A BLUEPRINT FOR HEALTH EQUITY

Health Equity Task Force Final Report

July 1, 2021
Established by Chapter 93 of the Acts of 2020

TABLE OF CONTENTS

LETTER FROM HEALTH EQUITY TASK FORCE CO-CHAIR

1. Executive Summary 5

IMMEDIATE ACTION

2. Ongoing Response to the COVID-19 Crisis 26
   - 2.1. Promote Vaccine Equity 26
   - 2.2. Continue and Enhance the Stop the Spread Campaign 31
   - 2.3. Address the Needs of Vulnerable Populations 32
   - 2.4. Fund Research on the Intermediate and Long-term Effects of COVID-19 35

IMMEDIATE AND INTERMEDIATE ACTION

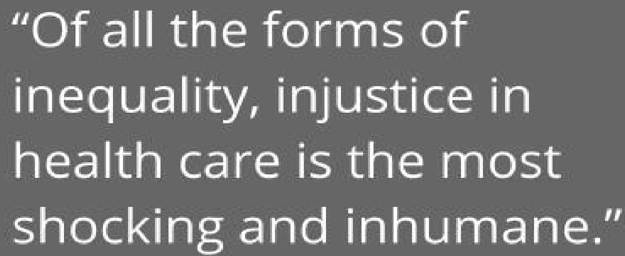
3. Strengthen Access to Quality, Affordable Health Care and Other Services 36
   - 3.1. Promote Digital Equity and Inclusion 36
   - 3.2. Expand Health Care Coverage for Immigrant Children 40
   - 3.3. Advance Equitable Resources for Safety Net Hospitals and the Communities They Serve 42
   - 3.4. Strengthen Community Health Centers 44
   - 3.5. Advance Behavioral Health Equity 46
   - 3.6. Support, Expand, and Diversify the Healthcare Workforce 54
   - 3.7. Advance Massachusetts Medicaid Opportunities to Address Health Equity 56
   - 3.8. Remove Copayment Barriers for Affordable Medications and Care to Address Health Disparities 61
   - 3.9. Improve Oral Health 62
4. Address Social Factors in Health 65
   - 4.1. Increase Food Access and Security 65
   - 4.2. Provide and Increase Emergency and Basic Income 67
   - 4.3. Assist Landlords, Homeowners and Tenants to Prevent Evictions and Foreclosure; Support Emergency Shelter 69
   - 4.4. Create Access and Inclusion for Immigrants 72
   - 4.5. Build “Communities of Opportunity” 74

ACTING NOW TO PREPARE FOR THE FUTURE

5. Strengthen the Local and State Public Health System 77
   - 5.1. Strengthen and Fund the Local Public Health System 77
   - 5.2. Support and Elevate the Massachusetts Department of Public Health 79
6. Integrate Equity and Resilience into Emergency and Disaster Preparedness 80
   - 6.1. Enact Legislation to Create a COVID-19 After Action Review with an Equity Lens 80
   - 6.2. Require the Appointment of a COVID-19 After Action Equity Commission 81
   - 6.3. Appoint A Diverse and Representative COVID-19 After Action Commission 81
   - 6.4. Retain Third-Party Experts to Facilitate and Produce COVID-19 After Action Review 82
   - 6.5. Initiate COVID-19 After Action Review Now to be Undertaken on a Rolling Basis Starting with the Review of the Vaccine Plan 82
7. Prioritize Equity in State Government 83
   - 7.1. Enact Legislation to Create and Resource a Cabinet-Level Executive Office of Equity 83
   - 7.2. Enact Provisions to Create and Resource Offices of Equity Within Every Secretariat 84
   - 7.3. Create Publicly Available Data Dashboards to Track Progress Towards Equity 85
   - 7.4. Adopt Standard Data Collection Practices Critical to Measuring Progress 86
   - 7.5. Require an Equity in All Policies/Equity impact Analysis on New Policies and Programs 88
   - 7.6. Equity Advisory Board 89
8. Conclusion 90

APPENDICES

Task Force Members 92
Legislative Charge to the Health Equity Task Force 93
Interim Report 95
Summary of Task Force Meetings, Public Hearing and Presentations 97



July 2021

We are pleased to submit this report with recommendations to the Massachusetts Legislature from the Health Equity Task Force, created by Chapter 93 of the Acts of 2020. We thank the Legislature for this important opportunity and Task Force Members for their dedicated work and contributions. We hope that these recommendations serve as a blueprint to address historic injustices that led to unequal burden of disease and death during COVID-19 for vulnerable populations.

The Task Force recognizes that as it diligently worked over the past ten months and provided ongoing input to state policymakers, the COVID-19 and response efforts have been dynamic and have rapidly evolved. The Task Force is pleased that policymakers have already implemented many initial recommendations included in the October 2020 Interim Report and those discussed in public hearings and meetings throughout this process.

This is a particularly fortuitous time to be releasing this report. The American Rescue Plan Act holds the promise to go to the heart of many of the structural inequities that led to the disproportionate impact of this pandemic. Among the Task Force’s most important recommendations are to use an equity lens in investing those funds and to use this report as a blueprint to set in motion enduring structures within state government to make durable progress to advance health equity.

If we had one guiding principle that we wish readers will take away from this report, it is that ***equity must be the “North Star” for guiding every decision about the response to and recovery from the COVID-19 pandemic.*** We have an opportunity to make significant progress to achieve this goal with concerted policy action and with the billions of dollars of new federal money coming to the state. We cannot afford to miss this opportunity.

2020 is a year that will forever be seared into the consciousness of Americans. Our nation’s collective and longstanding refusal to acknowledge the devastating effects of institutional racism on the health and life expectancy of Black, LatinX, and other diverse peoples of color can no longer be sustained.

It is now well-known that Black, LatinX and other diverse peoples of color, along with other socially vulnerable members of our society, fared far worse in the COVID-19 pandemic with significantly higher rates of infection and death.[1] In the midst of that suffering, we were further confronted with pervasive racial injustices by the tragic murder of George Floyd and many others.

The disparities in COVID-19 morbidity and mortality are the direct result of long-standing inequities in access to opportunities and resources for Black, LatinX, and diverse communities of color. These inequities have manifested through racist policies such as those that banned Black people from owning property and limited educational, social, political and economic opportunities. The stress of living with systemic racism has a dramatic and measurable impact on health and longevity, contributing to higher rates of disease.

COVID-19 has also revealed the vulnerabilities of groups such as persons with disabilities, older adults, and low-income people during a crisis. To achieve equity and remedy these historic injustices means that we need to take bold actions and place equity at the forefront of every decision. This report aims to provide a roadmap for doing so.

We are honored to serve as co-chairs of the Health Equity Task Force, created to study and make recommendations that address health disparities for a range of vulnerable populations, communities and providers during the COVID-19 pandemic. The charge included addressing all relevant factors.

The Task Force quickly decided that while it needed to respond to the immediate inequitable impacts of COVID-19, it also needed to address the underlying root causes to promote an equitable recovery and prevent such inequities in the future. We scanned the country to learn of best practices.

We are particularly proud of the recommendations that position Massachusetts to become an "equity leader" among states by building structures and systems that prioritize equity within state government so that we are never in this place again with the next pandemic or public health emergency. We do this by calling for the creation of a Cabinet level equity leader, an Equity in All Policies approach, and an After Action Review of the pandemic response with an equity lens, an equity analysis of how federal COVID-19 relief dollars are being invested, and more.

The Task Force received oral and written testimony from hundreds of individuals and organizations at three public hearings for which we are grateful. This participation and feedback provided critical lessons that are the fundamental guiding principles of this report. Two stand out loud and are clear.

First is the need for the ***community to be a partner and have a voice*** with state and local government in every aspect of planning and implementation of the COVID-19 response and recovery, and beyond. As one participant said, *"nothing about us, without us."*

The second is the need for *complete and* ***actionable data.*** This data must be stratified (and disaggregated) by race, ethnicity, language, ability, sexual orientation, gender identity, age, and geographic location. The community must participate in deciding the most important data elements to be collected. The data must be relevant, transparent, and available to the public, in order to be a driver of change. As someone else said, *"you can't change what you can't measure."*

Finally, ***returning to the pre-pandemic "normal" is not an option.*** "Normal" created the conditions that led to these disparities. Massachusetts is receiving historic amounts of federal funds to recover. This provides us a unique and historic opportunity to prioritize equity as we make decisions about how to invest those dollars. We must seize this opportunity to build a more equitable and resilient future ***for all.*** The time to act is now.

Sincerely,

---

[1] https://www.bostonindicators.org/reports/report-website-pages/covid_indicators-x2/2020/december/persisting-covid-disparities

Michael Curry, Esq.
Co-Chair
Chief Executive Officer
Massachusetts League of Community Health Centers

Assaad J. Sayah, MD
Co-Chair
Chief Executive Officer
Cambridge Health Alliance

1. EXECUTIVE SUMMARY

BACKGROUND

In June of 2020 the Massachusetts Legislature created the Health Equity Task Force in direct response to the well documented, egregious inequities in infection, hospitalization and death rates in communities of color, low-income communities and among vulnerable populations. Chapter 93 of the Acts of 2020, created the Task Force to:

> *"…study and make recommendations to the general court that address health disparities for underserved or underrepresented populations based on culture, race, ethnicity, language, disability, gender identity, sexual orientation, geographic location, including, but not limited to, gateway cities with hospitals dedicated to caring for patients who test positive for COVID-19, and age in the commonwealth during the COVID-19 pandemic." (Section 2A of Chapter 93 of the Acts of 2020)*

The Task Force was charged with developing recommendations including, but not limited to:

- Improving safety for populations at increased risk for COVID-19;
  (essential workers, individuals in congregate settings, individuals with underlying health conditions, and disproportionately impacted populations)
- Removing barriers and increasing access to quality and equitable health care services and treatment;
- Increasing access to personal protective equipment, medical supplies, and COVID-19 testing, including in diverse geographic locations;
- Providing informational materials to underserved or underrepresented populations in multiple languages on health care resources including, but not limited to prevention, testing, treatment and recovery;
- Any other factors deemed relevant by the Task Force to address health disparities for underserved or underrepresented populations based on culture, race, ethnicity, language, disability, gender identity, sexual orientation, geographic location and age; and
- further study of the impact of disparities on populations not subject to this study.

The 16-member Task Force (see appendix 9) was chaired by Michael Curry, Esq, President and Chief Executive Officer of the Massachusetts League of Community Health Centers, and Assaad Sayah, MD, Chief Executive Officer of Cambridge Health Alliance. The Task Force met 17 times, all of which were open to the public, and held 3 public hearings to obtain feedback from the general public.[2] [3]

The Task Force issued an Interim Report in October 2020 to provide timely considerations for state policy makers about immediate needs in the ongoing COVID-19 response, including further surges. The Interim Report highlighted urgent, time-sensitive key priorities for the state budget and policy action, a number of which have been adopted. The Task Force has been honored to contribute to the important policy dialogue that has informed the ongoing COVID-19 response efforts.

The interim recommendations reflected the multi-faceted COVID-19 and health equity steps needed to guide the response efforts: both to mitigate the spread of COVID-19 especially for diverse and

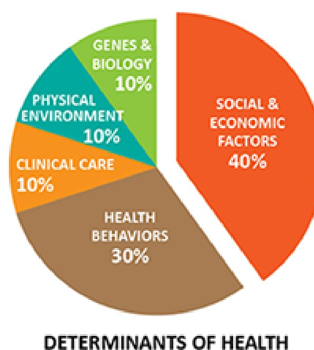
[2] https://malegislature.gov/Commissions/Detail/512/Documents
[3] https://malegislature.gov/Commissions/Detail/512/Hearings

vulnerable populations and to respond to disproportionate impacts based on learning to-date. Four major areas of focus included: 1) data and reporting for health equity-informed COVID- 19 efforts; 2) equitable COVID-19 vaccination; 3) a funding reserve account to support COVID-19 and health equity response initiatives; and 4) an array of pivotal supports to address social factors in health (food, housing, basic income), the safety of essential workers (including pandemic emergency paid sick leave) and in congregate settings, and health care access. Progress has continued in many of these areas and is carried through to this Final Report.

APPROACH

The Task Force quickly decided that while it needed to respond to the immediate inequitable impacts of COVID-19, it also needed to address the underlying root causes to advance an equitable recovery and to prevent such inequities in the future. In particular, the Task Force recognized that to achieve all of these aims required addressing the social determinants or factors that influence health.

This is because access to quality health care accounts for only 20% of health status. Social, economic, and environmental factors including where people live, work and spend time, as well as the effects of racism, account for the other 80%.



DETERMINANTS OF HEALTH

We know that there are wide gaps in income, wealth, education, neighborhood safety and other factors based on race and ethnicity in this country. An egregious example close to home is the wealth gap in Boston reported by the Federal Reserve's report The Color of Wealth. It shows the net worth of white Bostonians is $247,500 while the net worth of Black Bostonians is only $8.[4] **It is inequities like this one in wealth that lead directly to inequities in health.** Thus, the Task Force's recommendations address many of these social and economic factors, such as housing, income and food access that exacerbated the crisis for many during the pandemic.

Finally, key themes emerged over the course of the Task Force's deliberations and guided the recommendations. Among them, the voices of those most affected by this pandemic, Black and LatinX people and those with other social vulnerabilities, must guide and inform decision-making and be engaged in carrying out solutions.

Also among the key themes was, "you can't fix what you can't measure." Throughout every aspect of these proceedings, the public identified the need for more complete, granular and disaggregated data on race, ethnicity, language and other socio-demographic factors throughout every part of state government.

And finally, returning to the pre-pandemic "normal" is not an option. "Normal" created the conditions that led to these disparities. We must seize this opportunity to build a more equitable and resilient future for all.

[4] The Color of Wealth in Boston - Federal Reserve Bank of Boston

HOW THESE RECOMMENDATIONS POSITION MASSACHUSETTS TO BECOME A NATIONAL LEADER ON EQUITY

The overarching theme of these recommendations is that ***equity must be the "North Star" for guiding every decision about the response and recovery from the COVID-19 pandemic, and beyond.*** With billions of federal dollars arriving as a result of the American Rescue Plan Act, we have a unique opportunity to make significant and enduring progress on achieving this goal. **Among the most potentially impactful recommendations in this report is to develop an Equity Plan for the investment of these dollars that focus the dollars on the communities and populations with the highest rates of infection and lowest rates of vaccination and serve as a blueprint on a more equitable and resilient future for *ALL* Massachusetts residents.** We cannot afford to miss this opportunity.

In the report that follows, the Task Force is proud to offer the recommendations that address the immediate and ongoing need for vaccine equity and equity within the COVID-19 response and recovery. While many initial steps have been implemented, the Task Force felt it was important to incorporate them given the continued and significant racial and ethnic gaps in vaccination rates. There are also many recommendations that address the housing, food and income crises faced by families.

The recommendations that strengthen access to quality, affordable health care and coverage, including the long-standing underfunding of safety net and behavioral health providers and community health centers, are also critical to equitable access to care in Massachusetts, and fortifying the foundation of our health system. With deep gratitude to healthcare professionals for the extraordinary care and compassion they have provided throughout the pandemic, there are recommendations to respond to pressing workforce needs including staffing shortages, workforce diversity and to assist patients with new healthcare modalities including telehealth.

There is also a set of recommendations regarding structures and systems that lift up equity within state government. These recommendations would create a powerful opportunity for sustainable change and ongoing progress on the full range of recommendations in this report so that we are never in this place again. Specifically, the Task Force recommends:

★ CONDUCTING AN "AFTER-ACTION REVIEW" (AAR) WITH AN EQUITY LENS

After Action Reviews (AAR) are standard practice in emergency management and evaluate what worked well and what could be improved. Is it well known in the field that disasters disproportionately affect low-income persons, people of color and other vulnerable populations, yet the field does not fully account for this.

Massachusetts has the opportunity to be the first in the nation to conduct this review with an equity lens guided by an appointed Commission and a participatory process. The findings of the Commission should be filed with Legislative and Administration leadership, and the Administration should be required to respond. The Legislature should act now to require this review.

The AAR should commence immediately and be conducted on a rolling basis and completed within 12 months of the end of the public health emergency or by June 2022..

★ CREATING A CABINET-LEVEL EXECUTIVE OFFICE OF EQUITY AND A SECRETARY OF EQUITY, EQUITY OFFICES WITHIN EACH SECRETARIAT AND EQUITY ADVISORY BOARDS

The legislature should pass legislation now to ensure that equity is always central to the business of state government by creating and resourcing a cabinet level Executive Office of Equity led by a Secretary of Equity. The office should be charged with leading efforts toward equity, diversity and inclusion, including developing 3- to 5-year equity strategic plans.

The legislation should also create and resource equity offices within each secretariat with similar charges. There should be a central Equity Advisory Board and each secretariat should also have equity advisory boards.

★ THE CABINET AND SECRETARIAT EQUITY OFFICES SHOULD CREATE DATA DASHBOARDS TO MEASURE PROGRESS AND CREATE ACCOUNTABILITY

As part of the same legislation, the Task Force recommends that the Secretary of Equity create data dashboards stratified and disaggregated by race, ethnicity, language and other socio-demographic factors. The Task Force recommends modeling these dashboards on those created by the Hope Initiative that focus on opportunities within communities, rather than deficits.

★ DEVELOPING AND IMPLEMENTING AN EQUITY IN ALL POLICIES/EQUITY IMPACT ANALYSES STARTING WITH AN ANALYSIS AND PLAN FOR SPENDING FUNDS FROM THE AMERICAN RESCUE PLAN ACT

The Secretary would also be charged by the legislation to work with the Equity Advisory Board to develop an Equity in All Policies approach for evaluating the equity impacts of new policies and programs. **The Task Force calls on the Administration to develop an Equity Plan for the investment of billions of American Rescue Plan dollars available to Massachusetts.** This would once again position Massachusetts as a national equity leader. The following is an outline of all recommendations in the report, organized by topic.

2. ONGOING RESPONSE TO COVID-19

2.1. PROMOTE VACCINE EQUITY

2.1.1. EQUITY SHOULD BE THE "NORTH STAR" AND A KEY DRIVER OF AN ONGOING AND INTEGRATED RESPONSE TO THE COVID-19 PANDEMIC

The Commonwealth's COVID-19 Vaccine Equity Initiative now includes many of the components originally called for by the Task Force and in the public hearings sponsored by the Task Force, including an advisory process and a culturally and linguistically appropriate public awareness and education campaign, in partnership with trusted community organizations, local public health and health care providers.

At the outset, the Commonwealth's Vaccine Plan did not appear to prioritize equity, with a focus on large vaccination sites inaccessible to many without private transportation. However, significant progress has been made toward equity. The state's COVID-19 Vaccine Equity Initiative prioritizes the 20 hardest hit communities in the state, directing additional supply of vaccines to those communities and taking into account infection rates as well as social factors, and makes vaccines more available through mobile and local clinics, and is now working through 22 regional collaboratives.

Equity will need to remain in the forefront and all of these components will need to be continued and enhanced for youth and potential child vaccinations upon federal emergency use authorization, booster shots and/or annual vaccinations that are most likely on the horizon. Funds from the American Rescue Plan Act can supplement, enhance and continue these vaccine equity efforts.

2.1.2. Prioritize Funds from the American Rescue Plan to Enhance the Vaccine Equity Plan

Massachusetts and the nation are entering a new phase of vaccination efforts that are more targeted to bringing vaccinations to where people are through convenient and trusted provider and community relationships Additional and ongoing support and funds need to be directed to most of the components, particularly support to grassroots organizations, tailored community and faith-based outreach, support for local boards of public health, direct assistance to access vaccinations, administering vaccines in community settings, mobile vaccination, and communication materials. The Task Force strongly recommends that funds from the American Rescue Plan Act be directed to bring the components of this initiative to scale, and extend it to additional communities in need.

2.1.3. Maintain and Enhance Focus on Race, Ethnicity, and Vulnerable Populations Receiving Vaccine

The evidence is that more vaccines, as well as additional and more targeted outreach efforts, are still required. While Massachusetts is a leader in the nation on vaccinating people of color, there are still significant disparities. And while improving, communities of color are not currently being vaccinated at rates corresponding to their disproportionate COVID-19 case rates, particularly LatinX residents, even after controlling for age.

2.1.4. The Massachusetts Department of Public Health (MDPH) should prolong and continue to tailor its public education campaign to increase vaccine acceptance. This campaign should be culturally appropriate, in multiple languages, delivered by local, trusted community messengers, and tailored to address specific vulnerable populations.

The Massachusetts Department of Public Health is to be commended for launching a robust public education campaign to increase vaccine uptake in communities of color. In addition to a statewide campaign, it is positive that the campaign includes resourcing and empowering local, trusted community messengers to deliver culturally appropriate and tailored messages in multiple languages targeted to high-risk populations, including people of color (especially targeting the Black and LatinX communities), older adults, those with underlying conditions and persons with disabilities. Despite the urgency of this moment, the educational campaign will need to be prolonged as those who are deliberating about receiving vaccines make their decisions over time.

2.1.5. MDPH should contract with local community and faith-based organizations to employ ambassadors or community health workers.

The Task Force recommends the continuation and expansion of a statewide ambassador program through partnerships with local, trusted community-based organizations. Ambassadors are hired from the community, thus creating needed jobs and providing service in multiple languages. Their presence builds trust and serves as a bridge between the community, public health and the health care sectors. They can assist at clinics, link people to needed services, and participate in public messaging, outreach and education.

2.1.6. MDPH should include census tract data in their weekly vaccine dashboard.

DPH publishes weekly COVID-19 vaccination and case data by municipality, stratified by race and ethnicity and zip code. The Task Force recommends that MDPH also publish census tract data for cases and those receiving vaccines so that communities can map where outbreaks are occurring, where vaccinations are needed, and design tailored interventions.

2.2. CONTINUE AND ENHANCE THE STOP THE SPREAD CAMPAIGN

The state should continue and enhance the Stop the Spread campaign through at least calendar year 2021. Stop the Spread provides COVID-19 testing to anyone free of charge, and most sites are located in communities with high rates of infection.

Ambassadors or community health workers should be added to these sites to screen for social and economic needs and connect people to needed resources. This is also a place where people could be screened for chronic conditions and connected to health care. Many people have been unable to address these conditions during the COVID-19 pandemic. It is by offering these supports and resources that trust will be built and more people will become engaged in the process.

2.3. ADDRESS THE NEEDS OF VULNERABLE POPULATIONS

2.3.1. Essential Workers

The Task Force recommended the creation of an emergency paid sick leave policy and is pleased

that the Legislature passed Chapter 16 of the Acts of 2021. This new law creates that program.

Older Adults

Lessons learned during this pandemic are that older adults need easier access to vaccination including on site and in-home vaccination; transportation to vaccination; and assistance with scheduling. Furthermore, the pandemic highlighted important investments and delivery system reforms needed in nursing homes and long-term care facilities in light of the significant incidence and high fatality rate of COVID-19 among residents of senior care. Policy measures should also be taken to support older adults living in their homes and community settings, like the PACE program.

2.3.2. Persons with Disabilities

Persons with disabilities need to be prioritized for vaccines if their disability puts them at higher risk for COVID-19, and they need similar support as described for older adults above. It is imperative that the unique needs of persons with disabilities be incorporated in current and future pandemic planning. One such measure is promoting safety and mask wearing in buildings where a significant number of persons with disabilities and other at-risk populations live, particularly those in 40B housing.

2.3.3. Persons with Chronic or Underlying Medical Conditions

Persons with chronic and underlying medical conditions, many of which disproportionately affect persons of color, are at higher risk for COVID-19. They may also have been unable to address their underlying conditions during the pandemic. Special efforts should be made to reach out to these individuals with culturally appropriate education about the importance of vaccination to protect their health. These efforts would best be conducted by trusted, community-based organizations, faith-based organizations and other local entities that are known and trusted.

2.3.4. Incarcerated Persons

Per language in the FY'21 budget, incarcerated persons, particularly those at high risk for COVID-19, and near the end of their terms and/or at low level of risk to the community should be released to reduce risk of exposure to COVID-19. Few have been afforded this opportunity. The Task Force calls on the Administration to implement this budget language immediately and release those eligible. This practice should be extended to county houses of corrections as well. The Attorney General was also directed to appoint an ombudsperson to oversee the implementation of this policy, but there have been significant delays due to different interpretations of legislative intent between the executive and legislative branches. The Task Force calls on the Legislature to work with the Attorney General to amend the language so that this appointment can be made.

2.4. FUND RESEARCH ON THE INTERMEDIATE AND LONG-TERMS EFFECTS OF COVID-19

The Task Force recommends that the Legislature and Administration collaborate to fund plans for research and monitoring of the intermediate and long-term effects of COVID-19. This research should be conducted on the health effects, including long-haul health, behavioral health effects, the socio-economic implications of the pandemic, and ongoing response and recovery needs. Federal funding should be sought for this purpose as well.

3. STRENGTHENING ACCESS TO QUALITY, AFFORDABLE HEALTH CARE AND OTHER SERVICES

3.1. PROMOTE DIGITAL EQUITY AND INCLUSION

To close the digital divide will require more affordable broadband and higher speeds, access to devices and digital literacy. Digital access has been critical during this pandemic to access telehealth, for children to attend school and for adults to have access and information to services such as unemployment, income supports, food benefits, housing applications and more.

3.1.1. Promote Telehealth and Digital Equity for Patients

The Task Force supports expanding access to telehealth services to patients by increasing digital adoption and literacy, reducing financial barriers to accessing telehealth, expanding reimbursement parity, and requiring a public-health lens be utilized in assessments of telehealth impacts in the state. In addition, the Task Force supports policy actions to require insurers to cover interpreter services for telehealth patients with limited English proficiency or for those who are deaf or hard of hearing, waive co-pays during the pandemic, abolish prior authorization for virtual care that would not be required for in-person care, and reimburse providers for virtual care on a par with in person care. The Health Policy Commission should stratify the data in its required reports on the impact of telehealth on cost and access by race, ethnicity and other socio-demographic factors, and determine the impact on social determinants.

3.1.2. The Massachusetts Department of Telecommunications and Cable Should Work with the Massachusetts Broadband Institute and the Broadband Providers in Massachusetts to Establish Acceptable Minimum Download and Upload Speeds Provided at Affordable and Subsidized Prices.

During the pandemic households with multiple internet users often lost service because the download and upload speeds they could afford were inadequate to meet the needs of their families. This was challenging with children attempting to attend school remotely while parents simultaneously attempted to file for unemployment, for example. The Massachusetts Broadband Institute, the Massachusetts Department of Telecommunications and Cable and the Legislature should work to establish acceptable minimum speeds for service that is affordable and/or subsidized.

3.1.3. Support and Funding for Community Interventions to Make Broadband Access and Digital Devices More Affordable, and to Provide Digital Literacy Education.

The Task force urges funding in the state budget or other state/federal funding mechanisms for multi-sector community interventions to make broadband access and digital devices more affordable, and to provide digital literacy education. Across the state, digital alliances have launched local efforts to expand access to and education for use of digital services.

3.1.4. The Task Force Supports Legislation to Create a Funding Subsidy for Lifeline, a Federal Program that Supports Minimum Phone Service.

Massachusetts needs legislative action to provide a state subsidy to the Lifeline program, a federal

program that provides affordable mobile phones to eligible participants. Massachusetts is one of only 10 states that does not subsidize this program, which is currently very underutilized in this state.

3.1.5. Support and Fund for Community Interventions to Make Broadband Access and Digital Devices More Affordable, and to Provide Digital Literacy Education.

The Task Force heard presentations from two local Massachusetts efforts to expand broadband access, including Essex County and Springfield. The Task Force urges public funding to support local collaboratives to advance digital equity.

3.2. EXPAND HEALTH CARE COVERAGE FOR IMMIGRANT CHILDREN

3.2.1. Extend MassHealth CommonHealth Coverage for Immigrant Children with Disabilities

While over 98 percent of the Commonwealth's children have some form of health coverage, thousands of predominantly low-income children and young adults with disabilities, most of whom are undocumented immigrants, can only access safety net programs with strict limits on covered benefits. Legislation is urgently-needed to extend MassHealth CommonHealth to this population.

3.2.2. Expand MassHealth Coverage for All Eligible Children Regardless of Immigration Status

The ultimate goal is coverage of all children, regardless of immigration status. Toward this end, the Task Force calls for legislative action toward MassHealth coverage of all eligible children and youth, regardless of immigration status.

3.3. ADVANCE EQUITABLE RESOURCES FOR SAFETY NET HOSPITALS AND THE COMMUNITIES THEY SERVE

3.3.1. Require Commercial Rate Equity for Safety Net Hospitals and Providers as a Means to Reduce Racial and Ethnic Health Disparities

Safety net hospitals that provide care to a high proportion of Medicaid patients are not paid as much by commercial insurers for the same quality and level of services as non-safety net hospitals. This is despite the fact that safety nets serve low-income communities and the communities that have been disproportionately affected by COVID-19. Legislation is needed to require they receive at least the average commercial insurance reimbursement rates.

3.3.2. Enhance Funding for High Medicaid Safety Net Hospitals Under Medicaid Waiver Renewal

The Commonwealth is re-applying to the Centers for Medicaid and Medicare Services to renew the Medicaid 1115 Waiver. During its current term (2018-2022), this Waiver has provided supplemental payments to safety net providers and allowed for delivery system reform and innovations to achieve equity. The Task Force supports continued partnership between the Massachusetts Executive Office of Health and Human Services and safety net providers to enhance care through the renewed Waiver.

3.3.3. Sustain and Enhance Medicaid Rates for Safety Net Hospitals and Hospital-Licensed Health Centers

Sustaining Medicaid rates and reimbursement is fundamental to the care delivery of safety net health systems, including safety net hospitals and hospital-licensed health centers. Patients with public payers, including MassHealth, the Health Safety Net and others often account for 70-80% of the payer mix at these hospitals. As Massachusetts Medicaid policies are designed in the upcoming Medicaid Waiver Renewal and in the annual MassHealth Acute Hospital Request for Applications, reimbursement for safety net hospitals must be protected and enhanced.

3.3.4. Establish Equitable Global Payments/Budgets Under Alternative Payment Methods

Private health insurance spending is consistently lower on average for low-income members, who often reside in diverse communities, and higher on average for members residing in more affluent communities. This spending cannot be explained by health complexity.[5] The Task Force concurs with the Office of the Attorney General's 2020 report finding that, "COVID-19 has increased the urgency of swiftly addressing this problem by reimagining how we value and pay for health care."[6]

3.4. STRENGTHEN COMMUNITY HEALTH CENTERS

3.4.1. Invest in Health Center Rate Adequacy to Drive Access

The Task Force heard testimony about the chronic underpayment and resulting financial distress that left health centers in Massachusetts particularly vulnerable to the sudden revenue collapse brought on by COVID-19. Federal and state relief stabilized the health center network, but the financial fragility of the health center network was exposed. The Task Force recommends significantly increasing Medicaid payment for Federally-Qualified Health Centers' comprehensive, all-inclusive model of care. Policymakers should also explore commercial rate adequacy for CHCs.

3.4.2. Support Health Centers in "Growing Their Own" Workforce

The Task Force recommends supporting health centers in "growing their own" workforce. The Commonwealth should take a multipronged approach to continuing and expanding these efforts, including through MassHealth financing mechanisms, pilot programs, 1115 Waiver investments, and enactment of the Community Health Center Transformation Fund as a tool to sustain these programs.

3.5. ADVANCE BEHAVIORAL HEALTH EQUITY

3.5.1. Respond to Urgent Behavioral Health-Related COVID-19 Needs and Strengthen the Behavioral Health Delivery System

COVID-19 has starkly exposed the pre-pandemic vulnerability in the behavioral health delivery system and gaps in the continuum of care. At the same time, the need for behavioral health care has

[5] Office of Attorney General, Examination of Health Care Costs Trends and Cost Drivers: 2011 Report for Annual Public Hearing, at page 27 [AGO 2011 report], available at http://www.mass.gov/ago/docs/healthcare/2011-hcctd.pdf

[6] Office of the Attorney General, *Building Toward Racial Justice and Equity in Health: A Call to Action, 2020 at page 21,* available at https://www.mass.gov/doc/building-toward-racial-justice-and-equity-in-health-a-call-to-action/download

increased substantially during the pandemic. This has created an urgent need to build on the meaningful initial steps taken by the Administration and Legislature to develop additional mental health and substance use disorder inpatient capacity, and to expedite further capacity development along the continuum of care, including for individuals awaiting Department of Mental Health Continuing Care Treatment, outpatient care, and culturally and linguistically appropriate mental health services, especially for children and adolescents.

3.5.2. Address Behavioral Health Disparities Through a Multi-Agency/ Stakeholder Commission

The Task Force recommends a Multi-Agency/Stakeholder Commission to address the capacity of the behavioral health system and inequities that result, and to make recommendations for improvement. Behavioral health equity is a longstanding issue that will require concerted policy and societal efforts to address. Statewide, multi-agency, and cross-sector efforts in partnership with stakeholders are needed. Given the enormity of the task ahead, over multiple years, the Commission would meet not less than quarterly to map out the work, monitor progress on the pressing areas of recommendations in this report, issue publicly-available annual reports, and make legislative, regulatory or budgetary recommendations.

3.5.3. Collect and Make Publicly Available Robust Data on Behavioral Health Clinical, Demographic, and Disparities

There are disparities in access to behavioral health services across the Commonwealth depending on factors such as race/ethnicity, language, age, socioeconomic status, geography, sexual orientation, gender identity, and insurance. Yet, there is little data collected to analyze the issues and develop policy, program and resource responses. While there are recommendations for stratified data collection in section 7.4., the Task Force wants to emphasize the need to do so for persons with behavioral health diagnoses, including the need for health status indicators for persons with psychiatric diagnoses.

3.5.4. Invest in Behavioral Health Services, Including Integration with Physical Health

Behavioral health has been chronically underfunded (below the cost of care) by public and private payers. Legislation to require more sustainable behavioral health inpatient and outpatient payment rates is needed in public and private insurance. In addition, Medicaid, a predominant payer for people with behavioral health conditions, must improve its reimbursement methodology to recognize the costs of this care. Furthermore, resources should be available to integrate behavioral health within primary care and other health care services, and services such as brief consultations and recovery coaches should be reimbursed.

3.5.5. Achieve Behavioral Health Parity

The Task Force recommends legislative action toward full mental health parity in the 2021-2022 legislative session. This should include providing the state with more effective tools to enforce existing mental health parity laws. A range of policies to ensure behavioral health parity include addressing barriers to care such as preauthorization requirements for behavioral health services that are more restrictive than for medical or surgical services; applying parity in covered behavioral health services across payers; ensuring compliance through regular market conduct examinations;

enhancing opportunities and resources for consumers to assert parity rights; strengthening network adequacy standards; and requiring parity of reimbursement rates for behavioral health providers and medical providers.

3.5.6. Invest in Lasting Behavioral Health Workforce Improvements

The Task Force calls for actions to support and expand the behavioral health workforce through a variety of targeted initiatives including but not limited to expanding the student loan repayment program to include both inpatient and community-based behavioral health providers and additional behavioral health professionals, scholarships, and workforce training programs. Emphasis should be placed on growth in the behavioral health workforce that reflects the racial, ethnic and cultural diversity of the population to be served. Additional reimbursement is a critical priority to be able to recruit, retain and adequately compensate a behavioral health workforce. The Task Force supports legislation and Administrative actions to include peer support, recovery coaches, community health workers, and family partners as covered benefits in commercial insurance and within the Medicaid program, supported by federal matching funds.

3.5.7. Improve Behavioral Health Treatment at the Intersection with the Justice System

Many people intersecting with the criminal justice system suffer from behavioral health conditions. The Task Force recommends: (1) investment in alternatives to law enforcement response to divert people in behavioral health crises; (2) continued education of law enforcement officers in de-escalation techniques when interacting with individuals experiencing behavioral health distress; (3) reduction of trauma inflicted on persons who are incarcerated; and (4) vastly improved and coordinated care of individuals upon release from the justice system.

3.6. SUPPORT, EXPAND, AND DIVERSIFY THE HEALTH CARE WORKFORCE

3.6.1. Deploy State Initiatives and Funding to Advance the Health Care Workforce and Career Ladder Opportunities

The Task Force recommends state funding and initiatives, including those federally-supported under the Medicaid 1115 Waiver renewal, to provide health care career and pipeline development, student loan-forgiveness, job training and mentoring programs as pathways for current and prospective members of the healthcare workforce. The Task Force also supports initiatives to improve the process and timeliness for the licensing of healthcare professionals to practice in Massachusetts, and livable wages for essential health care workers.

3.6.2. Activate the Commission Charged with Making Recommendations on Licensing and Practice for Foreign-Trained Health Professionals

There are an estimated 3,000 foreign-trained medical professionals in Massachusetts, including physicians, nurses, dentists and other health professionals. The rich resource of highly trained but underutilized foreign-trained health professionals would not only meet a critical need for providers, but also enhance the racial and ethnic diversity, and cultural and linguistic capacity of the health care workforce, an acute need even prior to the pandemic. Last year, legislation directed the Massachusetts Department of Public Health to form a commission to review licensing and practice for foreign-trained health professionals and make recommendations. The Commission has yet to

meet. The Health Equity Task Force encourages the Governor to direct MDPH to activate this Commission as soon as possible.

3.6.3. Support Training and Initiatives that Increase Cultural Sensitivity, Address Racism, and Uncover the Implicit Bias that is Currently Rooted in the Health System

Testimony was received by the Task Force about the need for training and initiatives that increase cultural competency and sensitivity, address racism, and uncover the implicit bias that is currently rooted in the health system. Funding for statewide collaboratives is needed to carry out this training.

3.7. ADVANCE MASSACHUSETTS MEDICAID OPPORTUNITIES TO ADDRESS HEALTH EQUITY

3.7.1. Promote Maternal Health by Extending Maternal Postpartum Care Coverage in MassHealth from the Current 60 days to 12 months and Adding Doula Services

Maternal mortality, particularly among Black women, is a growing health crisis in the United States. Medicaid plays an important role in improving maternal and perinatal outcomes, covering 35% of births in Massachusetts. The American Rescue Plan Act gives states the option for 5 years to extend postpartum Medicaid/CHIP coverage for 12 months through their Medicaid State Plan or Waiver. This new option goes into effect on April 1, 2022, and MassHealth will be submitting a State Plan Amendment to request authority for the option as of April 1, 2022.[7]

In the meantime to extend postpartum coverage in the period leading up to April 2022, on March 23, 2021, Massachusetts announced its intent to file a Medicaid 1115 Waiver amendment that includes the extension of postpartum coverage the current 60 days to 12 months, including to authorize postpartum coverage for immigrant members. Should the waiver amendment be approved, Massachusetts will be a leader in providing postpartum Medicaid coverage, a critical policy lever to help address gaps in coverage and care. In order to further support pregnant women, MassHealth should be prepared to pursue Medicaid coverage for doula services through available federal authorities, including the upcoming Medicaid 1115 Waiver renewal or a Medicaid State Plan Amendment opportunity .[8] [9]

3.7.2. Integrate Health Equity Initiatives in Medicaid 1115 Waiver, including Innovations for Health-Related Social Needs and "Flexible Services"

Massachusetts' current Waiver includes a provision for "flexible services" funding that is being used to assist members in MassHealth Accountable Care Organizations with nutrition and housing, with the goal of improving health outcomes and reducing costs. These programs need to be continued and expanded to include a broader variety of services that can be tailored to address the social and economic needs of individual patients.

---

[7] https://www.mass.gov/doc/1115-masshealth-demonstration-waiver-amendment-public-listening-session-3312021-0/download

[8] https://www.congress.gov/bill/117th-congress/house-bill/1319/text#toc-H7381B14964A940089896309B190791E0

[9] https://www.mass.gov/service-details/amendment-of-1115-masshealth-demonstration-waiver-march-2021

3.7.3. Continue and Restore MassHealth Retroactive Coverage Beyond the Pandemic

While federal law allows for 90 days retroactive Medicaid coverage from the time a person applies, Massachusetts obtained a waiver to provide only 10 days of retroactive coverage. However, during the COVID-19 public health emergency, MassHealth has been providing at least 90 days of retroactive coverage. The Task Force calls on the Administration and the Legislature to take action to make permanent 90-day retroactive coverage in keeping with the federal Medicaid minimum standards of coverage.

3.7.4. Protect the Homes of Seniors and Persons with Disabilities with MassHealth through Estate Recovery Reform

Medicaid is the only public benefit program that requires the value of benefits to be recouped from a deceased enrollee's family. This is called "estate recovery" and includes the value of the family home. Estate recovery for nursing homes costs is federally mandated, but Massachusetts law goes beyond federal requirements to require estate recovery for the costs of all medical services after a MassHealth enrollee turns age 55. Maintaining home ownership can help combat intergenerational poverty and wealth inequality in communities of color. The Health Equity Task Force supports legislative action to reform MassHealth estate recovery, including but not limited to establishing that MassHealth would only recover for federally-mandated medical assistance, would establish hardship waivers, and provide information upfront to MassHealth members about estate recovery, among other necessary reforms. The federal Medicaid and CHIP Payment and Access Commission issued recent Medicaid estate recovery reform recommendations in this regard.

3.8. REMOVE COPAYMENT BARRIERS FOR AFFORDABLE MEDICATIONS AND CARE TO ADDRESS HEALTH DISPARITIES

3.8.1. Remove Copayments for Prescription Medications and Services to Prevent and Manage Chronic Health Conditions

High out-of-pocket costs and copayments for prescription drugs and medical visits can cause patients to forgo needed prescription medications and care, especially for persons with chronic health conditions, communities of color, and low-income communities. During the COVID-19 pandemic, people of color and others with underlying chronic health conditions are more susceptible to COVID-19 complications.

Removing barriers to care, such as out-of-pocket costs to affordable medications and health care services, is an important way to curb racial and other inequities, particularly related to preventive care, wellness, and chronic conditions.The Task Force encourages legislation that shifts toward a wellness system in part by removing copayment barriers in insurance design for preventive care, and care and medications for chronic conditions. Value-based insurance design that emphasizes cost sharing reductions for high-value care can be achieved without increasing premiums according to studies and an evaluation detailed in this report.

3.8.2. Enhance Patient Assistance Programs for Medications to Treat Conditions that Disproportionately Impact People of Color and are Risk Factors for COVID-19 Complications.

The Task Force supports additional legislative approaches to addressing medication affordability, particularly to treat chronic conditions that disproportionately impact people of color and other vulnerable populations, such as expanded patient medication assistance programs.

3.9. IMPROVE ORAL HEALTH

Oral health is among the deepest disparities in communities of color, low-income communities, vulnerable age groups, people with disabilities, and underserved geographic regions.

3.9.1. Sustain Full Restoration of Adult Dental Care Coverage in MassHealth

Full dental coverage for adults on MassHealth has waxed and waned since 2002. Adult dental benefits are currently restored and the restoration needs to be sustained with adequate state budget funding as an important step to address oral health needs.

3.9.2. Establish an Oral Health Commission and Statewide Needs Assessment

The Task Force recommends legislation to create a Special Legislative Commission on Oral Health, chaired and convened by the Massachusetts Commissioner of Public Health. It should be charged with (1) conducting a statewide oral health status and needs assessment, and (2) developing recommendations to address gaps in access to oral health services.

3.9.3. Enable Dental Professionals to Serve as Vaccinators

The Massachusetts Board of Registration in Dentistry provided guidance that allows dentists and certain dental hygienists to administer COVID-19 vaccinations within their scope of practice. The Task Force supports this, and encourages the continuation of dental professionals to serve as vaccinators through post-pandemic guidance.

4. ADDRESS SOCIAL FACTORS IN HEALTH

Social and economic factors are the primary drivers of inequities in health and their importance was revealed during the pandemic. Following are recommendations on the key social factors of health including food security, housing, transportation, language access, community safety for immigrants, and the environment.

4.1. INCREASE FOOD ACCESS AND SECURITY

Food insecurity in Massachusetts doubled during the pandemic, with a corresponding increase in demand on the emergency food system and with a dramatic increase in racial and ethnic disparities in food access.

4.1.1. Close the SNAP Gap

The SNAP Gap refers to the over 700,000 individuals who are MassHealth recipients and likely eligible for the Supplemental Nutrition Assistance Program (SNAP) but are not receiving the benefit. The Task Force encourages legislation that would create one application procedure for households to apply for MassHealth/Medicare Savings Program, SNAP and other benefits such as Transitional Assistance for Families with Dependent Children (TAFDC) or Emergency Aid for the Elderly, Disabled and Children (EAEDC), which would contribute to closing the gap.

4.1.2. Fully Fund the Healthy Incentives Program

The Healthy Incentives Program allows the 900,000 Massachusetts residents who rely on SNAP benefits to double the value of their benefit when they purchase fruits and vegetables from farmers' markets. The Task Force supports fully funding this program at current levels to meet demand and support local farmers.

4.1.3. Support Universal Free School Meals

During the pandemic, school meals became universally free to all students. Through state and federal actions, school meal availability has been extended. The Task Force supports requiring all schools to continue to make these meals available to all students at no charge.

4.1.4. Support for Massachusetts Hunger-Free Public Campuses

Two national surveys from 2017 and 2018 indicate more than one-third of four-year college students, and nearly half of all community college students, faced food insecurity in the previous 30 days. The Task Force supports policies that address student food insecurity and hunger across all 29 public higher education campuses.

4.1.5. Fund the Massachusetts Emergency Food Assistance Program to Support Increased Need for the Food Bank Coalition of Massachusetts

The Massachusetts Emergency Food Assistance Program supports the Food Bank Coalition of Massachusetts that provides food for a network of nearly 1,000 pantries, meal programs, shelters and mobile markets across the Commonwealth. Demand for this food has seen double-digit increases during the pandemic and there is no end in sight. The Task Force recommends that funding of $30 million be allocated for MEFAP to meet the expanded demand.

4.2. PROVIDE AND INCREASE EMERGENCY AND BASIC INCOME

Insufficient income is a long-standing challenge for the most disenfranchised in our state, and is a deeply rooted cause of multiple inequities, including inequities in health. During the pandemic, loss of income particularly impacted immigrants with no access to public benefits.

4.2.1. Provide Robust Funding for Emergency Cash Assistance in the Commonwealth's

The Emergency Cash Assistance Program provides state funding to community foundations to fund families in need. The foundations are required to match state dollars. In other words, a $10 Million state allocation provides $20 Million in family support that particularly benefits undocumented persons not eligible for other supports.

4.2.2. Make Progress Toward Eliminating Deep Poverty

"Deep Poverty" is defined as half the federal poverty level ($900 for a family of three). In Massachusetts, those on public assistance receive significantly less than that ($593 pre-pandemic for a family of three) and, until the pandemic, had not received an increase since 1988 and 2000, depending on the benefit. The Task Force supports maintaining the 10% increase in benefits that occurred during the pandemic and 20% annual increases until the benefit reaches at least 50% of federal poverty.

4.2.3. Extend the State Earned Income Tax Credit to all Massachusetts Taxpayers

Workers who pay taxes using Individual Tax Identification Numbers are not eligible to receive a federal or state earned income tax credit (EITC). Legislation is needed so that all families who pay state taxes are eligible for the state EITC.

4.3. INCREASE HOUSING STABILITY BY PREVENTING EVICTIONS AND FORECLOSURES AND SUPPORTING EMERGENCY SHELTER

In the wake of COVID-19 and its prolonged economic effects, the Task Force received resounding testimony about the urgent need for housing stabilization and eviction and foreclosure prevention efforts. In April 2020, Massachusetts took the bold and necessary step of instituting a complete moratorium on evictions and foreclosures. That moratorium expired in October and was replaced with the state's Eviction Diversion Initiative that provided important resources for rental assistance, housing counseling, and legal resources in eviction cases.

In April of 2021, the Baker administration announced $400 million in new federal funding for emergency rental assistance. Additional dollars will be coming through the American Rescue Plan. While these new federal funds will provide necessary protections for many, we will still need robust eviction and foreclosure protections in order to avoid further disruptions. The influx of these funds holds the potential to prevent a massive housing crisis.

4.3.1. Assist Landlords, Homeowners and Tenants to Prevent Evictions and Foreclosures

The Task Force recommends that the Massachusetts Department of Housing and Community Development prioritize funding for those communities with the highest COVID-19 infection . There is clear evidence of increased housing instability and risk of displacement in these communities.

In addition, a portion of the emergency rental assistance funds should be used to stabilize families timing out of the HomeBASE program, which provides families in emergency shelter funds for up to a year to make the transition to permanent housing. Additional measures that need to be taken around rental assistance include: require landlords to pursue and cooperate with rental assistance programs before pursuing eviction; simplify the application process by creating one application for all of the assistance programs at an appropriate reading level, available online and in multiple languages; take advantage of new federal rules that allow direct payment to tenants; and allow for expanded use of self-certification/attestation of things like housing instability and income in the rental assistance application process.

Measures should be included to prevent residential foreclosures for payments due during the state of emergency, and allow homeowners the same terms as federal lenders, including deferring mortgage, interest, and escrow payments to the end of the loan term.

4.3.2. Provide Legal Counsel in Eviction and Foreclosure Proceedings

Only 8% of tenants have legal representation at eviction proceedings, placing them at tremendous disadvantage. A pro-bono legal representation program for tenants and homeowners should be established and funded.

4.3.3. Seal Eviction Records

Once a tenant has an eviction proceeding on their record, it is extremely difficult to obtain housing, even if they were not found to be at fault. Eviction records should be sealed during proceedings, three years after a finding and if the tenant was found without fault.

4.3.4. Increase Funding for the Emergency Shelter System

In some cases, additional funding was provided to shelters during the emergency. These funds should be maintained if not increased. Processes for entering the family shelter system need to be streamlined. FEMA funds that are 100% reimbursable to the state should continue to be accessed to provide non-congregate shelter through the duration of the pandemic.

4.4. CREATE ACCESS AND INCLUSION FOR IMMIGRANTS

Our state is home to one of the most diverse immigrant populations, with almost 600,000 residents with Limited English Proficiency; 40% speak Spanish.

4.4.1. Promote Language Access in State Agencies

Legislation is needed to require state agencies that engage with the public to provide oral and written language access. Currently, it is challenging for non-English speakers to apply for unemployment or other benefits. Agencies would be required to do periodic assessments of the languages spoken by their clients and adapt their language access accordingly.

4.4.2. Protect the Civil Rights and Safety of all Massachusetts Residents

The Task Force supports protecting the civil rights and safety of all Massachusetts residents. The climate of fear experienced by many undocumented immigrants has important health and public health implications, especially in the COVID-19 response, testing, treatment, and vaccinations. Legislative measures should be considered that increase immigrants' sense of safety, particularly around clarifying and standardizing local law enforcement's role in immigration enforcement.

4.4.3. Promote Access to Driver's Licenses and Identification for All Massachusetts Residents

Policies should be advanced to allow all qualified state residents to obtain valid driver's licenses so that immigrant families can travel safely to their essential jobs, health care appointments, and schools especially in light of pandemic precautions. A driver's license provides official identification and reduces fear experienced by immigrants.

4.5. BUILD "COMMUNITIES OF OPPORTUNITY": PRIORITIZE INVESTMENT IN HISTORIC ENVIRONMENTAL JUSTICE COMMUNITIES HIGHLY IMPACTED BY COVID-19 AS AN EQUITY CATALYST

Studies and mapping show the connection between high rates of COVID-19 and environmental burdens carried by those same communities, known as environmental justice communities. The Task Force recommends that the Massachusetts Department of Public Health and/or the recommended new Executive Office of Equity explore adoption of "Communities of Opportunity" or "Health Empowerment Communities or Zones" as an approach for state investments to build the capacity of and empower communities. A first step toward environmental justice is support for

legislation that would advance local garden agriculture programs that promote health, nutrition, jobs and a healthy environment.

5. STRENGTHEN THE LOCAL AND STATE PUBLIC HEALTH SYSTEM

The fact that public health is the responsibility of 351 different cities and towns in Massachusetts with varying resources and without clear guidance translates into a fragmented and inequitable response around the Commonwealth. Around the country these responsibilities typically reside within county government.

5.1. STRENGTHEN AND FUND THE LOCAL PUBLIC HEALTH SYSTEM

Massachusetts needs to support and strengthen local public health by providing funding, establishing professional standards and incentives for sharing functions regionally and by enacting legislation to implement the recommendations of the Special Commission on Local and Regional Public Health.

5.2. SUPPORT AND ELEVATE THE MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

The Task Force supports elevating the Massachusetts Department of Public Health (MDPH) to play a more integral role through the duration of this pandemic and in all public health initiatives. To do so will require investments in MDPH to build a stronger foundation and infrastructure to enable more robust response.

6. INTEGRATE EQUITY AND RESILIENCE INTO EMERGENCY AND DISASTER PREPAREDNESS

6.1. ENACT LEGISLATION TO CREATE A COVID-19 AFTER ACTION REPORT WITH AN EQUITY LENS

The Legislature should enact legislation as soon as possible that requires an After Action Review (AAR) with an equity lens, an innovation on a standard practice in the field of emergency management and an opportunity for Massachusetts to lead the nation.

6.2. REQUIRE THE APPOINTMENT OF A COVID-19 AFTER ACTION EQUITY COMMISSION

The legislation should require the appointment of an COVID-19 After Action Equity Commission. The Commission should use standard AAR methods and integrate an equity framework into all aspects of the review.

6.3. APPOINT A DIVERSE AND REPRESENTATIVE COVID-19 AFTER ACTION EQUITY COMMISSION

The Commission should comprise representatives of: Appointees by the Governor, including but not limited to representatives of emergency management; legislative leadership; leaders from cities and towns disproportionately impacted by COVID-19; the healthcare sector; essential businesses and workers, social services (housing/food) organizations, and diverse people with lived experience.

6.4. RETAIN THIRD-PARTY EXPERTS TO FACILITATE AND PRODUCE COVID-19 AFTER ACTION REVIEW

The AAR, under the guidance of the Commission, should be facilitated and produced by a third party/ies with expertise in emergency management, equity and participatory community processes.

6.5. INITIATE COVID-19 AFTER ACTION REVIEW AS SOON AS POSSIBLE TO BE UNDERTAKEN ON A ROLLING BASIS, STARTING WITH THE REVIEW OF THE VACCINE PLAN

The AAR should be initiated as soon as possible and completed on a rolling basis, beginning as soon as possible with review of the Vaccine Plan. The final comprehensive AAR should be completed within 12 months of the end of the public health emergency. Findings should be filed with leaders of the Administrative and Legislative branches, and a response required from the Administration within one month of a rolling review, and three months of the final report.

7. PRIORITIZE EQUITY IN STATE GOVERNMENT

While the charge of this Task Force is around Health Equity, we recognize that health is the net result of myriad social, economic and other factors, as well as racism. These factors, or “determinants of health,” account for up to 80% of health status. Therefore, a focus on equity within economic development, housing, social services, education and many other responsibilities of government are a prerequisite to achieving *health* equity. This understanding informs the recommendations that follow.

7.1. ENACT LEGISLATION TO CREATE AND RESOURCE A CABINET-LEVEL EXECUTIVE OFFICE OF EQUITY

The Health Equity Task Force recommends that legislation be enacted to create and resource a cabinet-level Executive Office of Equity led by a Secretary of Equity. The Secretary of Equity would be charged with leading efforts toward equity, diversity and inclusion across all aspects of the executive branch of state government, including creating 3- to 5-year strategic plans, data dashboards and implementing an equity in all policies approach, working with an Equity Advisory Board. There would be a special -although not exclusive- obligation to address racial and ethnic equity, given this pandemic and our current racial reckoning.

7.2. ENACT LEGISLATIVE PROVISIONS TO CREATE AND RESOURCE OFFICES OF EQUITY WITHIN EVERY SECRETARIAT

The recommended legislation would also create and resource Offices of Equity within every Secretariat, charged with leading efforts toward equity, diversity and inclusion throughout that Secretariat, and coordinating with their peers across state government. Each Secretariat level office would develop strategic plans, create data dashboards and have an Equity Advisory Board.

7.3. CREATE PUBLICLY AVAILABLE DATA DASHBOARDS TO TRACK PROGRESS TOWARD EQUITY

The Office of Equity would create a set of high level and publicly available data dashboards to track overall progress toward equity. The Task Force recommends using the opportunity-based framework developed by the HOPE Initiative.

7.4. ADOPT STANDARD DATA COLLECTION PRACTICES CRITICAL TO MEASURING PROGRESS TOWARDS ACHIEVING EQUITY

The Task Force recommends that Massachusetts adopt standard and consistent demographics - including race, ethnicity, language, sexual orientation, gender identity and more - data collection practices at point of care, service and testing, and that to accomplish this it convenes key stakeholders. The goal of this data collection is to measure progress toward equity.

7.5. REQUIRE AN EQUITY IN ALL POLICIES/EQUITY IMPACT ANALYSIS ON NEW POLICIES AND PROGRAMS AND *BEGIN WITH AN EQUITY ANALYSIS OF SPENDING TO DATE AND AN EQUITY PLAN FOR SPENDING AMERICAN RESCUE PLAN FUNDS*

The Task Force recommends the legislation include a requirement for an Equity in All Policies/Equity Impact Analysis on new policies and programs. The Office of Equity will be responsible for developing regulations, tools and overseeing implementation. The federal government has already provided billions to Massachusetts for pandemic response, with substantial new funding through the American Rescue Plan Act. The Task Force calls for a comprehensive analysis of how these funds have been utilized to date, *and a plan to use them to achieve equity going forward.*

7.5.1. Create an Equity in All Policies/Equity Impact Program

The Task Force calls for the creation of an Equity in All Policies approach to new policies and programs of state government. An equity in all policies approach would require analyses of issues not typically thought of as related to health, including social, economic, environmental, housing, transportation and other issues, as well as the more obvious health and human service issues. As we know, health is created through equitable access to economic, social and behavioral resources and opportunities and thus these resources must be assessed to achieve health equity. The goal is to embed analysis of equity into all decision-making so that it becomes the routine way of doing business.

7.5.2. Conduct an Equity Impact Analysis on Investment of Federal Funds to Date and an Equity Plan for investment of American Rescue Plan Funds.

The Task Force calls for an immediate equity analysis and plan for investment of all American Rescue Plan funds. This is critical to ensuring that these funds are directed to implement recommendations in this report aimed at achieving equity.

7.6. EQUITY ADVISORY BOARD

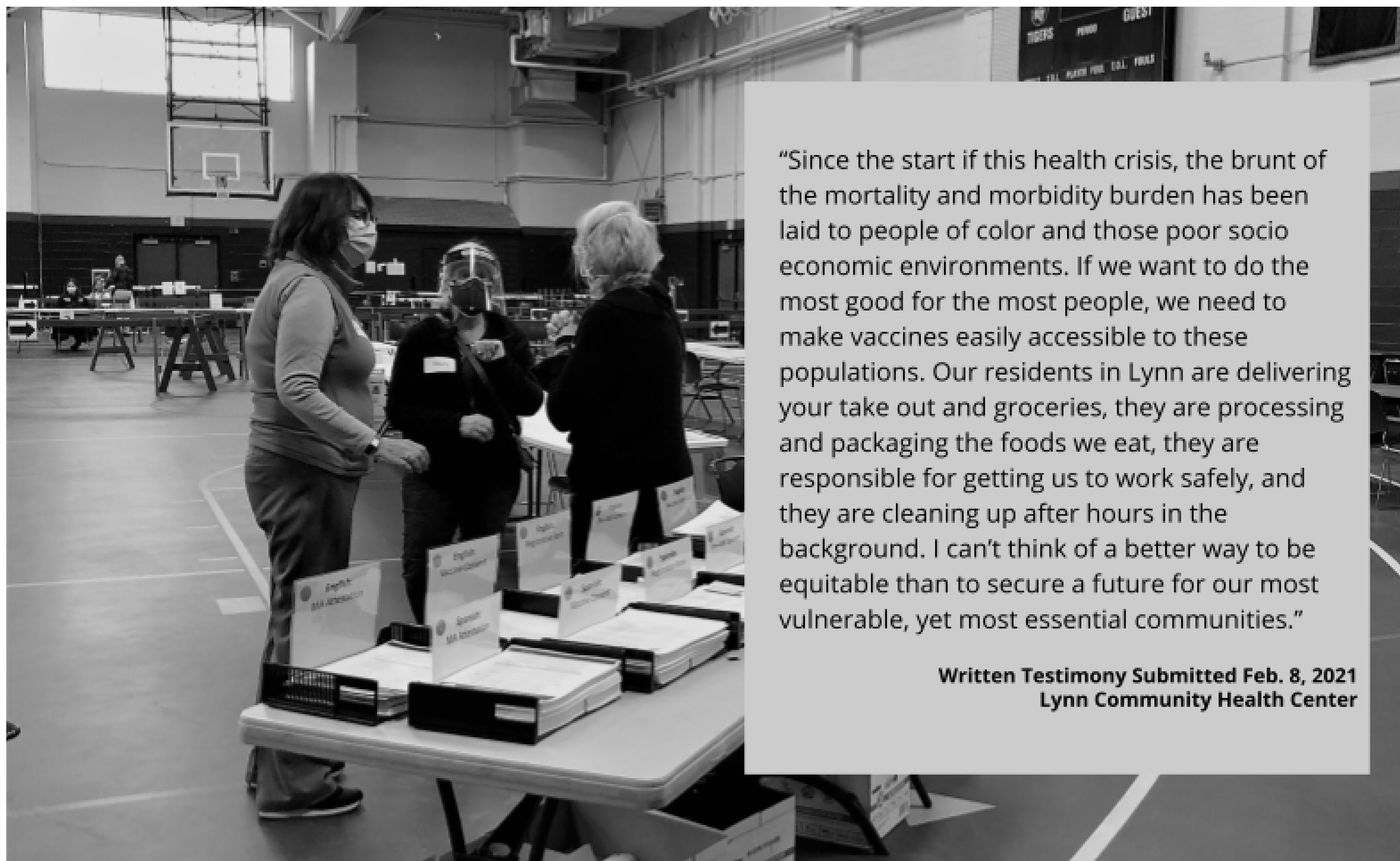
The Executive Board would be guided by an external Equity Advisory Board, with diverse experts in the fields of equity and health equity, community Based organizations that address the social and economic factors that impact equity, and people from communities around the Commonwealth with lived experience.

8. CONCLUSION

Many thanks to all who participated in the creation of this plan and to the Massachusetts State Legislature for providing this opportunity. This is an ambitious plan to guide the way toward achieving equity in our Commonwealth. **Now is the time.**

IMMEDIATE ACTION

2. ONGOING RESPONSE TO THE COVID-19 CRISIS



2.1. PROMOTE VACCINE EQUITY

2.1.1. Equity Should Be the "North Star" and a Key Driver of an Ongoing and Integrated Response to the COVID-19 Pandemic

It is well-known that COVID-19 hit poor communities and communities of color disproportionately.[10] The Health Equity Task Force recognized this in its Interim Report and is pleased that the Commonwealth has adopted many of its recommended actions to ensure that these communities were prioritized for vaccines. The Task Force recommended a participatory advisory process to

[10] https://www.bostonindicators.org/reports/report-website-pages/covid_indicators-x2/2020/december/persisting-covid-disparities

develop an equitable vaccine plan, and a culturally and linguistically appropriate public awareness and education campaign, in partnership with trusted community organizations, local public health and health care providers. At Task Force public hearings, the public asked for vaccination sites accessible to communities of color and other vulnerable populations, assistance with scheduling and transportation, in-home and on-site vaccination clinics and more.

At the outset, the Commonwealth's Vaccine Plan did not prioritize equity, with a focus on large vaccination sites inaccessible to many without private transportation. However, significant progress has been made toward equity, and this essential learning must be incorporated in all future phases of the COVID-19 response and beyond. The state's COVID-19 Vaccine Equity Initiative includes many of the components originally called for by the Task Force and the public who testified at hearings.[11] This Initiative prioritizes the 20 hardest hit communities in the state, directing additional supply of vaccines to those communities and taking into account infection rates as well as social factors.

Vaccinations are now available at mobile and walk-in clinics, community health centers, primary care offices and local pharmacies. And as of May 2021, 22 regional collaboratives are now receiving adequate supply of vaccines to design initiatives responsive to local needs. There is support for community outreach and education in partnership with community-based and faith-based organizations, local public health, and more. Equity will need to remain in the forefront and all of these components will need to be continued and enhanced for anticipated future vaccinations including children, booster shots and/or annual vaccinations that are most likely on the horizon.

From the beginning, the Task Force recommended that the vaccination strategy be guided by the needs and interests of the communities. We must partner with communities in the design and execution of all programs and services, and deliver to the community not only what we want them to have (vaccines) but also what they identify they need, including connection to food, shelter, medical care for underlying health conditions, and other essential services. It is only by demonstrating this level of respect and caring that trust in the system can be built, and we achieve the most effective and equitable outcome. Funds from the American Rescue Plan can supplement, enhance and continue these vaccine equity efforts.

The Task Force would like to recognize the work of the Vaccine Equity Now! Coalition, led by several Task Force members, which calls for many of the same measures that follow in this report. While many decisions about the vaccine plan have already been made or are evolving, the key point, which will always be relevant, is that equity should be the first and guiding priority.

2.1.2. Prioritize Funds from the American Rescue Plan to Enhance the Vaccine Equity Plan

The Vaccine Equity Plan contains many important elements to advance toward equity in vaccination rates. Massachusetts and the nation are entering a new phase of vaccination efforts that are more targeted to bringing vaccinations to where people are through convenient and trusted provider and community relationships The support for community health centers is particularly outstanding with outreach and community engagement, community health workers/ambassadors and support for workforce infrastructure. Additional and ongoing support and funds need to be directed to most of the components, particularly support to grassroots organizations, tailored community and

---

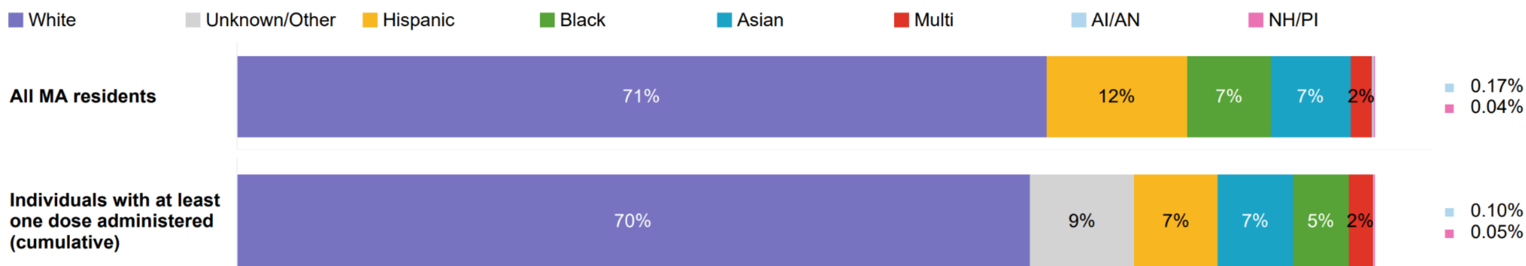
[11] https://www.mass.gov/info-details/covid-19-vaccine-equity-initiative

faith-based outreach, support for local boards of public health, direct assistance to access vaccinations, administering vaccines in community settings, mobile vaccination, and communication materials. The Task Force strongly recommends that funds from the American Rescue Plan Act be directed to bring the components of this initiative to scale, and extend it to additional communities in need.

2.1.3. Maintain and Enhance Focus on Race, Ethnicity, and Vulnerable Populations Receiving Vaccine

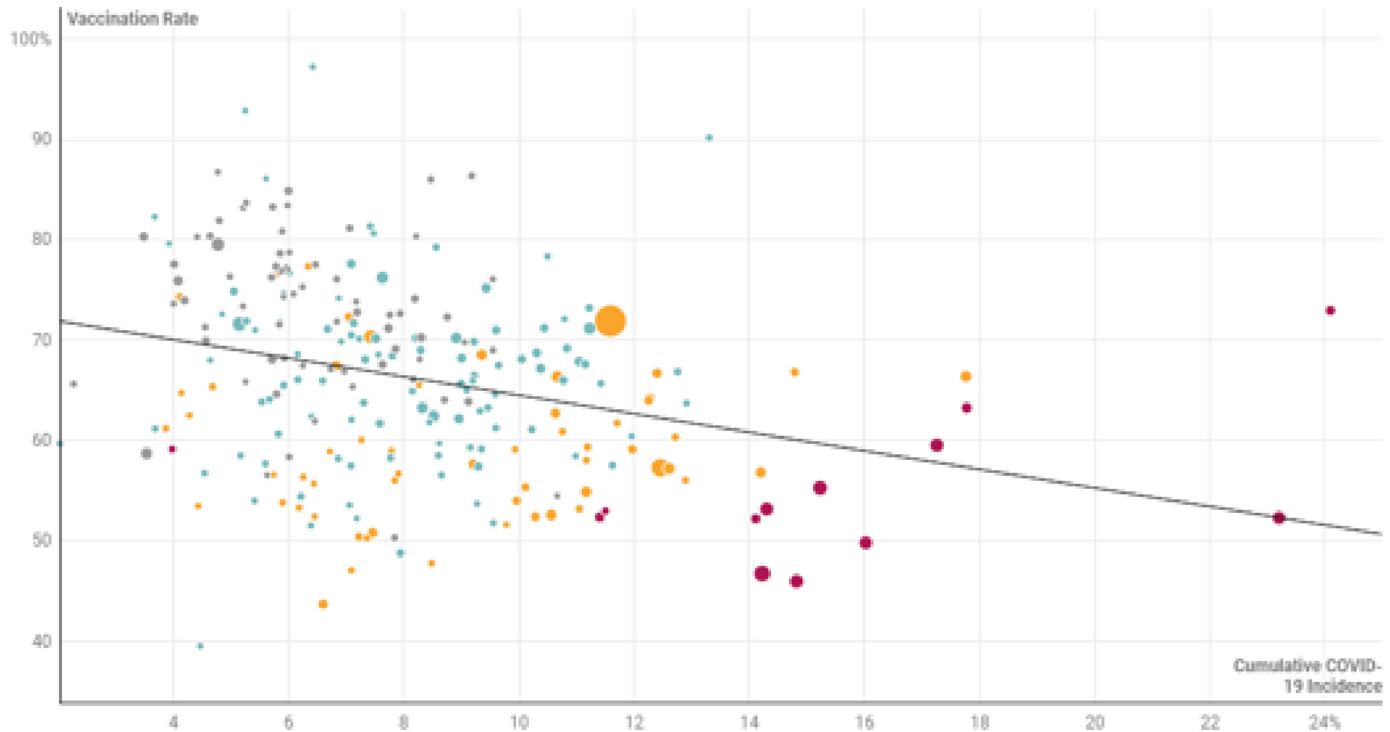
The evidence is that more vaccines, as well as additional and more targeted outreach efforts, are still required. Communities of color are not currently being vaccinated at rates corresponding to their disproportionate COVID-19 case rates. As of June 24, according to the MDPH weekly dashboard, of those who had received at least first doses:

- 68% were White and Whites comprise 71% of the state's population;
- 5% were Black although Blacks comprise 7% of the state's population;
- 9% were Hispanic although Hispanics comprise 12% of the state's population;
- 7% were Asian, compared with 7% of the population.

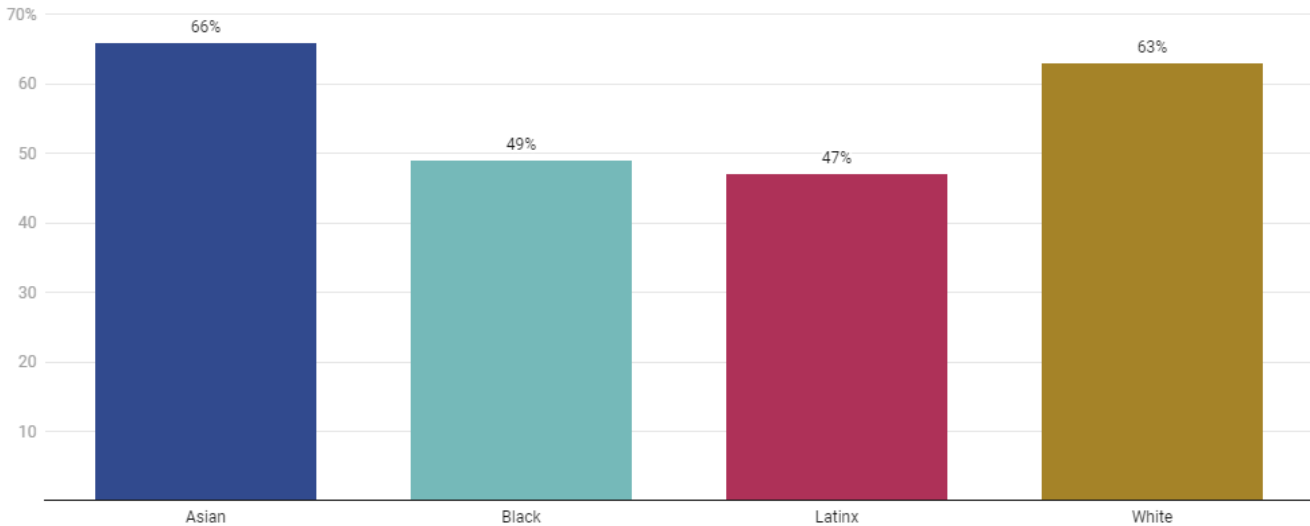


Aligned with race, ethnicity, and socioeconomic factors, there is a geographic divide in vaccination rates. Only 52% of Hampden County is fully vaccinated. The graph below, indicates that the lower the Social Vulnerability Index of a community, the fewer residents had obtained vaccination as of June 22, 2021 according to a report from the Boston Indicators Project [12] Clearly, outreach and engagement efforts are critical to achieving vaccine equity.

[12] https://www.bostonindicators.org/reports/report-website-pages/covid_indicators-x2/2021/april/vaccinations



Some assume that there may be lower vaccination rates among some groups of color because the average age is younger. But even after controlling for age, vaccination rates are lower, with rates among LatinX persons at 47% and their White counterparts at 63%, from the same report. This is all strong evidence of the need for continued and enhanced targeted outreach and engagement efforts.



2.1.4. Prolong and Tailor the Massachusetts Department of Public Health's (MDPH) public education campaign to increase vaccine acceptance. This campaign should be culturally appropriate, in multiple languages, delivered by local, trusted community messengers, tailored to address specific vulnerable populations and evolving phases of the vaccination effort.

The Massachusetts Department of Public Health is to be commended for launching a robust public education campaign to increase vaccine uptake in communities of color. In addition to a statewide campaign, it is positive that the campaign includes resourcing and empowering local, trusted community messengers to deliver culturally appropriate and tailored messages in multiple languages targeted to high-risk populations, including people of color (especially targeting the Black and LatinX communities), older adults, those with underlying conditions and persons with disabilities. Campaign messages should also be culturally sensitive to and delivered in partnership with faith-based groups and small businesses.

Despite the urgency of this moment, the educational campaign will need to be prolonged. Many in the community are displaying "vaccine deliberation," as they wait and see the impact of vaccination on their peers. It may take them some time to decide that vaccination is the right choice for them. There should be ongoing education about how and where to get vaccinated. Public education campaigns will need to be continuously tailored to the evolving phases of the vaccination effort and will also be essential for the vaccination of youth once federally approved, booster and re-vaccination efforts.

2.1.5. MDPH should contract with local community-based and faith-based organizations to employ ambassadors/community health workers who can assist at clinics, link people to needed services, and participate in public messaging, outreach and education.

Ambassadors, similar to community health workers (CHWs), work in testing and vaccine sites, perform outreach and education, and connect people to needed resources. Ambassadors are hired from the community, thus creating needed jobs and providing service in multiple languages. Their presence builds trust and serves as a bridge between the community and public health and the health care sectors. For example, the state has partnered with the Massachusetts League of Community Health Centers to train and deploy community health workers into their respective communities. This strategy is critical to achieving vaccine equity.

The Task Force recommends the extension of a statewide ambassador/community health worker program through partnerships with local, trusted community-based organizations and community health centers. Ambassadors and community health workers should reach out to people in community locations that are a part of their daily lives, including community-based organizations, churches, and small businesses. Staff need to be prioritized for vaccines, funded to have the equipment they need (iPads to schedule vaccine appointments, for example), and be paid a family-sustaining wage. It is also essential that future contracting for ambassadors, community health workers and communications campaigns be accessible to local, minority led non-profit organizations with familiarity and relationships in the community.

2.1.6. MDPH should report census tract in the municipal vaccination data they publish weekly.

DPH is also to be commended for greatly improving their vaccine data reporting over time. DPH publishes weekly vaccination data by municipality, stratified by race and ethnicity and multiple other factors, including zip code. The Task Force encourages MDPH to also include census tract data in this report. Zip code is often not granular enough to determine exactly where vaccines are being delivered. Infections often cluster within certain neighborhoods and streets, within a larger zip code. Communities need to be able to map this data to determine where outbreaks are occurring and design tailored interventions.

Later in this report, the Task Force calls for more comprehensive health equity data throughout state government that is stratified by race, ethnicity, geography and more. The Task Force would like to call out the need for data on race, ethnicity, language and geography for patients hospitalized and for those who die as a result of COVID-19.

2.2. CONTINUE AND ENHANCE THE *STOP THE SPREAD CAMPAIGN* THROUGH AT LEAST CALENDAR YEAR 2021, INCLUDING TESTING, CONTACT TRACING AND ISOLATION HOUSING

The state should continue and enhance the Stop the Spread campaign through calendar year 2021, if not longer. Stop the Spread provides COVID-19 testing to anyone free of charge and most sites are located in communities with high rates of infection. Ambassadors or community health workers, through partnerships with local community-based organizations, should be added to these sites to screen for social and economic needs and connect people to needed resources. This is also a place where people could be screened for chronic conditions, which disproportionately affect those vulnerable to COVID-19, and connected to ongoing health care and community-based organizations. Many people may have foregone health care for these conditions during COVID-19. It is by offering these supports and resources that trust will be built and more people will become engaged in the process.

As part of the continued and enhanced Stop the Spread program, continue to provide isolation housing for those needing quarantine, and add non-congregate housing for those from the most impacted communities, the elderly, those with medical and mental health conditions, and homeless persons.

2.3. ADDRESS THE NEEDS OF VULNERABLE POPULATIONS, INCLUDING ESSENTIAL WORKERS, OLDER ADULTS, PERSONS WITH CHRONIC, UNDERLYING MEDICAL, BEHAVIORAL HEALTH CONDITIONS, PERSONS WITH DISABILITIES, AND INCARCERATED PERSONS.

2.3.1. Essential Workers

Essential workers were on the front lines of this pandemic. They and others need an emergency sick leave benefit during a declared state of emergency or disaster. Essential workers often feel obligated to attend work even when sick for fear of losing a job and because they cannot afford to lose a paycheck, thus fueling the spread of infection. If a worker can work from home, there is less risk to the public. However, many workers of color, who disproportionately have low-wage jobs, are essential workers and do not have that option. They may be compelled to work to keep their jobs and feed their families.

Massachusetts' Earned Sick Time law, passed by the voters in 2014, provides 40 hours of paid sick time yearly, but that sick time must be accumulated over time, and for thousands of workers this isn't enough to meet the scale and impact of this public health crisis. The federal Families First Coronavirus Response Act (FFCRA) provided 10 days of additional paid sick time for many workers last year, but it expired at the end of December 2020.

The Task Force is encouraged that the state Legislature passed legislation recently to establish a COVID-19 Emergency Paid Sick Leave Fund (Chapter 16 of the Acts of 2021). It provides for up to 40 hours of reimbursement of eligible employers for COVID-19 emergency paid sick leave for full-time employees (pro-rated for part-time employees) and also covers time off for isolation after exposure, to seek medical care or immunization and other related reasons. The program is available until September 30, 2021 or until the $75 million of allocated federal funds are expended, whichever comes first.

The Task Force recommends ongoing monitoring of needs for future pandemic emergency paid sick leave beyond September 2021, and assistance to essential workers, as well as small businesses, with accessing income and other supports. Finally, the Task Force also recommends exploring extended unemployment benefits for essential workers, short term disability for those with lingering effects of COVID-19, and re-employment assistance for those who lost jobs due to business closures, furloughs or layoffs.

PROMISING PRACTICES FROM OTHER STATES

According to the National Conference of State Legislatures, New York passed a law last year in which, "large employers must provide 14 days of paid sick leave for any quarantine or isolation order. Midsize employers and small employers with more than $1 Million must provide 5 days of sick leave. Small employers must provide job-protected, unpaid leave for the duration of any quarantine or isolation order. Any worker who does not receive 14 days of paid sick leave can apply for "quarantine leave" benefits and the state will provide eligible employees with full wage replacement benefits for up to 14

days using a combination of state Temporary Disability Insurance and Paid Family and Medical leave insurance benefits."[13]

2.3.2. Older Adults

Older adults, particularly those living in long term care and skilled nursing facilities, suffered the highest fatality rates from COVID-19, with one in every five people living in senior care, or more than 8800 persons succumbing to the disease.[14] The residents of these facilities are more likely to be frail and physically vulnerable, and the workforce who cares for them is typically underpaid and comes from communities with high infection rates and high rates of social vulnerability. Older adults in the community often rely on homecare workers, also from the community, to stay in their homes. Both situations create a perfect storm for infection to spread and both groups deserve care and attention. While Massachusetts has ultimately vaccinated the vast majority of older adults, many lessons were learned to apply to future and ongoing situations. Based on testimony received at public hearings, the Health Equity Task Force recommends:

- Transportation to vaccination sites for seniors, and assistance with scheduling is essential.
- Vaccination clinics at all senior public housing, and on-site vaccination for homebound and disabled seniors and adults must be part of the plan from the beginning.
- Nursing home and homecare workers have adequate PPE, and access to free testing.
- Investments and delivery system reforms in nursing homes and long-term care facilities
- Policy action through the Legislature and state Administration to support older adults living in their homes and community settings, such as encouraging and facilitating enrollment in PACE (Program of All-Inclusive Care for the Elderly) programs and other care models that support non-congregate living.
- MassHealth estate recovery reform to address the intergenerational wealth gap for diverse and vulnerable individuals and their families (see Section 3).

2.3.3. Persons with Disabilities

Persons with disabilities testified at the Health Equity Task Force public hearings about their high risk for COVID-19, and its complications. The state's emergency/disaster planning does not take into account their unique needs and challenges. One woman described her ordeal, which resulted in her developing completely preventable major infections while attempting to obtain adequate supplies for the ventilator she depends on to survive. The Health Equity Task Force recommends prioritizing eligibility for vaccines for persons with disabilities in any future vaccine planning, and providing the necessary support to schedule and obtain transportation to vaccinations and/or deliver vaccines in the community and at-home. The unique needs of persons with disabilities should be incorporated into current and future pandemic planning. Finally, safety and mask wearing should be promoted, particularly in buildings where a significant number of persons with disabilities and other at-risk populations live, such as 40B housing.

2.3.4. Persons with Chronic or Underlying Medical Conditions

Persons with chronic and underlying medical conditions, many of which disproportionately affect persons of color, are at higher risk for COVID-19. They may also have been unable to address their

[13] https://www.nysenate.gov/legislation/bills/2019/s8091

[14] https://www.bostonglobe.com/2021/03/20/metro/you-are-my-sunshine-nursing-homes-covid-19-vaccinations-bring-hope-amid-an-uncertain-future/

underlying conditions during the pandemic. Special efforts should be made to reach out to these individuals with culturally appropriate education about the importance of vaccination to protect their health. These efforts would best be conducted by trusted, community-based organizations, faith-based organizations and other local entities that are known and trusted. In Section 2.2, Stop the Spread, the Task Force also recommended that these sites include screening and education around chronic conditions, as well as connection to ongoing health care.

2.3.5. Incarcerated Persons

Infection rates in Massachusetts jails and Department of Correction facilities are very high. The Task Force received testimony that over a third of those incarcerated were infected with COVID-19. In a study published last June, the rate of infection in Massachusetts prisons and jails was three times that of the general population. While the Administration is to be commended for prioritizing certain vulnerable populations in congregate settings for vaccination, such as those in homeless shelters and prisons, there is no substitute for depopulating congregate settings.

There have been low rates of vaccine uptake among incarcerated people and staff, creating risk for people incarcerated and the community. It is not enough to make the vaccine available to high-risk groups. Intentional and directed educational campaigns must be developed to build trust and reduce vaccine hesitancy using strategies of trusted voices, town hall meetings and distribution of information to every person either employed by or in the custody of the Department of Corrections. The Department should publish weekly, by facility, the numbers of incarcerated persons and staff who were vaccinated. Finally, weekly testing, with rapid results, must be available.

The state must monitor the progress in these correctional facilities and ensure greater accountability and transparency. In the FY'21 budget cycle (line-item 8900-0001) language was included that required the following, "given the continued prevalence and threat of COVID-19 within Department of Correction facilities, the commissioner of correction shall release, transition to home confinement or furlough individuals in the care and custody of the department who can be safely released, transitioned to home confinement or furloughed with prioritization given to populations most vulnerable to serious medical outcomes associated with COVID-19 according to the Centers for Disease Control and Prevention's guidelines."

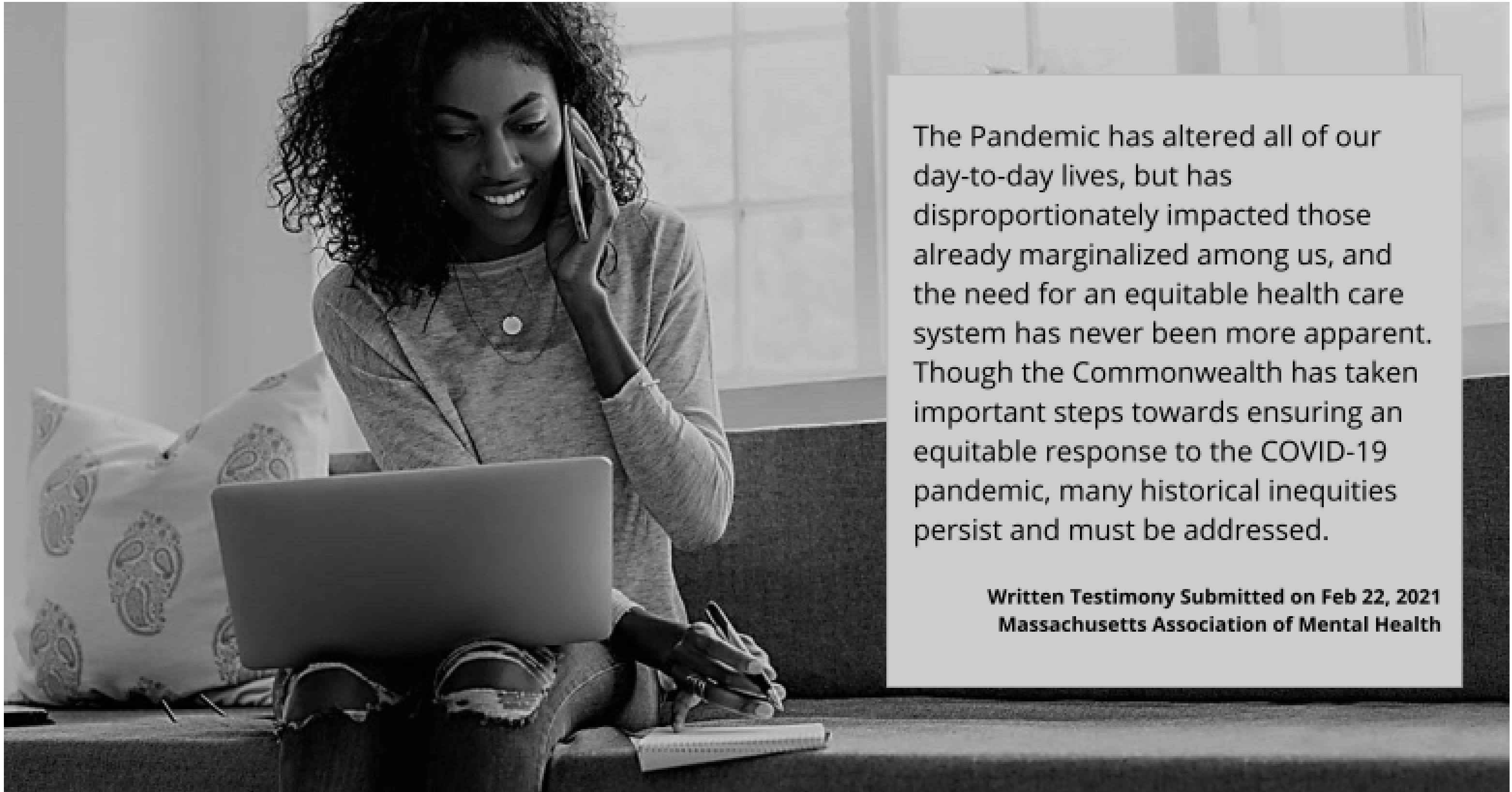
The language also calls for the appointment, for the duration of the pandemic, of an ombudsperson by the Attorney General's Office to provide accountability and information to support the health and safety of the incarcerated population, including progress of releases. However, the language does not provide resources and other provisions to enable the ombudsperson to accomplish their charge and the Attorney General has been unable to appoint someone. As a result, no ombudsperson is in place

The Task Force strongly recommends that the Department of Corrections to release from prison those persons who can be safely released, consistent with the provisions in the FY'21 state budget law. The Task Force also encourages the Legislature to work with the Attorney General to amend the budget language so that resources are in place and the time extended so that the Independent Ombudsman Office can do its job. The Commonwealth should apply for FEMA public assistance funding for non-congregate shelters for unhoused individuals returning from prison. The Commonwealth should partner with justice-centered, social services agencies as partners in transition planning.

2.4. FUND RESEARCH ON THE INTERMEDIATE AND LONG-TERM EFFECTS OF COVID-19

The Task Force recommends that the Legislature and Administration collaborate to establish and fund plans for research and monitoring of the intermediate and long-term effects of COVID-19. This should include research conducted on the health effects, including long-haul health, behavioral health effects, the socio-economic implications of the pandemic, and ongoing response and recovery needs. This research and monitoring should be analyzed using disaggregated population characteristics referenced in section 7.3. Federal funding for these research initiatives, through the National Institutes of Health (NIH) or other opportunities should be explored.

IMMEDIATE AND INTERMEDIATE ACTION



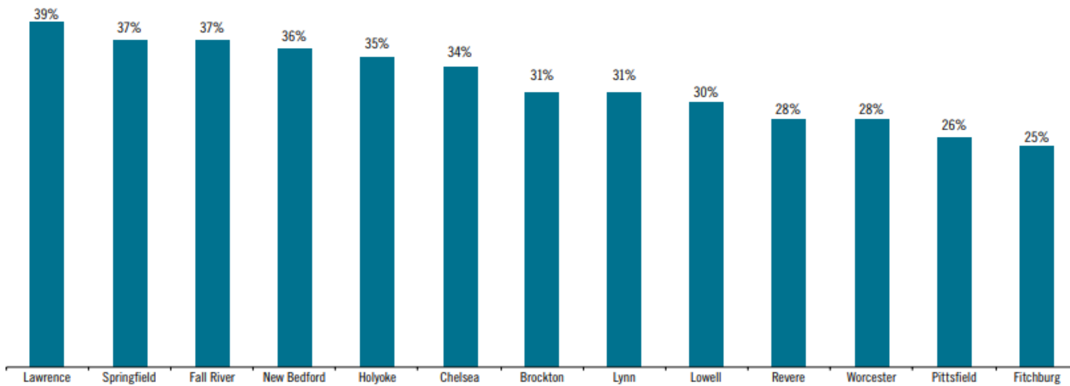
3. STRENGTHENING ACCESS TO QUALITY, AFFORDABLE HEALTH CARE AND OTHER SERVICES

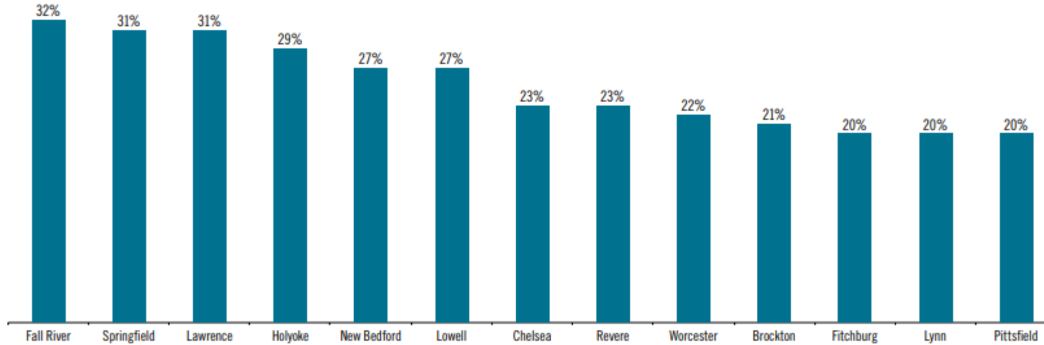
3.1. DIGITAL EQUITY AND INCLUSION

While the digital divide has been long-standing, it became a chasm during COVID-19. Massachusetts has significant geographic coverage for broadband. By addressing additional issues of access, affordability and literacy, Massachusetts has the opportunity to end the digital divide.

The Task Force heard testimony about insufficient broadband capacity of available products, lack of affordability, problems accessing devices and digital literacy. All are significant barriers to digital access with disproportionate impact in low-income communities and communities of color. During the spring COVID-19 surge, many people across the Commonwealth accessed health care through telehealth, but this was not an option for many low-income people and people of color. Digital barriers also had a significant impact on accessing a host of services and benefits necessary to address social determinants of health including unemployment, education, income and food benefits, housing applications and more.

According to *Going For Growth: Promoting Digital Equity in Massachusetts Gateway Cities,* a policy brief by the MassINC Gateway Cities Innovation Institute, about 25 percent of Gateway City households did not have internet service at home pre-pandemic, and another 10 percent depended on unstable connections such as a mobile phone. Contrast this with Federal Communications Commission data from 2018 showing that more than 97.9 percent of Massachusetts residents live in places where broadband runs under the street, indicating that not all households can afford internet services. Census data also shows that 18 percent of households in Massachusetts did not have a laptop or desktop computer in 2018. In Gateway Cities, the share was much larger, with 28 percent of households lacking such devices.[15]





Charts cited from *Going For Growth: Promoting Digital Equity in Massachusetts Gateway Cities* by the MassINC Gateway Cities Innovation Institute, November 2020

3.1.1. Support Measures to Promote Telehealth and Digital Equity for PatientsSupport Measures to Promote Telehealth and Digital Equity for Patients

[15]https://2gaiae1lifzt2tsfgr2vil6c-wpengine.netdna-ssl.com/wp-content/uploads/2020/12/MassINC-Digital-Divide-Policy-Brief.pdf

During the pandemic, the Governor issued an emergency order requiring insurers to cover telehealth, and waiving many barriers to telehealth, particularly by creating parity in coverage and reimbursement rates between virtual and in-person visits. This fulfilled a critical need for accessible health care and behavioral health services during the pandemic, resulting in a tremendous surge in the use of telehealth for those who could access it. Telehealth holds the promise on an ongoing basis to reduce barriers to health care for those with limitations of time due to work or other responsibilities, child care and/or transportation.

Massachusetts also made great strides forward at the end of the last legislative session with the passage of Chapter 260 of the Acts of 2020, which vastly improved and made more permanent access to telehealth. Among the provisions of the bill are coverage parity across all payers, a definition of telehealth including but not limited to audio (telephone) - of great benefit to those without devices and/or broadband, permanent reimbursement parity for behavioral health and two years of reimbursement parity for primary care and other services at which time the Health Policy Commission will issue a report on the impact of telehealth on access and cost. However, as one presenter at a Health Equity Task Force meeting stated, "the gains in Chapter 260 are only as good as how equitably they are implemented."

The Task Force supports legislative, regulatory, and other initiatives to ensure access to telehealth services for patients by increasing digital adoption and literacy, reducing financial barriers to accessing telehealth, coverage of interpreter services for telehealth patients with limited English proficiency or those who are deaf or hard of hearing, expanding reimbursement parity, and requiring social determinants in health to be taken into account in assessments of telehealth impacts in the state, including those undertaken by the Health Policy Commission (HPC).

Promising policy proposals would advance programs to overcome digital equity barriers to telehealth. One such legislative proposal would direct the HPC to establish two programs—a Digital Bridge Pilot Program and a Digital Health Navigator Tech Literacy Pilot Program with aims to increase telehealth access via the provision of digital technology and digital literacy education. As Massachusetts continues to respond to COVID-19, the Task Force recommends adoption of policies that would prohibit insurers from collecting co-pays for telehealth services for the duration of the public health emergency (PHE) and for 90 days after.

3.1.2. The Massachusetts Broadband Institute, the Massachusetts Department of Telecommunications and Cable and the Legislature should work with the broadband providers in Massachusetts to increase minimum download and upload speeds provided at affordable and subsidized prices.

The Massachusetts Broadband Institute along with the cable companies launched several initiatives during the COVID-19 pandemic, including internet access for job seekers, contracts with school departments to offer access and devices to their students, low-cost access to many families, and more. These initiatives are to be commended and there is more work to be done.[16]

Among the issues that need to be resolved is the definition of broadband internet speed. During the pandemic households with multiple users often lost service due to inadequate broadband speeds,

[16] https://broadband.masstech.org/

or an inability to afford the product that met their family's needs. This was challenging when children attempted to attend school remotely while parents simultaneously attempted to work or access benefits and supports such as unemployment.

The Federal Communications Commission has a definition for broadband internet speed (25 Mbps download and 3 Mbps upload) that many experts think is inadequate. Iowa states that communities with access to less than that are "unserved," while Missouri defines communities without 25Mbps/3Mbps as underserved. It is progress that Comcast Essentials will almost double these speeds by March 1 (50Mbps/5Mbps). The Massachusetts Broadband Institute, the Massachusetts Department of Telecommunications and Cable and the Legislature should work to establish acceptable minimum speeds for service that is affordable and/or subsidized.

3.1.3. Subsidize Broadband Access to Income Eligible Households

New federal funds from the American Rescue Plan Act are soon to be available to improve broadband access and close the digital divide. Those funds could be put to use closing the last geographic gap of broadband access in Massachusetts, as well as subsidizing adoption of low-cost broadband service and related equipment, in-home devices such as laptops, and digital literacy programs to income eligible households.

Too many families have not adopted the usage of broadband internet due to financial hurdles, access to computing equipment or other challenges. There are bills before the Legislature creating the Massachusetts Digital Equity Broadband Adoption Program, which if implemented, would subsidize 50 percent of a high-speed broadband subscription; subsidize 50 percent of installation, in-home equipment, and digital literacy programs, and; protect families from loss of services due to loss of employment or other factors.

3.1.4. Create a Funding Subsidy for Lifeline, a Federal Program that Supports Minimum Phone Service; Promote Existing Federal Benefit

LifeLine is a federal program that subsidizes phone service for low-income individuals. The Federal Communications Commission pays carriers $9.25 per household per month to provide minimum services. The program is dramatically underutilized in Massachusetts, with only about 100,000 participants, or 18% of those eligible. One reason for this is that Massachusetts is one of only 10 states in the country that does not provide a matching subsidy.

California boasts the most utilized LifeLine program and provides the greatest subsidy. For Massachusetts to do this would require the statutory authority of the Massachusetts Department of Telecommunications and Cable to be broadened to create this program and to negotiate with the carriers. Following this broadened authority, the Department would need to negotiate with the two current Lifeline carriers in Massachusetts on the appropriate state subsidy to get Lifeline customers unlimited minutes and text messages during the state of emergency, and adequate minutes and capacity beyond.

The Department of Transitional Assistance had previously started negotiations to share their database with the federal Lifeline administrator. By sharing this information, the Commonwealth

could more than double Lifeline enrollment at no additional cost to the state. This could expedite the enrollment of more than twice the current number of enrollees.

In addition, the Federal Communication Commission's Emergency Broadband Benefit[17] now provides a discount of up to $50 per month towards broadband service for eligible households and up to $75 per month for households on Tribal lands.[18] Eligible households can receive a one-time discount of up to $100 to purchase a laptop, desktop computer, or tablet from participating providers if they contribute $10-$50 toward the purchase price. The Task Force encourages the Commonwealth and the Massachusetts Broadband Institute to promote this benefit.[19]

3.1.5. Support and Fund for Community Interventions to Make Broadband Access and Digital Devices More Affordable, and to Provide Digital Literacy Education.

The Health Equity Task Force heard several presentations about communities taking the initiative to address digital equity locally. Following are two local initiatives from which lessons can be drawn by other Massachusetts communities. Each of these examples would have benefited from state funds to support and/or leverage additional private resources.

PROMISING PRACTICES FROM OTHER STATES

RHODE ISLAND

ONE Neighborhood Builders, a community development corporation in Providence, Rhode Island, raised $250,000 to provide free wireless mesh internet coverage to 3,000 households in Olneyville, the lowest income neighborhood in the City, for the next five years. It required significant public-private partnership. The biggest challenge was to educate the community and overcome their fears of getting trapped into paying for it and/or having personal data stolen. They energetically engaged with the community to do so.[20]

REGIONAL APPROACHES

The Essex County Community Foundation undertook a county-wide study and then convened key stakeholders from across the county to map the problem and develop a menu of potential partnership solutions, ranging from municipal broadband to public wifi, to subsidized accounts, free devices. Each of these initiatives would require public and private funding. The Digital Equity Alliance of Western Massachusetts works on similar issues with a range of community partners. In particular, they worked to address the significant digital equity gap over the past year for students in Springfield Public Schools.[21,22]

3.2. EXPANDING HEALTHCARE COVERAGE FOR IMMIGRANT CHILDREN

3.2.1. Extend MassHealth CommonHealth Coverage for Immigrant Children with Disabilities

[17] https://www.fcc.gov/broadbandbenefit

[18]https://www.fcc.gov/broadbandbenefit#:~:text=The%20Emergency%20Broadband%20Benefit%20will,households%20on%20qualifying%20Tribal%20lands.&text=The%20Emergency%20Broadband%20Benefit%20is%20limited%20to%20one%20monthly%20service,one%20device%20discount%20per%20household.

[19] https://www.natlawreview.com/article/overview-broadband-funding-opportunities-covid-19-relief-act

[20] https://oneneighborhoodbuilders.org/author/michelle-cheng/

[21] https://www.eccf.org/wp-content/uploads/2020/10/ECCF-Digital-Divide-Report_English.pdf

[22] https://sites.google.com/view/digitalequityalliance/home?authuser=0

The Task Force recommends legislation to provide MassHealth CommonHealth coverage to all children and youth with disabilities and the highest health care needs, as an urgent first step in expanding coverage to all immigrant children regardless of immigration status.

While over 98 percent of the Commonwealth's children have some form of health coverage, **thousands** of predominantly low-income children and young adults with disabilities can only access safety net programs with strict limits on covered benefits. These safety net programs, such as the Children's Medical Security Plan and Health Safety Net, do **not** cover important services that people with disabilities, complex medical and/or behavioral health conditions need, such as intensive behavioral health care and medical supplies like wheelchairs or specialized formulas.

Therefore, legislation is urgently-needed to extend MassHealth CommonHealth to this population by building on an existing approach in Massachusetts to use state funding to cover certain children with disabilities with "Permanent Residence Under Color of Law" (PRUCOL) status.

"CommonHealth" was specifically designed to provide services to individuals with disabilities, with a focus in recent decades to ensure that people can get the care they need in the least restrictive setting – at home and in the community.

The care for this population is concentrated with safety net hospitals and community health centers, who often face financial constraints in carrying out their mission to care for all due to the lack of comprehensive coverage for immigrant populations. Expanding MassHealth coverage is also beneficial for some additional community-based providers and their patients, who are not able to access payments from the Health Safety Net Fund, an important safety net program for the uninsured.

3.2.2. Expand MassHealth Coverage for All Eligible Children Regardless of Immigration Status

The Task Force calls for a progression of legislative action toward MassHealth coverage of all eligible children and youth, regardless of immigration status. This is a major health equity barrier that will make a significant difference in the health and well-being for this underserved population.

Both of these legislative actions would need to be accompanied by outreach and education to immigrant communities on eligibility and enrollment via trusted, community-based messengers including safety net and other healthcare providers. The public charge rule, which has been overturned by the current federal Administration, had a chilling effect on immigrants' willingness to accept benefits, even those they were eligible for out of fear of identification and implications on future immigration applications. As noted below, at least 6 other states have adopted a comprehensive Medicaid coverage approach for **all** children regardless of immigration status.

PROMISING PRACTICES FROM OTHER STATES

Other states including New York, California, Illinois, Washington, Oregon and Washington D.C. have gone further to extend comprehensive Medicaid coverage to all such children who are otherwise eligible, regardless of immigration status. The Health Equity Task Force encourages action to adopt this comprehensive approach as part of the progression of legislation for universal coverage for children of all backgrounds in Massachusetts.

3.3. ADVANCE EQUITABLE RESOURCES FOR SAFETY NET HOSPITALS AND THE COMMUNITIES THEY SERVE

The authorizing statute for the Task Force recognizes the role of safety net hospitals dedicated to caring for patients who test positive for COVID-19 in gateway cities.

Safety net hospitals and health systems, the predominant acute care and community health care providers in gateway communities, play a vital role in both ongoing health care and the local COVID-19 response. These hospitals, located in cities with the highest rates of COVID-19, experienced disproportionate surges in COVID-19 patients. The unequal surge is further evidence of the relationship between health status and the attendant economic factors and social vulnerability. The recent Attorney General's report *Building Toward Racial Justice and Equity in Health* recognized that "the disproportionate impact of COVID-19 on communities of color amplifies the longstanding need to change how health care resources are allocated, starting with payments to providers who care for underserved populations."[23]

Bold policy action is needed. Over the past decade, Massachusetts policymakers have required annual reporting on the statewide variation in commercial health insurance rates across hospitals and providers. This has provided an important baseline of data. However, public reporting alone has not changed the market-based insurance tactics and pervasive commercial rate inequities that continue to exist for the same quality and level of services, especially to the safety net hospitals and others who care for the highest proportion of Medicaid patient care, known as "high Medicaid" providers.[24] The pandemic's disproportionate impacts in poor and diverse communities have laid bare these inequities and call for structural action and accountability. Resources matter - to improve the health and care for populations with higher need.

In addition to the vital role of Medicaid and public payers, concerted action by commercial health insurers to achieve equitable rates for safety net hospitals and health systems is part of the paradigm that must shift toward greater investment (not below average rates) in diverse and lower-income communities, to reverse resource deficits compounded over the years.

3.3.1. Require Commercial Rate Equity for Safety Net Hospitals as a Means to Reduce Racial and Ethnic Health Disparities

Safety net hospitals that care for a high proportion of patients with Medicaid are paid less than other hospitals by commercial insurers.[25] Disparities in critical resources, particularly when need is higher, threaten access to care in low resource communities.

Inequitable rates, including by commercial insurance plans and in alternative payment models and global payments, contribute to the disparities in resources across communities. Legislative action to ensure equitable commercial insurance rates for high Medicaid safety net hospitals is now more imperative than ever.

The Task Force recommends legislative action to require commercial health plans, within their existing budgets, to pay high Medicaid safety net hospitals the statewide average relative price.

---

[23] Office of the Attorney General, *Building Toward Racial Justice and Equity in Health: A Call to Action, 2020* at page 19, available at https://www.mass.gov/doc/building-toward-racial-justice-and-equity-in-health-a-call-to-action/download

[24] https://www.chiamass.gov/relative-price-and-provider-price-variation/

[25] https://www.chiamass.gov/assets/docs/r/pubs/2020/S-RP-Final-Results-CY-2018.pdf

Legislation should require that commercial carriers annually certify and provide evidence to the Massachusetts Division of Insurance that each high Medicaid safety net acute hospital's rates meet a minimum threshold of the carrier's statewide average commercial relative price.

3.3.2. Enhance Funding for High Medicaid Safety Net Hospitals in Medicaid Waiver Renewal

The Task Force commends the Administration and MassHealth for its proactive funding support of safety net hospitals/providers during the pandemic. The Medicaid Waiver is a crucial vehicle for the state and federal government to continue to support safety net hospitals, particularly those with the highest concentration of Medicaid and low-income patient care they provide. During the current term (2018 - 2022), the Medicaid Waiver provides supplemental payments for safety net hospitals to ensure continued access to care for Medicaid and low-income uninsured individuals as well as other dedicated funding to support delivery system reforms and innovations integral to accountable care.

Authorization for this important funding for safety net providers must be renewed for fiscal year 2023 going forward through the Commonwealth's Medicaid Waiver 1115 Renewal. The Massachusetts Executive Office of Health and Human Services (EOHHS) has identified as one of its key goals for the next waiver renewal to, "sustainably support the Commonwealth's safety net – including level, predictable funding for safety net providers, with a continued linkage to accountable care."[26]

The Task Force encourages the continued partnership of EOHHS and safety net health systems and hospitals to enhance safety net hospital supplemental funding, including for new state-federal investments led by safety net health systems to advance care delivery and health equity.

3.3.3. Invest in Sustaining Medicaid Rates for Safety Net Hospitals and Hospital-Licensed Health Centers

Sustaining Medicaid rates and reimbursement is fundamental to the care delivery of safety net health systems, including safety net hospitals, hospital-licensed health centers, and affiliated providers. Patients with public payers, including MassHealth, the Health Safety Net and others often account for 70-80% of the payer mix at these hospitals.

The Task Force recognizes the important step enacted by the Legislature and currently being implemented by EOHHS for a five percent enhancement to inpatient and outpatient Medicaid reimbursement for two years for certain hospitals in Section 63 of Chapter 260 of the Acts of 2020. This is an important foundation upon which to build future reimbursement policies that meet the financial requirements of safety net hospitals that care predominantly for diverse, low-income and vulnerable populations.

As Massachusetts Medicaid policies are designed in the upcoming Medicaid Waiver Renewal and in the annual MassHealth Acute Hospital Request for Applications, reimbursement for safety net hospitals must be protected and enhanced. Several current policies under consideration, such as global budgets for primary care and changes to behavioral health and pharmacy programs, must embed and build upon current reimbursement for

[26] https://www.mass.gov/doc/section-1115-listening-session-1/download

hospital-licensed health centers and 340B pharmacies.

3.3.4. Establish Equitable Global Payments/Budgets under Alternative Payment Methods

Important research by the Office of the Attorney General shows that total medical spending is not equitable across communities and providers. The Office of the Attorney General's report documents a troubling relationship between income, health status and adjusted medical spending. Private health insurance spending is consistently lower on average for low-income members, who often reside in diverse communities, and higher on average for members residing in more affluent communities.

These spending inequities cannot be explained by health complexity,[27] but rather are a product of both services utilization and higher relative payment rates to providers serving higher-income communities.[28,29] These historic inequities are incorporated in alternative payment models and global budgets that often set lower overall budgets for the care of diverse and lower-income populations. The significant variation in global budgets established by insurers (both commercial and public payers including MassHealth) means that some doctors and health systems have more resources to care for their patients compared to others with a similar risk-adjusted panel of patients.

This practice needs to be reset so that there are equitable budgets. Additional resources are essential to advance health equity and address the greater social vulnerability of populations served by safety net health systems and providers. These greater needs are not fully captured and reflected in the traditional risk adjustment models.[30] The Task Force concurs with the Office of the Attorney General's 2020 report finding that, "COVID-19 has increased the urgency of swiftly addressing this problem by reimagining how we value and pay for health care."[31]

3.4. STRENGTHEN COMMUNITY HEALTH CENTERS

3.4.1. Invest in Community Health Center Rate Adequacy to Drive Access

Community health centers (CHCs) serve as the primary care safety net for the Commonwealth, caring for more than one million patients a year or one in seven state residents. Massachusetts Federally-Qualified Health Centers (FQHCs) predominantly serve patients who are low-income (84%), racial or ethnic minorities (67%), and best served in a language other than English (40%). By law and mission, FQHCs are located in Medically Underserved Areas or serve Medically Underserved Populations and are open to all, regardless of ability to pay. The vast majority of health center patients are publicly insured, subsidized, or uninsured.

The taskforce heard testimony about the chronic underpayment and resulting financial distress that left health centers in Massachusetts particularly vulnerable to the sudden revenue collapse brought

[27] Office of Attorney General, Examination of Health Care Costs Trends and Cost Drivers: 2011 Report for Annual Public Hearing, at page 27 [AGO 2011 report], available at http://www.mass.gov/ago/docs/healthcare/2011-hcctd.pdf
[28] AGO 2011 Report at page 31.
[29] https://www.mass.gov/doc/presentation-office-of-the-attorney-general-day-one/download slide 10
[30] Office of Attorney General, Commonwealth of Massachusetts, Examination of Health Care Cost Trends and Cost Drivers 2015 Report at page 29, available at https://www.mass.gov/doc/september-2015-examination-of-health-care-cost-trends-and-cost-drivers/download
[31] Office of the Attorney General, *Building Toward Racial Justice and Equity in Health: A Call to Action, 2020 at page 20,* available at https://www.mass.gov/doc/building-toward-racial-justice-and-equity-in-health-a-call-to-action/download

on by COVID-19 and the suspension of primary care services. Federal and state relief stabilized the health center network and enabled them to remain viable and respond to the pandemic while continuing to care for their patients, but the financial fragility of the health center network was exposed.

The need to increase payment for the services CHCs offer was recognized in both the Governor's health care legislation last legislative session, which called for thirty percent (30%) increases in primary care and behavioral health payment across all payers, including MassHealth, and the Attorney General's health equity report, entitled *Building Toward Racial Justice and Equity in Health: A Call to Action*, which called for fair and adequate payment for safety net providers, and specifically for community health centers in Medicaid.

Fair payment for health centers in Medicaid is not only good policy, but also an expectation under federal law. Increasing health centers' MassHealth payment will help to stabilize this critical network, but also catalyze growth in those services that improve health in the communities where the greatest inequities exist.

In addition, because health centers employ members of the diverse communities they serve, increased reimbursement will result in better pay and stimulate growth in these areas. Importantly to the task force, improved rates should also produce increased access to medical, behavioral, and oral health services. That means more community members served, shorter wait times for appointments, better retention of providers, improved outcomes, and reduced inequity for communities of color. The Task Force recommends significantly increasing Medicaid payment for Federally-Qualified Health Centers' comprehensive, all-inclusive model of care. Policymakers should also understand and make progress on commercial rate adequacy for community health centers.

3.4.2. Support Health Centers in "Growing Their Own" Workforce

Health centers have a long history of developing career ladder and advanced health professional training programs, both through the support of the state government and public-private partnerships. Training by and in health centers: expands access to care; produces providers with more experience serving diverse populations, who are more likely t o serve in underserved communities after training; and catalyzes economic empowerment and better paying jobs for local employees of health centers.

The state's current Medicaid 1115 Waiver has included historic investments in primary care and behavioral health workforce development programs. However, as the current Waiver approaches its end and the next waiver proposal is in development, policymakers must explore all options to ensure that there is a robust, racially and ethnically diverse, and well-trained pipeline of health care workers.

To that end, the Task Force recommends supporting health centers in "growing their own" workforce through training and retention efforts. The Commonwealth should take a multipronged approach to continuing and expanding these efforts, including through MassHealth financing mechanisms, pilot programs, 1115 Waiver investments, and enactment of the Community Health Center Transformation Fund as a tool to sustain these programs. Examples include:

- Nurse Practitioner residency training at health centers, including Family Medicine and Psychiatric Nurse Practitioners;

- Reestablishment of Medicaid Graduate Medical Education (GME) with a focus on health center-based residency slots;
- Loan repayment for health center providers with service commitment; and
- Career ladder programs for Community Health Workers, Medical Assistants, Social Workers and other behavioral health clinicians and other positions.

3.5. ADVANCE BEHAVIORAL HEALTH EQUITY

The COVID-19 pandemic layered additional challenges onto an already fragile behavioral health system that has led to a current crisis situation. The Commonwealth has taken important steps to respond to the behavioral health aspects of the COVID-19 pandemic; however, persistent challenges and historical health inequities have been exacerbated and must be addressed.

Approximately half a million adults in the Commonwealth are living with serious and debilitating psychological distress, according to an analysis of the Medical Expenditure Panel Survey conducted by the Health Equity Research Lab. Of this group, only about 40 percent of Blacks and Latinos, and 30 percent of Asians received any type of mental health treatment. This means that 60,000 - 70,000 racially/ethnically diverse adults in Massachusetts with serious psychological distress are disconnected from any type of mental health treatment.[32]

Racially and ethnically diverse populations living with mental illness are more likely to have persistent and severe mental illness than their white counterparts.[33] Diverse people living with mental illness are more likely to be arrested and incarcerated than their white counterparts. Many people of color are receiving behavioral health treatment in correctional facilities, as one testimony referenced as “a second behavioral healthcare system for people of color.”[34]

As detailed below, a range of matters - from race and ethnicity to language, age, sexual orientation, gender identity, socioeconomic status, geography, insurance policies and reimbursement, and workforce development - must be acknowledged and addressed in order to advance equity in behavioral healthcare.

3.5.1. Respond to Urgent Behavioral Health-Related COVID-19 Needs and Strengthen the Behavioral Health Delivery System

---

[32] Equity Research Lab's analysis of nationally representative Medical Expenditure Panel Survey applied to 2020 U.S. Census figures of the non-institutionalized adult population sizes of racial and ethnic groups in Massachusetts. Updated analysis adapted from Cook, B. L., Zuvekas, S. H., Carson, N., Wayne, G. F., Vesper, A., & McGuire, T. G. (2014). Assessing racial/ethnic disparities in treatment across episodes of mental health care. Health services research, 49(1), 206-229. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3844061/
Alegría, M., Cook, B., Loder, S., Doonan, M. (2014). *The Time is Now: Tackling Racial and Ethnic Disparities in Mental and Behavioral Health Services in Massachusetts*, Issue Brief, Massachusetts Health Policy Forum, December 11, 2014.
[33] Williams, D. R., Gonzalez, H. M., Neighbors, H., Nesse, R., Abelson, J. M., Sweetman, J., & Jackson, J. S. (2007). Prevalence and distribution of major depressive disorder in African Americans, Caribbean Blacks, and Non-Hispanic Whites: Results from the National Survey of American Life. *Archives of general psychiatry*, *64*(3), 305-315.
Breslau, J., Kendler, K. S., Su, M., Gaxiola-Aguilar, S., & Kessler, R. C. (2005). Lifetime risk and persistence of psychiatric disorders across ethnic groups in the United States. *Psychological medicine*, *35*(3), 317.
[34] Thompson, Melissa, Kimberly Barsamian Kahn, Jean McMahon, and Madeline O’Neil. "Mental illness, race, and policing." In *The Politics of Policing: Between Force and Legitimacy*. Emerald Group Publishing Limited, 2016.

COVID-19 has starkly exposed the pre-pandemic vulnerability in the behavioral health delivery system and gaps in the continuum of care for persons in need of behavioral health services. At the same time, the need for behavioral health care has increased substantially during the pandemic.[35] This has created an urgent need for additional mental health and substance use disorder inpatient capacity, outpatient care, and culturally and linguistically appropriate mental health services for patients of all ages, and especially for children and adolescents.

Significant emergency department boarding for patients awaiting psychiatric inpatient care placement is a major area of current state focus. As a result of the pandemic, the length of time behavioral health patients wait in an emergency department for an inpatient placement has increased substantially. Often patients present at an emergency department with psychiatric needs and end up waiting days for a behavioral health level of care placement; a situation referred to as emergency department boarding.

Patients turn to emergency department resources because of the acuity of their psychiatric and/or co-occurring conditions and/or a lack of community-based levels of care. This can be related to deficiencies in other parts of the behavioral health continuum of care (i.e., emergency response systems and/or community resources that could potentially help prevent emergencies). Furthermore, the current trend also reflects increased need for inpatient psychiatry treatment, especially among children and youth, and the loss of nearly 270 inpatient psychiatry beds due to facility closures and reduced bed capacity due to COVID-19 precautions. As of February 2021, there were up to 300 - 400 patients daily boarding in emergency departments across the state awaiting an inpatient psychiatry placement.[36] At the same time, there is an increase in high acuity patients.

In light of the continued and urgent need, the Administration, supported by the Legislature, has launched important incentive funding and enhanced MassHealth per diem rates to encourage expanded and new behavioral health inpatient capacity, including for youth and adults. Hospitals have committed more than 200 inpatient beds across the spectrum of youth, adults, and older adults.[37] The enhanced MassHealth rates for incremental inpatient psychiatry bed capacity are presently time-limited - one year for adults and up to three years for youth and children. .Long-term funding support beyond this time horizon is needed to sustain these essential services.

In addition to the steps to expand acute inpatient behavioral health capacity, urgent action is needed to enhance the Department of Mental Health (DMH) capacity to provide long-term treatment. The Task Force learned that approximately 100 DMH clients are "stuck" in acute inpatient behavioral health units, some for more than 6 months awaiting admission to DMH Continuing Care Treatment. This long-standing problem appears to be heightened during the pandemic.

Strengthening the community-based treatment system is also important to ensure that treatment across the care continuum is available to those who need it. Community residential capacity is also urgently needed, which can be supported in part through continued and increased funding for the DMH Rental Subsidy Program. This supported housing program helps DMH clients transition to the community via affordable housing, where clinical and social services are provided to support their tenancy, wellness, and recovery.

[35] The Implications of COVID-19 for Mental Health and Substance Use, Issue Brief published by the Kaiser Family Foundation, February 21, 2021, available at:
https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/
[36] Massachusetts Department of Mental Health and MassHealth updates via trade organization meetings
[37] Massachusetts EOHHS briefing on Behavioral Health Roadmap, February 24, 2021

Many behavioral health providers indicated that direct provider funding is needed to support the increased costs associated with the COVID-19 pandemic, including for workforce needs and staffing shortages, enhanced coordination and technical assistance for Personal Protective Equipment (PPE) acquisition, infection control, surveillance testing and vaccination efforts by behavioral health programs. During this time of intense need, supplemental funding for behavioral health staff could help prevent turnover and help fill current job openings for behavioral health workers, sitters and clinical staff.

The behavioral health system must be better equipped and designed to include appropriate inpatient placements (inclusive of new inpatient and community-based acute treatment capacity as well as partial hospitalization programs) and a more robust outpatient system including crisis stabilization services for children:

- Children/adolescents with co-occurring behavioral health/ autism spectrum disorder (ASD)/ intellectual and developmental disabilities (IDD);
- Children/adolescents with co-occurring behavioral health/chronic medical conditions;
- Department of Children and Families-involved youth with serious behavioral health conditions;
- Children exhibiting aggressive/assaultive behaviors; and
- Young children through age 6 in need of outpatient care after discharge from higher levels of inpatient care.

Long-term behavioral health impacts of the COVID-19 pandemic must be monitored to guide proportionate state response.

In February 2021, the Baker Administration announced a *Roadmap for Behavioral Health Reform: Ensuring the Right Treatment When and Where People Need It*.[38] The Task Force welcomes this development and the further details that are forthcoming as part of the crucial and timely policy response to strengthen the behavioral health system across the Administration, the Legislature, stakeholders, and providers.

3.5.2. Address Health Disparities for People with Behavioral Health Concerns through a Multi-Agency/Stakeholder Commission

Behavioral health equity is a longstanding issue that will require concerted policy and societal efforts to address. Statewide, multi-agency, and cross-sector efforts in partnership with stakeholders are needed. Given the enormity of the task ahead, over multiple years, the Task Force recommends a Multi-Agency and Stakeholder Commission to Address Behavioral Health Disparities to map out the work and monitor progress on the pressing areas of recommendations in this report. The Commission shall meet not less than quarterly and issue publicly-available annual reports tracking progress and making legislative, regulatory or budgetary recommendations.

[38] Roadmap for Behavioral Health Reform: Ensuring the right treatment when and where people need it, Massachusetts Executive Office of Health and Human Services; https://www.mass.gov/doc/roadmap-for-behavioral-health-reform-ensuring-the-right-treatment-when-and-where-people-need-it/download

In addition to the topics of behavioral health equity outlined in this report, focus areas for the Commission should include but not be limited to:

- Improving access to, and the quality of, culturally competent behavioral health services including (i) the need for greater racial, ethnic and linguistic diversity within the behavioral health workforce; (ii) the role of gender, gender identity, race, ethnicity, linguistic barriers, status as a client of the department of children and families, status as an incarcerated or formerly incarcerated individual, including justice-involved youth and emerging adults, status as a veteran, status as an individual with post-traumatic stress disorder, status as an aging adult, sexual orientation and social determinants of health regarding behavioral health needs; and (iii) any other factors that create disparities in access and quality within the existing behavioral health service delivery system, including stigma, transportation and cost; and
- Developing a set of evidence-based prevention and early intervention initiatives, given their impact on the onset and progression of behavioral health conditions including those that arise and/or become evident during the adolescent and young adult years.

The Commission to address health disparities for individuals with behavioral health conditions should include representation from:

- State agencies (such as Massachusetts Department of Mental Health, Department of Public Health and its Bureau of Substance Addiction Services, MassHealth, Department of Children and Families, Executive Office of Elder Affairs, and the Executive Office of Public Safety and Security);
- The Legislature (such as the Chairs of the Joint Committee on Mental Health, Substance Use and Recovery and the Chairs or designees of the Massachusetts Black and Latino Legislative Caucus and the Massachusetts Asian American Legislative Caucus);
- Health and behavioral health system (representing the outpatient and inpatient continuum of care including primary care-behavioral health integration and school-based mental health);
- Persons with lived experience;
- Family members and parents of children with lived experience;
- Racial/ethnic equity advocacy groups and linguistic equity advocacy groups;
- Behavioral health advocacy and trade organizations;
- Organizations providing services for individuals with housing insecurity;
- Criminal justice/legal system; and
- Organization serving the health care needs of the lesbian, gay, bisexual, transgender, queer and questioning community.

3.5.3. Develop Robust, Publicly Available Data on Behavioral Health Clinical, Demographic, and Disparities in the Commonwealth

Disparities in access to behavioral health services across the Commonwealth vary based on factors

such as race/ethnicity, language, age, socioeconomic status, geography, sexual orientation, gender identity, and insurance. However, there is little data collected to analyze the issues and develop policy, program and resource responses. While there are recommendations for stratified data collection in section 7.4, the Task Force emphasizes the need to do so for persons with behavioral health diagnoses, including the need for health status indicators for persons with psychiatric diagnoses.

Robust clinical and access data stratified by demographic factors is foundational to improving behavioral health services, access, and outcomes. The data should include health status indicators for persons with psychiatric diagnoses to assess disparities in health, rates of evidence-based screening in primary care and other settings for depression, substance use disorder, and other behavioral health conditions, and data on whether patients who screened positively received the follow-up care they needed.

3.5.4. Invest in Resources and Funding for Behavioral Health Services, Including Integration of Behavioral Health and Physical Health

Behavioral health has been chronically underfunded (below the cost of care) by public and private payers. This overall lack of resources makes it difficult to sustain behavioral health services let alone expand them to meet growing and complex needs. New and sustained investments are needed. For instance, the Administration's investments (with legislative support) for new inpatient psychiatry capacity through enhanced MassHealth per diem reimbursement for new inpatient bed days is time-limited. Permanent and enduring funding is needed.

Legislation to require more sustainable behavioral health inpatient and outpatient payment rates is needed in public and private insurance. In addition, Medicaid, a predominant payer for people with behavioral health conditions, must improve its reimbursement methodology to recognize the costs of this care. Every MassHealth managed care product should be transparent about their behavioral health rates and be accountable for their adequacy in covering the costs of care for Medicaid populations. Regular rate reviews must be incorporated for MassHealth reimbursement.

Furthermore, an important way of improving overall health, access, and health disparities is the integration of behavioral health and physical health care services, particularly in primary care. This model can facilitate evidence-based screening for mental health and substance use disorder and connect individuals to care often within the same primary care setting. In addition, there are promising behavioral health home models that integrate primary care into specialty behavioral health settings to make sure that individuals with serious mental health concerns are also receiving health screenings and care.

It is important that care delivery and payment models adequately reimburse for these services, including many integrated functions that are not presently reimbursed in the insurance system, such as brief consultations by and introductions to behavioral health clinicians in the primary care setting and care management for mental health and substance use disorder treatment including medication-assisted treatment for opioid use disorder.

Integral to tracking investments in behavioral health is adopting policies such as those proposed for the Commonwealth's health care cost trends process, supported by the Center for Health Information and Analysis and the Health Policy Commission, to tracking behavioral health expenditures as part of its annual cost trends reporting and hearing process.

3.5.5. Achieve Behavioral Health Parity

There remains a stark lack of parity between behavioral health and physical health insurance coverage. While the concept of "parity" is part of federal and state laws, it has been challenging to enforce. And these barriers are especially pronounced for low-income and diverse populations.

Examples of disparities between the two include the requirement for prior authorization for many behavioral health services, reimbursement - with behavioral health paid significantly less, the comprehensiveness - or lack thereof - of covered benefits, and limited access to some providers who are "out of network." Benefit access is not equivalent across insurances. For instance, commercially-insured individuals do not necessarily have access to crisis mental health services, residential rehabilitation services, recovery coaching or peer support. Within MassHealth, some members have access to services such as intensive outpatient programs and structured outpatient addiction programs, while others do not. Many behavioral health providers do not presently participate in certain insurance products.

The Task Force recommends legislative action toward full mental health parity in the 2021-2022 legislative session. This should include providing the state with more effective tools to enforce existing mental health parity laws. It is also integral to address barriers in insurance such as preauthorization requirements for behavioral health services that may be more restrictive when compared to those for medical and surgical services so that medical necessity determinations are made by the treating clinician. Because behavioral health covered services are not consistent across insurance products, there is an opportunity to explore policies in this direction. Other policies would ensure behavioral health parity through regular market conduct examinations; enhanced opportunities and resources for consumers to assert parity rights; network adequacy standards; and parity of reimbursement rates for behavioral health providers and medical providers. Achieving behavioral health parity is a shared responsibility of private and public payers and the behavioral health delivery system.

3.5.6. Invest in Lasting Behavioral Health Workforce Improvements

The ability to recruit and retain qualified behavioral health staff is among the greatest impediments to improving behavioral health access. The shortages in key behavioral health workforce positions warrant concerted action. These shortages are in all levels of the behavioral health workforce including behavioral health workers, registered nurses, clinical nurse specialists, licensed practical nurses, behavioral health associates providing one-on-one "sitter" care, social workers, psychiatrists, recovery coaches, care managers, and direct care counselors.

The Task Force calls for improvement to support and expand the behavioral health workforce through a variety of targeted initiatives. These include but are not limited to significant expansion of the student loan repayment program (including under the Medicaid 1115 Waiver) to include both inpatient and community-based behavioral health providers and additional behavioral health profession types, scholarships, and workforce training programs.

Emphasis should be placed on growth in the behavioral health workforce to meet the needs across the continuum of care and that is reflective of the racial and cultural diversity of the population with the ability to meet cultural and linguistic needs. Removing financial and other barriers to education would support people entering behavioral health careers and continuing their professional development.

Partnerships with universities and community colleges are integral to expanding and diversifying the behavioral health workforce. Graduate medical education funding is necessary for the training of future physicians and psychiatrists, including child and geriatric psychiatrists which are in shortage. A step in the direction would be to re-initiate Medicaid graduate medical education funding for psychiatrists. A promising workforce pipeline pilot to encourage a culturally, ethnically and linguistically diverse behavioral health workforce through collaboration between colleges and behavioral health providers was recently adopted as part of the FY'21 state budget law within budget line-item 4513-2020.

Additional reimbursement is a critical priority to be able to recruit and retain a behavioral health workforce. Pay must be increased for certain positions like mental health workers and differentials paid for hard to fill shifts. Testimony suggested creating a fund that hospitals could access for adding staff to meet fully licensed bed capacity; the fund could have safeguards to be used only when a hospital has had to close a unit or is unable to open a new unit due to staffing. Additional testimony was received about support needed to address staff vacancies across the entire behavioral health system.

Peer support, recovery coaches, community health workers, and family partners, who play critical roles in helping patients and families engage in behavioral health care should be added as covered benefits in Medicaid, supported by federal matching funds, and in commercial insurance. The Task Force supports legislation and Administrative actions to add these services as covered benefits in commercial insurance and within the Medicaid program, with federal matching funds.[39] [40] [41]

Furthermore, expanding the behavioral health workforce is also a matter of lessening the administrative complexities of insurance for providers so that more of them will participate, building on the recent legislative progress requiring a uniform credentialing form. A relevant study authorized within the FY'21 state budget law (budget line-item 4513-2020) has great promise to provide informative variables about the availability of culturally competent behavioral health providers within networks of both public and private health care payers. It will also identify potential barriers to care for underserved cultural, ethnic, linguistic, and other populations in the community; geographic challenges to access culturally competent providers; and training opportunities for providers to most effectively serve diverse populations.

3.5.7. Improve Behavioral Health Treatment at the Intersection with the Justice System

A multi-faceted strategy is recommended to effectively reduce health disparities among individuals with behavioral health conditions intersecting with the criminal justice system.

First, there should be investment in alternatives to law enforcement response to people in behavioral health crises and those in need of treatment services. Co-responder programs, such as partnerships between behavioral health professionals and the police, should be bolstered and built upon. There are promising models around the country, including those in Oregon and Missouri described below, that successfully divert the police from situations that require mental health

[39]https://www.macpac.gov/wp-content/uploads/2019/07/Recovery-Support-Services-for-Medicaid-Beneficiaries-with-a-Substance-Use-Disorder.pdf
[40] https://www.medicaid.gov/sites/default/files/2019-12/clarifying-guidance-support-policy.pdf
[41] https://www.nashp.org/wp-content/uploads/2019/11/SUD-Scan-findgs-final-11.21.19.pdf

intervention. This should be coupled with continued education of law enforcement officers in de-escalation techniques when interacting with individuals experiencing behavioral health distress.

Second, with policy changes, the existing emergency response system could better triage people in behavioral health crises away from law enforcement and to behavioral health care and the services described above. Several legislative proposals, including those noted below, merit consideration to improve the 911 system to better include behavioral health emergencies and to integrate the federal 988 system.

Third, policy efforts are needed to reduce trauma inflicted on persons who are incarcerated, addressing the documented harm to individuals with behavioral health conditions within the prison system. Fourth, there is an opportunity to vastly improve and coordinate the care of individuals upon release from the justice system.

PROMISING PRACTICES FROM OTHER STATES

OREGON

Eugene, Oregon has successfully implemented an innovative community mental health partnership with the Eugene Police Department that has been in place for nearly 30 years and is integrated in the community. The Crisis Assistance Helping Out On The Streets (CAHOOTS) is a mobile crisis intervention program in which behavioral health personnel provide primary and joint response, diverting 5 - 8% of calls from police for situations that require behavioral health intervention. CAHOOTS personnel often provide initial contact and transport for people with substance use and/or mental health concerns and transport for necessary non-emergency medical care.[42]

Each team consists of a medic (either a nurse or an EMT) and a crisis worker experienced in the mental health field. CAHOOTS provides immediate stabilization in case of urgent medical need or psychological crisis, assessment, information, referral, advocacy and transportation to the next step in treatment as needed. Services include but are not limited to:

- Crisis Counseling
- Suicide Prevention, Assessment, and Intervention
- Conflict Resolution and Mediation
- Grief and loss
- Substance Abuse
- Housing Crisis
- First Aid and Non-Emergency Medical Care
- Resource Connection and Referrals
- Transportation to Services.[43]

MISSOURI

Missouri's Community Mental Health Liaison (CMHL) program launched in 2013 as part of the Strengthening Mental Health Initiative. Thirty-one CMHLs employed by community behavioral health organizations work across the state to assist law enforcement and courts to link individuals with behavioral health needs to appropriate treatment and follow-up.

The goal is to form better community partnerships between Community Mental Health Centers, law enforcement, and courts to save valuable resources that might otherwise be expended on unnecessary jail, prison, and hospital stays and to improve outcomes for individuals with behavioral health issues.[44]

---

[42] https://www.eugene-or.gov/4508/CAHOOTS
[43] https://whitebirdclinic.org/cahoots/
[44] Missouri Community Mental Health Liaison Fact Sheet: https://www.mocoalition.org/community-mental-health-liaison
https://41e56e24-d282-42b5-b0f1-f16abf1bc04b.filesusr.com/ugd/6dadf9_4fff4740c18e4801bb7a973e66d99dc8.pdf

3.6. SUPPORT, EXPAND, AND DIVERSIFY THE HEALTH CARE WORKFORCE TO REFLECT THE POPULATION

The Task Force expresses its deep gratitude and respect for the extraordinary work of healthcare professionals at all levels for the care and compassion they have provided throughout the pandemic. At the same time, the COVID-19 pandemic has amplified stressors faced by the healthcare workforce including staffing shortages, the need to diversify the workforce to reflect the population, to support racially, ethnically, and linguistically competent care, to assist patients with new healthcare modalities including telehealth, and to compensate staff appropriately.

During the pandemic, we have seen significant percentages of staff leaving healthcare positions for industries with higher pay. Substantial testimony was received by the Task Force about the need for additional investments in rates of hospital and provider payment, especially for behavioral health providers, nurses, allied health professionals and other health professionals. According to some behavioral health organizations, the ability to recruit and retain qualified staff remains among the greatest challenges faced by behavioral health providers, slowing down improvements to behavioral health access.

3.6.1. Deploy State Initiatives and Funding to Advance the Healthcare Workforce and Create Career Ladders

The Task Force recommends state funding and initiatives, including those federally-supported under the Medicaid 1115 Waiver renewal, to provide health care career and pipeline development, student loan-forgiveness, job training and mentoring programs as pathways for current and prospective members of the healthcare workforce, with an emphasis on doing so for healthcare clinicians and professionals from diverse backgrounds and with multilingual capabilities.

Testimony was offered suggesting a Request for Information to gain input on health care professions, shortages, and vacancies at all levels and recommended strategies, potential state or regional programs, investments, and/or barriers to be addressed. This should be accompanied by an annual for bi-annual review of key workforce needs thereafter.

Furthermore, several important initiatives to improve the process and timeliness for the licensing of healthcare professionals to practice in Massachusetts were brought to the attention of the Task Force. Examples include legislation to require the Board of Registration in Medicine to process physician licensure applications within 90 days; to make recommendations to facilitate interstate medical practice (with implications for telehealth); and to authorize Massachusetts to enter into the Nurse Licensure Compact, allowing a nurse to have one license in their state of residency and to practice in other states, subject to the nurse practice law and regulations of each state.

Testimony was also received about livable wages (including for nursing home, home health, behavioral health, peer support workers, among other workforce members) and other employment supports for essential health care workers.

3.6.2. Activate the Commission Charged with Making Recommendations on Licensing and Practice for Foreign-Trained Health Professionals

There are an estimated 3,000 foreign-trained medical professionals in Massachusetts, including

physicians, nurses, dentists and other health professionals. The challenge for physicians is they must complete a three-year residency in the US, within five years of graduating from medical school to qualify to sit for a test for their license. Other professions have similar barriers. This is a high bar for people who are often in the country as refugees and immigrants with few personal resources.

The rich resource of highly trained but underutilized foreign-trained health professionals would not only meet a critical need for providers, but also enhance the racial and ethnic diversity, and cultural and linguistic capacity of the health care workforce, acute needs even prior to the pandemic.

During COVID-19, there was a desperate need for medical personnel and a modest change was made in the requirements. Governor Baker issued an executive order that allowed the Board of Registration in Medicine to license foreign-trained physicians who had completed two years of a US accredited training program. New York issued a similar executive order that required one year of such training. This was important progress, and more is needed.[45]

Last year, legislation passed that directed the Massachusetts Department of Public Health to form a commission to review licensing and practice for foreign trained health professionals and make recommendations with the goal of improving medical service in rural and underserved areas. In fact, this is the second time the Commonwealth has attempted this approach. In 2014, Governor Deval Patrick also formed a commission. The current Commission has not yet been convened. The Health Equity Task Force understands that MDPH has been fully consumed with responding to the COVID-19 crisis. The Health Equity Task Force encourages the Governor to direct the MDPH to appoint and convene the commission.

PROMISING PRACTICES FROM OTHER STATES

Minnesota

After creating a Task Force that submitted a set of recommendations, Minnesota launched the International Medical Assistance Program. It is implemented through community-based organizations, residency program providers, and other stakeholders. Community based organizations provide career guidance and support, funding assistance for testing fees, interview preparation, and general support so its participants can become "residency ready." The University of Minnesota offers a clinical assessment as well as a rigorous nine-month clinical experience program to further assist IMGs in meeting residency requirements. Last, but not least, the IMG assistance program offers funding for residency spots dedicated to IMGs in primary care. Participants selected in the dedicated IMG residency spots must sign a commitment to work in a rural or urban high-need area and pay fifteen thousand dollars into the program once they join the workforce. The program is administered through the Minnesota Department of Health.[47]

Arkansas

In 2019 Arkansas enacted SB 456, a bill requiring that the academic licensee practice under the supervision of a faculty member licensed by the Arkansas State Medical Board, adding a supervised clinical element to the existing academic license. An IMG who practices medicine under an academic license for a period of two consecutive years is eligible for an active, unrestricted license to practice medicine in the state, without needing to complete a U.S. residency.[48]

Additional state policy options put together by WES, Global Talent Bridge, a non-profit "dedicated to helping skilled

[45] https://www.mass.gov/doc/april-9-2020-foreign-medical-doctors/download
[46] https://budget.digital.mass.gov/summary/fy20/outside-section/section-102-special-commission-on-foreign-trained-medical-professional-licensure
[47] https://www.health.state.mn.us/facilities/ruralhealth/img/index.html
[48] https://www.arkleg.state.ar.us/Acts/Document?type=pdf&act=701&ddBienniumSession=2019%2F2019R

immigrants fully utilize their talents and education in Canada and the United States."[49]

3.6.3. Support Training and Initiatives that Increase Cultural Sensitivity, Address Racism, and Uncover the Implicit Bias in Health Care

Testimony was received by the Task Force about the need for training and initiatives that increase cultural sensitivity, address racism, and uncover the implicit bias that is currently rooted in the health system. The Task Force heard testimony from many individuals and families, of diverse racial and ethnic backgrounds, abilities, diagnoses, and gender identity, about the challenges they have faced within the health system that should be addressed through the training and other initiatives across the statewide healthcare system. Funding for statewide collaboratives is needed to carry out this training, and this training should be informed by and involve persons with lived experience.

Not only have these challenges led to the health disparities addressed in this report, they have fostered distrust in the healthcare system. As a step towards preparing for the future and building trust between structurally marginalized communities and the healthcare system, a process of sustained community engagement by all aspects of the public and private healthcare and public health systems is suggested.

3.7. ADVANCE HEALTH EQUITY THROUGH MASSACHUSETTS MEDICAID

Massachusetts is preparing its Medicaid 1115 Waiver demonstration renewal proposal to the federal government in the Spring of 2021 for submission in the summer of 2021. Medicaid 1115 demonstration Waivers provide federal flexibility for state Medicaid programs to test innovations that support the goals of the Medicaid program, including improving health care outcomes and reducing costs.[50]

Massachusetts has been leading the nation both in coverage expansions and in implementing new population health models through the MassHealth Accountable Care Organization (ACO) program, which covers approximately 1.3 million MassHealth members. Overall, MassHealth provides essential health care coverage to 2 million members, including 800,000 low- and moderate-income adults (40% of all members), 680,000 low- and moderate-income children (35% of all members) and 293,000 people with disabilities and 191,000 seniors (combined, 25% of all members).[51]

The Medicaid Waiver and accompanying Medicaid policies are an opportunity to attain federal support for extending postpartum Medicaid coverage and adding doula services, improving health equity, funding health-related social needs, and continuing retroactive MassHealth coverage beyond the pandemic. Please see the behavioral health section of this report for recommendations to add or augment peer support, recovery coaches, community health workers, and family partners as MassHealth covered benefits. Other Medicaid policies such as those affecting estate recovery for low-income seniors and persons with disabilities call out for reform using an equity lens.

---

[49] https://www.imprintproject.org/wp-content/uploads/2020/09/Removing-Barriers-to-Practice-State-Policy-Options.pdf
[50] https://www.mass.gov/doc/section-1115-listening-session-1/download
[51] https://www.mass.gov/doc/executive-office-of-health-human-services-governor-bakers-fy2022-budget-proposal-january-27/download

3.7.1. Promote Maternal Health by Extending Maternal Postpartum Care Coverage in MassHealth from the current 60 Days to 12 Months and Adding Doula Services

Maternal mortality is a growing health crisis in the United States. A recent 2020 study by the Commonwealth Fund reports that the United States has the highest maternal mortality rate among developed countries. Multiple factors contribute to this including access to maternity care providers and comprehensive postpartum supports.[52]

Women of color are disproportionately impacted and more likely than white women to die or experience serious illness and injury due to pregnancy-related causes. Black women have a pregnancy-related mortality rate nearly three times higher than white women.[53]

Medicaid plays an important role in improving maternal and perinatal outcomes. In Massachusetts, MassHealth covers 35% of births. Massachusetts has expanded MassHealth to many low-income residents, including pregnant and postpartum women. Yet, some postpartum women experience disruptions in coverage and care under current eligibility rules, leading to delays in identifying and treating pressing health challenges. Pregnancy-associated mortality increased 33% in Massachusetts between 2012 and 2014, the latest time period for which publicly available data is available.

Timely postpartum visits provide an opportunity to address chronic health conditions, such as diabetes and hypertension; mental health status, including postpartum depression; and substance use disorders.[54]

The Task Force supports legislative and administrative action to promote maternal health through extending postpartum Medicaid Coverage from the current 60 days to 12 months and adding coverage of doula services. Of note, there are promising recent developments at the federal and state levels. The American Rescue Plan Act of 2021 gives states the option for 5 years to extend postpartum Medicaid/CHIP coverage for 12 months through their Medicaid State Plan or waiver thereof.[55] This new option goes into effect on April 1, 2022, and MassHealth will be submitting a State Plan Amendment to request authority for the option as of April 1, 2022.[56]

In the meantime, on March 23, 2021, MassHealth announced its intent to file an 1115 Waiver amendment that includes the extension of postpartum coverage to 12 months, including for immigrant populations. If approved, this would provide coverage for the next year until the ARP goes into effect, making Massachusetts a leader in providing postpartum Medicaid coverage, a critical policy lever to help address gaps in coverage and care.

In order to further support pregnant women, MassHealth should be prepared to pursue Medicaid coverage for doula services through available federal authorities, including the upcoming Medicaid 1115 Waiver renewal or a Medicaid State Plan Amendment.

---

[52] https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries
[53] https://www.kff.org/report-section/racial-disparities-in-maternal-and-infant-health-an-overview-issue-brief/
[54] https://www.medicaid.gov/state-overviews/scorecard/postpartum-care/index.html
[55] Public Law No: 117-2, Sections 9812 and 9822 https://www.congress.gov/bill/117th-congress/house-bill/1319/
[56] https://www.mass.gov/doc/1115-masshealth-demonstration-waiver-amendment-public-listening-session-3312021-0/download

Doula services encompass physical, emotional, and informational support, but not medical care, for pregnant women, surrogates, foster care parents and adoptive parents during and after pregnancy, labor, childbirth, miscarriage, stillbirth or loss. This may include accompanying pregnant individuals to health care and social services appointments and connecting them to community-based and state- and federally-funded resources, including those which address needs within the social determinants of health.

Private insurers should review their postpartum coverage to make sure it recognizes coverage for conditions that extend beyond 90 days. The Task Force also received testimony about geographic access barriers to maternal health care.

PROMISING PRACTICES FROM OTHER STATES

POSTPARTUM COVERAGE

There are presently two approaches states can take to implement an extension of postpartum coverage from 60 days to 12 months: through the use of state-only funds or through a Medicaid Section 1115 Waiver. Note that the recently passed federal American Rescue Plan Act (Public Law No: 117-2) gives states this option of extending postpartum coverage to 12 months through their Medicaid State Plan effective in April 2022.

Extending Medicaid coverage to postpartum women beyond 60 days is emerging as a key state strategy to address the maternal mortality crisis, according to analysis prepared by the National Academy for State Health Policy.[57]

At least 24 states have taken steps to consider legislation, budget, and federal proposals to extend postpartum coverage. An interactive map and chart summarize proposed and approved legislation since 2018, Medicaid Waivers, financial estimates, and other initiatives designed to extend coverage during the postpartum period. Under the Families First Coronavirus Response Act, Medicaid enrollees who typically lose coverage after 60 days postpartum cannot be disenrolled until the end of the month in which the public emergency period ends. Several states have taken the step of filing Medicaid 1115 Waivers to extend postpartum Medicaid coverage including South Carolina, Georgia, Illinois, Indiana, Missouri, New Jersey, and Tennessee.

DOULA SERVICES

Several states, including Minnesota, Oregon and New Jersey, include Medicaid coverage for doula services. Under federal law, state Medicaid programs must cover a set of mandatory benefits, and states can also opt to offer optional benefits within federal guidelines. Several state Medicaid agencies have chosen to cover doula services as an optional benefit.[58]

OREGON

Oregon's Medicaid program has covered doula services as a preventive service since 2017.[59] The Oregon Health Authority covers two prenatal and two postpartum sessions and doula support during labor and delivery.

MINNESOTA

Minnesota's Medicaid program has covered doula services as an extended service since 2014.[60] It includes up to seven sessions with a doula, which include prenatal and postpartum support as well as during labor and delivery.

NEW JERSEY

---

[57] https://www.nashp.org/view-each-states-efforts-to-extend-medicaid-coverage-to-postpartum-women/

[58] https://www.nashp.org/four-state-strategies-to-employ-doulas-to-improve-maternal-health-and-birth-outcomes-in-medicaid/#toggle-id-4

[59] https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OR/OR-17-0006.pdf

[60] https://mn.gov/dhs/assets/14-07-spa_tcm1053-270737.pdf

New Jersey announced that its Medicaid program, known as NJ FamilyCare, will cover doula services effective January 1, 2021.[61] [62]

3.7.2. Integrate Health Equity Initiatives in Medicaid 1115 Waiver, including Innovations for Health-Related Social Needs and "Flexible Services"

The Medicaid Waiver renewal is an opportunity to advance health equity, including measures and initiatives to expand care and address social factors in health. Massachusetts' current Waiver includes a provision for "flexible services" funding that is being used to assist members and test whether MassHealth Accountable Care Organizations can improve members' health outcomes and reduce total costs of care through targeted evidence-based programs that address nutrition and housing needs. There is substantial support for continuing and building on this program.

Consistent with Massachusetts' experience this Medicaid Waiver term, there is an opportunity to further advance initiatives toward whole person care, including more integration of supported housing options. Promising practices from other states' Medicaid demonstration programs should be considered in Massachusetts.

PROMISING PRACTICES FROM OTHER STATES

CALIFORNIA

California's Medicaid Waiver, "Medi-Cal 2020 Waiver", initiated Whole Person Care (WPC) Pilots and is currently operating under an extension through December 2021. The state received authority and up to $1.5 billion in federal funds to pilot an innovative new approach to engaging and treating Medicaid beneficiaries who are high-utilizers of the health care system or present complex physical, behavioral, or social needs. Under this initiative, California counties and other local entities were provided the opportunity to develop and implement their own WPC pilot programs within certain parameters. The pilots are designed to coordinate physical health, behavioral health, and social services (e.g., housing supports) for one or more of the designated target populations, which include high utilizers with two or more chronic conditions, individuals who are homeless or at risk of homelessness, or individuals with a behavioral health condition or substance use disorder.[63] [64] [65]

OREGON

Since 2012, Oregon has fostered partnerships between its Medicaid accountable care organizations (called coordinated care organizations or CCOs) and community-based organizations (CBOs). These CCO/CBO partnerships have helped reduce health inequities by addressing both individual CCO members' social needs and community social determinants of health.

Recently, Oregon launched a five-year, second phase of its CCO program, called CCO 2.0, recognizing that many things affect health outside of the doctor's office. CCOs will increase their investments in strategies to address social determinants of health and health equity. CCOs will build stronger relationships with members, nonprofit organizations, hospitals, schools, and local public health departments. CCOs will align goals at the state and local level to improve health outcomes and advance health equity. Oregon is developing measurement and evaluation strategies to increase understanding of spending in this area and track outcomes.[66] [67] Recommended policies will:

[61] https://www.nj.gov/governor/news/news/562021/20210202b.shtml
[62] https://www.medicaid.gov/Medicaid/spa/downloads/NJ-20-0011.pdf
[63] https://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx
[64] https://caph.org/wp-content/uploads/2019/04/wpc-4.11.19.pdf
[65] https://caph.org/wp-content/uploads/2018/05/WPC-Brochure-7.20.2018.pdf
[66] https://www.nashp.org/oregons-community-care-organization-2-0-fosters-community-partnerships-to-address-social-determinants-of-health/
[67] https://www.oregon.gov/oha/OHPB/CCODocuments/2018-OHA-CCO-2.0-Report-Executive-Summary.PDF

- Increase strategic spending by CCOs on social determinants of health, health equity and disparities in communities, including encouraging effective community partnerships
- Increase CCO financial support of non-clinical and public health providers
- Align community health assessment and community health improvement plans to increase impact
- Strengthen meaningful engagement of tribes, diverse members, and community advisory councils
- Build CCOs' organizational capacity to advance health equity
- Increase the integration and use of traditional health workers.

3.7.3. Continue and Restore MassHealth Retroactive Coverage Beyond the Pandemic

While federal law allows for 90 days retroactive Medicaid coverage from the time a person applies, Massachusetts has obtained a waiver to provide only 10 days of retroactive coverage. However, during the COVID-19 public health emergency, MassHealth has been providing at least 90 days of retroactive coverage. The Task Force calls on the Administration and the Legislature to take action to make permanent 90-day retroactive coverage prior to the date of the application for MassHealth coverage. This is in keeping with the federal Medicaid minimum standards of coverage.

3.7.4. Protect the Homes of Seniors and Persons with Disabilities with MassHealth through Estate Recovery Reform

Medicaid is the only public benefit program that requires the value of benefits to be recouped from a deceased enrollee's family, called "estate recovery." Estate recovery for nursing homes costs is federally mandated, but Massachusetts law goes beyond federal requirements to require estate recovery for the costs of all medical services after a MassHealth enrollee turns age 55.

After a MassHealth recipient passes away, the agency seeks repayment of the medical expenses paid for that individual if that individual leaves a probate estate. Over 80% of the amount MassHealth recovers for itself and the federal government comes from sale of the family home. Current state law also fails to require adequate notice to MassHealth members and applicants about estate recovery. Few people know that Medicaid estate recovery is triggered by turning age 55,[68] not only by entering a nursing home. Most MassHealth members have incomes under 100% of the federal poverty level ($12,888 for one in 2021), and those 65 and over have countable assets of $2000 or less ($3000 for a couple).

The Task Force views Medicaid estate recovery reform legislation as crucial to protecting the homes of seniors and persons with disabilities with MassHealth. Health starts with housing. Reform is needed to address the disproportionate effect of "estate recovery" on the lowest income Medicaid beneficiaries. A home is often the only asset a person has to hand down to their children and grandchildren. When the state captures this asset to recoup health care costs, it contributes to and exacerbates the intergenerational racial and ethnic wealth gap.

The Task Force supports legislative action to reform MassHealth estate recovery, including but not limited to establishing that MassHealth will only recover for federally-mandated medical assistance, establish hardship waivers, and provide information upfront to MassHealth members about estate recovery, among other necessary reforms.

---

[68] See Massachusetts General Law 118E, 31(b)(3)

Easing the burden of Medicaid estate recovery to promote equity is also a recommendation of the federal Medicaid and CHIP Payment and Access Commission in its recent in-depth examination of the topic.[69]

3.8. REMOVE COPAYMENT AND OTHER BARRIERS TO AFFORDABLE MEDICATIONS AND CARE

High out-of-pocket costs and copayments for prescription drugs and medical visits can cause patients to forgo needed prescription medications and care. Research demonstrates that cost-sharing prevents people from accessing high-value care, and the impact is particularly pronounced for low-income consumers. Conversely, initiatives that eliminate cost barriers for patients by covering costs for screening and treatment in combination with patient navigation, can improve health outcomes for certain conditions like colorectal cancer and breast cancer.[70] [71]

The Task Force commends and aligns with the recent Attorney General's *Building toward Racial Justice and Equity in Health* report's recommendation to address affordability of cost-sharing as an equity priority for diverse people and low-income communities.

The Attorney General's report recommends opportunities such as insurance plans temporarily reducing cost-sharing for: (1) primary care and behavioral health visits during the pandemic and (2) medications for chronic conditions linked to COVID-19 complications. The report further recommends that the Health Policy Commission and Health Connector study longer-term strategies to address access barriers due to cost sharing to promote equitable access to services.[72]

3.8.1. Remove Copayments for Prescription Medications and Services to Prevent and Manage Chronic Health Conditions and for Preventive Care

Improving access to prescription drugs and health care services for chronic health conditions and for preventive care is a health equity issue. High out-of-pocket costs and copayments can be a barrier to care and medications, especially for persons with chronic health conditions, communities of color, and low-income communities. During the COVID-19 pandemic, people of color and others with underlying chronic health conditions are more susceptible to COVID-19 complications.

Removing barriers to care, such as out-of-pocket costs to affordable medications and health care services, is an important way to curb racial and other inequities, particularly related to preventive care, wellness, and chronic conditions. Removing barriers to care for chronic conditions can also be cost effective by fostering ambulatory sensitive care instead of at a later stage in treatment. This is especially key for chronic conditions, such as diabetes, asthma/COPD, hypertension and heart disease, substance use and opioid use disorder, certain mental health conditions, among others.

The Task Force encourages legislation that shifts toward a wellness system in part by removing copayment barriers in insurance design for preventive care and care and medications for chronic conditions. Value-based insurance design that emphasizes cost sharing reductions for high-value

---

[69] Medicaid and CHIP Payment and Access Commission (MACPAC), Report to Congress on Medicaid and CHIP, Chapter 3, Medicaid Estate Recovery: Improving Policy and Promoting Equity, (March 2021) available at https://www.macpac.gov/publication/medicaid-estate-recovery-improvingpolicy-and-promoting-equity/

[70] https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/

[71] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3661932/

[72] https://www.mass.gov/doc/building-toward-racial-justice-and-equity-in-health-a-call-to-actin/download

care can be achieved without increasing premiums, according to work of the Health Care Markets and Regulations Lab at Harvard Medical School and the Center for Value-Based Insurance Design at the University of Michigan.[73] Individuals and families are increasingly likely to be enrolled in health plans that require significant patient cost-sharing when they purchase medications or go to a physician's office, which can result in the under-usage of evidence-based, high-value health care. "The problem with making patients pay more out of pocket is that it discourages the use of high-value services, and it also makes the sick patients pay more in some ways for things that we want them to get, for those important quality services that they need," observed Dr. Michael Chernow of the Harvard Health Care Markets and Regulations Lab and Health Policy Commission Board Member.[74]

Value-based insurance design is a pathway to address the financial barriers to high value care that are particularly challenging for persons with chronic conditions, low-income individuals and families, and those with fixed incomes. An initial evaluation of the Medicare Advantage value-based insurance design pilot between 2017 and 2019 showed increased use of high-value services such as visits to primary care doctors and specialists for targeted conditions and prescription refills for people with coronary artery disease, congestive heart failure, COPD, diabetes, and hypertension on a cost neutral basis to Medicare.[75] Efforts in this direction have promise in advancing overall health and important health equity opportunities relative to the disproportionate burden of chronic conditions.

3.8.2. Enhance Patient Assistance Programs for Medications to Treat Conditions that Disproportionately Impact People of Color and Are Risk Factors for COVID-19 Complications

The Task Force supports legislative approaches such as expanded patient medication assistance programs to complement legislation to remove cost-sharing barriers to necessary prescriptions medications. This could make a difference for people who rely on medications, such as insulin, asthma inhalers, and other medications, to treat chronic conditions that disproportionately impact people of color and other vulnerable populations. These chronic health conditions are also risk factors for increased COVID-19 complications. Other legislative provisions could ensure consumers know their lowest cost options for their prescriptions at the pharmacy.

3.9. IMPROVE ORAL HEALTH

Oral health is among the deepest disparities in communities of color, low-income communities, vulnerable age groups, people with disabilities, and underserved geographic regions. Integral to overall health, poor oral health can significantly affect an individual's physical, mental, and financial health.

Lower-income people and people of color are more likely to have unmet dental needs. Poor oral health is connected to higher risk for diabetes, cardiovascular disease and stroke, complications in pregnancy and childbirth, adverse mental health outcomes, and other conditions.[76] One in five working-age adults does not get needed dental care. Black adults are 68% more likely to have an unmet dental need than white adults. Latino adults are 52% more likely than white adults to report

[73] http://vbidcenter.org/wp-content/uploads/2019/09/VBID-X-White-Paper-92019.pdf
[74] https://www.ajmc.com/view/dr-michael-chernew-foresees-more-experimentation-with-vbid-principles
[75] https://innovation.cms.gov/data-and-reports/2020/vbid-yr1-3-fg-evalrpt
[76] https://www.dentaquestpartnership.org/system/files/Impacts%20Beyond%20The%20Mouth_0.pdf

difficulty performing at work due to poor oral health.[77]

Among people with COVID-19, those with poor oral health and chronic larger amounts of pathogenic oral bacteria associated with poor oral health, have poorer outcomes and more severe COVID-19 complications.[78] [79]

3.9.1. Sustain Full Restoration of Adult Dental Care Coverage in MassHealth

Oral health is a critical component of overall health care, yet full dental coverage for adults on MassHealth has waxed and waned since 2002, making access to dental coverage and services uncertain for many Massachusetts residents. Adult dental benefits are currently restored and the restoration needs to be sustained with adequate state budget funding as an important step to address oral health needs.

Underserved communities across the state have historically faced the greatest barriers to accessing dental care. Black and Latino families are more likely to have unmet needs for medical or dental care. In Massachusetts, 15 percent of low-income adults say their mouth and teeth are in poor condition. Those with family incomes at or below 138 percent FPL were less likely than all other income groups to report a dental visit (56% versus 82% of individuals at higher income levels). Furthermore, 18 percent of adults reported an unmet need for dental care.[80] [81]

3.9.2. Establish an Oral Health Commission and Statewide Needs Assessment

Massachusetts' data on oral health needs and access to care is outdated, hindering the ability to understand the challenges and the policy solutions needed to ensure equitable access to dental services. The first step is to get an accurate picture of the oral health needs of residents across the state.

Therefore, the Task Force recommends legislation to create a Special Legislative Commission on Oral Health (SLCOH), chaired and staffed by the Massachusetts Commissioner of Public Health. The SLCOH should be charged with: (1) conducting a statewide oral health status and needs assessment to get an accurate picture of the oral health needs of Massachusetts residents and (2) developing recommendations to address gaps in access to oral health services and to improve the overall health status of residents including pediatric, adult, and older adult populations. Innovative programs should be highlighted.

3.9.3. Support Dental Professionals to Serve as Vaccinators

Oral health, and oral health providers, play an important role in health for underserved populations during and beyond the COVID-19 pandemic, including the overture to be part of vaccination efforts. The Massachusetts Board of Registration in Dentistry issued a clarification that administering COVID-19 vaccinations is within the scope of practice of dentists and permitted dental hygienists.[82]

---

[77] https://www.dentaquestpartnership.org/system/files/New%20NHANES%20Oral%20Health%20Data%20Reflect%20Barriers%20%26%20Inequalities.pdf
[78] https://www.nature.com/articles/s41415-020-1747-8
[79] https://www.dentaquestpartnership.org/vap-oral-health
[80] https://www.ada.org/en/science-research/health-policy-institute/oral-health-and-well-being/Massachusetts-facts
[81] https://www.mass.gov/doc/oral-health-brief
[82] https://www.mass.gov/info-details/massachusetts-covid-19-vaccine-program-mcvp-overview#who-can-administer-the-covid-19-vaccine?-

The Task Force supports action to direct the:

- Massachusetts Department of Public Health to continually review and update effective and easy-to-use resources – training materials, checklists, etc. – for dental practices to serve as vaccination sites with dental professionals administering vaccines during the current public health crisis; and
- Massachusetts Board of Registration of Dentistry to develop and issue guidelines post-pandemic emergency, that build on the COVID-19 guidance noted above, to allow dentists and permitted dental hygienists to administer certain vaccinations in support of public health goals and improved access to vaccinations for their patients.

Defining Health Equity

"Everyone has a fair and just opportunity to be as healthy as possible.This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."

Presentation by the Health Opportunity and Equity (HOPE) Initiative to Health Equity Task Force, Feb, 2021

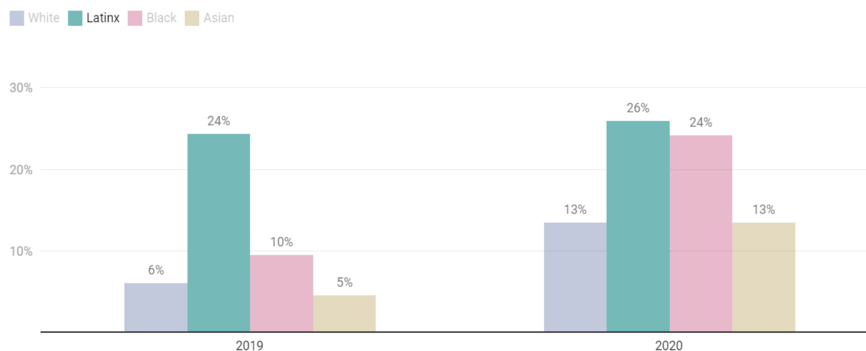
4. SOCIAL AND ECONOMIC FACTORS THAT IMPACT HEALTH

Social and economic inequities are the primary drivers of inequities in health. Following are recommendations on the key social factors of health including food security, housing, transportation, language access, community safety for immigrants, and environmental justice.

4.1. INCREASE FOOD ACCESS AND SECURITY

Food insecurity has been concentrated in Latinx and Black communities, who have been hardest hit by the pandemic.

Share of the population 18+ indicating low or very low food security by race/ethnicity, Massachusetts.



Food insecurity in Massachusetts doubled during the pandemic from 8% to almost 17%, according to a report from The Boston Indicators Project, with a corresponding increase in demand on the emergency food system. That report also documents persistent disparities in rates of

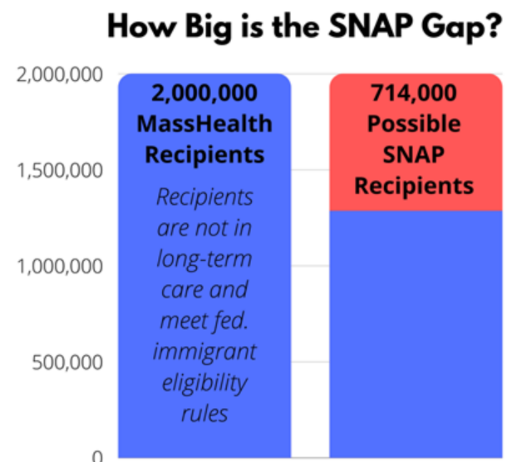
Graphic cited from: *Food Insecurity Has Doubled During the Pandemic: Data, Insights and Policy Solutions.*[83]

food insecurity between racial and ethnic groups, with a dramatic increase for most and a widening of that gap during the pandemic.

Another report from Feeding America documents that during the pandemic, Massachusetts had the highest rate of increase in food insecurity in the country (59%), with one in five children living in a food insecure household, an increase of 102%. Norfolk County had the highest rate of increase in food insecurity for children in the country (163%).[84]

4.1.1. Close the SNAP Gap

The SNAP Gap refers to the over 700,000 individuals who are MassHealth recipients and likely eligible for the Supplemental Nutrition Assistance Program (SNAP) but are not receiving the benefit.[85] These benefits could make the critical difference in helping families put food on the table, yet people are often unaware of what they are eligible for and/or overwhelmed with the processes to apply.



Currently families have to apply for these and other benefits that provide income through separate and unrelated processes. Often when families apply for one benefit, they are not aware of the availability of another benefit. The Task Force encourages legislation that would create one application procedure for households to apply for SNAP as well as MassHealth/Medicare Savings Program, and Transitional Assistance for Families with Dependent Children (TAFDC) or Emergency Aid for the Elderly, Disabled and Children (EAEDC).

A common application would reduce duplicate data collection thus increasing the efficiency of state government, improve access to desperately needed cash assistance for families, and increase access to 100% federally-funded nutrition which has documented benefits in improving health.

4.1.2. Fully Fund The Healthy Incentives Program (HIP)

This program allows Massachusetts residents who rely on SNAP to double the value of their benefit each month when they purchase fruits and vegetables from farmers' markets. Fruits and vegetables are often omitted from the shopping list of SNAP recipients because they can be expensive. The incentive allows SNAP recipients to make the choice to include fresh fruits and vegetables on their shopping lists. The program is administered by the Massachusetts Department of Agricultural Resources and the Massachusetts Department of Public Health.

---

[83] https://www.bostonindicators.org/reports/report-website-pages/covid_indicators-x2/2020/october/food-insecurity#:~:text=Despite%20the%20fact%20that%20Massachusetts,in%20Massachusetts%20were%20food%20insecure.

[84] https://www.feedingamerica.org/sites/default/files/2020-10/Brief_Local%20Impact_10.2020_0.pd

[85] Graphic cited from: Massachusetts Legal Service https://www.masslegalservices.org/content/its-time-finally-close-massachusetts-snap-gap-and-expand-common-apps-2021

The Task Force supports full funding for HIP in FY'22, commensurate with the $13 Million allocation in the FY'21 budget. Anything less falls short of the demand from families for healthy food, and hurts local farmers who provide this food to Farmer's Markets.

4.1.3. The Task Force Recommends Making School Meals Universal as Part of the Feed Kids Campaign

During the pandemic, school meals became universally free to all students. This provided desperately needed nutrition to children and families, and reduced the stigma of being "poor." The Task Force supports requiring all schools to continue to make these meals available to all students at no charge. Universal school meals were temporarily extended during COVID-19 and then again through September 2021 through the American Rescue Plan Act. While there is some ongoing relief in the ARPA for highest need schools and districts, it is time to ensure at the state level that all students have access to nutritious food without stigma.

Pre-pandemic, about one in five MA families with children experiences hunger and 27% of those children are not eligible for free or reduced school meals. Research shows when a child is well fed, they perform better in school, are at lower risk for obesity, and adjust to social situations better. Additionally, by making meal access universal, we help remove stigma around economic status and family situations—creating a more equitable and just educational environment. It is estimated that up to 50,000 children would benefit daily from this policy.[86]

4.1.4. The Task Force Supports Hunger-Free Massachusetts Public College Campuses

Two national surveys from 2017 and 2018 indicate more than one-third of four-year college students, and nearly half of all community college students, faced food insecurity in the previous 30 days. Many of these students are the first generation in their families to attend college, are immigrants or their parents are immigrants.

The Task Force encourages policies to address student food insecurity and hunger across all 29 public higher education campuses. The goal is to build the capacity of colleges to address student food insecurity among their student body.

4.1.5. Fund the Massachusetts Emergency Food Assistance Program to Support Increased Need for the Food Bank Coalition of Massachusetts

The Massachusetts Emergency Food Assistance Program (MEFAP) supports the Food Bank Coalition of Massachusetts (The Food Bank of Western Massachusetts, The Greater Boston Food Bank, the Merrimack Valley Food Bank, and the Worcester County Food Bank) that provides food for a network of nearly 1,000 pantries, meal programs, shelters and mobile markets across the Commonwealth. Demand for this food has seen double-digit increases during the pandemic and there is no end in sight. The Task Force recommends that funding of $30 million be allocated for MEFAP to meet the expanded demand.

4.2. PROVIDE AND INCREASE EMERGENCY AND BASIC INCOME THROUGH EMERGENCY CASH ASSISTANCE, AN INCREASE IN PUBLIC BENEFITS AND ACCESS TO EARNED INCOME TAX CREDITS FOR ALL TAXPAYING FAMILIES.

[86] https://feedkidsma.org/about-the-bill

4.2.1. The Task Force Recommends Robust Funding for Emergency Cash Assistance in the Commonwealth's Fiscal Year 2022 Budget

Insufficient income is a long-standing challenge for the most disenfranchised in our state and is a deeply rooted cause of multiple inequities, including health inequities. During the pandemic, loss of income particularly impacted immigrants with no access to public benefits. According to the MIRA Coalition's community survey conducted in August, 59 percent of immigrant households reported reliance on food or cash assistance; among households with undocumented members, the share was 77.8 percent. Three in five such households reported housing insecurity. This was partially possible because the Commonwealth launched the emergency cash assistance program last summer.

The Emergency Cash Assistance funding supported the Community Foundations Grant Program for COVID-19, managed by the Executive Office for Housing and Economic Development, specifically for emergency cash assistance to our most impacted state residents, especially those without access to federal or state assistance. The program funds community foundations who partner with trusted, local community organizations to provide assistance to families most in need. The Community Foundations are expected to match the state funding dollar for dollar. Thus, a $10 Million allocation from the state results in $20 Million in cash assistance for vulnerable persons and families.

4.2.2. The Task Force Supports Progress Toward Eliminating Deep Poverty

The federal government defines "deep poverty" as half the federal poverty level. A family of three with a monthly income of less than about $900 would be considered in deep poverty. In Massachusetts, the maximum Emergency Aid to the Elderly, Disabled and Children (EAEDC) and Transitional Aid to Families with Dependent Children (TAFDC) those families could receive was $593 pre-pandemic per month. The Commonwealth's Fiscal Year 2021 budget provided a 10 percent increase from January through June of 2021. This was the first increase for TAFDC since 2000, and the first for EAEDC since 1998.

At minimum, the Task Force strongly supports efforts to: (1) maintain the 10 percent benefit increase; (2) continue to increase benefits by 20 percent annually until they are at least at 50 percent of the federal poverty level, and; (3) continue to increase benefits through cost-of-living increases so that they remain at a minimum of 50 percent of federal poverty. This would benefit about 29,000 families.

There are at least eight states with higher benefits than Massachusetts, including Connecticut ($698 a month maximum for a family of three), Vermont (increasing to $700 in August), New York ($789), and New Hampshire ($1066).[87]

4.2.3. The Task Force Supports Extending the State Earned Income Tax Credit to All Taxpayers in Massachusetts

Many immigrant taxpayers who work, pay taxes, and file federal and state tax returns are not eligible for social security numbers, so they file their returns using Individual Tax Identification Numbers (ITINs). In 2018, the Department of Revenue received 30,821 returns from taxpayers with ITINs, of which 24,427 reported annual income under $50,000. Every one of these filers paid their share of state and federal income tax.

[87] https://www.liftourkidsma.org/

Under current law, only those Massachusetts residents who have social security numbers can receive the state earned income credit. In a comparison of two families, both earning $35,000/year and both raising two children, the family in which all members have a social security number will receive $3,390 from state and federal credits, including $785 from the state. The other family may have children with social security numbers, but if both parents, or even one of them has an ITIN, they will receive zero. The state EITC should be available to all families who pay state taxes.

4.3. INCREASE HOUSING STABILITY BY PREVENTING EVICTIONS AND FORECLOSURES, AND SUPPORTING EMERGENCY SHELTER

In the wake of COVID-19 and its prolonged economic effects, the Task Force received resounding testimony about the urgent need for housing stabilization and eviction and foreclosure prevention efforts. With eviction bans expiring, thousands of renters and homeowners face the threat of losing their homes.

For more than a year, people were told to stay at home to stay safe. But for many, there has been no home to stay in, and for countless others that home has become increasingly unstable as the financial crisis continues. In April 2020, Massachusetts took the bold and necessary step of instituting a complete moratorium on evictions and foreclosures, ensuring that residents were not forced out of their homes. That moratorium expired in October, and was replaced with the state's Eviction Diversion Initiative. That initiative provided important resources for rental assistance, housing counseling, and legal resources in eviction cases.

In April of 2021, the Baker administration announced $400 million in new federal funding for emergency rental assistance. These are in addition to other federal dollars to stabilize housing. These additional funds will extend income eligibility for the program, allow households 12 months of rental arrears, plus three months of rent going forward and $1500 in overdue utility costs. The previous limit had been $10,000. Landlords and housing authorities will also be able to apply for assistance directly on behalf of their tenants.

We also know that communities that had the highest rates of infection, where there is overcrowding and high rates of employment, are the same communities that were facing a housing crisis before the public health emergency began. While federal ARPA funds will provide necessary protections for many, we will still need robust eviction and foreclosure protections in order to avoid further disruptions. The influx of these funds holds the potential to prevent a massive housing crisis.

4.3.1. Assist Landlords, Homeowners and Tenants to Prevent COVID-19 Evictions and Foreclosures and Take Measures to Stabilize Housing.

The Task Force recommends that MDHCD prioritize ARPA funds for those communities with the highest COVID-19 infection rates per 100,000. There is clear evidence of increased housing instability and risk of displacement in these communities.

In addition, a portion of the emergency rental assistance funds should be used to stabilize families timing out of the HomeBASE program, which provides families in emergency shelter funds for up to a year to make the transition to permanent housing. Such funds should be targeted to HomeBASE participants in good standing in housing, whose benefits are set to expire and would otherwise likely

face eviction. This would help ensure that these children and families do not face the trauma of experiencing homelessness again.

Among other measures that need to be taken around rental assistance include:

- Require landlords to pursue and cooperate with rental assistance programs before pursuing eviction;
- Simplify the application process - There should be one application for all of the assistance programs at an appropriate reading level, available online and in multiple languages. Applicants should be able to check the status of their application at any time.
- Allow for expanded use of self-certification/attestation of things like housing instability and income in the rental assistance application process. The Task Force Urges the Massachusetts Department Housing and Community Development (MDHCD) to promote this practice.
- Since federal rental assistance dollars are only available in three month prospective increments, MDHCD should work to ensure that the "re-up" process is as simplified as possible.
- Provide funds directly to tenants - New guidance from the federal Treasury Department allows funds to be directly paid to tenants and the Task Force encourages that DHCD fully implement this practice. Sometimes a landlord or utility company is unresponsive or refuses to accept the funds directly. Direct-to-tenant payments would remove a burden from landlords and are also a critical tool for housing situations such as sublets, sub-tenancies, rooming situations, and 'encargados' – all of which are more common in high housing-cost communities with large numbers of immigrants and people of color. This is a critical policy change that would ensure many more of our most vulnerable households are able to be served.

The Task Force recommends policies that would prevent actions for "COVID-19" evictions or foreclosure until parties have worked in good faith to explore and exhaust every alternative. Measures should be included to prevent residential foreclosures for payments due during the state of emergency, and allow homeowners the same terms as federal lenders, including deferring mortgage, interest, and escrow payments to the end of the loan term.

4.3.2. Promoting Housing Stability and Preventing Homelessness by Providing Legal Counsel in Eviction and Foreclosure Proceedings.

In 2020, only 8.5 percent of tenants had legal representation when in court facing eviction. During the COVID-19 emergency, the Governor is funding a special project to provide legal help to income eligible tenants and owner-occupants during the eviction process who are at risk of losing their homes. The project is being administered through the Massachusetts Legal Assistance Corporation with legal aid partners. A full right to counsel in eviction cases would build upon this project and continue to secure the resources necessary to stabilize housing for thousands of vulnerable people.

4.3.3. Seal Eviction Records at Appropriate Times

Once a tenant has an eviction proceeding on their record, it is extremely difficult to obtain housing, even if they were not found to be at fault. When records became available online in 2013, landlords

made it a habit to check eviction records, making housing all the more difficult for vulnerable families to obtain. This has a vastly disproportionate effect on families of color, particularly female headed households.

A January 2020 report from the ACLU found Black renters in Massachusetts are 2.4 times more likely to have an eviction case filed against them than others. The report also found, "black women are more likely to be denied housing due to prior eviction filings, even when they won." A June 2020 report from MIT and City Life/Vida Urbana shows that 70 percent of eviction filings in Boston are in majority-minority communities, despite only half of the city's rental housing being in those communities.[88]

Eviction records should be sealed as soon as proceedings are filed, while they are pending, and until or unless an allegation is proven. No-fault evictions should be sealed and non-payment and fault eviction cases should be publicly available only when there is a judgment against the tenant, or there is an agreement for judgment and the tenant has actually been evicted. All eviction records should be sealed after 3 years and a process should be developed to seal records for good cause before the 3-year point and when tenants satisfy their judgments or agreements.

4.3.4. Increase Funding for and Access to the Emergency Shelter System

During the pandemic, families and individuals experiencing homelessness were often offered congregate shelter only when they had an emergency housing need. This was obviously dangerous during a pandemic. Funding from the Federal Emergency Management Agency allows for 100 percent federal reimbursement for non-congregate shelter during the pandemic, and the Massachusetts Emergency Management Agency and the Massachusetts Department of Housing and Community Development are urged to continue to make these options available to as many people experiencing homelessness as possible for the duration of the pandemic. Vaccines should continue to be prioritized for homeless persons and staff of shelters for the homeless, and rapid testing made available.

The process for entering the Emergency Assistance family shelter system desperately needs to be streamlined. Currently, the process relies on the person in need of shelter reaching someone on the phone and providing documentation electronically, both of which are often challenging to accomplish. The Task Force recommends the creation of an ombudsperson to assist families in applying for emergency shelter and in retaining shelter benefits, and the removal of the shelter exclusion for families reapplying for shelter within 12 months of a previous shelter stay.

The family shelter program and single adult emergency shelter program have been maximally taxed this past year. They have had to work to decompress shelters, prevent infections and keep staff safe. They are anticipating the potential for a significant need for their services during a prolonged recovery. Despite the influx of federal funds, so many families and individuals have lost businesses, income and employment that the need for shelter services could grow exponentially.

[88] https://www.bostonglobe.com/2021/02/16/opinion/baker-should-seal-eviction-records-give-residents-second-chance/

In some cases, additional funding was provided to shelters during the emergency. At minimum, this funding should be maintained. These investments in shelter and related rehousing programs are especially critical as the state navigates the pandemic and recovery.

4.4. CREATE ACCESS AND INCLUSION FOR IMMIGRANTS THROUGH LANGUAGE ACCESS, DRIVERS' LICENSES AND CIVIL RIGHTS

COVID-19 hit communities with large numbers of immigrants the hardest. According to MIRA Coalition, the Massachusetts organization that advocates on behalf of immigrants and refugees, "more than one-sixth of Massachusetts residents are foreign-born: almost 1.2 Million people, or 17.4 percent of the population." The communities with the highest percentage of their residents who are immigrants are: Chelsea (45%), Malden (43%), Everett (43%), Lawrence (41%), Revere (39%), Lynn (37%), Quincy (33%) and Randolph (32%).[89]It is no surprise that many of these same communities had the highest rates of COVID-19 infection statewide.

4.4.1. Promote Language Access in State Agencies

Our state is home to one of the most diverse immigrant populations in the country - nearly 600,000 people are Limited English Proficient (LEP) - and only forty percent of those individuals speak Spanish, indicating that the remaining sixty percent speak a multitude of other languages. While efforts have been made to communicate in multiple languages during the pandemic, much remains to be done.

The Task Force supports requiring public facing state agencies to provide oral and written language access to those they serve. State agencies should be required to create, implement and update targeted language access, including an assessment of languages spoken by their clients, with timelines and periodic reporting to the Legislature. The agencies should conduct periodic comprehensive training to staff on the importance of language access, how to work with interpreters and protocols on steps to take when dealing with an LEP individual.

Non-English speakers cannot easily access health information about COVID-19, and they cannot apply for benefits to meet their basic needs such as food (SNAP), housing, health care, unemployment and cash assistance, and cannot read notices that they have to re-apply to continue benefits.

The Task Force recommends that state agencies immediately adjust their telephone answering systems to provide short recorded greetings in multiple languages indicating which telephone key to press for each language. The multiple language greeting choices should be the very first in the queue of greetings. While a language menu is frequently available, it follows a long message in English, often discouraging the caller before they get there.

PROMISING PRACTICES FROM OTHER STATES

HAWAII

[89] https://miracoalition.org/get-the-facts/massachusetts-reports-data/

Legislation sets out requirements for state funded agencies regarding oral and written language services, requires each agency to establish language access plans and designate a language access coordinator, sets out requirements regarding translation of public hearings, and establishes a Language Access Office and Advisory Council.[90]

MARYLAND

Among the provisions of this legislation are a requirement that state agencies (over several years) take reasonable steps to provide equal access to public services for LEP individuals. It directs identified state agencies to translate "vital documents" (defined as all applications, or informational materials, notices, and complaint forms) into the language spoken by LEP population that constitutes 3 percent of the overall population within the geographic area served by a local office and to provide oral language services (which must be through face-to-face, in-house oral language services if contact between the agency and individuals with limited English proficiency is on a weekly or more frequent basis)

The legislation also requires equal access versions of government websites for any language spoken by limited English proficient populations that constitutes at least 0.5% of the overall population within the State. Finally, it calls for oversight and technical assistance to state agencies by the Department of Human Services, Office of the Attorney General and the Department of Information Technology.[91]

4.4.2. Protect the Civil Rights and Safety of All Massachusetts Residents

Undocumented immigrants are afraid to come forward for health care and other necessary services due to a climate of fear, including fear of being identified and detained by Immigration and Customs Enforcement. This has implications related to the public health response to COVID-19, testing, treatment, and vaccinations.

The Task Force supports protecting the civil rights and safety of all Massachusetts residents. Legislative measures should be considered to increase immigrants' sense of safety. One measure that would contribute to this would be clarifying police, courts and sheriffs roles in immigration enforcement and creating a uniform statewide standard for law enforcement's interactions with federal Immigration and Customs Enforcement. Such policies would increase the health and safety of undocumented immigrants, thus positively affecting the health of their families and communities.[92]

4.4.3. Transportation: Access to Driver's Licenses and Identification for All Massachusetts Residents

All qualified state residents should be able to apply for a standard Massachusetts driver's license or identification card, regardless of immigrant status, while keeping our Commonwealth in full compliance with REAL ID requirements.

Having a valid ID would increase the comfort and reduce the fear of immigrants, particularly undocumented immigrants, to access health care, including vaccination, and other supportive services. If people can drive, they will also reduce their risk of exposure to the spread of infection on public transportation during the COVID-19 pandemic. And driving would increase the economic options available to workers and families to get to work, take their children to the doctor, or buy groceries. Public transportation is far too limited, particularly in the western part of the state.[93]

---

[90] https://health.hawaii.gov/ola/files/2016/12/CHAPTER-321C-January-2015.pdf
[91] https://www.peoples-law.org/maryland-language-access-law-your-right-interpretation-and-translation
[92] https://www.miracoalition.org/wp-content/uploads/2021/02/SCA-factsheet-2021-1.pdf
[93] https://drive.google.com/drive/folders/1M761ssafO0bnzNu8onbRF0cttESUz4Ov

PROMISING PRACTICES FROM OTHER STATES

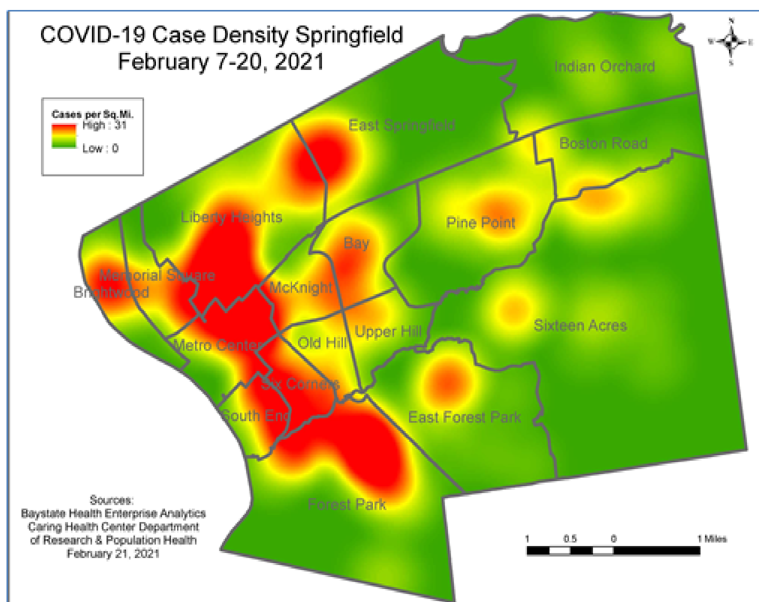
There is bipartisan support for driver's license legislation across the U.S. Sixteen states, the District of Columbia and Puerto Rico already allow residents the right to apply for driver's licenses regardless of immigration status, including our neighbors New York, Vermont and Connecticut. New Jersey and Virginia passed similar legislation, as did states with Republican governors – in Utah, Nevada and New Mexico. The following link provides a complete summary of these bills by state.[94]

4.5. BUILD "COMMUNITIES OF OPPORTUNITY" BY PRIORITIZING INVESTMENT IN ENVIRONMENTAL JUSTICE COMMUNITIES HIGHLY IMPACTED BY COVID-19

Studies and mapping by CRESSH (Center for Research on Environmental and Social Stressors in Housing Across the Life Course) show the connection between high rates of COVID-19 and environmental burdens carried by those same communities, known as environmental justice (EJ) communities. CRESSH finds that the "burden of COVID-19 is falling unequally across Massachusetts communities based on vulnerability across multiple dimensions including health, economic, social, language, isolation, race/ethnicity, housing density and environmental factors.[95] The Task Force received testimony that supports these findings, which are common in Gateway Communities.

Modeling in Springfield's neighborhoods, conducted by Baystate Health's COVID-19 Mitigation Team, highlights disproportionately high rates of infections in traditionally underserved communities. Neighborhood-level maps (zip code is too large and at times too demographically and economically diverse) show a concentrated COVID-19 pattern in EJ populations and neighborhoods, defined through spatial epidemiological analysis as places of very high-risk.

A report of the Kirwan Institute for the Study of Race and Ethnicity at The Ohio State University, entitled "The Geography of Opportunity: Building Communities of Opportunity in Massachusetts," identifies that low-income communities, and particularly racial and ethnic populations, are isolated from the essential opportunity structures needed to thrive. Neighborhood conditions (high quality education, a healthy and safe environment, sustainable employment, housing stability, etc.) play a substantial role in the life outcomes of residents."[96]



The HOPE Initiative observed that Black and Hispanic populations in Massachusetts are the least likely to live in areas of low poverty, pointing to greater racialized isolation or

[94] https://www.ncsl.org/research/immigration/states-offering-driver-s-licenses-to-immigrants.aspx
[95] https://sites.sph.harvard.edu/cressh/community-engagement-core/covid-19-community-resources/
[96] https://kirwaninstitute.osu.edu/research/geography-opportunity-building-communities-opportunity-massachusetts
http://www.kirwaninstitute.osu.edu/reports/2009/01_2009_GeographyofOpportunityMassachusetts.pdf

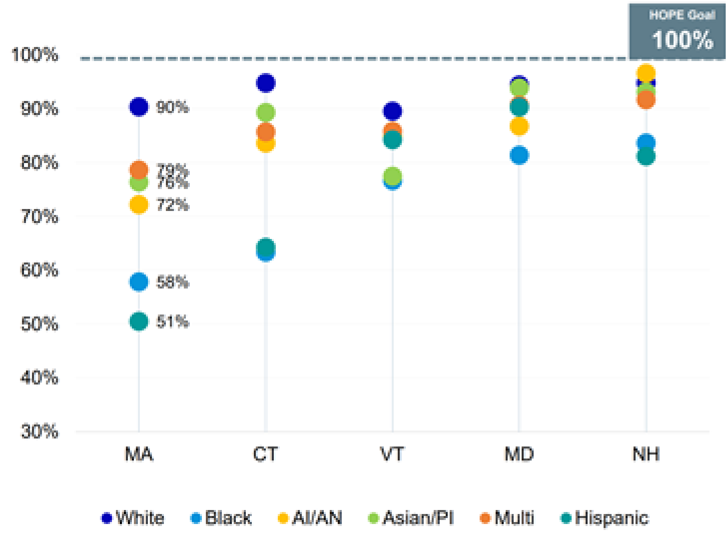
segregation from high opportunity communities when compared to other states. Further, the HOPE Initiative similarly found less access to livable income, reflecting the importance of addressing opportunity gaps so all residents flourish and can achieve their full potential.[97]

Black and Hispanic populations in Massachusetts are the least likely to live in areas of low poverty concentration. Whereas 90% of White people live in areas of low poverty, only 58% of the Black and 51% of Hispanic people do so.

Low Poverty Concentration
Portion of people in neighborhoods with fewer than 20% of residents living in poverty

CURRENT RATE	HOPE GOAL
83%	100%
of people in Massachusetts live in neighborhoods with low poverty concentration	of people live in neighborhoods with low poverty concentration

DISTANCE TO GOAL
1.1 million
more people in Massachusetts would need to live in neighborhoods with low poverty concentration

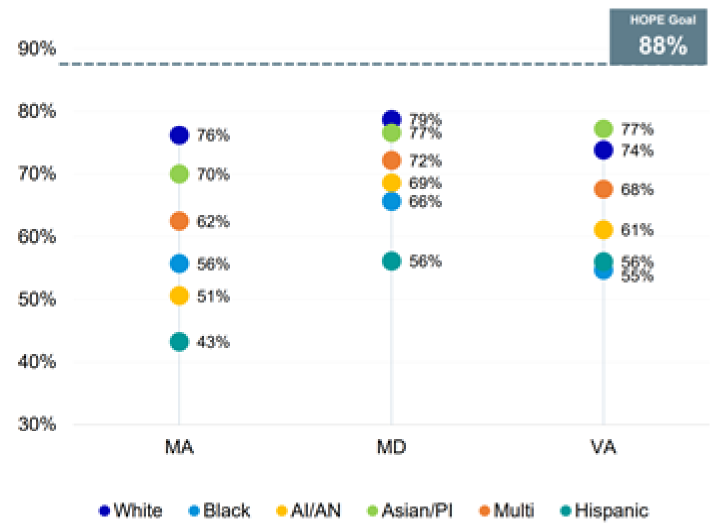


Hispanic, Native American, and Black adults in Massachusetts face the greatest barriers to achieving a livable income. In many cases, they face greater challenges than their counterparts in other states.

LIVABLE INCOME
Portion of adults living in households with income greater than 250% FPL

CURRENT RATE	HOPE GOAL
71%	88%
of Massachusetts adults live in households with livable income	of adults living in households with livable income

DISTANCE TO GOAL
774,439
more Massachusetts adults living in households with livable income



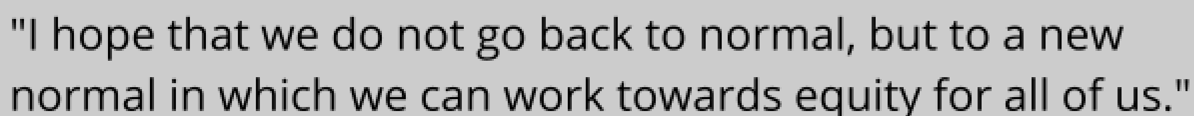
The Task Force recommends that the Massachusetts Department of Public Health and/or the recommended new Executive Office of Equity explore adoption of "Communities of Opportunity" or "Health Empowerment Communities or Zones" (see Public Health section) as an approach for state

[97] https://www.hopeinitiative.org/state/massachusetts

investments to build the capacity of and empower communities. Uplifting equity, health, and opportunity for all Massachusetts communities and residents starts by driving equity action in communities where the greatest gaps exist.

A first step toward environmental justice and community opportunity plans is legislation that would advance local garden agriculture programs that promote health, nutrition, jobs and a healthy environment.

ACTING NOW TO PREPARE FOR THE FUTURE



5. STRENGTHEN THE PUBLIC HEALTH SYSTEM

5.1. SUPPORT AND STRENGTHEN LOCAL PUBLIC HEALTH

Local public health officials have stepped up to respond to this pandemic amid significant challenges and constraints and deserve our utmost appreciation. But they have been operating with one hand tied behind their backs with limited funding, staffing and other resources. *The fact that public health is the responsibility of 351 different cities and towns with varying resources and without clear guidance translates into a fragmented and inequitable response around the Commonwealth.* Around the country these responsibilities typically reside within county government. Massachusetts lacks a strong county government structure.

These challenges are well-documented and solutions have been proposed. The Special Commission on Local and Regional Public Health issued its report in June of 2019 (pre-COVID-19). According to the executive summary of the report,

> *Massachusetts is unique in the country in that it has a board of health for each of its 351 cities and towns and a long and proud history of home rule. Its tiny, stand-alone boards of health, many formed over a century ago, stand in contrast to the county or regional organization of local public health authorities in most other states. Their budgets, often bare bones, are the sole responsibility of individual cities and towns with no dedicated*

state funding. Their ever-expanding duties are determined by a patchwork of state laws and regulations in addition to local ordinances and by-laws. They report to numerous officials, yet there are few systems in place to assess their performance and no benchmarks for their overall success.

The Executive Summary continues with key findings, including:

- Many Massachusetts cities and towns are unable to meet statutory requirements and even more lack the capacity to meet rigorous national public health standards.
- Because Massachusetts lacks a comprehensive system to collect local public health data, there is limited capacity to measure local public health system performance and to use local data to plan public health improvements.

A high-level summary of the Commission's recommendations includes[98]:

- Elevate the standards for and improve the performance of local public health departments.
- Increase cross-jurisdictional sharing of public health services to strengthen the service delivery capabilities of local public health departments.
- Explore improvements in the current platforms to report, analyze, and interpret data.
- Set education and training standards for local public health officials and staff and expand access to professional development.
- Commit appropriate (state) resources for the local public health system changes proposed by the Commission.

The Task Force strongly supports measures to strengthen and streamline local public health. We cannot face another public health crisis with the fractured, inequitable and underfunded system we have. The Task Force urges MDPH to implement the findings of the Special Commission as soon as possible, and urges the Legislature to enact time-sensitive legislation this session to codify these recommendations in law. New investments of funds must accompany the modernization and improvements in the local and regional public health system.

In the meantime, federal COVID-19 funds could be deployed to accelerate the transition to a strengthened local and regional public health system. These resources should be allocated according to the needs of cities and towns, as measured by equity based on infection rates, socio-economic factors including poverty, race and ethnicity in burden of disease.

In addition, the Task Force recommends that incentives be incorporated for the local public health system to establish community advisory groups and processes (reflective of the community) to encourage collaboration and the input of diverse community representatives.

[98] https://www.mass.gov/doc/executive-summary-blueprint-for-public-health-excellence-0/download

5.2. MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

Public Health has been underfunded for decades at the national, state and local levels, leaving us vulnerable and exposed to the devastating impacts of this pandemic. The Massachusetts Department of Public Health (MDPH) is deeply committed to health equity and to addressing the social determinants of health, but does so with the same limited resources as their peers across the country.

Over the past decade or more, MDPH successfully obtained federal funds to backfill gaps and cuts in their budget. While they are to be commended for these efforts, the grants further exacerbated a "silo" approach to public health. This limited the ability of the agency to holistically assess health needs across the population and to direct resources appropriately. Programs were driven by the funding source, instead of the needs. It is time to address this.

MDPH has a critical role to play in pandemic preparedness and response, particularly through the Office of Preparedness and Emergency Management (OPEM), which provides planning and management of public health disasters. The central role of MDPH, through OPEM and other divisions, could have been more elevated in the COVID-19 pandemic response and within the COVID-19 Command Center structure. The Task Force recognizes the vital role of public health in a pandemic response and supports elevating MDPH to play a more integral role through the duration of this pandemic, into any future public health threats and beyond. The Task Force also supports building the overall capacity of MDPH to carry out prevention and intervention policies and programs to achieve health equity on an ongoing basis.

To do this, MDPH needs funding for data collection, analysis, reporting and surveillance, not only for a disaster but also for a host of public health indicators. All of these should be stratified by race, ethnicity and other socio-demographic factors and disaggregated within each category (see Data Dashboards within Prioritizing Equity in State Government).

MDPH needs funding for robust prevention and early intervention programs that braid resources together to build community assets and prevent poor and inequitable health outcomes. MDPH needs the capacity to work across state agencies, as public health is inextricably linked to the social factors in health such as food, housing, the environment and beyond.

MDPH needs funding to build local capacity to address public health issues. That includes building local and regional capacity to carry out basic public health functions as well as pandemic responses. It also includes resources to empower local communities to address their own public health concerns as Rhode Island and California have done (see promising practices below).

According to *The Impact of Chronic Underfunding on America's Public Health System: Trends, Risks, and Recommendations, 2020* from Trust for American's Health the core capabilities of a robust public health system include[99]:

- Increased funding to strengthen the public health infrastructure and workforce, including modernizing the system's data and surveillance capacities.
- Safeguarding and improving Americans' health by investing in chronic disease prevention and the prevention of substance misuse and suicide.

[99] https://www.tfah.org/report-details/publichealthfunding2020/

- Improving emergency preparedness, including preparation for weather-related events and infectious disease outbreaks.
- Addressing the social determinants of health and advancing health equity.

The Task Force urges legislative and administrative actions to empower the Massachusetts Department of Public Health to robustly carry out these functions.

PROMISING PRACTICES FROM OTHER STATES

RHODE ISLAND

Rhode Island provides funding to 10 Health Equity Zones. Essentially, those Zones are collaboratives of key local leaders and organizations that identify and address the issues of greatest concern to them. The Rhode Island Department of Public Health provides not only funding but also training, technical assistance, evaluation and overall support to create healthier communities.[100]

6. INTEGRATE EQUITY AND RESILIENCE INTO EMERGENCY AND DISASTER PREPAREDNESS

6.1. THE LEGISLATURE SHOULD ENACT LEGISLATION AS SOON AS POSSIBLE THAT REQUIRES AN AFTER ACTION REVIEW (AAR) WITH AN EQUITY LENS, AN INNOVATION ON A STANDARD PRACTICE IN THE FIELD OF EMERGENCY MANAGEMENT AND AN OPPORTUNITY FOR MASSACHUSETTS TO LEAD THE NATION.

It is well known throughout the disaster literature that vulnerable populations bear the disproportionate burden of devastation when disaster strikes. Hurricanes Katrina and Maria are prime examples. COVID-19 is often referenced as a “national Katrina” in light of its foreseeable disproportionate impacts on vulnerable people, notably those of diverse backgrounds. Yet, the field of disaster and emergency planning and preparedness does not yet fully recognize and incorporate that reality into their planning. Across the field of emergency preparedness, issues of equity can be peripheral, not central and core, to everything about preparing for, responding to and recovering from emergencies and disasters.

Equity should be the “North Star,” a central and driving consideration in all aspects of the field. The planning should consider the unique needs of the populations including, race, ethnicity, language, disability, gender, sexual orientation, identification, age, social and economic vulnerability and other considerations.

To this end, the Task Force recommends that the Legislature enact legislation as soon as possible that requires an After Action Review (AAR), *using an equity and resilience lens*, an innovation on a standard practice and an opportunity for Massachusetts to lead the nation.

An AAR is a standard practice accepted by organizations ranging from The World Health Organization (WHO), to FEMA to the Department of Homeland Security and more. According to WHO an AAR is a “qualitative review of actions taken as a means of identifying and documenting best

[100] https://health.ri.gov/programs/detail.php?pgm_id=1108

practices demonstrated and challenges encountered during the response to the event or the implementation of the project.

The AAR is an important management tool for continuous performance improvement and learning. It is a basic quality improvement practice familiar to many in healthcare and business. It is designed to capture what went well, best practices, and future opportunities for improvement. Such practices intentionally avoid blame and instead treat opportunities for improvement as learning and growth.[101] In fact, AARs were conducted following the Boston Marathon bombing, one on the overall emergency response and one on the public health aspects of the response.[102,103]

The typical AAR is conducted by an independent third party, often an emergency management consultant. There are standard practices for how to conduct an AAR from the various emergency management agencies including the National Incident Management System (NIMS) and the Homeland Security Exercise and Evaluation Program (HSEEP). Typical methods include key stakeholder interviews, surveys of additional key stakeholders and document review. While AAR's may be standard practice, **what is not standard is to conduct them with an equity lens and to be more inclusive where possible.**

6.2. THE LEGISLATION SHOULD REQUIRE THE APPOINTMENT OF A COVID-19 AFTER ACTION, EQUITY, AND RESILIENCE COMMISSION. THE AAR SHOULD BE INITIATED AS SOON AS POSSIBLE, CONDUCTED ON A ROLLING BASIS AND COMPLETED WITHIN 12 MONTHS OF THE END OF THE PUBLIC HEALTH EMERGENCY.

Creating a Commission to oversee the AAR is somewhat different from the usual methods emergency management agencies utilize to conduct an assessment. Those methods typically are overseen by internal committees and seek only arms-length community and stakeholder input through interviews and surveys. The Task Force believes that this pandemic has had such a historic and far-reaching impact, that a different and more inclusive statewide approach augmented with an equity and resilience lens, is warranted. If we have learned anything, it is that the way we usually do business must change. There is precedent, however. After 9/11, the President appointed a 9/11 Commission to do an AAR and make recommendations. We think that COVID-19 rises to at least this level.

The Commission, with the guidance of the facilitator, should begin their work with assessing potential frameworks to evaluate all actions with an equity lens and making a selection. It is critical that this framework be fully integrated and embedded into all aspects of the review, and not a separate, add-on section of the review. Equity must be prominent in every decision. Potential equity frameworks could include, but not be limited to "Targeted Universalism," a method for setting universal goals that may require different resources and approaches for different populations to achieve those goals. It is often used in making policy and program decisions.[104]

6.3. THE COMMISSION SHOULD COMPRISE REPRESENTATIVES OF: APPOINTEES BY THE GOVERNOR, INCLUDING BUT NOT LIMITED TO REPRESENTATIVES OF EMERGENCY MANAGEMENT; LEGISLATIVE LEADERSHIP AND APPOINTEES; LEADERS FROM CITIES AND TOWNS DISPROPORTIONATELY IMPACTED BY

---

[101] https://www.who.int/ihr/procedures/after-action-review/en/

[102] https://www.mass.gov/doc/after-action-report-for-the-response-to-the-2013-boston-marathon-bombings/download

[103] https://delvalle.bphc.org/mod/wiki/view.php?pageid=63

[104] https://belonging.berkeley.edu/targeteduniversalism

COVID-19; THE HEALTHCARE SECTOR; ESSENTIAL BUSINESSES AND WORKERS, SOCIAL SERVICES (HOUSING/FOOD) ORGANIZATIONS, AND PEOPLE WITH LIVED EXPERIENCE.

The Commission should include representatives of the executive branch appointed by the Governor including but not limited to the Massachusetts COVID-19 Command Center, the Massachusetts Emergency Management Agency, the Massachusetts Department of Public Health; legislative leadership, including appointees from the House Speaker and Senate President, including but not limited to representatives of the Joint Committee on Racial Equity, Civil Rights and Inclusion and the Joint COVID-19 and Emergency Preparedness and Management); city and town leaders from disproportionately impacted communities including emergency managers and public health personnel; representatives across the healthcare continuum of care, long-term care and congregate setting;, essential businesses and workers; social services and those organizations addressing social determinants of health including but not limited to housing and food. The Commission should also include broad sector representation including business and labor.

6.4. THE AAR, UNDER THE GUIDANCE OF THE COMMISSION, SHOULD BE FACILITATED AND PRODUCED BY A THIRD PARTY/IES WITH EXPERTISE IN EMERGENCY MANAGEMENT, EQUITY AND PARTICIPATORY COMMUNITY PROCESSES.

Legislation should provide resources to the Commission to contract with an outside third party to facilitate the process and produce the report. Essential to a request for proposals for this vendor is that they have significant expertise in emergency management, equity and participatory processes. To achieve this may require a joint or "teamed" contract with multiple parties each holding pieces of the expertise but cooperating together in one process.

With the facilitators' help, the Commission will design a process that builds on standard AAR methods, and encourage inclusive and representative public participation to the greatest extent possible.

The legislation should direct the Commission to design methods that allow for additional community input, including but not limited to public hearings and open meetings, recognizing that some of the business of the Commission may include items that must remain confidential for security purposes. A major theme in public hearings of the Task Force was that people felt that all processes needed to be public and transparent. Input should be sought from diverse constituents across the Commonwealth.

6.5. THE AAR SHOULD BE CONDUCTED ON A ROLLING BASIS, BEGINNING AS SOON AS POSSIBLE WITH A REVIEW OF THE VACCINE PLAN. ADDITIONAL PHASES WILL BE DETERMINED BY THE COMMISSION, AND THE FINAL COMPREHENSIVE AAR SHOULD BE COMPLETED WITHIN 12 MONTHS OF THE END OF THE PUBLIC HEALTH EMERGENCY. REPORTS WILL BE FILED WITH LEADERS OF THE ADMINISTRATIVE AND LEGISLATIVE BRANCHES, AND A RESPONSE REQUIRED FROM THE ADMINISTRATION WITHIN ONE MONTH OF A ROLLING REVIEW, AND THREE MONTHS OF THE FINAL REPORT.

A rolling and phased AAR process is a common practice so that learning can rapidly be incorporated into future phases of the emergency response and recovery. Additional phases will be determined

by the Commission, and the final comprehensive AAR should be completed within 12 months of the end of the public health emergency.

The Commission will file their AAR reports with actionable recommendations with the Governor, Speaker of the House, the Senate President, the Joint Committee on Racial Equity, Civil Rights and Inclusion, and with the Joint COVID-19 and Emergency Preparedness and Management, and post the report on the public website.

AAR's run the risk of being completed and then filed away on a shelf. The next time an emergency or disaster occurs, the risk is that the same lessons are learned all over again. To prevent this from happening, the Task Force strongly recommends that the Legislature create an obligation for the Administration to file a response to the AAR, specifically stating point by point how they will amend the statewide Comprehensive Emergency Management Plan to incorporate the recommendations of the AAR, particularly regarding equity.

The legislation should require the Administration to respond to the recommendations within one month of the phased AAR reports and within three months of the completion of the overall AAR.

The response to the AAR should include the corresponding resources necessary, including identified funding streams, where available, including the use of federal monies.

PROMISING PRACTICES FROM OTHER STATES

KIRKLAND, WASHINGTON

AAR's on the COVID-19 pandemic response have already been undertaken in some localities, are occurring on a rolling basis, and are being developed in some states around the country. The City of Kirkland, WA, where the first nursing home outbreak occurred, completed an AAR on the city's initial response last spring. The report focuses on improving the city's response to future pandemics and emergencies. It was conducted by a third-party consultant and uses the standard methods of document review, stakeholder interviews and surveys. It does not incorporate an equity lens.[105]

OREGON

A similar COVID-19 AAR is underway on a rolling basis in Oregon and relies on similar methods. The state retained an emergency management consultant to conduct the review.[106]

IOWA

Iowa is presently in the midst of procuring a vendor to plan, develop and manage a multi-step AAR and associated Improvement Plan (IP) based on the emergency management effort of the State of Iowa in response to the pandemic. The AAR and IP will provide data to document strengths and areas for improvement for preparedness and response efforts associated with pandemics and other disasters.[107]

7. Prioritize Equity in State Government

7.1. THE HEALTH EQUITY TASK FORCE RECOMMENDS THAT LEGISLATION BE ENACTED TO CREATE AND RESOURCE A CABINET LEVEL EXECUTIVE OFFICE OF EQUITY LED BY A SECRETARY OF EQUITY CHARGED WITH LEADING EFFORTS

[105] https://www.kirklandwa.gov/files/sharedassets/public/fire/emergency-mgmt/plans/kirkland-covid-19-initial-aar-11-2020.pdf
[106] https://olis.oregonlegislature.gov/liz/2019I1/Downloads/CommitteeMeetingDocument/22757
[107] https://ibdopportunities.iowa.gov/Home/BidInfo?bidID=339972bd-8e21-4800-99ad-767187f9b9dc

TOWARD EQUITY, DIVERSITY AND INCLUSION ACROSS ALL ASPECTS OF THE EXECUTIVE BRANCH OF STATE GOVERNMENT.

To promote opportunity and equity, address systemic drivers of inequity and root out racism will require a large-scale and intentional effort to drive system, policy, budget and program change throughout state government. While the charge of this Task Force is around Health Equity, we recognize that health is the net result of myriad social, economic and other factors, as well as racism. These factors, or “determinants” of health”, account for up to 80% of health status. Therefore, a focus on equity within economic development, housing, social services, education and many other responsibilities of government are a prerequisite to achieving health equity.

A word on the definition of equity. The Legislature charged the Health Equity Task Force with making recommendations “to the general court that address health disparities for underserved or underrepresented populations based on culture, race, ethnicity, language, disability, gender identity, sexual orientation, geographic location, including, but not limited to, gateway cities with hospitals dedicated to caring for patients who test positive for COVID-19, and age in the commonwealth during the COVID-19 pandemic.” (Section 2A of Chapter 93 of the Acts of 2020, see appendix).

The Task Force takes that charge seriously and the Secretary of Equity would have responsibility for all residents of the Commonwealth. There would however, be a special obligation to address racial and ethnic equity given the disproportionate impact the pandemic has had on Black and LatinX communities, and the racial reckoning our country is currently engaged in. The Secretary would work closely with others in state government with responsibilities for other populations and would include them in strategic planning, data monitoring and within an Interagency Council on Equity.

The Secretary of Equity, in consultation with the legislative branch, Attorney General and an Equity Advisory Board, would be responsible for developing an overall equity strategic plan for the executive branch of state government, overseeing the Departmental strategic plans through an Interagency Equity Working Group, creating data dashboards, implementing the Equity In All Policies/Equity Impact Analysis policy and working collaboratively with the Equity Advisory Board.

7.2. THE LEGISLATION WOULD ALSO CREATE AND RESOURCE OFFICES OF EQUITY WITHIN EVERY SECRETARIAT, CHARGED WITH LEADING EFFORTS TOWARD EQUITY, DIVERSITY AND INCLUSION THROUGHOUT THAT SECRETARIAT, AND COORDINATING WITH THEIR PEERS ACROSS STATE GOVERNMENT. EACH SECRETARIAT LEVEL OFFICE SHOULD ALSO HAVE AN EQUITY ADVISORY BOARD.

The legislation would create and resource equity offices within each executive office of the administrative branch of state government. These offices, in conjunction with the departmental Equity Advisory Boards, and in consultation with relevant legislative committees, would be responsible for working across the Secretariat to develop 3-to-5-year strategic plans, data collection and dashboards, and the implementation of the Equity Impact Analysis. They would also be charged with inter-agency initiatives where relevant. While accountable to the Secretary of their Executive Office, they would have matrixed accountability to the Secretary of Equity.

The Executive Office of Equity would provide technical assistance/training to agencies to complete agency strategic plans, dashboards, and foster a diverse, inclusive, and culturally sensitive workforce that delivers culturally sensitive services.

The Task Force acknowledges the important 2018 budget law provision in Section 16AA of Chapter 6A of the General Laws that established an office of health equity reporting directly to the Secretary of the Executive Office of Health and Human Services. The legislation was implemented somewhat differently than written, with the creation of the Office of Health Equity within the Massachusetts Department of Public Health. The original intent of this legislative approach could serve as a foundation upon which to build equity firmly into all executive branch secretariats with additional specificity about responsibilities, accountability, advisory structures, resources, stature and reporting relationships, and collaboration across branches of government.

PROMISING PRACTICES FROM OTHER STATES

WASHINGTON

In April of 2020, Washington state enacted Chapter 332 of the Laws of 2020 (House Bill 1783) to create the nation's first Office of Equity. The Office sits within the Governor's Office for the purpose of promoting access to equitable opportunities and resources that reduce disparities, and improve outcomes statewide across state government. The Office is charged with developing a five-year strategic plan and assisting state agencies in doing likewise. The director is appointed by and reports to the Governor with advice and consent of the Senate. The office is charged with:[108]

- Assisting state agencies in applying an equity lens in all aspects of agency decision making, including service delivery, program development, policy development, and budgeting
- Community outreach and engagement
- Training on maintaining a diverse, inclusive, and culturally sensitive workforce
- Data maintenance and establishing performance metrics
- Performance accountability to equity plans and measures

VIRGINIA

Governor Ralph Northam appointed a cabinet level Chief Diversity Officer. According to a press release from the Governor's Office, "As the Director of Diversity, Equity, and Inclusion in the Commonwealth of Virginia, Dr. Underwood will develop a sustainable framework to promote inclusive practices across Virginia state government; implement a measurable, strategic plan to address systemic inequities in state government practices; and facilitate ways to turn feedback from state employees, external stakeholders, and community leaders into concrete equity policy."

The CDO is also charged with creating The ONE Virginia Plan, a strategic plan for achieving diversity, equity and inclusion across more than 100 state agencies. This year, the CDO has chaired the COVID-19 Equity Leadership Task Force. There is a Multi-Agency Health Equity Working Group as well as an Office of Health Equity within the Virginia Department of Health. There is no statutory mandate to create or sustain this position.[109]

INDIANA

Governor Eric Holcomb appointed Indiana's first chief equity, inclusion, and opportunity officer in November 2020.[110] The new officer joined the Indiana Administration on February 1, 2021 and will advise the Governor on efforts to improve equity, inclusion and opportunity across state government. The officer will focus on improving state government operations as well as drive systemic change to remove hurdles in the government workplace and services the state provides. The role also helps state agencies develop strategic plans to remove any barriers. As a member of the governor's cabinet, the officer reports directly to the Governor. [111]

7.3. THE OFFICE OF EQUITY WOULD CREATE A SET OF HIGH LEVEL AND PUBLICLY AVAILABLE DATA DASHBOARDS TO TRACK OVERALL PROGRESS TOWARD

[108] http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/House/1783-S2.SL.pdf#page=1

[109] https://www.governor.virginia.gov/newsroom/all-releases/2019/september/headline-846422-en.html

[110] https://events.in.gov/event/gov_holcomb_announces_state_equity_chief

[111] https://www.in.gov/gov/newsroom/true-equality-and-equity-leads-to-opportunity-for-all/

EQUITY. THE TASK FORCE RECOMMENDS USING THE OPPORTUNITY-BASED FRAMEWORK DEVELOPED BY THE HOPE INITIATIVE.

Since the passage of Chapter 93, data collection and reporting on COVID-19 has improved. The Department of Public Health now stratifies data by race, ethnicity, gender and other factors, and provides community-level data on rates of infection. This is important progress in the midst of a pandemic, and continuing progress is vital to guiding ongoing COVID-19 response and vaccination efforts from an equity perspective. As we look to the future, the Task Force heard much testimony on the need for more specific equity data collection, not only on COVID-19, but also on a range of health status indicators. As many stated, "You cannot address what you can't measure." Thus, the recommendations for data dashboards are a leading priority.

The Task Force recommends that the Secretary of Equity look to the data dashboard model created by the Hope Initiative that focuses on opportunities within communities, rather than deficits. There are also important lessons to learn from the state of Connecticut (see box below).

7.4. THE TASK FORCE RECOMMENDS THAT MASSACHUSETTS ADOPT STANDARD AND CONSISTENT DEMOGRAPHIC DATA COLLECTION PRACTICES AT POINT OF CARE, SERVICE AND TESTING, AND THAT TO ACCOMPLISH THIS IT CONVENES KEY STAKEHOLDERS.

In designing those dashboards, one of the most vexing issues is data collection. The collection of accurate and comprehensive data at the front end - the point of care, service, or testing - is a vital prerequisite to accurate and comprehensive data at the back end - public reporting. The Task Force heard much testimony about the need to disaggregate the data and include additional categories. The categories of Black, Hispanic and Asian, for example, encompass multitudes of different cultures, languages and customs, making it difficult to tailor interventions. In addition, the Task Force heard compelling testimony to collect and report data for persons with psychiatric diagnoses, including health status indicators, stratified by socio-demographic factors. This is an important endeavor that must also take into account patient privacy considerations and requirements.

As part of these initiatives, it is integral to train staff in best practices for collecting this information in a respectful manner. Providers do not routinely ask about sexual orientation or identity, ability, or occupation and place of employment. While some of this data is mandatory at the point of contact tracing, others are not. The challenge is to create a system where this information is requested by providers, payers and the public health and social service systems routinely and in a consistent and respectful manner.

To that end, the Task Force recommends that the Secretary of Equity convene key stakeholders to study and recommend best practices for collecting demographic data from patients at the point of care or testing, starting in the health care sector. The convening should include providers, payers, consumer advocates, relevant state agencies (HPC, CHIA, DPH, EOHHS) data experts and others. The group should consider and recommend best practices for data collection for at least the following groups:

- Race (including meaningful capture of "multi-racial")
- Ethnicity
- Country of familial origin

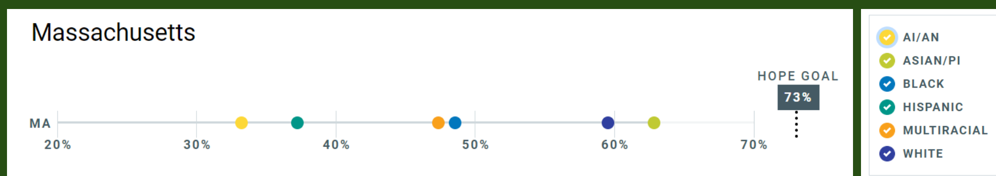
- Language including language in which person prefers to receive health care as well as primary language spoken in the home
- Sexual orientation
- Gender Identify
- Disability
- Occupation and place of employment (for reportable communicable diseases)
- Zip code or census tract
- Religious affiliation.

PROMISING PRACTICES ON DATA DASHBOARDS

THE HOPE INITIATIVE

The Health Opportunity and Equity (HOPE) Initiative presented their model dashboards to the Task Force. HOPE is funded by the Robert Wood Johnson Foundation (RWJF), and led by the National Collaborative for Health Equity and the Texas Health Institute in partnership with Virginia Commonwealth University's Center on Society and Health. HOPE sets benchmarks and tracks 27 indicators by race, ethnicity, and socioeconomic status. The indicators measure Social and Economic Factors, Community & Safety, Physical Environment, Access to Healthcare, and Health Outcomes. This dashboard has data for every state in the country. Notable about these dashboards is that they focus on opportunities rather than deficits, and on conditions that are modifiable by policy change. They exclude health behaviors since those are driven by the social and economic factors where people live, work and spend time.[112]

Also notable from HOPE, is the Massachusetts dashboard. They stressed in their presentation that while Massachusetts overall performs well on a host of key indicators, that masks the fact that the white majority does extremely well, while Black and LatinX residents frequently perform below their counterparts around the country. That means that even though Massachusetts overall does well on certain indicators, the disparities in the state are significant compared to peers around the country. For example, while Massachusetts is 8th in the nation in overall health status, we are 24th in social and economic factors which disproportionately affect people of color and 46th in physical environment.



Adult Health Status data for Massachusetts based on HOPE goal of 73% adults in good health status.[113]

CONNECTICUT

The Connecticut Office of Health Strategy also presented at the February 2 Task Force meeting. They are leading the way as a state with the development of data dashboards with the goal of aligning public health, provider and payer measures. Connecticut has developed a Healthy Connecticut 2020 Dashboard. It is based on the State Health Improvement Plan and the CDC Healthy People 2020 goals, and measures a series of indicators drawn from the Institute of Medicine's Leading Health Indicators. Data is stratified by race and ethnicity wherever possible.

Of particular interest, Connecticut encountered the challenge of the quality of the demographic data collected at the point of care. The Connecticut Health Foundation brought the Cambridge-based Institute for Healthcare Improvement to Connecticut to facilitate a process with multiple stakeholders around what data should be

[112] https://www.nationalcollaborative.org/our-programs/hope-initiative-project/
[113] https://www.hopeinitiative.org/state/massachusetts

collected. Of note, they are filing legislation to clarify and standardize race, ethnicity and language data collection for health care providers required to connect to the State-wide Health Information Exchange.[114,115]

CALIFORNIA

Regarding the collection of data on sexual orientation and gender identity, in September 2020 through Chapter 183 of the Acts of 2020, California became the first state in the nation to require the collection of sexual orientation and gender identity data for all reportable diseases, including COVID-19. The burden to collect this data lies on the provider (if the information is known) and the health officer (local/county public health officials).[116]

7.5. THE TASK FORCE RECOMMENDS THE LEGISLATION INCLUDE A REQUIREMENT FOR AN EQUITY IN ALL POLICIES/EQUITY IMPACT ANALYSIS ON NEW POLICIES AND PROGRAMS. IT ALSO RECOMMENDS AN IMMEDIATE EQUITY ANALYSIS OF HOW FEDERAL FUNDS HAVE BEEN INVESTED IN MASSACHUSETTS, ALONG WITH AN EQUITY PLAN FOR INVESTMENT OF FUNDS FROM THE AMERICAN RESCUE PLAN.

7.5.1. Create an Equity in All Policies/Equity Impact Program

There is an opportunity for Massachusetts to build on an existing model and create a bold new approach for rooting out systemic inequity. Multiple jurisdictions (see Promising Practices below) around the country have used Health in All Policies approaches to analyze the health impacts of everything from transportation projects to building developments. Now is the time to innovate on this model and evolve this practice and implement an *equity in all policies* approach.

Health in All Policies requires analyses of issues not typically thought of as related to health, including social, economic, environmental, housing, transportation and other issues, as well as the more obvious health and human service issues. An equity in all policies approach would require the same. As we know, health is created through equitable access to economic, social and behavioral resources and opportunities and thus these resources must be assessed to achieve health equity. The goal is to embed analysis of equity into all decision-making so that it becomes the routine way of doing business.

Critical to the success of such processes is a clear mandate through legislation or other means. There must be clear processes and tools for policy evaluation. One method to be considered for conducting these analyses would be contracting with academic institutions, as recommended in the HEALING Bill (Health Equity In All Levels In Government) cited in the blue box above. There must also be adequate resources for this policy to succeed.

An equity impact analysis could be triggered by a request from any member of the Legislature, or the executive branch. The Office of Equity will be responsible for developing regulations, tools and overseeing implementation. The Equity Advisory Board will approve final proposals for doing so.

7.5.2. Conduct an Equity Impact Analysis on Investment of Federal Funds to Date and an Equity Plan for investment of American Rescue Plan Funds.

---

[114] C G A (ct.gov)

[115] https://portal.ct.gov/en/DPH/State-Health-Planning/Healthy-Connecticut/Healthy-Connecticut-2020-Performance-Dashboard

[116] https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB932

Needless to say, the recommendations in this report will require commitment and resources of substantial funds to be implemented. Through the CARES Act and the American Rescue Plan Act, the Commonwealth has unprecedented resources at its disposal. While the Commonwealth is to be commended for publicly posting related information, **there has been no comprehensive analysis of the equity impact of these funds and no comprehensive plan for how ARPA funds can be directed to achieve equity.**

For example, are these funds going to the communities and populations hardest hit by this pandemic? Are they targeted to address barriers to vaccines for vulnerable populations? And how can these funds serve as an essential bridge to a stronger, more equitable future? These are just a few of the questions that need to be examined.

This Task Force calls for such an **equity impact analysis** of funds that have already been expended, and an **equity plan for the American Rescue Plan funds** that will flow to state and local governments. It is often said that you can tell an entity's priorities by looking at their budget. Let's make it clear in the Commonwealth's budget plans, that equity is priority number one.

PROMISING PRACTICES FROM OTHER STATES

CALIFORNIA

California's Health in All Policies program is an example for Massachusetts to learn from and adapt as it develops its own innovative, cutting-edge model focused on *equity.* A case study of California is cited in the Public Health Institute report. Executive Order S-04-10 created the Health in All Policies Task Force charged with identifying "priority programs, policies, and strategies to improve the health of Californians while advancing the goals of improving air and water quality, protecting natural resources and agricultural lands, increasing the availability of affordable housing, improving infrastructure systems, promoting public health, planning sustainable communities, and meeting the climate change goals." The Attorney General sits on the Task Force, along with officers of 18 other California state agencies, departments, and offices.[117,118]

WASHINGTON

In Washington state, legislation established the Washington State Governor's Interagency Council on Health Disparities and dictates that the council's action plan must address a number of specific diseases, health issues, and behaviors. These include diabetes, infant mortality, HIV/AIDS, breast cancer, sudden infant death syndrome, mental health, and the immunization rates of children and senior citizens. In Washington State, the governor or any legislator can request that the Board of Health complete a Health Impact Review on the impacts of legislation on health disparities.[119]

SEATTLE, WA

Seattle has a comprehensive commitment to addressing structural racism. As part of that commitment, they developed the attached tool to assess the impact of new policies and programs on equity.[120]

7.6. EQUITY ADVISORY BOARD

The Executive Office would be guided by an external Equity Advisory Board, with diverse experts in the fields of equity and health equity, community-based organizations that address the social and economic factors that impact equity, and people from communities around the Commonwealth with lived experience. The Equity Advisory Board should have 25 to 30 members who represent the

[117] https://oag.ca.gov/environment/communities/policies
[118] https://sgc.ca.gov/programs/hiap/
[119] https://healthequity.wa.gov/
[120] https://www.seattle.gov/Documents/Departments/RSJI/Racial%20Equity%20Toolkit_FINAL_August2012_with%20new%20cncl%20districts(0).pdf

diverse Commonwealth and are appointed by the Governor, the Speaker of the House, the Senate President, and the Attorney General. The chairs of the joint committees on Racial Equity, Civil Rights and Inclusion should be considered for appointment. Among the organizations that should also be considered are community health centers; a safety net hospital; an immigrant advocacy organization, along with health care consumers, housing, food, child advocacy and other organizations representing social factors in health, as well as health equity policy experts. This Board will approve the Commonwealth's equity strategic plan, have input and final approval of Data Dashboards, and approve the Equity in All Policies implementation plan and monitor results of all.

PROMISING PRACTICES FROM OTHER STATES

CALIFORNIA

California's Health in All Policies program is an example for Massachusetts to learn from and adapt as it develops its own innovative, cutting-edge model focused on equity. A case study of California is cited in the Public Health Institute report. Executive Order S-04-10 created the Health in All Policies Task Force charged with identifying "priority programs, policies, and strategies to improve the health of Californians while advancing the goals of improving air and water quality, protecting natural resources and agricultural lands, increasing the availability of affordable housing, improving infrastructure systems, promoting public health, planning sustainable communities, and meeting the climate change goals." The Attorney General sits on the Task Force, along with officers of 18 other California state agencies, departments, and offices.[121]

WASHINGTON

In *Washington* state, legislation established the Washington State Governor's Interagency Council on Health Disparities and dictates that the council's action plan must address a number of specific diseases, health issues, and behaviors. These include diabetes, infant mortality, HIV/AIDS, breast cancer, sudden infant death syndrome, mental health, and the immunization rates of children and senior citizens. In Washington State, the governor or any legislator can request that the Board of Health complete a Health Impact Review on the impacts of legislation on health disparities.

Seattle has a comprehensive commitment to addressing structural racism. As part of that commitment, they developed the attached tool to assess the impact of new policies and programs on equity.[122]

8. CONCLUSION

This report provides a comprehensive roadmap to address the disproportionate impacts of COVID-19 on persons from diverse racial and ethnic backgrounds, and on other vulnerable populations and communities. It also seeks to put the Commonwealth on a path toward addressing underlying, root causes of these inequities and to prevent them in the future. The goal of this roadmap is to ensure that equity is front and center in all decisions by the state government going forward. Our hope is that the Legislature will use this Blueprint and continue to explore additional means to achieve health equity.

It is incontrovertible that COVID-19 laid bare long-standing inequities throughout our Commonwealth and our country. We must continue to mount a vigorous response to COVID-19 for some time to come through an enhanced Stop the Spread campaign, while we work diligently to make vaccination accessible to every person and community in the Commonwealth and plan for booster and annual vaccinations.

---

[121] https://oag.ca.gov/environment/communities/policies https://sgc.ca.gov/programs/hiap/
[122] https://www.seattle.gov/Documents/Departments/RSJI/Racial%20Equity%20Toolkit_FINAL_August2012_with%20new%20cncl%20districts(0).pd

Meanwhile, we must stem the economic damage that leaves families unstably housed, or not housed at all, and seeking food from emergency providers. The evidence shows that it is these economic and social conditions that have a powerful impact on health. And we must redress long-standing underfunding of the health and behavioral health care systems that care for the poor and underserved. They exist on a thin margin of resources.

We look to the future in this report and recommend actions to prevent glaring inequities in the future. An important component of this response is more robust support of local and state public health, and an After Action Review with an equity lens, of the Commonwealth's pandemic response, which would be the first of its kind in the country.

Finally, it is time that equity becomes a central tenet of all decisions of state government. To that end, the Task Force recommends creating a cabinet-level Executive Office of Equity, led by a Secretary of Equity. Each executive office would also have an office of equity, and all, including the central office, would be charged with developing 3 to 5 year strategic plans, with measurable goals publicly available and tracked through data dashboards. Each would also have advisory boards.

As the letter of introduction says, ***returning to the pre-pandemic "normal" is not an option.*** "Normal" created the conditions that led to these disparities. Massachusetts has received and will receive historic amounts of federal funds to recover. This provides us a unique opportunity to prioritize equity as we make decisions about how to invest those dollars. We must seize this opportunity to build a more equitable and resilient future ***for all.*** The time to act is now.

APPENDICES

TASK FORCE MEMBERS

Senate Appointees:

Michael Curry, Esq.
Task Force Co-Chair
President & CEO, Massachusetts League of Community Health Centers

Senator Julian Cyr

Senator Sonia Chang-Diaz

Dr. Milagros Abreu
Executive Director, President and Founder of The Latino Health Insurance Program

Dr. Cassandra Pierre
Infectious Disease Physician and Assistant Professor of Medicine at Boston University

Dr. Frank Robinson
Vice President, Public Health, Baystate Health

Hirak Shah
Legal Counsel for Senate Minority Leader Bruce Tar

House Appointees:

Dr. Assaad J. Sayah
Task-Force Co-Chair
CEO, Cambridge Health Alliance; Commissioner of Public Health, City of Cambridge; Assistant Professor, Harvard Medical School

Representative Chynah Tyler
Chair of the MA Black and Latino Legislative Caucus

Representative Jose Tosado
(term through January 2021)

Dr. Kiame Mahaniah
CEO, Lynn Community Health Center

Dr. Myechia Minter-Jordan
President & CEO, DentaQuest Partnership for Oral Health Advancement and Catalyst Institute

Jeffrey Sanchez
Lecturer, Center for Public Health Leadership, TH Chan School of Public Health; Senior Advisor, Rasky Partners

Beverly Stables
Health Care Policy Analyst for House Minority Leader Bradley H. Jones, Jr.

Representative Carlos González

Representative Liz Miranda
(term commenced in February 2021)

Representative Donald H. Wong
Chair of the MA Asian-American Legislative Caucus

LEGISLATIVE CHARGE OF THE HEALTH EQUITY TASK FORCE

Chapter 93 of the Acts of 2020:
https://malegislature.gov/Laws/SessionLaws/Acts/2020/Chapter93

SECTION 2. (a) Notwithstanding any general or special law to the contrary, there shall be a task force to study and make recommendations to the general court that address health disparities for underserved or underrepresented populations based on culture, race, ethnicity, language, disability, gender identity, sexual orientation, geographic location, including, but not limited to, gateway cities with hospitals dedicated to caring for patients who test positive for COVID-19, and age in the commonwealth during the COVID-19 pandemic.(b) The recommendations shall include, but shall not be limited to, ways to: (1) improve safety for populations at increased risk for COVID-19, which may include, but shall not be limited to: (i) employees of businesses and organizations defined as providing "COVID-19 Essential Services" under the governor's March 23, 2020 emergency order; (ii) individuals residing in congregate housing and group home facilities, including, but not limited to, those operating under contracts with the department of developmental services, the department of mental health, the department of children and families, executive office of elder affairs, the department of housing and community development, the department of youth services, or the department of public health; (iii) inmates confined to a house of correction or state prison; (iv) individuals with serious underlying medical conditions linked to increased risk of severe illness from COVID-19 according to the federal Centers for Disease Control and Prevention; and (v) individuals residing in municipalities or neighborhoods disproportionately impacted by COVID-19;

SECTION 2. (b) (1) (cont.) (2) remove barriers and increase access to quality and equitable health care services and treatment; (3) increase access to medical supplies; (4) increase access to testing for COVID-19, including identifying ways to ensure that testing occurs in diverse geographic locations throughout the commonwealth; (5) provide informational materials to underserved or underrepresented populations in multiple languages on available and affordable health care resources in the commonwealth, including, but not limited to, prevention, testing, treatment and recovery; and (6) address any other factor the task force deems relevant to address health disparities for underserved or underrepresented populations based on culture, race, ethnicity, language, disability, gender identity, sexual orientation, geographic location and age in the commonwealth during the COVID-19 pandemic. As part of its recommendations, the task force may recommend the further study of the impact of disparities on populations not subject to this study.

(c) The task force shall consist of: 6 members appointed by the senate president, not more than 2 of whom shall be members of the senate; 6 members appointed by the speaker of the house of representatives, not more than 2 of whom shall be members of the house of representatives; 1 member appointed by the minority leader of the senate; 1 member appointed by the minority leader of the house of representatives; the chair of the Massachusetts Asian-American Legislative Caucus or a designee; and the chair of the Massachusetts Black and Latino Legislative Caucus or a designee. Task force membership shall reflect diverse representation in the commonwealth including, but not limited to, diverse cultures, races, ethnicities, languages, disabilities, gender identities, sexual orientations, geographic locations and ages. Appointees of the senate president, speaker of the house, minority leader of the senate and minority leader of the house who are not members of the general court shall be knowledgeable in public health or healthcare. When making

appointments, the senate president, speaker of the house, minority leader of the senate and minority leader of the house shall give consideration to individuals who have experience addressing disparities in underserved or underrepresented populations based on culture, race, ethnicity, language, disability, gender identity, sexual orientation, geographic location and age or who work in the healthcare system with a diverse patient population. Two members of the task force shall be elected by a majority of the task force membership to serve as co-chairs; provided, however, that neither member shall be a member of the general court. The task force may consult with the office of health equity to inform its work. The office of health equity shall provide requested information to the task force upon request.

(d) The task force shall file its recommendations with the clerks of the house of representatives and the senate and the house and senate committees on ways and means not later than August 1, 2020 *[date amended by section 70 of Chapter 227 of the Acts of 2020].*

(e) The task force shall file an interim report describing any initial recommendations and issues requiring further study with the clerks of the house of representatives and the senate and the house and senate committees on ways and means not later than June 30, 2020; provided, however, that the task force may file earlier interim recommendations if deemed advisable or additional interim recommendations between June 30, 2020 and August 1, 2020 *[date amended by section 71 of Chapter 227 of the Acts of 2020]*.

(f) The task force shall hold at least 1 public hearing and accept public comment before filing its interim report under subsection (e) and shall hold not less than 2 additional public hearings and accept public comment before filing its final report under subsection (d); provided, however, that the task force may hold virtual public hearings if it is in the interest of public health.

SECTION 3. Notwithstanding any general or special law to the contrary, the department of correction and each house of correction shall provide to the department of public health any data necessary to implement sections 1 and 2.

SECTION 4. Notwithstanding any general or special law to the contrary, the department of public health may enter into interagency agreements with other state agencies to facilitate the collection of data requested pursuant to this act.

SECTION 5. Sections 1 and 3 to 4, inclusive, are hereby repealed.

SECTION 6. The governor shall certify in writing to the state secretary when the department of public health has not received a report of a positive test of COVID-19 in the commonwealth within the preceding 30 days.

SECTION 7. Section 5 shall take effect upon the certification required by section 6.

Approved, June 7, 2020.

HEALTH EQUITY TASK FORCE INTERIM REPORT

Health Equity Task Force Interim Report: Report SD.3081 (malegislature.gov) and Report HD.5415 (malegislature.gov)

Interim Report of the Health Equity Task Force (pursuant to §2 of Chapter 93 of the Acts of 2020) to study and make recommendations to the General Court that address health disparities for underserved or underrepresented populations during the COVID-19 pandemic

COVER LETTER
October 15, 2020

To the Honorable Michael D. Hurley
Clerk of the Senate
State House, Room 335
Boston, MA 02133

To the Honorable Steven T. James
Clerk of the House of Representatives
State House, Room 145
Boston, MA 02133

Dear Mr. Hurley and Mr. James:

Please find attached the Interim Report of the Health Equity Task Force (pursuant to §2 of Chapter 93 of the Acts of 2020, which is attached to this letter as a description of the legislative mandate vested in the Health Equity Task Force).

The Task Force is charged to study and make recommendations that will promote an equitable COVID-19 response and address troubling health inequities by learning from experiences to date. Drawing on the significant work done by others, the Task Force has an ultimate goal of making progress on longstanding structural inequities and improvements in ongoing and future pandemic response efforts, which will be a focus of a future Final Report. Health disparities are not new, but have been amplified in the COVID-19 pandemic and its economic aftermath.

Based on extensive stakeholder input of approximately 100 organizations and individuals thus far, this Interim Report is issued to provide timely considerations for state policy makers about immediate needs in the ongoing COVID-19 response, as we face the possibility of a second surge. To that end, the Interim Report highlights key priorities for the FY 2021 state budget and policy action expected this Fall.

Respectfully,

Michael Curry, Esq. Task Force Co-Chair, Deputy CEO and General Counsel at Massachusetts League of Community Health Centers

Dr. Assaad Sayah, Task Force Co-Chair, CEO, Cambridge Health Alliance; Commissioner of Public Health, City of Cambridge; Assistant Professor, Harvard Medical School

Senate Appointees

Senator Sonia Chang-Diaz

Senator Julian Cyr*

Dr. Milagros Abreu, Executive Director, President and Founder of The Latino Health Insurance Program

Dr. Cassandra Pierre, Infectious Diseases Physician and Assistant Professor of Medicine at Boston University

Dr. Frank Robinson, Vice President, Public Health Baystate Health

Hirak Shah, Legal Counsel for Senate Minority Leader Bruce Tarr

Chair of the MA Black and Latino Legislative Caucus
Representative Carlos González

House Appointees

Representative Chynah Tyler

Representative José F. Tosado

Dr. Kiame Mahaniah, CEO, Lynn Community Health Center

Dr. Myechia Minter-Jordan, President & CEO, DentaQuest Partnership for Oral Health Advancement and Catalyst Institute

Jeffrey Sanchez, Lecturer, Center for Public Health Leadership, TH Chan School of Public Health; Senior Advisor, Rasky Partners

Beverly Stables, Health Care Policy Analyst for House Minority Leader Bradley H. Jones, Jr.

Chair of the MA Asian-American Legislative Caucus
Representative Donald H. Wong

*Senator Cyr voted to approve the Health Equity Interim Report, noting his recusal on the report's telehealth provisions related to his service on the pending Health Care Conference Committee and on Appendix IV of the Interim Report.

SUMMARY OF TASK FORCE MEETINGS, PUBLIC HEARING AND PRESENTATIONS

Meeting/Hearing	Topics	Resources
August 24, 2020 **Task Force Meeting**	• Introductory Meeting • Selection of Co-Chairs • Presentation by Office of Health Equity	• Task Force Meeting Slides • MA Department of Public Health Office of Health Equity Presentation
September 3, 2020 **Task Force Meeting**	• Review of Task Force Mandate • COVID-19 Recommendations	• Task Force Meeting Slides • MA Public Health Association Presentation
September 16, 2020 **Public Hearing**	• Public Hearing to Receive Stakeholder Input	• Task Force Meeting Slides • Testimony by Diverse Stakeholders
September 18, 2020 **Task Force Meeting**	• Insights from Public Hearing • Process for Interim Report	• Task Force Meeting Slides
September 29, 2020 **Task Force Meeting**	• Perspectives from Hotspot Community	• Task Force Meeting Slides • Presentations by Chelsea Collaborative and Chelsea City Manager Presentation by Boston Black COVID-19 Caucus
October 7, 2020 **Task Force Meeting**	• Interim Summary Report Review • Perspectives from Black & Latino and Asian-American Legislative Caucuses	• Listening Session with MA Black and Latino Legislative Caucus and MA Asian-American Legislative Caucus
October 14, 2020 **Task Force Meeting**	• Discussion and Approval of Interim Report	• Filed Interim Report • Task Force Meeting Slides
October 28, 2020 **Task Force Meeting**	• Discussion on Updates relative to the filed Interim Report & the State Budget/Policy Process • Task Force Open Discussion	• Task Force Meeting Slides
November 18, 2020 **Task Force Meeting**	• Presentation and Dialogue with National Academy for State Health Policy • Announcement re: Attorney General Healey's "Building Toward Racial Justice and Equity in Health" Forum/Report	• Task Force Meeting Slides • Presentation by National Academy for State Health Policy: Snapshot of State Approaches to Address Health Equity
December 16, 2020 **Task Force Meeting**	• COVID-19 Vaccine Presentation and Equity Considerations • Presentation and Dialogue with the Office of Attorney General: "Building Toward Racial Justice and Equity in Health: A Call to Action"	• Task Force Meeting Slides • Presentation by the Office of MA Attorney General Maura Healey: Building Toward Racial Justice and Equity in Health: A Call to Action

January 19, 2021 **Task Force Meeting**	• Panel Presentations: Telehealth, Digital Equity, and Health Equity Zones • Panel Presentations: Cross-Sector Digital Equity and Inclusion	• Task Force Meeting Slides • Presentations by MA Health and Hospital Association and convener of tMed Coalition, Community Care Collaborative, MA Medical Society, and One Neighborhood Builders, Providence, Rhode Island • Presentations by Lynn Public Schools, Essex County Community Foundation, and Springfield Public Schools/Digital Equity Alliance
February 1, 2021 **Public Hearing**	• Public Hearing to Receive Stakeholder Input	• Task Force Meeting Slides • Testimony by Diverse Stakeholders
February 2, 2021 **Task Force Meeting**	• Presentation and Dialogue on Connecticut's Health and Health Equity Dashboards • Presentation and Dialogue on the Health Opportunity and Equity (HOPE) Initiative: Measures to Advance Health and Opportunity	• Task Force Meeting Slides • Presentation on Connecticut's Health and Health Equity Dashboards • Presentation of Health Opportunity and Equity (HOPE) Initiative: Measures to Advance Health and Opportunity
February 8, 2021 **Public Hearing**	• Public Hearing to Receive Stakeholder Input	• Task Force Meeting Slides • Testimony by Diverse Stakeholders
February 16, 2021 **Task Force Meeting**	• Task Force Discussion of Subset of Elements of Final Report • Overview and Framing of Final Report • Ongoing COVID-19 Response • Prioritizing Equity through Structures in State Government • Cabinet-level Multidisciplinary Office of Equity • Equity Data and Dashboards • Equity in All Policies/Equity Impact Analysis • Integrating Equity into Emergency and Disaster Preparedness: A Call for an After Action Review	• Task Force Meeting Slides
February 23, 2021 **Task Force Meeting**	• Task Force Discussion of Subset of Elements of Final Report • Social Factors in Health - Addressing Root Causes of Inequity • Access to Quality, Equitable Health Care and Other Services • Strengthening the Public Health System/Other	• Task Force Meeting Slides
July 1, 2021 **Task Force Meeting**	• Meeting to Consider and Approve the Task Force's Final Report	• Final Report and Slides