SENATE DOCKET, NO. 1351 FILED ON: 1/19/2023

SENATE . . . . . No. 799

The Commonwealth of Massachusetts

PRESENTED BY:

Pavel M. Payano

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

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

An Act to advance health equity.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	
Pavel M. Payano	*First Essex*	
Liz Miranda	*Second Suffolk*	*1/19/2023*
Joanne M. Comerford	*Hampshire, Franklin and Worcester*	*1/23/2023*
Vanna Howard	*17th Middlesex*	*1/30/2023*
Sal N. DiDomenico	*Middlesex and Suffolk*	*2/6/2023*
Manny Cruz	*7th Essex*	*2/21/2023*
Robyn K. Kennedy	*First Worcester*	*3/28/2023*
Jason M. Lewis	*Fifth Middlesex*	*3/30/2023*
Francisco E. Paulino	*16th Essex*	*5/11/2023*
Rebecca L. Rausch	*Norfolk, Worcester and Middlesex*	*7/10/2023*
Brendan P. Crighton	*Third Essex*	*9/12/2023*
Adam Gomez	*Hampden*	*9/22/2023*
John J. Cronin	*Worcester and Middlesex*	*10/19/2023*
Patricia A. Duffy	*5th Hampden*	*1/30/2024*
Joan B. Lovely	*Second Essex*	*1/30/2024*
Jacob R. Oliveira	*Hampden, Hampshire and Worcester*	*3/25/2024*

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SENATE . . . . . No. 799

By Mr. Payano, a petition (accompanied by bill, Senate, No. 799) of Pavel M. Payano, Liz Miranda, Joanne M. Comerford, Vanna Howard and other members of the General Court for legislation to advance health equity. Health Care Financing.

The Commonwealth of Massachusetts

In the One Hundred and Ninety-Third General Court
(2023-2024)

An Act to advance health equity.

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

SECTION 1. Section 17A of chapter 6 of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by inserting after "the secretary of energy and environmental affairs,", in line 4, the following words:- the secretary of equity,.

SECTION 2. Section 2 of chapter 6A of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by inserting after "energy and environmental affairs,", in line 3, the following word:- equity,.

SECTION 3. Section 1 of chapter 6D, as appearing in the 2020 Official Edition, is hereby further amended by inserting after the definition of "Health care services" the following definition:-

"Health equity", as defined in section 1 of chapter 6F.

SECTION 4. Said section 1 of said chapter 6D, as so appearing, is hereby further amended by inserting after the definition of “Primary care provider” the following definition:-

“Priority population”, a population that is disproportionately impacted by health disparities.

SECTION 5. Subsection (b) of section 2 of said chapter 6D, as so appearing, is hereby amended by inserting after the word “chairperson”, in line 12, the following words:- and 1 of whom shall have professional experience related to health equity and be Black, Indigenous, or a person of color.

SECTION 6. Clause (iv) of the fourth paragraph of subsection (e) of said section 2 of said chapter 6D, as so appearing, is hereby amended by striking out, in line 115, the word “and”, and by inserting after said clause (iv) the following clause:-

(v) incorporate health equity into the exercising of powers and duties under this chapter; and.

SECTION 7. Said subsection (e) of said section 2 of said chapter 6D, as so appearing, is hereby further amended by redesignating clause (v), as inserted by section 15 of chapter 224 of the acts of 2012, as clause (vi).

SECTION 8. Subsection (g) of said section 2 of said chapter 6D, as so appearing, is hereby amended by striking out, in line 140, “,” and inserting in place thereof the following words:- , including a chief health equity officer to assist in the carrying out of powers and duties relating to reducing health inequities experienced by priority populations.

SECTION 9. Section 3 of said chapter 6D, as so appearing, is hereby amended in subsection (k) by striking out, in line 38, the word “and”, in subsection (l) by striking out, in line 41, “.” and inserting in place thereof the word:- ; and.

SECTION 10. Said section 3 of said chapter 6D, as so appearing, is hereby amended by inserting after said subsection (l) the following subsection:-

(m) to incorporate health equity into the exercising of powers and duties under this chapter.

SECTION 11. Section 4 of said chapter 6D, as so appearing, is hereby amended by inserting after “commission”, in line 3, the following words:- , including policies relating to reducing health inequities experienced by priority populations.

SECTION 12. Section 5 of said chapter 6D, as so appearing, is hereby amended by striking out, in line 11, “services” and inserting in place thereof the following words:- “services, including such access for priority populations to ensure health equity”.

SECTION 13. Subsection (d) of section 7 of said chapter 6D, as so appearing, is hereby amended by striking out, in line 35, “those treatments; and (vi)” and inserting in place thereof the following words:- those treatments; (vi) to reduce identified disparities or otherwise advance equity in care delivery; and (vii).

SECTION 14. Subsection (a) of section 8 of said chapter 6D, as so appearing, is hereby amended by striking out, in line 6, “shall examine” and inserting in place thereof the following words:- shall examine: (1).

SECTION 15. Said subsection (a) of said section 8 of said chapter 6D, as so appearing, is hereby amended by striking out, in line 9, “health care system” and inserting in place thereof the following words:- health care system; and (2) health inequities experienced by priority populations.

SECTION 16. Clause (i) of subsection (e) of said section 8 of said chapter 6D, as so appearing, is hereby amended by striking out, in line 45, “and the impact of price transparency on prices” and inserting in place thereof the following words:- , the impact of price transparency on prices, and efforts to reduce health inequities experienced by priority populations.

SECTION 17. Clause (ii) of said subsection (e) of said section 8 of said chapter 6D, as so appearing, is hereby amended by striking out, in line 58, “and any” and inserting in place thereof the following words:- , efforts to reduce health inequities experienced by priority populations, and any.

SECTION 18. Subsection (g) of said section 8 of said chapter 6D, as so appearing, is hereby amended by striking out, in lines 93 to 96, “annual report concerning spending trends and underlying factors, along with any recommendations for strategies to increase the efficiency of the health care system” and inserting in place thereof the following words: annual report concerning: (1) spending trends and underlying factors (including estimates of the cost of inequity for the purpose of identifying the impact of health disparities on total costs of care); (2) any recommendations for strategies to increase the efficiency of the health care system; and (3) any recommendations to reduce health inequities for priority populations based on data and input received pursuant to sections 10A and 2A(c)(7), respectively.

SECTION 19. Said subsection (g) of said section 8 of said chapter 6D, as so appearing, is hereby amended by striking out, in line 100, “sections 8, 9 and 10” and inserting in place thereof:- sections 2A(c)(7), 8, 9, 10, and 10A.

SECTION 20. Said chapter 6D of the General Laws is hereby further amended by inserting after section 9 the following section:-

Section 9A. (a) The board shall establish aggregate primary care and behavioral health expenditure targets for the commonwealth, which the commission shall prominently publish on its website.

(b) The commission shall establish the aggregate primary care and behavioral health expenditure targets as follows:

(1) For the 3-year period ending with calendar year 2026, the aggregate target shall be equal to a 30 per cent increase above aggregate baseline expenditures and the target shall be equal to a 30 per cent increase above baseline expenditures.

(2) For calendar years 2027 and beyond, the commission may modify the target and aggregate target, to be effective for a 3-year period provided that the target and aggregate target shall be approved by a two-thirds vote of the board not later than December 31 of the final calendar year of the preceding 3-year period. If the commission does not act to establish an updated target and aggregate target pursuant to this subsection, the target shall be equal to a 30 per cent increase above baseline expenditures, and the aggregate target shall be equal to a 30 per cent increase above aggregate baseline expenditures until such time as the commission acts to modify the target and aggregate target. If the commission modifies the target and aggregate

target, the modification shall not take effect until the 3-year period beginning with the next full calendar year.

(c) Prior to establishing the target and aggregate target, the commission shall hold a public hearing. The public hearing shall be based on the report submitted by the center under section 16(a) of chapter 12C, comparing the actual aggregate expenditures on primary care and behavioral health services to the aggregate target, any other data submitted by the center and such other pertinent information or data as may be available to the board. The hearing shall examine the performance of health care entities in meeting the target and the commonwealth's health care system in meeting the aggregate target. The commission shall provide public notice of the hearing at least 45 days prior to the date of the hearing, including notice to the joint committee on health care financing. The joint committee on health care financing may participate in the hearing. The commission shall identify as witnesses for the public hearing a representative sample of providers, provider organizations, payers, community-based organizations, and such other interested parties as the commission may determine. Any other interested parties may testify at the hearing.

SECTION 21. Paragraph (15) of subsection (c) of section 15 of said chapter 6D, as so appearing, is hereby amended by striking out, in line 168, "and".

SECTION 22. Said subsection (c) of said chapter 6D, as so appearing, is hereby amended by inserting after said paragraph (15) the following paragraphs:-

(16) to ensure ACOs demonstrate compliance with standards that meet or exceed the national culturally and linguistically appropriate services standards of the United States

Department of Health and Human Services, which also take into account care that is delivered in-person or via telehealth;

(17) to ensure ACOs demonstrate compliance with standards that meet or exceed the standards to attain the certification of the National Committee for Quality Assurance for the distinction in multicultural health care, which also take into account care that is delivered in-person or via telehealth; and.

SECTION 23. Said subsection (c) of section 15 of said chapter 6D, as so appearing, is hereby amended by redesignating paragraph (16), as inserted by section 15 of chapter 224 of the acts of 2012, as paragraph (18).

SECTION 24. The General Laws are hereby amended by inserting after chapter 6E the following chapter:-

CHAPTER 6F

EXECUTIVE OFFICE OF EQUITY

Section 1. Definitions

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

“Data dashboards”, information management tools used to track, analyze, and display in a user-friendly and accessible format important performance indicators, metrics, and data points for review by the general public and others.

"Equity", the consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have historically been denied such treatment, including: (1) Black, Latino, Indigenous and Native American persons, Asian Americans and Pacific Islanders, and other persons of color; (2) members of religious minorities; lesbian, gay, bisexual, transgender, and queer persons; (3) persons with disabilities; persons who live in rural areas; and (4) persons otherwise adversely affected by persistent poverty or inequality.

"Health equity", the state in which everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health and to health care services. Achieving health equity requires focused and ongoing efforts to address historical and contemporary injustices such as poverty and racism and efforts to address social determinants of health, including lack of access to good jobs with fair pay, quality education, safe and affordable housing, public transportation, safe and healthy environments, and health care. For the purposes of measurement, advancing health equity means reducing and ultimately eliminating disparities in health outcomes that adversely affect underserved, excluded, or marginalized groups.

"Office", executive office of equity.

"Secretary", secretary of equity.

"Social determinants of health", the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health outcomes, functioning, and quality-of-life outcomes and risks, including economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community contexts.

Section 2. Establishment of office

There shall be an executive office of equity, which shall serve directly under the governor.

Section 3. Principal agency of executive department; purposes

The executive office of equity shall serve as the principal agency of the executive department for the following purposes:

(a) leading efforts toward equity, diversity, and inclusion across state government, within each executive office, and throughout the commonwealth; promoting access to equitable opportunities and resources that reduce disparities; and improving outcomes statewide across state government;

(b) developing multi-year strategic plans to advance equity within each executive office;

(c) developing standards for the collection, analysis, and public reporting of disaggregated data by race, ethnicity, language, and other socio-demographic factors as it pertains to tracking population level outcomes of communities; and creating statewide and executive office-specific process and outcome measures using outcome-based methodologies to determine the effectiveness of agency programs and services on reducing disparities;

(d) developing and implementing equity impact analyses at the request of any constitutional, executive, or legislative office and from time to time as deemed necessary by the secretary;

(e) creating and publishing data dashboards stratified and disaggregated by race, ethnicity, language, and other socio-demographic factors. Said dashboards shall include data

relative to population level outcomes and to the process and outcome measures described in subsection (c) as well as any additional data the office deems important for the general public and decision makers. These dashboards shall comply with applicable privacy law but shall be publicly presented in a user-friendly format, with a focus on ensuring accessibility in its design; and

(f) coordinating with quasi-public entities in the commonwealth, including the health policy commission under chapter 6D and the center for health information and analysis under chapter 12C, for the purposes described in subsection (a).

Section 4. Secretary of equity; appointment; salary; powers and duties; undersecretaries of equity

The governor shall appoint the secretary of equity. Said secretary shall serve at the pleasure of the governor, shall receive such salary as the governor may determine, and shall devote full time to the duties of this office.

The secretary, in consultation with each respective secretary of each Massachusetts executive office, shall appoint an undersecretary of equity to assist each other Massachusetts executive office in applying an equity lens in all aspects of agency decision making, including service delivery, program development, policy development, and budgeting. The secretary shall appoint an undersecretary of equity for administration and finance, an undersecretary of equity for education, an undersecretary of equity for energy and environmental affairs, an undersecretary of equity for health and human services, an undersecretary of equity for housing, an undersecretary of economic development, an undersecretary of equity for labor and workforce development, an undersecretary of equity for public safety and security, an

undersecretary of equity for transportation, an undersecretary of equity for veterans affairs, and an undersecretary of equity for climate innovation and resilience. Each person appointed as an undersecretary shall serve at the pleasure of her appointing secretary, shall have experience, and shall know the field or functions of such position.

The undersecretaries shall provide assistance to the executive offices by:

(a) facilitating information sharing between agencies related to diversity, equity, and inclusion;

(b) convening work groups or stakeholder advisory boards as needed;

(c) developing and providing assessment tools for agencies to use in the development and evaluation of agency programs, services, policies, and budgets;

(d) training the appropriate executive office staff on how to effectively use the assessment tools developed under subsection (c), including developing guidance on how to apply an equity lens to the executive office's work when carrying out duties under this chapter;

(e) developing a form that will serve as each appropriate executive office's diversity, equity, and inclusion plan, required to be submitted by the secretary of the executive office of equity under section 7 in a manner and at frequency determined appropriate by the undersecretaries. The office must post each final plan on the dashboard described in section 3;

(f) maintaining an inventory of the appropriate executive office's work in the area of diversity, equity, and inclusion; and

(g) compiling and creating resources for executive offices to use as guidance when carrying out the requirements of this chapter.

Section 5. Advisory board

(a) There shall be an advisory board to the executive office of equity. The advisory board shall consist of: 3 persons appointed by the governor; 3 persons appointed by the president of the senate; 3 persons appointed by the speaker of the house of representatives; 3 persons appointed by the Massachusetts Black and Latino Legislative Caucus; 1 person appointed by the Secretary of Administration and Finance who shall have expertise in economic matters; 1 person appointed by the Secretary of Education who shall have expertise in education matters; 1 person appointed by the Secretary of Energy and Environmental Affairs who shall have expertise in environmental justice; 1 person appointed by the Secretary of Health and Human Services who shall have expertise in health equity and the social determinants of health; 1 person appointed by the Secretary of Housing who shall have expertise in housing policy; 1 person appointed by the Secretary of Economic Development who shall have expertise in economic development policy; 1 person appointed by the Secretary of Labor and Workforce Development who shall have expertise in labor and workforce development policy; 1 person appointed by the Secretary of Public Safety and Security who shall have expertise in criminal justice matters; 1 person appointed by the Secretary of Transportation who shall have expertise in transportation matters; 1 person appointed by the Secretary of Veterans Affairs who shall have expertise in matters related to veterans, and 1 person appointed by the Secretary of Office of Climate Innovation and Resilience who shall have experience in climate matters.

All members of the advisory board shall be residents of the commonwealth who are not employed by the commonwealth who have demonstrated a commitment to advancing equity and expertise in utilizing policy, systems and environmental strategies to address inequities. Criteria for selection of members shall consider diversity of geography; diversity of race and ethnicity;

diversity of age; inclusion of individuals living with disabilities; and inclusion of individuals from the LGBTQ+ community. All members must have expertise in utilizing policy, systems and environmental strategies to address inequities. Members shall be considered special state employees for purposes of chapter 268A. All community representatives serving on the board shall be compensated for their time. The appointing authorities shall confer prior to making final appointments to ensure compliance with this provision.

(b) A member of the board shall serve a term of 3 years and until they vacate their membership or until a successor is appointed. Vacancies in the membership of the board shall be filled by the original appointing authority for the balance of the unexpired term.

(c) The board shall annually elect from among its members a chair, a vice chair, a treasurer, and any other officers it considers necessary. Notwithstanding the foregoing, the members of the board shall receive no compensation for their services; provided however that members shall be reimbursed for any usual and customary expenses incurred in the performance of their duties.

(d) The board shall advise the executive office of equity on the overall operation and policies of the office.

(e) The board shall meet no less than quarterly to discuss and debate matters related to the overall operation and policies of the executive office of equity.

(f) The board may request information and assistance from executive offices as the board requires.

Section 6. Strategic Plan; data dashboards; equity impact analysis

(a) The secretary, in collaboration with other secretaries in the governor's cabinet, shall develop a multi-year equity strategy to improve equity across government and the commonwealth, including improved access to affordable health care, quality food and housing, safe communities, quality education, employment for which people are paid a living wage and that includes good working conditions, and affordable transportation and child care.

(b) Notwithstanding any general or special law to the contrary, the secretary, in collaboration with other secretaries in the governor's cabinet, shall publish and regularly update data dashboards on the executive office of equity's website. To the extent possible, all data dashboards shall include data able to be disaggregated by (1) gender; (2) race; (3) ethnicity; (4) primary city or town of residence; (5) age; (6) disability; (7) primary language; (8) occupation; and (9) any other demographic information that the secretary deems important to understand inequities and disparities in the commonwealth.

(c) The secretary, in collaboration with other secretaries in the governor's cabinet, shall develop and implement equity impact analyses at the request of any constitutional, executive, or legislative office and from time to time as deemed necessary by the secretary. Equity impact analyses shall include, at a minimum, and to the extent that information is available, an analysis of whether the proposed policy is likely to promote or undermine equity, including health equity, in the commonwealth. Equity impact analyses may consider:

(1) direct impacts on disparities, inequities, the social determinants of health, and the determinants of equity, with special attention to the impacts on populations that have experienced marginalization or oppression;

(2) the quality and relevance of studies to evaluate said impacts;

(3) the availability of measures that would minimize any anticipated adverse equity consequences;

(4) the existence of adverse short-term and long-term equity consequences that cannot be avoided should the proposed policy be implemented;

(5) the availability of reasonable alternatives to the proposed policy; and

(6) the impact of the proposed policy on factors, including:

(A) income security, including adequate wages, relevant tax policies, access to affordable health insurance, retirement benefits, and paid leave;

(B) food security and nutrition, including food assistance program eligibility, enrollment, and assessments of food access and rates of access to unhealthy food and beverages;

(C) child development, education, and literacy rates, including opportunities for early childhood development and parenting support, rates of graduation compared to dropout rates, college attainment and adult literacy;

(D) housing, including access to affordable, safe and healthy housing; housing near parks and with access to healthy foods; and housing that incorporates universal design and visitability features;

(E) environmental quality, including exposure to toxins in the air, water and soil;

(F) accessible built environments that promote health and safety, including mixed-used land; active transportation such as improved pedestrian, bicycle and automobile safety; parks and green space; and healthy school siting;

(G) health care access, including accessible chronic disease management programs, access to affordable, high-quality health and behavioral health care, and the recruitment and retention of a diverse health care workforce;

(H) prevention efforts, including community-based education and availability of preventive services;

(I) assessing ongoing discrimination and minority stressors against individuals and groups in populations that have experienced marginalization or oppression based upon race, gender, gender identity, gender expression, ethnicity, marital status, language, sexual orientation, disability, and other factors, including discrimination that is based upon bias and negative attitudes of health professionals and providers;

(J) neighborhood safety and collective efficacy, including rates of violence, increases or decreases in community cohesion, and collaborative efforts to improve the health and well-being of the community;

(K) culturally appropriate and competent services and training in all sectors, including training to eliminate bias, discrimination and mistreatment of persons in populations that have experienced marginalization or oppression;

(L) linguistically appropriate and competent services and training in all sectors, including the availability of information in alternative formats such as large font, braille and American Sign Language; and

(M) accessible, affordable and appropriate mental health services.

Section 7. Annual Report

The secretary shall, on or before the first Wednesday in December of each year, submit a report to the governor, the president of the senate, the speaker of the house of representatives, the chair of the senate committee on ways and means, and the chair of the house committee on ways and means. Such report shall list and discuss the proposals which have been made and the accomplishments which have been achieved during the preceding two years towards advancing equity within the executive office of equity, each other executive office and throughout the commonwealth. Said report shall contain a summary of the objectives of such proposals, their disposition, and such further recommendations for legislative or executive actions concerning these proposals or additional proposals as, in the judgment of the secretary, should be made to improve equity in the programs, services and business affairs of the commonwealth.

SECTION 25. Section 1 of said chapter 12C, as appearing in the 2020 Official Edition, is hereby amended by inserting after the definition of "Health care services" the following definition:-

"Health equity", as defined in section 1 of chapter 6F.

SECTION 26. Said section 1 of said chapter 12C, as so appearing, is hereby further amended by inserting after the definition of "Primary service area" the following definition:-

"Priority population", as defined in section 1 of chapter 6D.

SECTION 27. Subsection (a) of section 2A of said chapter 12C, as so appearing, is hereby amended by inserting after "cybersecurity", in line 9, the following words:- and 1 of whom shall have professional experience related to health equity and be Black, Indigenous, or a person of color.

SECTION 28. Paragraph (4) of subsection (c) of said section 2A of said chapter 12C, as so appearing, is hereby amended by striking out, in line 42, “center” and inserting in place thereof the following words:- center, including research and analysis concerning health disparities and health equity for priority populations of the commonwealth.

SECTION 29. Said section 2A of said chapter 12C, as so appearing, is hereby amended in paragraph (5) by striking out, in line 47, “and”, in paragraph (6) by striking out, in line 50, “.” and inserting in place thereof the following “; and”, and by inserting after said paragraph (6) the following new paragraph:-

(7) develop a process to hold annual public hearings to obtain input relating to health equity research and analysis priorities from healthcare consumers in the commonwealth, and it shall be the goal of the council for such hearings to obtain input from priority populations, the health disparities council under section 16O of chapter 6A, the division of medical assistance, and the department of public health. The council shall analyze the input received for the purposes of inclusion in the annual report described in section 16(a).

SECTION 30. Clause (v) of section 3 of said chapter 12C, as so appearing, is hereby amended by striking out, in line 25, the following word:- “and”, and in clause (vi) by striking out, in line 27, “.” and inserting in place thereof:- ; (vii) to conduct research to improve the center’s understanding of: (I) barriers to health equity data collection under sections 10A; and (II) how to restore trust and respectfully engage with individuals from priority populations who are paid participants in such research; and (viii) to conduct research to improve the center’s understanding of how racial ethnic, cultural, and linguistic diversity in the healthcare workforce impacts health care access and care quality for priority populations. The center shall prepare a

report on the research described in clauses (vii) and (viii), which shall include recommendations for policy improvements based on the center's improved understanding and plans to implement such improvements.

SECTION 31. Said section 3 of said chapter 12C, as so appearing, is hereby amended by inserting after the first paragraph the following paragraph:-

The executive director shall appoint and may remove a chief health equity officer to assist in the carrying out of powers and duties under this chapter relating to reducing health inequities experienced by priority populations.

SECTION 32. Chapter 12C of the General Laws is hereby amended by inserting after section 10 the following section:-

Section 10A. (a) The center shall promulgate regulations that identify the types of entities specified in sections 8, 9, and 10 which the center determines possess data necessary to analyze health inequities experienced by priority populations in the commonwealth.

(b)(1) The center shall promulgate regulations necessary to ensure, to the extent practicable, the uniform reporting of information from such entities identified pursuant to the regulations described in subsection (a) and any other information the center determines appropriate. In promulgating such regulations, the center shall consult with: (A) the department of public health; and (B) the division of medical assistance.

(2) To ensure that standards with respect to health equity data for accountable care organizations under MassHealth are incorporated into such regulations, the regulations shall specify standardized measures for data collection to: (A) standardize and strengthen social risk

factors data collection, including race (including meaningful capture of multi-racial), ethnicity, language, disability, sexual orientation, gender identity, ZIP code or census tract, and health-related social needs; (B) maintain robust structures to identify and understand disparities, including through stratified reporting on key performance indicators; and (C) account for social determinants of health, including food insecurity, housing stability, and community violence.

(c) The center shall provide technical assistance to such entities to ensure the data is reported in a manner consistent with such regulations.

(d) The center shall analyze such data and input received pursuant to subsection (b) and section 2A(c)(7), respectively.

(e) The center shall coordinate with the office of equity with respect to such data for the purpose of section 6 of chapter 6F.

SECTION 33. Section 11 of said chapter 12C, as so appearing, is hereby amended by striking out, in line 2, “sections 8, 9 and 10” and inserting in place thereof the following words:- sections 8, 9, 10, and 10A.

SECTION 34. Section 16 of said chapter 12C, as so appearing, is hereby amended by striking out subsection (a) and inserting in place thereof the following subsection:-

(a) The center shall publish an annual report based on the information submitted under this chapter concerning health care provider, provider organization and private and public health care payer costs and cost trends, section 13 of chapter 6D relative to market power reviews and section 15 relative to quality data. The center shall compare the costs, cost trends, and expenditures with the health care cost growth benchmark established under section 9A of said

chapter 6D, analyzed by regions of the commonwealth, and shall compare the costs, cost trends, and expenditures with the aggregate primary care and behavioral health expenditure targets established under section 9A of said chapter 6D, and shall detail: (1) baseline information about cost, price, quality, utilization and market power in the commonwealth's health care system; (2) cost growth trends for care provided within and outside of accountable care organizations and patient-centered medical homes; (3) cost growth trends by provider sector, including but not limited to, hospitals, hospital systems, non-acute providers, pharmaceuticals, medical devices and durable medical equipment; provided, however, that any detailed cost growth trend in the pharmaceutical sector shall consider the effect of drug rebates and other price concessions in the aggregate without disclosure of any product or manufacturer-specific rebate or price concession information, and without limiting or otherwise affecting the confidential or proprietary nature of any rebate or price concession agreement; (4) factors that contribute to cost growth within the commonwealth's health care system and to the relationship between provider costs and payer premium rates; (5) primary care and behavioral health expenditure trends as compared to the aggregate baseline expenditures, as defined in section 1 of said chapter 6D; (6) the proportion of health care expenditures reimbursed under fee-for-service and alternative payment methodologies; (7) the impact of health care payment and delivery reform efforts on health care costs including, but not limited to, the development of limited and tiered networks, increased price transparency, increased utilization of electronic medical records and other health technology; (8) the impact of any assessments including, but not limited to, the health system benefit surcharge collected under section 68 of chapter 118E, on health insurance premiums; (9) trends in utilization of unnecessary or duplicative services, with particular emphasis on imaging and other high-cost services; (10) the prevalence and trends in adoption of alternative payment

methodologies and impact of alternative payment methodologies on overall health care spending, insurance premiums and provider rates; (11) the development and status of provider organizations in the commonwealth including, but not limited to, acquisitions, mergers, consolidations and any evidence of excess consolidation or anti-competitive behavior by provider organizations; and (12) the impact of health care payment and delivery reform on the quality of care delivered in the commonwealth.

As part of its annual report, the center shall report on price variation between health care providers, by payer and provider type. The center's report shall include: (1) baseline information about price variation between health care providers by payer including, but not limited to, identifying providers or provider organizations that are paid more than 10 per cent above or more than 10 per cent below the average relative price and identifying payers which have entered into alternative payment contracts that vary by more than 10 per cent; (2) the annual change in price variation, by payer, among the payer's participating providers; (3) factors that contribute to price variation in the commonwealth's health care system; (4) the impact of price variations on disproportionate share hospitals and other safety net providers; and (5) the impact of health reform efforts on price variation including, but not limited to, the impact of increased price transparency, increased prevalence of alternative payment contracts and increased prevalence of accountable care organizations and patient centered medical homes.

As part of its annual report, the center shall report on data and information received pursuant to section 10A and input received pursuant to section 2A(c)(7), including an analysis of the factors that may lead to health inequities for priority populations.

The center shall publish and provide the report to health policy commission at least 30 days before any hearing required under section 8 of chapter 6D. The center may contract with an outside organization with expertise in issues related to the topics of the hearings to produce this report.

The center shall publish the aggregate baseline expenditures starting in the 2024 annual report.

The center, in consultation with the commission, shall hold a public hearing and adopt or amend rules and regulations establishing the methodology for calculating baseline and subsequent years' expenditures for individual health care entities within 90 days of the effective date.

The center, in consultation with the commission, shall determine the baseline expenditures for individual health care entities and shall report to each health care entity its respective baseline expenditures by not less than thirty days before publishing the results.

SECTION 35. Subsection (c) section 2GGGG of chapter 29 of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by striking out, in line 36, "and (6) to improve the affordability and quality of care" and inserting in place thereof the following words:- (6) to improve the affordability and quality of care; and (7) to reduce identified disparities or otherwise advance equity in care delivery.

SECTION 36. Chapter 111 of the General Laws is hereby amended by inserting after section 2J the following sections:-

Section 2K. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:-

“Environmental justice population”, as defined in section 62 of chapter 30.

"Health equity zone", a contiguous geographic area that: (1) demonstrates measurable and documented health inequities and poor health outcomes (including disproportionately high rates of maternal mortality and morbidity, infant and child health conditions, or chronic and infectious disease in the general population); and (2) meets criteria to be an environmental justice population or other definition of social inequity as determined by the department.

(b) There shall be established and set upon the books of the commonwealth a separate fund to be known as the Health Equity Zone Trust Fund to be expended, without further appropriation, by the department of public health. The fund shall consist of revenues collected by the commonwealth including: (1) any revenue from appropriations or other monies authorized by the general court and specifically designated to be credited to the fund; (2) any fines and penalties allocated to the fund under the General Laws; (3) any funds from public and private sources such as gifts, grants and donations to further community-based prevention activities; (4) any interest earned on such revenues; and (5) any funds provided from other sources.

The commissioner of public health, as trustee, shall administer the fund. The commissioner, in consultation with the Health Equity Zone Advisory Board established under section 2L, shall make expenditures from the fund consistent with subsection (e).

(c) Revenues deposited in the fund that are unexpended at the end of the fiscal year shall not revert to the General Fund and shall be available for expenditure in the following fiscal year.

(d) All expenditures from the Health Equity Zone Trust Fund shall support the state's efforts to address health disparities and develop a stronger evidence base of effective place-based health equity interventions.

(e) The purpose of the Health Equity Zone Trust Fund is to enable the creation of so-called health equity zones, namely geographic areas where existing opportunities emerge and investments are made to address inequities in health outcomes. The Health Equity Zone Trust Fund will equip multi-sector partnerships which may include residents, businesses, community-organizations, municipal agencies to identify and create community determined solutions necessary to create just and fair conditions for health. Investments shall prioritize investment in the communities that have been systematically oppressed and where decades of disinvestment have created inequitable health outcomes.

The commissioner shall award not less than 85 per cent of the Health Equity Zone Trust Fund through a competitive grant process to municipalities, community-based organizations, regional-planning agencies that apply for the implementation, technical assistance, and evaluation of health equity activities. To be eligible to receive a grant to lead Health Equity Zone under this subsection, a recipient shall be: (1) a community-based organization or group of community-based organizations working in collaboration; (2) a community-based organization working in collaboration with 1 or more municipality; or (3) a regional planning agency. Expenditures from the fund for such purposes shall supplement and not replace existing local, state, private or federal public health-related funding.

(f) Priority shall be given to proposals in a geographic region of the state with a higher than average prevalence of preventable health conditions, as determined by the commissioner of

public health, in consultation with the Health Equity Zone Advisory Board. If no proposals were offered in areas of the state with particular need, the department shall ask for a specific request for proposal for that specific region. If the commissioner determines that no suitable proposals have been received, such that the specific needs remain unmet, the department may work directly with municipalities or community-based organizations to develop grant proposals.

The department of public health shall, in consultation with the Health Equity Zone Advisory Board, develop guidelines for an annual review of the progress being made by each grantee. Each grantee shall participate in any evaluation or accountability process implemented or authorized by the department, provided, however, that the department shall make evaluation and accountability processes as minimally burdensome as is possible.

(g) The department of public health shall, annually on or before January 31, report on expenditures from the Health Equity Zone Trust Fund. The report shall include, but not be limited to: (1) the revenue credited to the fund; (2) the amount of fund expenditures attributable to the administrative costs of the department of public health; (3) an itemized list of the funds expended through the competitive grant process and a description of the grantee activities; (4) the results of the evaluation assessing the activities funded through grants; and (5) an itemized list of expenditures used to support place-based health equity interventions. The report shall be provided to the chairpersons of the house and senate committees on ways and means and the joint committee on public health and shall be posted on the department of public health's website.

(h) The department of public health shall, under the advice and guidance of the Health Equity Zone Advisory Board, annually report on its strategy for administration and allocation of

the fund, including relevant evaluation criteria. The report shall set forth the rationale for such strategy.

(i) The department of public health shall promulgate regulations necessary to carry out this section.

Section 2L. There shall be a Health Equity Zone Advisory Board to make recommendations to the commissioner concerning the administration and allocation of the Health Equity Zone Trust Fund established in section 2K, establish evaluation criteria and perform any other functions specifically granted to it by law.

The board shall consist of: the commissioner of public health or a designee, who shall serve as co-chairperson; and 10 persons to be appointed by the commissioner through a public nomination process, 4 of whom shall be community representatives with lived experience of health inequities in their communities (one of whom shall serve as co-chair); 1 of whom shall be a person with expertise in the field of health equity; 1 of whom shall be a person from a local board of health for a city or town with a population greater than 50,000; 1 of whom shall be a person of a board of health for a city or town with a population of fewer than 50,000; 1 of whom shall be a person from a hospital association; 1 of whom shall be a person from a statewide public health organization; 1 of whom shall be a representative of a community development corporation or association representing community development corporations and 1 of whom shall be a community health worker or a person from an association representing community health workers. Criteria for selection of members shall consider diversity of geography; diversity by race and ethnicity; expertise in program design and implementation; expertise in health equity; expertise in utilizing policy, systems and environmental strategies to address health

inequities. All community representatives serving on the board shall be compensated for their time at an amount determined by the Commissioner.

SECTION 37. Subsection (g) of section 25C of chapter 111 of the General Laws, as appearing in the 2020 Official Edition, is hereby amended, by inserting after “account”, in line 103, the following words:- the findings of the health equity assessment described in subsection (o) and.

SECTION 38. Said subsection (g) of section 25C of chapter 111, as so appearing, is hereby amended by striking out, in line 104, “from” and inserting in place thereof the following words:- “from the office of equity,”.

SECTION 39. Said section 25C of chapter 111, as so appearing, is hereby amended, by inserting after subsection (n) the following subsection:-

(o) A determination of need under this section shall take into account a health equity assessment, which shall be included in the application described in subsection (h). Such application shall include: (1) a demonstration of whether, and if so how, the extent to which such populations in the applicant’s service area access the applicant’s facility or services at the time of the application and the extent to which the proposed construction or change of services is expected to impact that access; (2) a description of the amount of indigent care, both free and below cost, that will be offered by the applicant if the construction or service change is approved; (3) an assessment of any impacts on access by public or private transportation, including applicant-sponsored transportation services, to the applicant’s facility if the construction or change in services is implemented, highlighting access by public transportation; and (4) a description of the proposed means of assuring effective communication between the

applicant's facility, health-related service staff, people of limited English-speaking ability, and those with speech, hearing or visual impairments handicaps if the construction or change in services is implemented.

SECTION 40. Clause (ii) of paragraph (4) of subsection (a) of section 25L of chapter 111, as so appearing, is hereby amended by striking out, in line 47, "comprehensive recruitment initiatives" and inserting in place thereof the following words:- comprehensive recruitment initiatives (including initiatives to support the recruitment and retention of individuals, notwithstanding immigration status, who work in health care settings and are not traditionally recipients of scholarship and student loan repayment programs).

SECTION 41.Chapter 112 of the General Laws is hereby amended by inserting after section 51A the following section:-

Section 51B. (a) As used in this section, the following words shall have the following meanings:

"Board", each board of registration authorized to establish continuing education requirements for healthcare professions under this chapter (as determined by the commissioner of public health) and the Massachusetts Board of Registration in Medicine.

"Cultural safety", an examination by health care professionals of themselves and the potential impact of their own culture on clinical interactions and health care service delivery. This requires individual health care professionals and health care organizations to acknowledge and address their own biases, attitudes, assumptions, stereotypes, prejudices, structures, and characteristics that may affect the quality of care provided. In doing so, cultural safety encompasses a critical consciousness where health care professionals and health care

organizations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities, and as measured through progress towards achieving health equity. Cultural safety requires health care professionals and their associated health care organizations to influence health care to reduce bias and achieve equity within the workforce and working environment.

"Structural competency", a shift in medical education away from pedagogic approaches to stigma and inequalities that emphasize cross-cultural understandings of individual patients, toward attention to forces that influence health outcomes at levels above individual interactions. Structural competency reviews existing structural approaches to stigma and health inequities developed outside of medicine and proposes changes to United States medical education that will infuse clinical training with a structural focus.

(b) By January 1, 2026, the board shall adopt rules requiring a licensee to complete health equity continuing education training at least once every four years.

(c) Health equity continuing education courses may be taken in addition to or, if the board determines the course fulfills existing continuing education requirements, in place of other continuing education requirements imposed by the board.

(d)(1) The secretary and the board must work collaboratively to provide information to licensees about available courses. The secretary and board shall consult with patients and communities with lived experiences of health inequities or racism in the health care system and relevant professional organizations when developing the information and must make this information available by July 1, 2025. The information should include a course option that is free of charge to licensees.

(2) By January 1, 2026, the department, in consultation with the board, shall adopt model rules establishing the minimum standards for continuing education programs meeting the requirements of this section. The department shall consult with patients and communities with lived experience of health inequities or racism in the health care system, relevant professional organizations, and the board in the development of these rules.

(3) The minimum standards must include instruction on skills to address the structural factors, such as bias, racism, and poverty, that manifest as health inequities. These skills include individual-level and system-level intervention, and self-reflection to assess how the licensee's social position can influence their relationship with patients and their communities. These skills enable a health care professional to care effectively for patients from diverse cultures, groups, and communities, varying in race, ethnicity, gender identity, sexuality, religion, age, ability, socioeconomic status, and other categories of identity. The courses must assess the licensee's ability to apply health equity concepts into practice. Course topics may include, but are not limited to: (A) strategies for recognizing patterns of health care disparities on an individual, institutional, and structural level and eliminating factors that influence them; (B) intercultural communication skills training, including how to work effectively with an interpreter and how communication styles differ across cultures; (C) implicit bias training to identify strategies to reduce bias during assessment and diagnosis; (D) methods for addressing the emotional well-being of children and youth of diverse backgrounds; (E) ensuring equity and antiracism in care delivery pertaining to medical developments and emerging therapies; (F) structural competency training addressing five core competencies, which are: (i) recognizing the structures that shape clinical interactions; (ii) developing an extra clinical language of structure; (iii) rearticulating

cultural formulations in structural terms; (iv) observing and imagining structural interventions; and (v) developing structural humility; and (G) cultural safety training.

(e) The board may adopt rules to implement and administer this section, including rules to establish a process to determine if a continuing education course meets the health equity continuing education requirement established in this section.

SECTION 42. Chapter 118E of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by adding after section 16D the following sections:-

Section 16E. (a) Notwithstanding any other law, there is hereby established a program of comprehensive health coverage for children and young adults under the age of 21 who are residents of the commonwealth, as defined under section 8 of this chapter, who are not otherwise eligible for comprehensive benefits under Title XIX or XXI of the Social Security Act or under the demonstration pursuant to Section 9A of this chapter solely due to their immigration status. Children and young adults shall be eligible to receive comprehensive MassHealth benefits equivalent to the benefits available to individuals of like age and income under categorical and financial eligibility requirements established by the executive office pursuant to said Title XIX and Title XXI.

(b) The executive office shall maximize federal financial participation for the benefits provided under this section, however benefits under this section shall not be conditioned on the availability of federal financial participation.

(c) The program shall be implemented no later than January 1, 2025.

Section 16F. (a) Notwithstanding any other law, there is hereby established a program of comprehensive health coverage for individuals who are residents of the commonwealth, as defined under section 8 of chapter 118E, who are not otherwise eligible for comprehensive benefits under Title XIX or XXI of the Social Security Act or under the demonstration pursuant to Section 9A of chapter 118E solely due to their immigration status, except in the case of children or young adults otherwise eligible for comprehensive health coverage pursuant to section 16E. Such individuals shall be eligible to receive comprehensive MassHealth benefits equivalent to the benefits available to individuals of like age and income under categorical and financial eligibility requirements established by the Executive Office pursuant to said Title XIX and Title XXI.

(b) The Executive Office shall maximize federal financial participation for the benefits provided under this section, provided, however, that benefits under this section shall not be conditioned on the availability of federal financial participation.

(c) The program shall be implemented no later than January 1, 2025.

SECTION 43. Paragraph (5) of section 36 of chapter 118E of the General Laws, as so appearing, is hereby amended by striking out, in line 14, "." and inserting in place thereof the following:- ;.

SECTION 44. Said section 36 of said chapter 118E, as so appearing, is hereby amended by inserting after said paragraph (5) the following paragraphs:-

(6) with respect to institutional providers, agree to implement measurable diversity, equity, and inclusion initiatives (including recruitment, hiring, and retention); and

(7) with respect to institutional providers, agree to expand mental health and wellness benefits for employees.

SECTION 45. Section 76 of chapter 260 of the Acts of 2020 is hereby amended by striking out the words “Sections 63 and 69 are hereby repealed” and inserting in place thereof the following words:- Section 63 is hereby repealed.

SECTION 46. (a) Notwithstanding any general or special law to the contrary, there shall be established a program for cost-sharing eliminations for targeted high-value services, treatments and prescription drugs used to treat certain chronic conditions. In order to implement said program, the secretary of health and human services, in consultation with the secretary of equity, the commissioner of insurance, the commissioner of public health and the center for health information and analysis, shall identify one to three services, treatments and prescription drugs in total used to treat each of the following chronic conditions: diabetes, asthma, chronic obstructive pulmonary disease, hypertension, coronary artery disease, congestive heart failure, opioid use disorder, bipolar disorder, and schizophrenia.

In determining the targeted high-value services, treatments and prescription drugs, the secretary shall consider appropriate services, treatments and prescription drugs that are: (1) out-patient or ambulatory services, including medications, lab tests, procedures, and office visits, generally offered in the primary care or medical home setting; (2) of clear benefit, strongly supported by clinical evidence to be cost-effective; (3) likely to reduce hospitalizations or emergency department visits, or reduce future exacerbations of illness progression, or improve quality of life; (4) relatively low cost when compared to the cost of an acute illness or incident

prevented or delayed by the use of the service, treatment or drug; and (5) at low risk for overutilization, abuse, addiction, diversion or fraud.

The secretary may further take into consideration other independent resources or models proven effective in reducing financial barriers to high-value care.

(b) Any policy, contract or certificate of health insurance subject to chapters 32A, 118E, 175, 176A, 176B, 176G or 176Q of the General Laws shall provide coverage for the identified services, treatments and prescription drugs. Such coverage shall not be subject to any cost-sharing, including co-payments and co-insurance, and shall not be subject to any deductible, pursuant to guidance from the secretary of health and human services, notwithstanding whether an identified service or treatment was delivered in-person or via telehealth (as defined in section 79(a) of chapter 118E). The commissioner of the division of insurance shall adopt any written policies, procedures or regulations necessary to implement said program.

(c) Every two years, the center for health information and analysis shall evaluate the effect of this section and update the targeted high-value services, treatments and prescription drugs specified pursuant to subsection (a). Said evaluation shall include the impact of this section on treatment adherence, incidence of related acute events, premiums and cost sharing, overall health, long-term health costs, and other issues that the center may determine necessary. The center may collaborate with an independent research organization to conduct said evaluation. The center shall file a report on its findings, which shall be filed with the clerks of the house of representatives and senate, the joint committee on public health, the joint committee on health care financing and the house and senate committees on ways and means.

(d) The program shall be implemented no later than January 1, 2026.

SECTION 47. The first sentence of the first paragraph of section 410 of chapter 159 of the Acts of 2000 is hereby amended by striking out “upgrade skills of certified nurse's aides and entry-level workers entry-level workers” and inserting in place thereof the following words:- in nursing homes and in safety net hospitals and other providers (as determined by the Corporation).

(b) The first sentence of the second paragraph of said section 410 of said chapter 159 is hereby amended by striking out “nursing homes or consortiums of nursing homes” and inserting in place thereof the following words:- nursing homes or consortiums of nursing homes, and safety net hospitals and other providers as determined by the Corporation.

SECTION 48. Notwithstanding any general or special law to the contrary, the commissioner of public health shall revise the licensing requirements under chapter 112 of the General Laws of foreign-trained health professionals to increase healthcare access in underserved areas of the commonwealth. Such revisions shall maintain licensure standards that are substantially similar to standards applicable to domestically-trained health professionals licensed under this chapter.

SECTION 49. Notwithstanding any general or special law to the contrary, the commissioner of public health, in consultation with the assistant secretary for MassHealth, shall develop standardized, tiered, and stackable credentials for certification of lower-wage positions furnishing services funded through the MassHealth program.

SECTION 50. (a) Notwithstanding any general or special law to the contrary, the secretary of health and human services or designee shall, subject to appropriation, provide funding, in consultation with the secretary of equity and commissioner of public health, to safety

net hospitals and community-based providers with a high Medicaid payer mix (as determined by the secretary) to advance health equity and to address disparities in resources for facilities serving priority populations who predominantly rely on Medicaid. In providing such funding, the secretary shall prioritize safety net hospitals that: (1) have a high Medicaid payer mix; (2) have an average statewide average acute hospital commercial relative price of less than 0.90 (as calculated by the center for health information and analysis); and (3) are not a part of a large health system (as determined by the secretary). Such support may be used as the safety net hospital or community-based provider determines appropriate, including for such purposes as patient care operations, access, infrastructure, or capacity building.

(b) The executive office shall maximize federal financial participation for the funding under this section, provided, however, that funding under this section shall not be conditioned on the availability of federal financial participation.

SECTION 51. (a) Notwithstanding any general or special law to the contrary, the assistant secretary for MassHealth shall establish payment models that incentivize the integration of behavioral health, oral health, and pharmacy services in primary care settings under the MassHealth program.

(b) The executive office shall maximize federal financial participation for the benefits provided under this section, provided, however, that benefits under this section shall not be conditioned on the availability of federal financial participation.

SECTION 52. (a) Notwithstanding any general or special law to the contrary, the appointive boards and commissions of the commonwealth identified pursuant to subsection (b) shall, to the extent practicable, be composed of at least 50 percent women, and at least 25 percent

Black, Indigenous, or other people of color. The appointing authorities for the board shall consult each other to ensure compliance with this provision.

(b) For purposes of subsection (a), the appointive boards and commissions of the commonwealth identified in this subsection are the following:

(1) the governing board of the health policy commission under section 2 of chapter 6D of the General Laws;

(2) the advisory board to the executive office of equity under section 5 of chapter 6F of the General Laws;

(3) the health information and analysis oversight council under section 2A of chapter 12C of the General Laws;

(4) the board of registration in medicine, the board of registration of nursing, and the board of certification of community health workers under sections 10, 13, and 108 of chapter 13 of the General Laws, respectively;

(5) the public health council under section 3 of chapter 17 of the General Laws; and

(6) any other board or commission under the supervision of the commissioner of public health that the commissioner determines appropriate.

SECTION 53. Sections 5, 8, 27, and 31 shall take effect 90 days after passage of this act.

SECTION 54. Sections 6, 7, 9, 10, 11, 12, 28, 34, 40, 43, 44, 47, 48, 49, and 52 shall take effect 180 days after passage of this act.

SECTION 55. Sections 29, 32, 33, and 51 shall take effect 1 year after passage of this act.