiction; a health maintenance contract issued by a health maintenance organization under chapter 176G or the laws of any other jurisdiction; and an insured health benefit plan that includes a preferred provider arrangement issued under chapter 176I or the laws of any other jurisdiction. "Health plan" shall not include accident only, credit-only, limited scope dental or vision benefits if offered separately, hospital indemnity insurance policies if offered as independent, noncoordinated benefits which for the purposes of this chapter shall mean policies issued pursuant to chapter 175 which provide a benefit not to exceed $500 per day, as adjusted on an annual basis by the amount of increase in the average weekly wages in the commonwealth as defined in section 1 of chapter 152, to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent, disability income insurance, coverage issued as a supplement to liability insurance, specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meets any requirements the commissioner by regulation may set, insurance arising out of a workers' compensation law or similar law, automobile medical payment insurance, insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self insurance, long-term care if offered separately, coverage supplemental to the coverage provided under 10 U.S.C. chapter 55 if offered as a separate insurance policy, or any policy subject to the provisions of chapter 176K. The commissioner may by regulation define other health coverage as a health plan for the purposes of this chapter.

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

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

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

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

Section 4. A carrier shall annually report to the commissioner and to the health care quality and cost council, established under section 16K of chapter 6A, no later than May 1, the actual loss ratio calculated for each health plan for the previous calendar year.

Section 5. If a carrier files for an increase in premium of 7 per cent or more than the premium previously charged for any rate classification or coverage, or if a carrier files an initial premium request that is 7 per cent or more than the adjusted weighted average market premium price, or if the attorney general files with the commissioner, within 30 days of the carrier's filing, a preliminary determination that the benefits provided in any health insurance policy are unreasonable in relation to the premium charged, the commissioner shall initiate a hearing conducted pursuant to chapter 30A on any such filing prior to its effective date on at least 10 days notice. The commissioner may consolidate hearings for more than 1 carrier, and may consolidate hearings for multiple health plans filed by one carrier. The carrier shall provide information on the reasons for the proposed premium increase, and members of the public may testify. All testimony and evidence received shall be public records. The commissioner may promulgate guidelines to safeguard the confidentiality of contracts that establish rates between insurers and institutional providers licensed under section 51 of chapter 111 which shall apply when the commissioner obtains such contracts under his authority in section 8A of chapter 175 for purposes of a hearing under this section.

The attorney general shall have the authority to intervene in any hearing called for under this paragraph.

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

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

Within 30 days of the conclusion of any hearing initiated under this section, the commissioner shall issue a report containing findings of fact from the evidence presented *in the carrier's filing and in the hearing. The findings of fact shall include, but shall not* be limited to:

1) the carrier's administrative expenses, including but not limited to the carrier's salary structure, advertising and other marketing expenses, and commissions, brokerage fees and other distribution expenses, as compared to other carriers within and without the commonwealth;
2) the carrier's expenses related to health care contract, including but not limited to the costs of services rendered by health care providers, the rates at which it pays for such services and the volume of services provided;
3) the carrier's loss experience under the health plan, including evaluations of the carrier's loss ratio and of utilization by the carrier's insureds, and of identifiable cost drivers for that health plan, as compared to other carriers within and without the commonwealth;
4) cost-sharing assumptions made in the health plan, including, but not limited to, the use of deductibles, co-payments and coinsurance;
5) the carrier's provisions in the rates for reserves and surplus; and

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

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

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

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

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

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

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

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

Pharmaceutical Industry Gift Ban

SECTION 22. The General Laws are hereby amended by inserting after chapter 268B the following chapter:-

CHAPTER 268C

PHYSICIAN AND PHARMACEUTICAL MANUFACTURER CONDUCT

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

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

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

"Medical device", an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part, or accessory, which is: (1) recognized in the official National Formulary, or the United States Pharmacopeia, or any supplement to them; (2) intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals; or (3) intended to affect the structure or any function of the body of man or other animals, and which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of its primary intended purposes.

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

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

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

wholesale drug distributor licensed under section 36A of chapter 112 or a retail pharmacist registered under section 37 of chapter 112.

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

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

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

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

Section 3. A person who violates this chapter shall be punished by a fine of not more than $5,000 or by imprisonment for not more than 2 years, or both.

Expansion of Medical School Enrollment

SECTION 23. Notwithstanding any general or special law to the contrary, the trustees of the University of Massachusetts shall expand the entering class at its medical school and increase residencies for medical school graduates for students committed to entering the primary care field and to working in underserved regions of the commonwealth. The trustees shall develop a master plan for expanding medical student enrollment and increasing internships and residencies for medical school graduates who are committed to primary care and work in underserved regions without reducing academic quality, together with a financial plan to support such expansion, and shall report that plan to the joint committee on health care financing and the house and senate committees on ways and means not later than January 1, 2009.

Primary Care Provider Medical Debt Relief

SECTION 24. Notwithstanding any general or special law to the contrary, the center for primary care recruitment and placement established under section 8 of this act, in consultation with the board of higher education and the executive office of health and human services, shall, subject to appropriation, establish a primary care workforce development and loan forgiveness grant program at community health centers, community hospitals and other facilities in underserved areas for the purpose of enhancing the recruitment and retention of primary care physicians and nurse practitioners who are authorized to practice as provided for in section 80B of chapter 112 of the General Laws. Loan forgiveness programs or zero interest loan programs or other forms of assistance utilizing public funds, in whole or in part, shall require each recipient medical or nursing student to enter into a contract with the commonwealth as primary care fellows which shall obligate the recipient to perform at least 4 years of service within the commonwealth in areas of primary care, public or community service or underserved areas as determined by the center.

UMass Medical Student Enhanced Learning Contract

SECTION 25. Notwithstanding any general or special law to the contrary, the trustees of the University of Massachusetts, in conjunction with the state health education center at the University of Massachusetts medical center, shall establish and maintain an enhanced learning contract program available to medical students every academic year. The program shall provide full waivers of tuition and fees at the University of Massachusetts medical school. The contract shall require payback service, so-called, of at least 4 years of service within the commonwealth in areas of primary care, public or community service, or underserved areas as determined by the center for primary care recruitment and placement and the learning contract committee, in coordination with the area health education center and state and regional health planning agencies. If a student does not perform payback service as required by an enhanced learning contract, that student shall pay the difference between the tuition paid and double the amount of the tuition charged together with an origination, or "O," fee, interest per annum at prime rate as reported at the time of origination by the Federal Reserve, a margin and repayment fee as set by the board. No payback service or tuition loan repayment shall be required prior to the termination of any internship and residency requirements. Interest shall begin to accrue upon completion of the requirement 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 on the number of students participating in enhanced learning contracts, the area of medicine within which payback will 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.

Establishment of a Nursing and Allied Health Trust Fund

SECTION 26. (a) Notwithstanding any general or special law to the contrary, there is hereby established and set up on the books of the commonwealth a separate trust fund to be known as the Massachusetts Nursing and Allied Health Workforce Development Trust Fund, hereinafter referred to as the health care workforce trust fund, to which shall be credited any appropriations, bond proceeds or other monies authorized

by the general court and specifically designated to be credited thereto, and additional funds including federal grants or loans, or private donations made available to the chancellor of higher education for this purpose. The board of higher education shall hold this trust fund in an account or accounts separate from other funds or accounts. Amounts credited to the fund shall be expended by the chancellor of higher education to carry out the purposes set forth in subsection (b). Expenditures from the fund shall not be subject to appropriation. Any balance in the trust fund at the close of a fiscal year shall be available for expenditure in subsequent fiscal years and shall not revert to the general fund.

(b) The public purposes of the Massachusetts Nursing and Allied Health Workforce Development Trust Fund shall be to develop and support, in consultation with the Massachusetts Nursing and Allied Health Workforce Development Advisory Committee, short and long-term strategies that increase the number of Massachusetts public and private higher education faculty and students who participate in programs that support careers in fields related to nursing and allied health. The chancellor of higher education may expend from the health care workforce trust fund such administrative monies as may be necessary for the administration of the Massachusetts Nursing and Allied Health Workforce Development Initiative. In furtherance of these public purposes, the chancellor of higher education shall expend the health care workforce trust fund monies on activities that are calculated to increase the number of qualified nursing and allied health faculty and students in the commonwealth and improve the nursing and allied health educational offerings available in public higher education institutions. Grants and other disbursements and activities may involve, without limitation, the University of Massachusetts, state and community colleges, private higher education institutions in partnership with public higher education institutions, business and industry partnerships, regional alliances, workforce investment boards, 501(c)(3) organizations and other community groups which promote the nursing profession. Grants and other disbursements and activities may support, without limitation: (i) the goal of rapidly increasing the number of nurses and allied health workers (ii) enhancing the role of the system of public higher education, as institutions and in partnerships with other

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

Housing Assistance Pilot Program for Health Care Professionals

SECTION 27. Notwithstanding any general or special law to the contrary, the department of housing and community development, in consultation with the executive office of health and human services and the department of workforce development, shall establish a pilot program to help hospitals, community health centers, and physician practices provide housing grants or loans for health care professionals in underserved areas. The department shall establish an assisted housing fund that shall provide grants or loans for health care professionals who contract to provide care in underserved regions of the commonwealth and whose incomes do not exceed certain benchmarks, as established by the department. Grants and loans from the assisted housing fund shall be spent in the commonwealth and may be used for (i) the cost to purchase housing that is to be a principal residence, including cooperative housing, and falls within price guidelines established by the department, including costs for down payments, mortgage interest rate buy-downs, closing costs and other costs determined to be eligible by the department, and (ii) payments for security deposits and advance payments for rental housing. The department, subject to appropriation, shall contribute to the assisted housing fund $1 for every $2 expended by the hospital, community health center, and physician practice from the assisted housing fund as provided in this act. The assistance granted pursuant to this act shall be determined by the department. The department shall adopt written

procedures for the establishment and operation of the assisted housing fund. Such procedures shall include provisions for eligibility and shall specify expenses for which grants and loans may be made and provide the documentation and procedures necessary to qualify for the assistance. 2 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.

Report on Strategies to Increase Primary Care Workforce

SECTION 28. Notwithstanding any special or general law to the contrary, the center for primary care recruitment and placement, in conjunction with the University of Massachusetts medical school and area health education centers, shall study the efforts of Massachusetts-based public and private graduate medical education institutions to foster and expand the supply of primary care physicians in the commonwealth. The study shall include, but shall not be limited to, a survey of institutional efforts to both increase the percentage of medical residents who choose a primary care specialty and to increase overall enrollment of medical students committed to entering the primary care field. The study shall recommend innovative primary care educational programs and strategies that foster a culture within graduate medical education which embraces primary care. The center shall report its findings and recommendations to the house and senate committee on ways and means and the joint committee on health care financing no later than January 1, 2009.

Commission on Health Insurer Reserves and Surpluses

SECTION 29. (a) Notwithstanding any general or special laws to the contrary, there shall be a special commission to examine options and alternatives available to the Commonwealth with respect to the regulation, oversight and disposition of the reserves and surpluses of health insurers.

(b) The commission shall consist of the commissioner of insurance, who shall serve as chair; the secretary of administration and finance or his designee; the attorney general or his designee; the commissioner of the division of health care finance and policy or his designee; and 3 members appointed by the governor, including an actuary in good standing with the American Society of Actuaries, a health care consumer advocate, and a health economist.

(c) This commission shall conduct a study that shall include, but shall not be limited to: (1) an analysis of the statutes, regulations and other measures currently in effect in this 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 could cause extraordinary medical losses; (2) a review of recent fiscal practices and financial reporting by health insurers with respect to reserves and surpluses under the laws of the commonwealth; (3) a comparison of the commonwealth's current statutes and regulations with those of other states which the division deems to be reasonably comparable to those of the commonwealth; (4) a review and assessment of model acts and regulations and any other information which the division finds to be relevant to its inquiry; (5) a summary of alternative approaches to regulation of reserves and surpluses, including the disposition of amounts held by or on behalf of health insurers, with particular consideration of alternatives that would govern the use of those amounts to reduce premiums or to delay or to moderate premium increases; and (6) a review of how carriers fund community benefit programs, including, but not limited to, how such 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 operating in this commonwealth, the attorney general, the executive office of health and human services, and the health care quality and cost council, established under section 16K of section 6A of the General Laws.

(d) For the purpose of conducting this study, the division may contract with an outside organization with expertise in fiscal analysis of the private insurance market. In conducting its examination, the organization shall, to the extent possible, obtain and use

actual health plan data; but such data shall be confidential and shall not be a public record. The division shall report its findings and recommendations to the house and senate committee on ways and means and the joint committee on health care financing no later than January 1, 2009.

(e) The commission shall meet no later than October 1, 2008 and shall file a report with the clerks of the senate and house of representatives no later than April 1, 2009.

Ensuring Compliance with Hospital-Acquired Infection Rate Regulations

SECTION 30. Notwithstanding any special or general law to the contrary, the department of public health, in consultation with the health care quality and cost council, shall promulgate regulations requiring hospitals, as a standard of eligibility for original licensure and renewal of licensure, to register with the National Healthcare Safety Network. Each hospital that registers with the National Healthcare Safety Network must grant access to the department and the Betsy Lehman center for patient safety and medical error reduction, in accordance with guidelines of the department to (1) healthcare associated infection data elements reportable to the National Healthcare Safety Network and (2) hospital specific reports generated by the National Healthcare Safety Network. Each registered hospital shall collect and submit to the National Healthcare Safety Network healthcare-associated infection data elements in accordance with guidelines of the department.

Massachusetts e-Health Advisory Committee

SECTION 31. Notwithstanding any special or general law to the contrary, there is hereby established a Massachusetts e-Health Advisory Committee to advise the Massachusetts e-health institute established in section 6.

(a) The members of the Massachusetts e-health advisory committee shall include the secretary of health and human services, who shall serve as the chair, the secretary of administration and finance or his designee, the executive director of the Massachusetts e-

health institute, the executive director of the health care cost and quality council, and additional members to be appointed by the secretary to include persons representing local public health agencies, licensed hospitals and other licensed facilities and providers, private purchasers, the medical and nursing professions, physicians, health insurers and health plans, the state quality improvement organization, academic and research institutions, consumer advisory organizations with an interest and expertise in health information technology, and other stakeholders as identified by the secretary of health and human services.

(b) The committee shall prepare a statewide electronic health records plan that shall provide for the following:

(1) the establishment and implementation throughout the commonwealth of a statewide health information network that: (i) allows the seamless, secure, electronic sharing of health information among health care providers, health plans, and other authorized users; (ii) provides consumers with secure, electronic access to their own health information; (iii) meets data standards for interoperability adopted by the Massachusetts Technology Collaborative, including any standards providing for interoperability among other health information networks, in cooperation with the Massachusetts e-Health Initiative, the Massachusetts Health Data Consortium, MA-SHARE and other appropriate organizations; (iv) provides for interoperability with any health information technology product certified by the Massachusetts e-Health Institute; (v) meets privacy requirements; (vi) gives patients the option of allowing only designated health care providers to access their individually identifiable information concerning diagnosis and treatment of sexually transmitted diseases, addiction, and mental illnesses; (vii) provides such public health reporting capability as the Secretary of Health and Human Services requires; (viii) allows for such reporting of, and access to, health information for purposes of research (other than individually identifiable patient health information) as the Secretary of Health and Human Services requires; and (ix) allows for the reporting of provider-specific health information (other than individually identifiable

patient health information) required for the calculation of any voluntary consensus standard endorsed by the National Quality Forum;

(2) the financing and technical assistance required to allow health care providers, especially small physician groups, to acquire and implement electronic medical records necessary to participate in the statewide health information network; and

(3) agreements among health care stakeholders regarding data reporting, reimbursement practices, or other mechanisms to use the statewide health information network to improve patient safety, quality, and efficiency within the health care system.

(c) The statewide electronic health records plan prepared under subsection (b) shall: (i) be developed with the participation and widespread support of all health care stakeholders, including but not limited to hospitals, practicing physicians (including those from small physician groups), nursing facilities and skilled nursing facilities, other health care providers, health plans, employers, and patient groups; (ii) describe the governance structure of the statewide health information network; (iii) describe the technologies and systems, including interoperability data standards, that will be used to establish a health information network consistent with paragraph (b)(1); (iv) explain what information will be able to be accessed, transferred, or exchanged through the health information network and what capabilities the network will have to include other types of information in the future; (v) describe plans to ensure network reliability, expected frequency of network interruptions, and backup procedures in the event of network interruptions; (vi) describe a financing model for long-term sustainability of the network that maximizes private funds; (vii) describe private sources of financing the acquisition, implementation, and maintenance of technology necessary to allow health care providers, especially small physician groups, to participate in the health information network; (viii) describe how the health information network will be used to improve health care quality and the health outcomes of patients; (ix) establish how administrative and clinical savings resulting from widespread use of the new health information network will be accounted for and allocated; (x) explain how the statewide health information organization involved will

ensure widespread participation by health care providers (especially small physician groups) in the health information network and what support and assistance will be available to physicians seeking to integrate health information technologies into their practices; (xi) describe how patients and caregivers who are not health care providers will be able to access and utilize the health information network; (xii) explain how the statewide health information network will protect patient privacy and maintain security; and (xiii) explain how the statewide health information network will ensure the participation of health care providers serving minority communities, including communities in which English is not the primary language spoken.

(d) The secretary shall prepare and issue an annual report not later than January 30 of each year outlining progress to date in implementing a statewide health information infrastructure and recommending future projects.

Statewide Adoption of Computerized Physician Order Entry Systems

SECTION 32. Notwithstanding any special or general law to the contrary, no later than October 1, 2012, the department of public health, in consultation with the health care quality and cost council, shall promulgate 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 provided, however, that said product, system or network shall be certified by the Certification Commission for Healthcare Information Technology (CCHIT), or any successor agency or organization established for the purpose of certifying that health information technology shall meet national interoperability standards.

Statewide Adoption of Electronic Health Records

SECTION 33. Notwithstanding any special or general law to the contrary, no later than October 1, 2015, the department of public health, in consultation with the health care quality and cost council, shall promulgate 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 provided, however, that said product, system or network shall be certified by the Certification Commission for Healthcare Information Technology (CCHIT), or any successor agency or organization established for the purpose of certifying that health information technology shall meet national interoperability standards.

Maximize Enrollment in the Senior Care Options Program

SECTION 34. Notwithstanding any special or general 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, or comparable successor program, and shall develop a plan to offer similar coverage to Medicaid and Medicare-eligible disabled persons under age 65, hereinafter referred to as dual eligible plans.

Not later than 6 months after the effective date of this act, the executive office of health and human services shall prepare a report identifying clinical, administrative and financial barriers to expanded dual eligible plans, and recommending steps to remove the barriers and implement coverage for Medicaid and Medicare-eligible disabled persons under age 65. Before finalizing the report, the executive office shall hold a public consultative session that includes 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 includes 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, the house and senate committees on ways and means.

Subject to appropriation, the executive office of health and human services shall implement the steps recommended by the report. Not later than 1 year following the filing of the report, the executive office shall issue a progress statement on expanded enrollment in dual eligible plans

Registry and Sunset of Physician Letters of Exemption

SECTION 35. Notwithstanding any general or special law or rule or regulation to the contrary, the department of public health shall, by July 1, 2009, establish a registry of exemptions granted by the department under section 6 of chapter 350 of the acts of 1993 and the department's regulations to any person who filed with the department by December 23, 1993, a notice of intent to acquire medical, diagnostic or therapeutic equipment used to provide an innovative service or which is a new technology, as defined in section 25B of chapter 111 of the General Laws. All registered exemptions shall be non-transferable. After July 1, 2009, all exemptions qualifying for the registry established in this act that have not been registered with the department shall be null and void. Holders of registered exemptions for medical, diagnostic or therapeutic equipment not placed in regular service by July 1, 2009, shall, upon application, be eligible for an expedited determination of need process, as determined by the department. All exemptions granted by the department under said section 6 of said chapter 350 of the acts of 1993 and the department's regulations to any person who filed with the department by December 23, 1993, a notice of intent to acquire medical, diagnostic or therapeutic equipment used to provide an innovative service or which is a new technology shall expire on July 1, 2010, if the equipment for which the exemption was granted was not placed in regular service by July 1, 2009, and if no determination of need was granted by the department.

Study of Medical Malpractice Insurance Premiums

SECTION 36. 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. The investigation and study shall include, but shall not be

limited to, examination and analysis of the following: (1) the availability and affordability of medical malpractice insurance; (2) the factors considered by medical malpractice insurers when increasing premiums; (3) options for decreasing premiums, including but not limited to establishing a reinsurance pool with additional stop loss coverage, subsidizing premium payments of providers practicing in certain high-risk specialties or in specialties where the cost of premiums represents a disproportionately high proportion of a health care provider's income, subsidizing premium payments of providers who do not qualify for group coverage rates and pay higher premiums for commercial market insurance and prorating premiums for providers who practice less than full time; and (4) funding mechanisms that would facilitate the implementation of recommendations arising out of the study, which may include, but which shall not be limited to, charges borne by the health care industry or other entities. The division shall hold at least 2 public hearings to take testimony relating to the investigation and study, 1 of which shall be held outside the metropolitan Boston area. The division shall report its findings and recommendations to the house and senate committee on ways and means and the joint committee on health care financing no later than January 1, 2009.

Study of Medicaid Reimbursement Rates for Primary Care Providers

SECTION 37. Notwithstanding the provisions of any general or special law, the medicaid advisory committee, established pursuant to section 6 of chapter 118E of the general laws, is hereby authorized and directed to conduct a study of the need for an increase in Medicaid rates and/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. Said committee, in collaboration with the director, shall report, including recommendations for the amount of funding and the sources of funding to the

joint committee on health care financing, the house and senate committees on ways and means with its recommendations not later than January 1, 2009.

Community Benefits Task Force

SECTION 38. There is hereby established the community benefits taskforce, which shall include the attorney general, the commissioner of public health, and other members as determined by the attorney general and which shall convene to conduct a study of the community benefits contributions by non-profit healthcare providers and insurers in the commonwealth. The study shall include, but shall not be limited to, examination and analysis of the following: (1) current community benefits programs, including but not limited to plans filed with the attorney general's voluntary community benefits program; (2) methods used to identify and define communities to be served by community benefit programs; (3) methods used to measure and evaluate the contributions by non-profit healthcare providers and insurers to various communities; (4) the administrative and technological needs of non-profit healthcare providers; and (5) potential collaborations between providers to fund improved administrative and technological support systems and information infrastructures as part of a statewide community benefits program, including but not limited to the creation of a statewide electronic medical records database and computerized physician order entry to improve access and the portability of health information. The task force 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 task force shall report its findings and recommendations to the house and senate committee on ways and means and the joint committee on health care financing no later than January 1, 2009.

Effective Dates

SECTION 39. The enhanced learning contract program at the University of Massachusetts medical center required under section 25 of this act shall be established by the commencement of the 2008 academic year.

SECTION 40. Section 11 shall take effect upon passage of this act. Any entity providing ambulatory surgical center services which is in operation or under construction on the day when section 53E of chapter 111 becomes effective shall be exempt from the determination of need requirement of said section 53E of said chapter 111 and shall be eligible for up to 6 months from the effective date of regulations promulgated by the department pursuant to section 53E of chapter 111 to make application to the department for a clinic license.

SECTION 41. The health care quality and cost council shall promulgate the regulations required under clause (i) of subsection (e) of section 16L of chapter 6A of the General Laws not later than October 1, 2009.

SECTION 42. The health care quality and cost council shall publish the never event occurrences as required under said clause (i) of said subsection (e) of said section 16L of said chapter 6A, as so appearing, on its consumer health information website not later than 1 year after the effective date of said clause (i).

SECTION 43. The department of public health shall promulgate regulations as necessary to implement section 4N of chapter 111 of the General Laws in accordance with chapter 30A not later than July 1, 2008.

SECTION 44. The department of public health shall begin implementing the outreach and education program established under said section 4N of said chapter 111 not later than January 1, 2009.

SECTION 45. The last sentence of subsection (m) of section 11A of chapter 13 as added by Section 4 shall take effect on January 1, 2015.

SECTION 46. Section 61 of chapter 118E is hereby amended by striking subsection (d) and inserting the following: - (d) The Executive Office and their

subcontractors must accept and recognize all claims submitted by health care providers pursuant to and consistent with the provisions set forth in this section.

SECTION 47. Section 5A of chapter 176O is hereby amended by striking subsection (d) and inserting the following:- (d) Carriers and their subcontractors must accept and recognize all claims submitted by health care providers pursuant to and consistent with the provisions set forth in this section.

SECTION 48. Sections 46 and 47 shall take effect on July 1, 2012.

SECTION 49. Section 20 shall take effect on January 1, 2009.

SECTION 50. Section 30 shall take effect on October 1, 2008.

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

The undersigned, citizen of _____, respectfully petitions for the passage of the accompanying bill and for legislation.

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

Therese Murray(T M0)	Plymouth and Barnstable
Richard Moore(RTM0)	Worcester and Norfolk
Mark Montigny(MCM0)	Second Bristol and Plymouth
Karen Spilka(KES0)	Second Middlesex and Norfolk
Steven Panagiotakos(SCP0)	First Middlesex
Robert O'Leary(ROL0)	Cape and Islands
Steven Tolman(SAT0)	Second Suffolk and Middlesex
Stephen Buoniconti(SJB0)	Hampden
Susan C. Fargo(SCF0)	Third Middlesex
Steven A. Baddour(SAB0)	First Essex