

**HOUSE . . . . . No.**

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**The Commonwealth of Massachusetts**

PRESENTED BY:

***Bud L. Williams and Judith A. Garcia***

*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>1/16/2025</i>
<i>Judith A. Garcia</i>	<i>11th Suffolk</i>	<i>1/16/2025</i>

**HOUSE . . . . . No.**

[Pin Slip]

**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 is hereby amended by  
2 inserting after “the secretary of energy and environmental affairs,” in line 4, the following  
3 words:- the secretary of equity,.

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

6 SECTION 3. Section 1 of chapter 6D is hereby further amended by inserting after the  
7 definition of “Health care services” the following definition:-

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

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

11 “Priority population”, a population that is disproportionately affected by health  
12 disparities.

13 SECTION 5. Subsection (b) of section 2 of said chapter 6D, as so appearing, is hereby  
14 amended by inserting after the word “chairperson”, in line 12, the following words:- and 1 of  
15 whom shall be a person of color with lived experience of social inequities and a professional  
16 record of health equity advocacy.

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

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

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

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

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

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

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

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

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

42 SECTION 13. Subsection (a) of section 8 of said chapter 6D, as so appearing, is hereby  
43 amended by striking out, in line 6, “shall examine” and inserting in place thereof the following  
44 words:- shall examine: (1).

45 SECTION 14. Said subsection (a) of said section 8 of said chapter 6D, as so appearing, is  
46 hereby amended by striking out, in line 9, “health care system” and inserting in place thereof the  
47 following words:- health care system; and (2) health inequities experienced by priority  
48 populations.

49 SECTION 15. Clause (i) of subsection (e) of said section 8 of said chapter 6D, as so  
50 appearing, is hereby amended by striking out, in line 45, “and the impact of price transparency  
51 on prices” and inserting in place thereof the following words:- , the impact of price transparency  
52 on prices, and efforts to reduce health inequities experienced by priority populations.

53 SECTION 16. Clause (ii) of said subsection (e) of said section 8 of said chapter 6D, as so  
54 appearing, is hereby amended by striking out, in line 58, “and any” and inserting in place thereof

55 the following words:- , efforts to reduce health inequities experienced by priority populations,  
56 and any.

57 SECTION 17. Subsection (g) of said section 8 of said chapter 6D, as so appearing, is  
58 hereby amended by striking out, in lines 93 to 96, “annual report concerning spending trends and  
59 underlying factors, along with any recommendations for strategies to increase the efficiency of  
60 the health care system” and inserting in place thereof the following words: annual report  
61 concerning: (1) spending trends and underlying factors (including estimates of the cost of  
62 inequity for the purpose of identifying the impact of health disparities on total costs of care); (2)  
63 any recommendations for strategies to increase the efficiency of the health care system; and (3)  
64 any recommendations to reduce health inequities for priority populations based on data and input  
65 received pursuant to sections 10A and 2A(c)(7) of chapter 12C, respectively.

66 SECTION 18. Said subsection (g) of said section 8 of said chapter 6D, as so appearing, is  
67 hereby amended by striking out, in line 100, “sections 8, 9 and 10” and inserting in place  
68 thereof:- sections 2A(c)(7), 8, 9, 10, and 10A.

69 SECTION 19. Said chapter 6D of the General Laws is hereby further amended by  
70 inserting after section 9 the following section:-

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

74 (b) Prior to establishing the target and aggregate target, the commission shall hold a  
75 public hearing. The public hearing shall be based on the report submitted by the center under  
76 section 16(a) of chapter 12C, comparing the actual aggregate expenditures on primary care and

77 behavioral health services to the aggregate target, any other data submitted by the center and  
78 such other pertinent information or data as may be available to the board. The hearing shall  
79 examine the performance of health care entities in meeting the target and the commonwealth's  
80 health care system in meeting the aggregate target. The commission shall provide public notice  
81 of the hearing at least 45 days prior to the date of the hearing, including notice to the joint  
82 committee on health care financing. The joint committee on health care financing may  
83 participate in the hearing. The commission shall identify as witnesses for the public hearing a  
84 representative sample of providers, provider organizations, payers, community-based  
85 organizations, and such other interested parties as the commission may determine. Any other  
86 interested parties may testify at the hearing.

87 SECTION 20. Paragraph (15) of subsection (c) of section 15 of said chapter 6D, as so  
88 appearing, is hereby amended by striking out, in line 168, "and".

89 SECTION 21. Said subsection (c) of said chapter 6D, as so appearing, is hereby amended  
90 by inserting after said paragraph (15) the following paragraphs:-

91 (16) to advance health equity by meeting health equity standards that reflect best  
92 practices, including standards that the commission may develop as part of the certification  
93 process; and

94 SECTION 22. Said subsection (c) of section 15 of said chapter 6D, as so appearing, is  
95 hereby amended by redesignating paragraph (16), as inserted by section 15 of chapter 224 of the  
96 acts of 2012, as paragraph (18).

97 SECTION 23. Chapter 6D of the General Laws is hereby amended by inserting after  
98 section 21 the following Section:-

99           Section 22. Every 2 years, the commission, in consultation with the center for health  
100 information and analysis, the group insurance commission, the office of Medicaid, and the  
101 division of insurance shall evaluate the impact of section 17S of chapter 32A, section 10O of  
102 chapter 118E, section 47PP of 175, section 8RR of 176A, section 4RR of 176B, and section 4HH  
103 of 176G on health care costs, including premiums, pharmaceutical spending, aggregate rebates,  
104 and cost-sharing; drug treatment utilization and adherence; incidence of related acute events; and  
105 health equity. The commission shall file a report of its findings with the clerks of the house of  
106 representatives and senate, the chairs of the joint committee on public health, the chairs of the  
107 joint committee on health care financing and the chairs of house and senate committees on ways  
108 and means.

109           SECTION 24. a) There shall be a special commission to address areas of longstanding  
110 health inequities in the state by establishing benchmarks (i.e., specific, measurable targets) from  
111 which to measure statewide improvement. The commission shall consist of: the senate chair of  
112 the joint committee on health care financing who shall serve as co-chair; the house chair of the  
113 joint committee on health care financing who shall serve as co-chair; the senate chair of the joint  
114 committee on public health; the house chair of the joint committee on public health; the senate  
115 chair of the joint committee on racial equity, civil rights, and inclusion; the house chair of the  
116 joint committee on racial equity, civil rights, and inclusion; the attorney general or a designee;  
117 the secretary of health and human services or a designee; the commissioner of public health or a  
118 designee; the executive director of the health policy commission or a designee; the executive  
119 director of the center for health information and analysis or a designee; 1 person with a  
120 professional record of health equity advocacy or expertise who shall be appointed by the senate  
121 president; 1 person with a professional record of health equity advocacy or expertise who shall

122 be appointed by the speaker of the house of representatives; 1 person with a professional record  
123 of health equity advocacy or expertise who shall be appointed by the minority leader of the  
124 senate; 1 person with a professional record of health equity advocacy or expertise who shall be  
125 appointed by the minority leader of the house of representatives; 11 persons who shall be  
126 appointed by the governor, 1 of whom shall be a health economist, 1 of whom shall represent a  
127 high-Medicaid and low-income public payer disproportionate share hospital, 1 of whom shall  
128 represent a hospital with not more than 200 beds, 1 of whom shall represent a hospital with at  
129 least 800 staffed beds, 1 of whom shall have demonstrated expertise in representing the health  
130 care workforce as a leader in a labor organization, 1 of whom shall be a representative of an  
131 employer with not more than 50 employees, 1 of whom shall be a representative of an employer  
132 with more than 50 employees, 1 of whom shall have significant experience in the health equity  
133 sub-sector of the life sciences sector, 1 of whom shall be an expert in health and social services  
134 for children, 1 of whom shall be an expert in health and social services for seniors, 1 of whom  
135 shall be an expert in healthcare and social services for persons with disabilities, and 1 of whom  
136 shall be a representative of a healthcare consumer advocacy organization; 1 person who shall be  
137 a representative of the Massachusetts Health and Hospital Association; 1 person who shall be a  
138 representative of the Massachusetts League of Community Health Centers; 1 person who shall be  
139 a representative of the Massachusetts Association of Health Plans; 1 person who shall be a  
140 representative of Blue Cross Blue Shield of Massachusetts; 1 person who shall be a  
141 representative of the Massachusetts Medical Society; 1 person who shall be a representative of  
142 the Massachusetts Public Health Alliance; and 1 person who shall be a representative of the  
143 Health Equity Compact.



144 In making appointments, elected officials shall, to the maximum extent feasible, ensure  
145 that the commission represents a broad distribution of geographic regions and diverse  
146 perspectives, including persons of color with lived experience of social inequities and  
147 professional records of health equity advocacy.

148 b) The commission shall collaborate with relevant state agencies and external experts,  
149 both in public health and health care as well as other key sectors that influence health and well-  
150 being, including but not limited to housing and social services, to: agree upon the highest priority  
151 health inequities to address in the state; establish measurable benchmarks for achieving health  
152 equity in the state (“Health Equity Benchmarks”); and develop a framework for driving and  
153 assessing state performance on such Health Equity Benchmarks that promotes accountability  
154 with respect to achieving material progress in addressing health inequities in the state.

155 c) The Health Equity Benchmarks established by the commission shall include, but not be  
156 limited to, the following:

157 1) Reducing disparities in overarching metrics between racial and ethnic groups, such as,  
158 for example, reducing the life expectancy gap in Massachusetts;

159 2) Reducing disparities in overarching metrics across geographic regions within the state;

160 3) Improving performance with respect to certain population-based outcome metrics,  
161 such as, for example, reducing pregnancy-associated deaths among certain racial and ethnic  
162 groups;

163 4) Improving performance with respect to certain process metrics applicable to health  
164 equity including, for example, utilization metrics, financial investment, data collection, and  
165 structural reforms; and

166 5) Stakeholder-specific responsibilities and performance targets, where stakeholders  
167 include both public and private sector entities.

168 d) The framework for driving and assessing statewide performance shall include, but not  
169 be limited to, the following:

170 1) Data reporting, tracking, and transparency mechanisms for both public and private  
171 stakeholders, such as through the use of public data dashboards;

172 2) Enforcement mechanisms to hold public and private stakeholders accountable for  
173 making progress towards achieving the benchmarks;

174 3) Evaluation criteria, including allowance for periodic benchmark refinement;

175 4) Mechanisms to facilitate coordination, collaboration, and improvement among  
176 stakeholders in order to support progress towards achieving the benchmarks;

177 5) Mechanisms for financing the implementation of and progress towards the  
178 benchmarks; and

179 6) Identification of the relevant agency or agencies responsible for implementation of the  
180 above data reporting, tracking, accountability, evaluation, improvement support, and financing  
181 mechanisms.

182 e) In developing its recommendations, the commission shall identify and build on areas  
183 of alignment across other major frameworks, goals, benchmarks, and initiatives in Massachusetts  
184 related to health equity, in both the public and private sectors. In developing its  
185 recommendations, the commission shall consider and, to the extent possible, incorporate recent  
186 findings from significant community engagement initiatives and needs assessments in the most  
187 disproportionately impacted communities. The commission shall consult with external experts  
188 and focus on topics including but not limited to data collection and reporting, and inequities in  
189 health outcomes, healthcare access and quality in such consultations. The commission may hold  
190 public meetings and fact-finding hearings as it considers necessary. The commission may also  
191 establish working groups to further investigate and develop draft recommendations. To conduct  
192 its review and analysis, the commission may contract with an outside organization to assist the  
193 commission in carrying out its functions as described in this section. The center for health  
194 information and analysis and the health policy commission shall provide the commission and any  
195 contracted outside organization, to the extent possible, relevant data and analysis necessary for  
196 the evaluation.

197 f) The commission shall hold its first meeting not later than 90 days after enactment of  
198 this act, and shall meet periodically thereafter as determined necessary by the commission co-  
199 chairs to carry out the duties of the commission.

200 g) By no later than sixteen months after enactment of this act, the commission shall  
201 complete the activities described in the preceding paragraphs and submit a final report to the  
202 Governor's office, the state legislature, and the health policy commission, which shall include,  
203 but not be limited to: the high-priority areas of health inequities in the state identified by the  
204 commission; the Health Equity Benchmarks drafted by the commission; the framework for

205 driving and assessing state performance that promotes accountability with respect to achieving  
206 material progress in addressing health inequities in the state; and recommendations for  
207 operationalizing the Health Equity Benchmarks and the framework for driving and assessing  
208 state performance.

209 h) If the commission determines that legislation is necessary to operationalize its  
210 recommendations, the commission, as part of its final report, shall file proposals for such  
211 legislation not later than twenty months after enactment of this act with the clerks of the house of  
212 representatives and the senate, who shall forward a copy of the materials filed by the commission  
213 to the house and senate committees on ways and means and the joint committee on health care  
214 financing.

215 SECTION 25. The General Laws are hereby amended by inserting after chapter 6E the  
216 following chapter:-

217 CHAPTER 6F

218 EXECUTIVE OFFICE OF EQUITY

219 Section 1. Definitions

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

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

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

232 “Health equity”, the state in which everyone has a fair and just opportunity to be as  
233 healthy as possible. Such a state requires removing obstacles to health and to health care  
234 services, and promoting individuals’ ability to control their own healthcare and set their own care  
235 goals. For purposes of the preceding sentences, achieving health equity requires focused and  
236 ongoing efforts to address historical and contemporary injustices such as poverty and racism and  
237 efforts to address social determinants of health, including lack of access to good jobs with fair  
238 pay; quality education; safe, accessible, and affordable housing; public transportation; safe and  
239 healthy environments; and health care. In this term, health includes physical health, oral health,  
240 and behavioral health. For the purposes of measurement, advancing health equity means  
241 reducing and ultimately eliminating disparities in health outcomes that adversely affect  
242 underserved, excluded, or marginalized groups.

243 “Office”, executive office of equity.

244 “Secretary”, secretary of equity.

245 “Social determinants of health”, the conditions in the environments where people are  
246 born, live, learn, work, play, worship, and age that affect a wide range of health outcomes,

247 functioning, and quality-of-life outcomes and risks, including economic stability, education  
248 access and quality, health care access and quality, neighborhood and built environment, and  
249 social and community contexts.

250 Section 2. Establishment of office

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

253 Section 3. Principal agency of executive department; purposes

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

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

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

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

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

270 (e) creating and publishing data dashboards stratified and disaggregated by race,  
271 ethnicity, language, disability, and other socio-demographic factors. Said dashboards shall  
272 include data relative to population level outcomes and to the process and outcome measures  
273 described in subsection (c) as well as any additional data the office deems important for the  
274 general public and decision makers. These dashboards shall comply with applicable privacy law  
275 but shall be publicly presented in a user-friendly format, with a focus on ensuring accessibility in  
276 its design; and

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

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

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

285 The secretary, in consultation with each respective secretary of each Massachusetts  
286 executive office, shall appoint an undersecretary of equity to assist each other Massachusetts  
287 executive office in applying an equity lens in all aspects of agency decision making, including  
288 service delivery, program development, policy development, and budgeting. The secretary shall

289 appoint an undersecretary of equity for administration and finance, an undersecretary of equity  
290 for education, an undersecretary of equity for energy and environmental affairs, an  
291 undersecretary of equity for health and human services, an undersecretary of equity for housing,  
292 an undersecretary of economic development, an undersecretary of equity for labor and workforce  
293 development, an undersecretary of equity for public safety and security, an undersecretary of  
294 equity for transportation, an undersecretary of equity for veterans affairs, and an undersecretary  
295 of equity for climate innovation and resilience. Each person appointed as an undersecretary shall  
296 have experience, and shall know the field or functions of such position.

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

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

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

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

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

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



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

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

314 Section 5. Advisory board

315 (a) There shall be an advisory board to the executive office of equity. The advisory board  
316 shall consist of: 3 persons appointed by the governor; 3 persons appointed by the president of the  
317 senate; 3 persons appointed by the speaker of the house of representatives; 3 persons appointed  
318 by the Massachusetts Black and Latino Legislative Caucus; 1 person appointed by the Secretary  
319 of Administration and Finance who shall have expertise in economic matters; 1 person appointed  
320 by the Secretary of Education who shall have expertise in education matters; 1 person appointed  
321 by the Secretary of Energy and Environmental Affairs who shall have expertise in environmental  
322 justice; 1 person appointed by the Secretary of Health and Human Services who shall have  
323 expertise in health equity and the social determinants of health; 1 person appointed by the  
324 Secretary of Housing who shall have expertise in housing policy; 1 person appointed by the  
325 Secretary of Economic Development who shall have expertise in economic development policy;  
326 1 person appointed by the Secretary of Labor and Workforce Development who shall have  
327 expertise in labor and workforce development policy; 1 person appointed by the Secretary of  
328 Public Safety and Security who shall have expertise in criminal justice matters; 1 person  
329 appointed by the Secretary of Transportation who shall have expertise in transportation matters;  
330 1 person appointed by the Secretary of Veterans Affairs who shall have expertise in matters

331 related to veterans, and 1 person appointed by the Secretary of Office of Climate Innovation and  
332 Resilience who shall have experience in climate matters.

333 All members of the advisory board shall be residents of the commonwealth who are not  
334 employed by the commonwealth who have demonstrated a commitment to advancing equity and  
335 expertise in utilizing policy, systems and environmental strategies to address inequities. Criteria  
336 for selection of members shall consider diversity of geography; diversity of race and ethnicity;  
337 diversity of age; inclusion of individuals living with disabilities; and inclusion of individuals  
338 from the LGBTQ+ community. All members must have expertise in utilizing policy, systems and  
339 environmental strategies to address inequities. Members shall be considered special state  
340 employees for purposes of chapter 268A. All community representatives serving on the board  
341 shall be compensated for their time. The appointing authorities shall confer prior to making final  
342 appointments to ensure compliance with this provision.

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

346 (c) The board shall annually elect from among its members a chair, a vice chair, a  
347 treasurer, and any other officers it considers necessary.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

417 (M) accessible, affordable and appropriate mental health and substance use disorder  
418 services; and

419 (N) accessible, affordable, and appropriate oral health services.

#### 420 Section 7. Annual Report

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

431 SECTION 26. Section 1 of said chapter 12C is hereby amended by inserting after the  
432 definition of “Health care services” the following definition:-

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

434 SECTION 27. Said section 1 of said chapter 12C, as so appearing, is hereby further  
435 amended by inserting after the definition of “Primary service area” the following definition:-

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

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

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

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

451 SECTION 30. Clause (v) of section 3 of said chapter 12C, as so appearing, is hereby  
452 amended by striking out, in line 25, the following word:- “and”, and in clause (vi) by striking  
453 out, in line 27, “.” and inserting in place thereof:- ; (vii) to conduct research to improve the  
454 center’s understanding of: (I) barriers to health equity data collection under sections 10A; and  
455 (II) how to restore trust and respectfully engage with individuals from priority populations who

456 are paid participants in such research; and (viii) to conduct research to improve the center's  
457 understanding of how racial ethnic, cultural, ability, and linguistic diversity in the healthcare  
458 workforce impacts health care access and care quality for priority populations. The center shall  
459 report on the research described in clauses (vii) and (viii).

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

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

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

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

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

475 (2) To ensure that standards with respect to health equity data for accountable care  
476 organizations under MassHealth are incorporated into such regulations, the regulations shall



477 specify standardized measures for data collection to: (A) standardize and strengthen social risk  
478 factors data collection, including race (including meaningful capture of multi-racial), ethnicity,  
479 language, disability, sexual orientation, gender identity, geographic location (including, for  
480 example, ZIP code, census tract, and/or primary city or town of residence), and health-related  
481 social needs; (B) maintain robust structures to identify and understand disparities, including  
482 through stratified reporting on key performance indicators; and (C) account for social  
483 determinants of health, including food insecurity, housing stability, and community violence.

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

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

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

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

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

495 (a) The center shall publish an annual report based on the information submitted under  
496 this chapter concerning health care provider, provider organization and private and public health  
497 care payer costs and cost trends, section 13 of chapter 6D relative to market power reviews and

498 section 15 relative to quality data. The center shall compare the costs, cost trends, and  
499 expenditures with the health care cost growth benchmark established under section 9A of said  
500 chapter 6D, analyzed by regions of the commonwealth, and shall compare the costs, cost trends,  
501 and expenditures with the aggregate primary care and behavioral health expenditure targets  
502 established under section 9A of said chapter 6D, and shall detail: (1) baseline information about  
503 cost, price, quality, utilization and market power in the commonwealth's health care system; (2)  
504 cost growth trends for care provided within and outside of accountable care organizations and  
505 patient-centered medical homes; (3) cost growth trends by provider sector, including but not  
506 limited to, hospitals, hospital systems, non-acute providers, pharmaceuticals, medical devices  
507 and durable medical equipment; provided, however, that any detailed cost growth trend in the  
508 pharmaceutical sector shall consider the effect of drug rebates and other price concessions in the  
509 aggregate without disclosure of any product or manufacturer-specific rebate or price concession  
510 information, and without limiting or otherwise affecting the confidential or proprietary nature of  
511 any rebate or price concession agreement; (4) factors that contribute to cost growth within the  
512 commonwealth's health care system and to the relationship between provider costs and payer  
513 premium rates; (5) primary care and behavioral health expenditure trends as compared to the  
514 aggregate baseline expenditures, as defined in section 1 of said chapter 6D; (6) the proportion of  
515 health care expenditures reimbursed under fee-for-service and alternative payment  
516 methodologies; (7) the impact of health care payment and delivery reform efforts on health care  
517 costs including, but not limited to, the development of limited and tiered networks, increased  
518 price transparency, increased utilization of electronic medical records and other health  
519 technology; (8) the impact of any assessments including, but not limited to, the health system  
520 benefit surcharge collected under section 68 of chapter 118E, on health insurance premiums; (9)

521 trends in utilization of unnecessary or duplicative services, with particular emphasis on imaging  
522 and other high-cost services; (10) the prevalence and trends in adoption of alternative payment  
523 methodologies and impact of alternative payment methodologies on overall health care spending,  
524 insurance premiums and provider rates; (11) the development and status of provider  
525 organizations in the commonwealth including, but not limited to, acquisitions, mergers,  
526 consolidations and any evidence of excess consolidation or anti-competitive behavior by  
527 provider organizations; and (12) the impact of health care payment and delivery reform on the  
528 quality of care delivered in the commonwealth.

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

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

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

548 The center shall publish the aggregate baseline expenditures starting in the 2025 annual  
549 report.

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

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

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

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

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

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

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

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

582 The department of public health shall establish a framework to incentivize private sector  
583 participation to implement the activities described in this section, that includes, but is not limited  
584 to, establishing a mechanism to facilitate financial contributions from private organizations to the  
585 Health Equity Zone Trust Fund to supplement public revenues allocated by the commonwealth,

586 and the ability of private organizations to participate as part of a multi-sector partnership,  
587 consistent with subsection (e).

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

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

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

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

605 The commissioner shall award not less than 85 per cent of the Health Equity Zone Trust  
606 Fund through a competitive grant process to municipalities, community-based organizations, and  
607 regional-planning agencies that apply for the implementation, technical assistance, and

608 evaluation of health equity activities, consistent with the below. To be eligible to receive a grant  
609 under this subsection, a recipient shall be: (1) a community-based organization or group of  
610 community-based organizations working in collaboration; (2) a community-based organization  
611 working in collaboration with 1 or more municipality; or (3) a regional planning agency.  
612 Expenditures from the fund for such purposes shall supplement and not replace existing local,  
613 state, private or federal public health-related funding.

614 (f) Priority shall be given to proposals in a geographic region of the state with a higher  
615 than average prevalence of preventable health conditions (including oral and behavioral health  
616 conditions), as determined by the commissioner of public health, in consultation with the Health  
617 Equity Zone Advisory Board. If no proposals were offered in areas of the state with particular  
618 need, the department shall ask for a specific request for proposal for that specific region. If the  
619 commissioner determines that no suitable proposals have been received, such that the specific  
620 needs remain unmet, the department may work directly with municipalities or community-based  
621 organizations to develop grant proposals. The department should also gather feedback from  
622 community-based organizations and municipalities in such region(s) in order to understand the  
623 barriers to applying and make every effort to mitigate these barriers for future rounds of funding.

624 The department of public health shall, in consultation with the Health Equity Zone  
625 Advisory Board, conduct a periodic review of the funding allocations, grant activities, and  
626 progress being made by each grantee as well as the overall grant program, for the purposes of  
627 program improvement. Each grantee shall participate in any evaluation, transparency and  
628 accountability processes, and reporting requirements implemented or authorized by the  
629 department in carrying out its duties to conduct the periodic review described herein, provided,

630 however, that the department shall make such evaluation, transparency and accountability  
631 processes, and reporting requirements as minimally burdensome as is possible.

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

642 (h) The department of public health shall, under the advice and guidance of the Health  
643 Equity Zone Advisory Board, regularly report on its strategy for administration and allocation of  
644 the fund, including relevant evaluation criteria. The report shall set forth the rationale for such  
645 strategy.

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

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



652           The board shall consist of: the commissioner of public health or a designee, who shall  
653   serve as co-chairperson; and 10 persons to be appointed by the commissioner through a public  
654   nomination process, 4 of whom shall be community representatives with lived experience of  
655   health inequities in their communities (one of whom shall serve as co-chair); 1 of whom shall be  
656   a person with expertise in the field of health equity; 1 of whom shall be a person from a local  
657   board of health for a city or town with a population greater than 50,000; 1 of whom shall be a  
658   person of a board of health for a city or town with a population of fewer than 50,000; 1 of whom  
659   shall be a person from a hospital association; 1 of whom shall be a person from a statewide  
660   public health organization; 1 of whom shall be a representative of a community development  
661   corporation or association representing community development corporations and 1 of whom  
662   shall be a community health worker or a person from an association representing community  
663   health workers. Criteria for selection of members shall consider diversity of geography; diversity  
664   by race, ethnicity, gender, and ability; expertise in program design and implementation; expertise  
665   in health equity; expertise in utilizing policy, systems and environmental strategies to address  
666   health inequities. All community representatives serving on the board shall be compensated for  
667   their time at an amount determined by the Commissioner.

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

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

674 SECTION 39. Clause (ii) of paragraph (4) of subsection (a) of section 25L of chapter  
675 111, as so appearing, is hereby amended by striking out, in line 47, “comprehensive recruitment  
676 initiatives” and inserting in place thereof the following words:- comprehensive recruitment  
677 initiatives (including initiatives to support the recruitment and retention of individuals,  
678 notwithstanding immigration status, who work in health care settings and are from priority  
679 populations).

680 SECTION 40. Chapter 112 of the General Laws is hereby amended by inserting after  
681 section 51A the following section:-

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

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

687 “Cultural safety”, an examination by health care professionals of themselves and the  
688 potential impact of their own culture on clinical interactions and health care service delivery.  
689 This requires individual health care professionals and health care organizations to acknowledge  
690 and address their own biases, attitudes, assumptions, stereotypes, prejudices, structures, and  
691 characteristics that may affect the quality of care provided. In doing so, cultural safety  
692 encompasses a critical consciousness where health care professionals and health care  
693 organizations engage in ongoing self-reflection and self-awareness and hold themselves  
694 accountable for providing culturally safe care, as defined by the patient and their communities,  
695 and as measured through progress towards achieving health equity. Cultural safety requires

696 health care professionals and their associated health care organizations to influence health care to  
697 reduce bias and achieve equity within the workforce and working environment.

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

704 (b) By January 1, 2028, the board shall adopt rules requiring a licensee to complete health  
705 equity continuing education training at least once per licensing cycle, as determined by the  
706 licensing requirements for each respective profession.

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

710 (d)(1) The secretary and the board must work collaboratively to provide information to  
711 licensees about available courses. The secretary and board shall consult with patients from  
712 priority populations and communities with lived experiences of health inequities or racism in the  
713 health care system and relevant professional organizations when developing the information and  
714 must make this information available by July 1, 2027. The information should include a course  
715 option that is free of charge to licensees.

716 (2) By January 1, 2028, the department, in consultation with the board, shall adopt model  
717 rules establishing the minimum standards for continuing education programs meeting the

718 requirements of this section. The department shall consult with patients and communities with  
719 lived experience of health inequities or racism in the health care system, relevant professional  
720 organizations, and the board in the development of these rules.

721 (3) The minimum standards must include instruction on skills to address the structural  
722 factors, such as bias, racism, ableism, and poverty, that manifest as health inequities. These skills  
723 include individual-level and system-level intervention, and self-reflection to assess how the  
724 licensee's social position can influence their relationship with patients and their communities.  
725 These skills enable a health care professional to care effectively for patients from diverse  
726 cultures, groups, and communities, varying in race, ethnicity, gender identity, sexuality, religion,  
727 age, ability, socioeconomic status, and other categories of identity. The courses must assess the  
728 licensee's ability to apply health equity concepts into practice. Course topics may include, but  
729 are not limited to: (A) strategies for recognizing patterns of health care disparities on an  
730 individual, institutional, and structural level and eliminating factors that influence them; (B)  
731 intercultural communication skills training, including how to work effectively with an interpreter  
732 and how communication styles differ across cultures; (C) implicit bias training to identify  
733 strategies to reduce bias during assessment and diagnosis; (D) methods for addressing the  
734 emotional well-being of children and youth of diverse backgrounds; (E) ensuring equity and  
735 antiracism in care delivery pertaining to medical developments and emerging therapies; (F)  
736 structural competency training addressing five core competencies, which are: (i) recognizing the  
737 structures that shape clinical interactions; (ii) developing an extra clinical language of structure;  
738 (iii) rearticulating cultural formulations in structural terms; (iv) observing and imagining  
739 structural interventions; and (v) developing structural humility; (G) cultural safety training; and  
740 (H) providing effective care to individuals with disabilities and behavioral health diagnoses.

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

744

745 SECTION 41. Chapter 118E of the General Laws is hereby amended by adding after  
746 section 16D the following sections:-

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

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

759 (c) The program shall be implemented no later than January 1, 2027.

760 Section 16F. (a) Notwithstanding any other law, there is hereby established a program of  
761 comprehensive health coverage for individuals who are residents of the commonwealth, as

762 defined under section 8 of chapter 118E, who are not otherwise eligible for comprehensive  
763 benefits under Title XIX or XXI of the Social Security Act or under the demonstration pursuant  
764 to Section 9A of chapter 118E solely due to their immigration status, except in the case of  
765 children or young adults otherwise eligible for comprehensive health coverage pursuant to  
766 section 16E. Such individuals shall be eligible to receive comprehensive MassHealth benefits  
767 equivalent to the benefits available to individuals of like age and income under categorical and  
768 financial eligibility requirements established by the Executive Office pursuant to said Title XIX  
769 and Title XXI.

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

773 (c) The program shall be implemented no later than January 1, 2027.

774 SECTION 42. Paragraph (5) of section 36 of chapter 118E of the General Laws, as so  
775 appearing, is hereby amended by striking out, in line 14, “.” and inserting in place thereof the  
776 following:- ;.

777 SECTION 43. Said section 36 of said chapter 118E, as so appearing, is hereby amended  
778 by inserting after said paragraph (5) the following paragraphs:-

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

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

783 SECTION 44. Section 76 of chapter 260 of the Acts of 2020 is hereby amended by  
784 striking out the words “Sections 63 and 69 are hereby repealed” and inserting in place thereof the  
785 following words:- Section 63 is hereby repealed.

786 SECTION 45. (a) The first sentence of the first paragraph of section 410 of chapter 159  
787 of the Acts of 2000 is hereby amended by striking out “in nursing homes,” and inserting in place  
788 thereof the following words:- in nursing homes, in safety net hospitals, community health  
789 centers, and other providers (as determined by the Corporation).

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

795 (c) The first sentence of the third paragraph of said section 410 of said chapter 159 is  
796 hereby amended by striking out “nursing homes and nursing home employees” and inserting in  
797 place thereof the following words:- nursing homes, safety net hospitals, community health  
798 centers, other providers determined by the Corporation and employees of such entities.

799 SECTION 46. Notwithstanding any general or special law to the contrary, the  
800 commissioner of public health, in consultation with the assistant secretary for MassHealth, shall  
801 develop standardized, tiered, and stackable credentials for certification of lower-wage positions  
802 furnishing services funded through the MassHealth program.

803 SECTION 47. (a) Notwithstanding any general or special law to the contrary, the  
804 secretary of health and human services or designee shall, subject to appropriation, provide

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

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

818 SECTION 48. (a) Notwithstanding any general or special law to the contrary, the  
819 assistant secretary for MassHealth shall establish payment models that incentivize the integration  
820 of behavioral health, oral health, and pharmacy services in primary care settings under the  
821 MassHealth program.

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

825 SECTION 49. Section 259 of Chapter 112 of the General Laws is hereby amended by  
826 striking out the definition of “Core competencies” and inserting in place thereof the following:-



827 "Core competencies", a set of overlapping and mutually reinforcing skills and knowledge  
828 essential for effective community health work in core areas that include, but are not limited to:

- 829 (a) outreach methods and strategies;
- 830 (b) client and community assessment;
- 831 (c) effective communication;
- 832 (d) culturally-based communication and care;
- 833 (e) health education for behavior change;
- 834 (f) support, advocacy and coordination of care for clients;
- 835 (g) application of public health concepts and approaches;
- 836 (h) community capacity building;
- 837 (i) writing and technical communication skills; and
- 838 (j) patient navigation services.

839 SECTION 50. Section 259 of said Chapter 112 of the General Laws is hereby further  
840 amended by inserting after the definition of "Core competencies" the following definition:-

841 "Patient navigation services, the following services furnished by a community health  
842 worker to patients in their communities:

- 843 a) Services to prevent or screen for chronic diseases and services designed to slow the  
844 progression of chronic diseases; and

845           b) Screenings for nonclinical and social needs and referrals to appropriate services and  
846 agencies to meet those needs.

847           SECTION 51. Section 260 of said chapter 112 is hereby amended by striking out the  
848 third paragraph in its entirety.

849           SECTION 52. Notwithstanding any general or special law to the contrary, the group  
850 insurance commission public employee plans under Chapter 32A; the division of medical  
851 assistance under chapter 118E and its contracted health insurers, health plans, health  
852 maintenance organizations, behavioral health management firms and third-party administrators  
853 under contract to a Medicaid managed care organization or primary care clinician plan; insurance  
854 companies organized under Chapter 175; non-profit hospital service corporations organized  
855 under Chapter 176A; medical service corporations organized under chapter 176B; and health  
856 maintenance organizations organized under chapter 176G shall not decline to provide coverage  
857 and reimbursement for covered health care services solely on the basis that those services were  
858 delivered by a certified community health worker, as defined by Section 259 of Chapter 112,  
859 employed by health care providers or provider groups, including but not limited, an acute care  
860 hospital, health system, community health center, school-based health center, community  
861 behavioral health center, community mental health center, or behavioral health community  
862 partner.

863           SECTION 53. Section 13F of Chapter 118E of the General Laws is hereby amended by  
864 adding at the end of the first paragraph the following sentence:

865           Provided however, the costs of providing competent interpreter services through sign and  
866 spoken languages by facilities licensed under section 19 of chapter 19 of the general laws or

867 Section 51 of Chapter 111 of the general laws, shall be recognized and separately reimbursed by  
868 the division and its contracted health insurers, health plans, health maintenance organizations,  
869 behavioral health management firms and third party contractors under contract to a division  
870 managed care organization or primary care clinician program.

871 SECTION 54. Notwithstanding any general or special law, rule or regulation to the  
872 contrary, “Carriers” and “Behavioral Health Managers” as defined in Section 1 of Chapter 176O  
873 and their contractors, shall recognize and separately reimburse facilities licensed under section  
874 19 of Chapter 19 of the general laws or Section 51 of Chapter 111 of the general laws for the  
875 costs of providing competent interpreter services through sign and spoken languages.

876 SECTION 55. (a) Notwithstanding any general or special law to the contrary, the  
877 appointive boards and commissions of the commonwealth identified pursuant to subsection (b)  
878 shall, to the extent practicable, be composed of at least 50 percent women, and at least 25 percent  
879 Black, Indigenous, or other people of color. The appointing authorities for the board shall consult  
880 each other to ensure compliance with this provision.

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

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

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

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

889 (4) each board of registration under the bureau of health professions licensure and the  
890 board of registration in medicine;

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

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

894 SECTION 56. (a) On an annual basis, each carrier shall report to the division the drugs  
895 selected to be provided with no or limited cost-sharing under section 17S of chapter 32A, section  
896 10O of chapter 118E, section 47PP of 175, section 8RR of 176A, section 4RR of 176B, and  
897 section 4HH of 176G. The commissioner shall review the drugs to verify that the selected drugs  
898 meet the criteria identified in those sections. Should a selected drug be deemed by the  
899 commissioner to not meet the criteria, the commissioner may require a different drug to be  
900 selected. The commissioner shall disclose the list of drugs selected by each entity annually on the  
901 division's website.

902 SECTION 57. Chapter 118E of the General Laws is hereby amended by adding at the end  
903 thereof, the following Section:-

904 Section 83. (a) The office shall make Graduate Medical Education payments for primary  
905 care, including but not limited to internists, family medicine, pediatrics, and gerontology,  
906 behavioral health, maternal health, including obstetrics and gynecology, and other physician  
907 residency training in fields experiencing physician shortages, as determined by the secretary;

908 provided, that said payments may support community-based training for other health  
909 professionals, including but not limited to, family medicine nurse practitioners, sexual and  
910 reproductive health practitioners, ophthalmologists, optometrists, dentists, and dental hygienists.  
911 Eligible recipients shall include community health centers and hospitals licensed in the  
912 Commonwealth. Payments shall take into consideration MassHealth utilization and primary care,  
913 behavioral health, and maternal health, including obstetrics and gynecology, and other physician  
914 residency training in fields experiencing physician shortages; provided further, that the executive  
915 office will prioritize placements at community-based settings, at organizations that serve a high  
916 public payer mix.

917 (b) No later than July 1, 2025, the secretary, in consultation with the executive office of  
918 administration and finance, shall identify an adequate amount of annual Medicaid graduate  
919 medical education funding necessary to fulfill the requirements of this section, as well as state  
920 and other funding sources for use for graduate medical education expenditures. The secretary  
921 shall report its recommendations to the joint committee on healthcare finance and committees on  
922 ways and means.

923 (c) The first annual payment to qualifying acute care hospitals and community health  
924 centers under this section shall be made no later than October 1, 2025.

925 SECTION 58. Sections 5, 8, and 31 shall take effect 90 days after passage of this act.

926 SECTION 59. Sections 6, 7, 9, 10, 11, 12, , 34, 39, 42, 43, 45, 46, and 55 shall take  
927 effect 180 days after passage of this act.

928 SECTION 60. Sections 29, 32, 33, and 48 shall take effect 1 year after passage of this act.

SECTION 61. Section 23 shall take effect on January 1, 2027.