

HOUSE No.

The Commonwealth of Massachusetts

PRESENTED BY:

Bud L. Williams

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

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

An Act to advance health equity.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
<i>Bud L. Williams</i>	<i>11th Hampden</i>	<i>1/6/2025</i>

HOUSE No.

[Pin Slip]

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE HOUSE, NO. 1250 OF 2023-2024.]

The Commonwealth of Massachusetts

**In the One Hundred and Ninety-Fourth General Court
(2025-2026)**

An Act to advance health equity.

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

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

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

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

10 “Health equity”, as defined in section 1 of chapter 6F.

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

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

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

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

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

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

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

31 SECTION 9. Section 3 of said chapter 6D, as so appearing, is hereby amended in
32 subsection (k) by striking out, in line 38, the word “and”, in subsection (l) by striking out, in line
33 41, “.,” and inserting in place thereof the word:- ; and.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

125 CHAPTER 6F

126 EXECUTIVE OFFICE OF EQUITY

127 Section 1. Definitions

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

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

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

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

148 “Office”, executive office of equity.

149 “Secretary”, secretary of equity.

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

155 Section 2. Establishment of office

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

158 Section 3. Principal agency of executive department; purposes

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

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

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

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

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

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

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

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

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

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

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

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

202 The undersecretaries shall provide assistance to the executive offices by:

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

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

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

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

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

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

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

219 Section 5. Advisory board

220 (a) There shall be an advisory board to the executive office of equity. The advisory board
221 shall consist of: 3 persons appointed by the governor; 3 persons appointed by the president of the
222 senate; 3 persons appointed by the speaker of the house of representatives; 3 persons appointed
223 by the Massachusetts Black and Latino Legislative Caucus; 1 person appointed by the Secretary
224 of Administration and Finance who shall have expertise in economic matters; 1 person appointed
225 by the Secretary of Education who shall have expertise in education matters; 1 person appointed
226 by the Secretary of Energy and Environmental Affairs who shall have expertise in environmental
227 justice; 1 person appointed by the Secretary of Health and Human Services who shall have
228 expertise in health equity and the social determinants of health; 1 person appointed by the
229 Secretary of Housing who shall have expertise in housing policy; 1 person appointed by the
230 Secretary of Economic Development who shall have expertise in economic development policy;
231 1 person appointed by the Secretary of Labor and Workforce Development who shall have
232 expertise in labor and workforce development policy; 1 person appointed by the Secretary of
233 Public Safety and Security who shall have expertise in criminal justice matters; 1 person
234 appointed by the Secretary of Transportation who shall have expertise in transportation matters;
235 1 person appointed by the Secretary of Veterans Affairs who shall have expertise in matters
236 related to veterans, and 1 person appointed by the Secretary of Office of Climate Innovation and
237 Resilience who shall have experience in climate matters.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

325 Section 7. Annual Report

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

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

339 “Health equity”, as defined in section 1 of chapter 6F.

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

342 “Priority population”, as defined in section 1 of chapter 6D.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

477 "Environmental justice population", as defined in section 62 of chapter 30.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

564 SECTION 37. Subsection (g) of section 25C of chapter 111 of the General Laws, as
565 appearing in the 2020 Official Edition, is hereby amended, by inserting after “account”, in line
566 103, the following words:- the findings of the health equity assessment described in subsection
567 (o) and.

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

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

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

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

587 SECTION 40. Clause (ii) of paragraph (4) of subsection (a) of section 25L of chapter
588 111, as so appearing, is hereby amended by striking out, in line 47, “comprehensive recruitment
589 initiatives” and inserting in place thereof the following words:- comprehensive recruitment
590 initiatives (including initiatives to support the recruitment and retention of individuals,
591 notwithstanding immigration status, who work in health care settings and are not traditionally
592 recipients of scholarship and student loan repayment programs).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

716 (b) Any policy, contract or certificate of health insurance subject to chapters 32A, 118E,
717 175, 176A, 176B, 176G or 176Q of the General Laws shall provide coverage for the identified
718 services, treatments and prescription drugs. Such coverage shall not be subject to any cost-
719 sharing, including co-payments and co-insurance, and shall not be subject to any deductible,
720 pursuant to guidance from the secretary of health and human services, notwithstanding whether
721 an identified service or treatment was delivered in-person or via telehealth (as defined in section
722 79(a) of chapter 118E). The commissioner of the division of insurance shall adopt any written
723 policies, procedures or regulations necessary to implement said program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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