SENATE DOCKET, NO. 1202   FILED ON: 1/15/2025

SENATE . . . . No.

The Commonwealth of Massachusetts

PRESENTED BY:

Pavel Payano

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

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

An Act An act to advance health equity.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Pavel Payano	*First Essex*
Liz Miranda	*Second Suffolk*

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SENATE . . . . No.

[Pin Slip]

The Commonwealth of Massachusetts

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

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

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

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

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

759 Section 16F. (a) Notwithstanding any other law, there is hereby established a program of
760 comprehensive health coverage for individuals who are residents of the commonwealth, as
761 defined under section 8 of chapter 118E, who are not otherwise eligible for comprehensive
762 benefits under Title XIX or XXI of the Social Security Act or under the demonstration pursuant

763 to Section 9A of chapter 118E solely due to their immigration status, except in the case of
764 children or young adults otherwise eligible for comprehensive health coverage pursuant to
765 section 16E. Such individuals shall be eligible to receive comprehensive MassHealth benefits
766 equivalent to the benefits available to individuals of like age and income under categorical and
767 financial eligibility requirements established by the Executive Office pursuant to said Title XIX
768 and Title XXI.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

828 (a) outreach methods and strategies;

829 (b) client and community assessment;

830 (c) effective communication;

831 (d) culturally-based communication and care;

832 (e) health education for behavior change;

833 (f) support, advocacy and coordination of care for clients;

834 (g) application of public health concepts and approaches;

835 (h) community capacity building;

836 (i) writing and technical communication skills; and

837 (j) patient navigation services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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