Joint Committee on Health Care Financing
2025-2026 (194th) Bill Summary

Bill Number: House, No. 1416

Title: AN ACT TO ADVANCE HEALTH EQUITY

Sponsor: Representatives Bud L. Williams (Springfield) and Judith A. Garcia (Chelsa)

Hearing Date: July 15, 2025

Reporting Deadline: September 13, 2025

Prior History: 2023-24 (H1250/S799): S799 reported favorably, accompanied by H1250 and referred to Senate Ways and Means. No further action.

Similar Matters: S901 (Payano – Identical, Health Care Financing)

Current Law

M.G.L. Ch. 6 § 17A establishes a cabinet serving under the Governor and lists the executive office secretaries designated as members of the cabinet.
M.G.L. Ch. 6 §§ 2 and 3 establish the executive offices that serve under the Governor and provide for the appointment of individuals to the positions of secretary and undersecretary of the executive offices.
M.G.L. Ch 6A § 16O establishes a Health Disparities Council (HDC) within the Executive Office of Health and Human Services (EOHHS) to advise the Director of the Office of Health Equity. The HDC is directed to provide recommendations to eliminate disparities in access to quality health care access and outcomes based on race, ethnicity, and disability status. HDC's scope includes specific conditions such as cancer, diabetes, heart disease, asthma, HIV/AIDS, and infant mortality, and it also considers broader social determinants of health such as housing, education, environment, and employment. The council is also responsible for recommending quality metrics, strategies to improve health workforce diversity, and ways to address the needs of highly affected subpopulations. HDC is composed of a broad, multi-sectoral membership, including legislators, state officials, and representatives from community organizations, healthcare institutions, advocacy groups, and public health associations. HDC must meet at least **every two months** and produce an **annual report by July 1** each year. The report must include data on health disparities and workforce diversity, recommendations for improving access and outcomes, and proposals for legislative or regulatory changes.
M.G.L. Ch. 6A §16T establishes the health planning council and advisory committee to develop a state health plan for distributing health care resources throughout the commonwealth.
M.G.L. Ch. 6A § 16AA establishes the Office of Health Equity within EOHHS, overseen by a Director of Health Equity and advised by the Health Disparities Council. This office is tasked with coordinating all statewide activities to eliminate racial and ethnic health disparities, setting measurable goals, and developing an annual plan to guide the Commonwealth's progress. It works interagency across sectors—such as housing, education, labor, transportation, and environmental affairs—to address the social determinants of health and ensure that structural drivers of health inequities are confronted through coordinated policy interventions. Annually, on or before July 1, the report of the Office is required to be posted on the website of the Commonwealth and filed with the Governor, the clerks of the Rouse of Representatives and Senate, the members of the Health Disparities Council and the Health Policy Commission.
M.G.L. Ch. 6D § 1, as amended by chapter 343 of the acts of 2024, "*An Act enhancing the market review process [H5159]*", defines certain terms as they are to be understood within the context of Chapter 6D, which governs the operations and activities of the Health Policy Commission (HPC), an independent agency within the Executive Office of Administration and Finance to set health care cost growth goals, enhance provider

organization transparency, monitor and review marketplace changes, and establish a health care cost growth benchmark for the average growth in total health care expenditures.

M.G.L. Ch. 6D § 2(b) establishes the governing board of the HPC consisting of 11 members: 1 of whom shall be the secretary for administration and finance (A&F) ex officio; 1 of whom shall be the secretary of health and human services [EOHHS], ex-officio; and 3 of whom shall be shall be appointed by the governor, 1 of whom shall serve as chairperson; 3 of whom shall be appointed by the attorney general [AGO]; and three members shall be appointed by the auditor. All appointments after the initial term of appointment shall serve a term of 5 years.

The qualifications for appointment are as follows:

Of the 3 gubernatorial appointees:

---1 shall serve as Chair with demonstrated expertise in health care delivery, health care management at a senior level or health care finance and administration, including payment methodologies;

---1 shall have demonstrated expertise in health plan administration and finance;

---1 shall be a primary care physician.

Of the 3 AGO appointees:

---1 shall have demonstrated expertise in health care consumer advocacy;

---1 shall be a health economist;

---1 shall have demonstrated expertise in behavioral health, substance use disorder, mental health services and mental health reimbursement systems.

Of the 3 Auditor appointees:

---1 shall have demonstrated expertise in representing the health care workforce as a leader in a labor organization;

---1 shall have demonstrated expertise as a purchaser of health insurance representing business management or health benefits administration;

---1 shall registered nurse with demonstrated expertise in the development and utilization of innovative treatments for patient care.

M.G.L. Ch. 6D §2(e) directs the board of the HPC to appoint an executive director and establishes the duties to be performed by the executive director, subject to the approval of the board.

M.G.L. Ch. 6D §2(g) authorizes the executive director of the HPC to appoint agents and subordinate officers and to establish subdivisions within the commission as deemed appropriate to fulfill the purposes of chapter 6D.

M.G.L. Ch. 6D § 3 authorizes the HPC to execute on its own behalf certain legal and administrative powers necessary for the operation and management of the commission.

M.G.L. Ch. 6D § 4 establishes an advisory council to the HPC and directs the executive director of the HPC to appoint representatives of health care interests to the advisory council.

M.G.L. Chapter 6D § 5 directs the HPC to monitor the reform of the health care delivery and payment system including health care costs and patient access to care. This section establishes the primary duties of the HPC as follows: (i) set health care cost growth goals for the state; (ii) enhance the transparency of provider organizations; (iii) monitor the development of Accountable Care Organizations [ACOs] and patient-centered medical homes; (iv) monitor the adoption of alternative payment methodologies; (v) foster innovative health care delivery and payment models that lower health care cost growth while improving the quality of patient care; (vi) monitor and review the impact of changes within the health care marketplace and (vii) protect patient access to necessary health care services. This section further directs the HPC to establish goals that are intended to reduce health care disparities in racial, ethnic and disabled communities and in doing so shall seek to incorporate the recommendations of the Health Disparities Council established pursuant to Section 16O of chapter 6A, and the Office of Health Equity established pursuant to section 16AA of chapter 6A.

M.G.L. Ch. 6D § 7 directs the HPC to administer the Healthcare Payment Reform Fund and to establishes a competitive funding process for incentives, grants or other assistance to providers for the purpose of fostering health care innovation in payment and delivery systems.

M.G.L. Ch. 6D § 8 directs the HPC to hold annual public hearings, based on the report submitted by the Center for Health Information and Analysis [CHIA] pursuant to section 16 of chapter 12. Within this section:

---Subsection (a) states that the HPC's annual public hearings shall examine provider and payer costs, prices, and cost trends, with particular attention to factors that contribute to cost growth and trends in annual behavioral health expenditures.
---Subsection (e) of section 8 identifies specific information that must be provided to the HPC by witnesses called to give testimony at the annual public hearings on health care cost trends.
---Subsection (g) directs the HPC to compile an annual report concerning spending trends, including behavioral health expenditures, and underlying factors, along with any recommendations for strategies to increase the efficiency of the health care system.
M.G.L. Ch. 6D § 9 directs the HPC board to establish a health care cost growth benchmark for the average growth in total health care expenditures. In making that determination, the statue requires the HPC to hold a public hearing to consider available data, information, and testimony from market participants and other interested parties. The statute also grants the Joint Committee on Health Care Financing the right to participate in the public hearing.
M.G.L 6D § 15 authorizes HPC to establish a process for certifying registered ACOs to promote alternative payment methodologies that include incentives to reduce avoidable hospital readmissions.
M.G.L. Ch. 12 § 11N authorizes the AGO to monitor trends in the health care market; including but not limited to, trends in provider organization size and composition, consolidation in the provider market, payer contracting trends and patient access and quality issues in the health care market.
Chapter 12C of the General Laws establishes the Center for Health Information and Analysis (CHIA) as an independent agency tasked with collecting and analyzing health care data and publishing annual reports on health care costs, cost trends, market power, and quality data in support of the annual health care cost trends hearings conducted by the HPC.
M.G.L. Ch. 12C § 1, as amended by chapter 343 of the acts of 2024, "*An Act enhancing the market review process [H5159]*", defines certain terms as understood within the context of Chapter 12C, which governs the operations and activities of CHIA.
M.G.L. Ch. 12C § 2A establishes Health Information and Analysis Oversight Council, which oversees the CHIA. The council consists of 11 members from across state government and appointed by the Governor (3 appointees), Attorney General (2 appointees), and State Auditor (2 appointees), with expertise specifications per each nominee including healthcare delivery, data analytics, finance, and cybersecurity. Members serve 5-year terms, must be Massachusetts residents, and cannot be affiliated with hospitals or insurers.
The council meets quarterly, operates under public meeting laws, and requires a quorum of six to conduct business. It is responsible for managing CHIA's annual operating budget, setting research priorities, overseeing data collection standards, and guiding the maintenance of the state's claims database.
M.G.L. Ch. 12C § 3 authorizes the executive director of CHIA, subject to appropriation, to appoint such agents and subordinate officers and employees as the executive director may consider necessary and may establish such subdivisions within the center as the executive director considers appropriate to fulfill the duties of the center.
M.G.L. Ch. 12C § 8, as amended by chapter 343 of the acts of 2024, "*An Act enhancing the market review process [H5159]*", governs data reporting requirements for institutional providers and their parent organizations and any other affiliated entities including significant equity investors, health care real estate investment trusts and management services organizations, non-institutional providers and provider organizations.
M.G.L. Ch. 12C § 9, as amended by chapter 343 of the acts of 2024, "*An Act enhancing the market review process [H5159]*", governs data reporting requirements for registered provider organizations.
M.G.L. Ch. 12C § 10 governs data reporting requirements for private and public health care payers and third party administrators of information necessary to analyze trends in health insurance costs and utilization.
M.G.L. Ch. 12C §11, as amended by chapter 343 of the acts of 2024, "*An Act enhancing the market review process [H5159]*", directs the Center for Health Information and Analysis to ensure the timely reporting of data and of information required under sections 8, 9, 10 and 10A od chapter 12C.
M.G.L. Chapter 12C § 16, as amended by chapter 343 of the acts of 2024, "*An Act enhancing the market review process [H5159]*", requires CHIA to publish an annual report on health care cost trends based on data collected from health care providers, provider organizations, private and public health care payers,

pharmaceutical manufacturing companies and pharmacy benefit managers under sections 8 through 10A of chapter 12C, market power reviews as required under section 13 of chapter 6D, and quality data collected under section 15 of chapter 12C.

M.G.L. Ch. 13 § 9 places certain professional boards of registration under the authority of the Department of Public Health [DPH].

M.G.L. Ch. 13 § 10 establishes the Board of Registration in Medicine within, but independent from, DPH.

M.G.L. Ch.23H §1 establishes within Executive Office of Labor and Workforce Development [EOLWD] a Department of Career Services, which itself oversees the following state agencies and funds: the One Stop Career Centers, the State Workforce Development Board, the Commonwealth Corporation, and the Workforce Training Fund. The department's mission is to develop, coordinate, and maintain a coherent workforce development system that fills the needs of employers for a skilled workforce and promotes lifelong learning among employees. The department shall cooperate with all federal, state, and local agencies active in the field of workforce development to achieve this goal.

M.G.L. Ch. 29 § 7H ½ states that, on or before Jan. 15th each year, the secretary of A&F and the House and Senate Committees on Ways & Means will develop a Growth Rate of Potential (GSP). GSP is the long-run average growth rate of the Commonwealth's economy, excluding fluctuations due to the business cycle.

M.G.L. Ch. 29 § 2GGGG establishes the Distressed Hospital Trust Fund, to be expended by the HPC through an annual competitive grant process to acute care hospitals. The purpose of the grants is to enhance the ability of community hospitals to serve populations efficiently and effectively; advance the adoption of health information technology; accelerate electronic information exchange; support infrastructure investments; aid in establishing accountable care organization certification; and improve the affordability and quality of care.

M.G.L. Ch 30 § 62 defines certain terms as used in the Massachusetts Environmental Protection Act, including the term "Environmental justice population", defined as "a neighborhood that meets 1 or more of the following criteria: (i) the annual median household income is not more than 65 per cent of the statewide annual median household income; (ii) minorities comprise 40 per cent or more of the population; (iii) 25 per cent or more of households lack English language proficiency; or (iv) minorities comprise 25 per cent or more of the population and the annual median household income of the municipality in which the neighborhood is located does not exceed 150 per cent of the statewide annual median household income; provided, however, that for a neighborhood that does not meet said criteria, but a geographic portion of that neighborhood meets at least 1 criterion, the secretary may designate that geographic portion as an environmental justice population upon the petition of at least 10 residents of the geographic portion of that neighborhood meeting any such criteria; provided further, that the secretary may determine that a neighborhood, including any geographic portion thereof, shall not be designated an environmental justice population upon finding that: (A) the annual median household income of that neighborhood is greater than 125 per cent of the statewide median household income; (B) a majority of persons age 25 and older in that neighborhood have a college education; (C) the neighborhood does not bear an unfair burden of environmental pollution; and (D) the neighborhood has more than limited access to natural resources, including open spaces and water resources, playgrounds and other constructed outdoor recreational facilities and venues."

Chapters 32A and 32B of the General Laws establishes contributory group general or blanket insurance for persons in the service of the Commonwealth and participating authorities and municipalities under the Group Insurance Commission [GIC].

M.G.L. Ch. 32A § 30, inserted by section 3 of chapter 260 of the Acts of 2020, mandates telehealth coverage by all carriers that contract with the GIC mandates for all services in-person covered services that are appropriate to be delivered via telehealth. This section also requires mandates permanent rate parity for behavioral health services delivered by telehealth. Additionally, under sections 69, 76 and 78 of chapter 260, a temporary 2-year period of mandated rate parity for chronic disease management and primary care telehealth services was established, which expired on December 31, 2022.

Chapter 111 of the General Laws directs DPH to establish, maintain, and enforce certain offices, programs, and authorities pertaining to the general health and welfare of the Commonwealth.

M.G.L. Ch. 111 § 2 directs the commissioner of DPH to administer all laws and regulations relating to the department. In the performance their duties, this section requires the secretary of elder affairs and the

commissioner to jointly develop and submit to the Public Health Council, pursuant to section 3 of chapter 111, rules and regulations governing the licensure and operation of convalescent or nursing homes, rest homes, infirmaries maintained in a town and charitable homes for the aged.

M.G.L. Ch. 111 §§ 25B through 25G, inclusive, govern the Determination of Need [DON] process, which requires certain health care facilities to seek and receive a DON approval from DPH before making substantial capital expenditures, construct a health care facility or substantially change the service of the facility.

M.G.L. Ch. 111 § 25C(g) requires DPH to, in making any DON decision: be guided by the state health plan; encourage appropriate allocation of private and public health care resources and the development of alternative or substitute methods of delivering health care services so that adequate health care services will be made reasonably available to every person within the commonwealth at the lowest reasonable aggregate cost; take into account any comments from CHIA, HPC, and any other state agency or entity; and impose reasonable terms and conditions as the department determines are necessary to achieve the purposes and intent of this section.

M.G.L. Ch. 111 § 25L establishes a Health Care Workforce Center within DPH to improve access to health care services in the Commonwealth, with a particular emphasis primary care and behavioral, substance use disorder and mental health care services. The Center is required to maintain ongoing communication and coordination with the Health Disparities Council established under section 16O of chapter 6A and must annually report to the council, the Governor, and specific legislative joint committees.

Chapter 112 of the General Laws governs the licensing and registration of health care professionals, the operation of the boards of registration with oversight over those professions and provides the statutory basis for the professional scope of practice for licensed health professionals.

Chapter 118E of the General Laws establishes the Division of Medical Assistance within EOHHS and empowers the office to implement and administer the state Medicaid program [MassHealth].

M.G.L. Ch. 118E § 8 defines certain terms as they are to be understood within the context of chapter 118E. Such terms include the following:

--- “Person”, any individual who resides in the commonwealth, or any individual residing outside the commonwealth who is deemed to be a resident of the commonwealth under Title XIX, Title XXI or other state or federal programs established or administered pursuant to this chapter.”

--- “Reside”, to occupy an established place of abode with no present intention of definite and early removal, but not necessarily with the intention of remaining permanently, but in no event shall the word “reside” be construed more restrictively or less restrictively than as defined by the Secretary under Title XIX, Title XXI or other state or federal programs established or administered pursuant to this chapter.”

M.G.L. Ch. 118E § 9 establishes Massachusetts Medicaid program, sets criteria for eligibility, and authorizes the design, establishment, and administration of a basic health program for individuals whose household income is 200 per cent or less of the federal poverty level.

M.G.L. Ch. 118E § 9A authorizes the division to implement MassHealth in accordance with the terms and conditions of a demonstration project approved by the Secretary pursuant to section 1115(a) of the Social Security Act, 42 USC Section 1315(a) or any other federal waiver or demonstration authority.

This section authorizes MassHealth, subject to appropriation, to provide a program or programs of medical benefits to one or more of the beneficiary categories described within or as otherwise directed under this chapter. This section also permits MassHealth to exclude from coverage persons in any or all of eligibility categories who: (i) at the time of application, are eligible for health insurance, or (ii) do not meet citizenship or residency requirements established by the division, provided that any person whose residency in the commonwealth was established solely for the purpose of seeking medical benefits shall not be eligible for MassHealth.

M.G.L. Ch. 118E §§ 13, 13A, 13B, 13C, 13D, 13E1/2, 13F, 13J provide for the review of MassHealth reimbursement rates or rate methodologies and requires rates to be established by contract and contingent upon performance and quality standards developed by EOHHS. Payment rates must be i) “adequate to meet the costs incurred by efficiently and economically operated facilities providing care and services in conformity with applicable state and federal laws and regulations and quality and safety standards” and ii) within the financial capacity of the commonwealth.

Summary Prepared by the House Staff of the Joint Committee on Health Care Financing

M.G.L. Ch. 118E § 15 requires the division of medical assistance to develop regulations that outline benefits for MassHealth enrollees.
M.G.L. Ch. 118E § 36 governs the eligibility of providers for participation in the MassHealth program, including the requirement that participating providers agree to accept, as payment in full, the amounts paid in accordance with the fee schedules established by MassHealth.
M.G.L. Ch. 118E § 79, inserted by section 40 of chapter 260 of the Acts of 2020, mandates telehealth coverage by all carriers that contract with the GIC mandates for all services in-person covered services that are appropriate to be delivered via telehealth. This section also requires mandates permanent rate parity for behavioral health services delivered by telehealth. Additionally, under sections 69, 76 and 78 of chapter 260, a temporary 2-year period of mandated rate parity for chronic disease management and primary care telehealth services was established, which expired on December 31, 2022.
M.G.L. Ch. 175 § 47MM, inserted by section 47 of chapter 260 of the Acts of 2020, mandates telehealth coverage under individual or group accident and sickness health insurance policies for all services in-person covered services that are appropriate to be delivered via telehealth. This section also requires mandates permanent rate parity for behavioral health services delivered by telehealth. Additionally, under sections 69, 76 and 78 of chapter 260, a temporary 2-year period of mandated rate parity for chronic disease management and primary care telehealth services was established, which expired on December 31, 2022.
M.G.L. Ch. 175 § 108 governs individual accident and sickness health insurance policies, including the conditions under which the commissioner of insurance may approve or disapprove "of such form of policy if the benefits provided therein are unreasonable in relation to the premium charged, or if it contains any provision which is unjust, unfair, inequitable, misleading or deceptive, or which encourages misrepresentation as to such policy."
M.G.L. Ch. 175 § 110 governs group accident and sickness health insurance policies.
M.G.L. Ch. 176A § 38, inserted by section 49 of chapter 260 of the Acts of 2020, mandates telehealth coverage under nonprofit hospital service plans for all services in-person covered services that are appropriate to be delivered via telehealth. This section also requires mandates permanent rate parity for behavioral health services delivered by telehealth. Additionally, under sections 69, 76 and 78 of chapter 260, a temporary 2-year period of mandated rate parity for chronic disease management and primary care telehealth services was established, which expired on December 31, 2022.
M.G.L. Ch. 176B § 25, inserted by section 51 of chapter 260 of the Acts of 2020, mandates telehealth coverage under nonprofit medical service plans for all services in-person covered services that are appropriate to be delivered via telehealth. This section also requires mandates permanent rate parity for behavioral health services delivered by telehealth. Additionally, under sections 69, 76 and 78 of chapter 260, a temporary 2-year period of mandated rate parity for chronic disease management and primary care telehealth services was established, which expired on December 31, 2022.
M.G.L. Ch. 176G § 33, inserted by section 53 of chapter 260 of the Acts of 2020, mandates telehealth coverage under HMO contracts for all services in-person covered services that are appropriate to be delivered via telehealth. This section also requires mandates permanent rate parity for behavioral health services delivered by telehealth. Additionally, under sections 69, 76 and 78 of chapter 260, a temporary 2-year period of mandated rate parity for chronic disease management and primary care telehealth services was established, which expired on December 31, 2022.
M.G.L. Ch. 176I § 13, inserted by section 54 of chapter 260 of the Acts of 2020, mandates telehealth coverage under PPO plans for all services in-person covered services that are appropriate to be delivered via telehealth. This section also requires mandates permanent rate parity for behavioral health services delivered by telehealth. Additionally, under sections 69, 76 and 78 of chapter 260, a temporary 2-year period of mandated rate parity for chronic disease management and primary care telehealth services was established, which expired on December 31, 2022.
Chapter 176J of the General Laws governs the merged individual and small group insurance market [Merged Market].
M.G.L. Ch. 176J § 6 authorizes the commissioner of DOI to approve health insurance policies submitted to the division for the purpose of being provided in the Merged Market. Carriers offering small group health insurance

plans, including carriers licensed under Chapters 175, 176A, 176B or 176G, shall file with DOI small group product base rates and any changes to small group rating factors that are to be effective on January 1 of each year, on or before July 1 of the preceding year. The commissioner of DOI shall disapprove any proposed changes to base rates that are excessive, inadequate or unreasonable in relation to the benefits charged.
M.G.L. Ch. 176O § 1 defines certain terms as they are to be understood within the context of chapter 176O, which provides for various health insurance consumer protections. Such terms include the following:
--- "Chronic disease management", defined by section 56 of chapter 260 of the Acts of 2020 to mean, "care and services for the management of chronic conditions, as defined by the federal Centers for Medicare and Medicaid Services, that include, but are not limited to, diabetes, chronic obstructive pulmonary disease, asthma, congestive heart failure, hypertension, history of stroke, cancer and coronary artery disease."
--- "Primary care services", defined by section 57 of chapter 260 of the Acts of 2020 to mean, "services delivered by a primary care provider."
Chapter 176Q of the General Laws governs the Commonwealth Connector Authority to facilitate the availability, choice and adoption of private health insurance plans to eligible individuals and groups.
Section 410 of Chapter 159 of the Acts of 2000, the FY2001 General Appropriation Act, established a long-term care facility career ladder program for certified nurses aides and entry-level workers in nursing homes. The program was established under the administration of the Corporation for Business Work and Learning, the predecessor entity of the Commonwealth Corporation, the quasi-public agency operating under the authority of the Department of Career Services pursuant to section 1 of chapter 23H.
Section 100 of Chapter 194 of the Acts of 2011, "*An Act establishing expanded gaming in the commonwealth*", establishes the Healthcare Payment Reform Fund.
Section 241 of Chapter 224 of the Acts of 2012, "*An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation",* directed the HPC to assess a one-time surcharge on totaling $60M on providers and totaling $165M on insurers to be distributed as follows: (1) 60% or a total of $135M to the Distressed Hospital Fund, (2) 26.66% or $60M to the Wellness and Prevention Trust Fund, and (3) 13.33% or $30M to the E-Health Institute Fund. This section further directed the HPC to deposit 5% of each distribution deposited into the Health Care Payment Reform Fund established under Section 100 of Chapter 194 of the Acts of 2011.
Section 63 of Chapter 260 Acts of 2020 directs EOHHS to provide enhanced Medicaid payments for certain eligible hospitals. Eligible hospitals are non-profit or municipal acute hospitals that (i) have a statewide relative price less than 0.90, as calculated by CHIA according to data from the most recent year; (ii) have a public-payer mix equal to or greater than 60%; and (iii) are not owned, financially consolidated or corporately affiliated with a provider organization that (a) owns or controls 2 or more licensed acute care hospitals; and (b) has total net assets of all affiliated licensed acute care hospitals within the provider organization that are greater than $600,000,000 as calculated by CHIA according to data from the most recent year. Eligible hospitals shall receive payment equal to 5 per cent of the hospital's average monthly Medicaid payments for inpatient and outpatient acute hospital services for the preceding year or the most recent year that data is available. The sum of all payments made to eligible hospitals shall not exceed $35,000,000 in any fiscal year. This section was repealed by section 76 and 78 of Chapter 260 Acts of 2020, effective January 1, 2023.

Summary:
The proposed legislation establishes a new executive office, the Executive Office of Equity. The office is tasked with leading in equity, diversity, inclusion across state agencies, executive offices and throughout Massachusetts, to promote access to opportunities and reduce disparities, to improve outcomes.

Legislation intends to embed health equity principles and standards throughout the health care system and across all agencies, focusing on data-collection, community engagement to address systemic barriers to health care access.

Creates multiple new definitions, including:

- **Equity:** the consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have historically been denied such treatment, including: (1) Black, Latino, Indigenous and Native American persons, Asian Americans and Pacific Islanders, and other persons of color; (2) members of religious minorities; lesbian, gay, bisexual, transgender, and queer persons; (3) persons with disabilities; persons who live in rural areas; and (4) persons otherwise adversely affected by persistent poverty or inequality.
- **Health equity**: the state in which everyone has a fair and just opportunity to be as healthy as possible. Such a state requires removing obstacles to health and to health care services, and promoting individuals' ability to control their own healthcare and set their own care goals. For purposes of the preceding sentences, achieving health equity requires focused and ongoing efforts to address historical and contemporary injustices such as poverty and racism and efforts to address social determinants of health, including lack of access to good jobs with fair pay; quality education; safe, accessible, and affordable housing; public transportation; safe and healthy environments; and health care. In this term, health includes physical health, oral health, and behavioral health. For the purposes of measurement, advancing health equity means reducing and ultimately eliminating disparities in health outcomes that adversely affect underserved, excluded, or marginalized groups.
- **Priority population**: a population that is disproportionately affected by health disparities.
- **Social determinants of health:** the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health outcomes, functioning, and quality-of-life outcomes and risks, including economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community contexts.

SECTION 1: Amends section 17A, ch. 6 adding "the secretary of equity" to the list of the executive office secretaries designated as members of the Governor's cabinet. The Executive Office of Equity is established in section 25 of the proposed legislation.
Note: Within DPH (EOHHS) there is an established Office of Health Equity and Community Engagement. Within Executive Office of Energy and Environmental Affairs, there is an Office of Environmental Justice and Equity.

SECTION: 2 Amends section 2, ch. 6A adding that the Executive Office of Equity (EOE), established by section 25 of this bill, to the list of executive offices serving under the Governor.

SECTIONS 3, 4: Amends section 1, ch. 6D, inserting definitions for health equity and priority populations.

SECTION 5: Amends subsection (b), section 2, ch. 6D, requiring 1 of 3 gubernatorial appointments to the HPC board be a person of color with lived experiences of social inequities and a professional record of health equity advocacy.

SECTIONS 6-16: Amends multiple sections of ch. 6D (Health Policy Commission), requiring the HPC to incorporate health equity and examine health inequities and access experienced by priority populations within the HPC's duties. Duties include prescription transparency, monitoring health care delivery and payment systems, policy recommendations, health service delivery and health care market oversight. Establishes a new HPC position, the chief health equity officer, to reduce health inequities of priority populations and incorporate health equity within HPC's work.

SECTION 17, 18: Amends subsection (a), section 8, ch. 6D expanding the scope of the HPC's annual public hearing on health care cost trends to require that the examination of costs, prices and cost trends pay particular attention to health inequities experienced by priority populations.
NOTE: As drafted, the proposed legislation strikes language directing the HPC to make trends in annual behavioral health expenditures a focus of the annual cost trends hearing.

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SECTION 19-22: Inserts a new section into chapter 6D, proposed section 9A, directing the HPC to establish aggregate primary care and behavioral health expenditure targets. Requires providers, providers organizations, and public and private payers called as witnesses at the HPC's annual public hearings on health care cost trends provide testimony on "efforts to reduce health inequities experienced by priority populations."

SECTION 23: Inserts new section directing that every 2 years the HPC, in consultation CHIA, GIC, the office of Medicaid, and the division of insurance to file a report on health care costs, pharmaceutical spending, aggregate rebates, and cost-sharing; drug treatment utilization and adherence; incidence of related acute events; and health equity, with the house and senate clerks, and the chairs of the joint committee on health care financing, joint committee on public health, and the chairs of the house and senate committees on ways and means.

SECTION 24: Establishes a 30-person special commission to address health inequities in Massachusetts through measurable benchmarks, which said commission sets.
NOTE: Drafting error, bill states 11 governor appointees but 12 are listed.

SECTION 25: Inserts a new chapter in the General Laws, Chapter 6F, establishing the Executive Office of Equity (EOE). The Governor appoints the secretary of equity. EOE is tasked with leading efforts toward equity, diversity, and inclusion across state government, within each executive office, and throughout the commonwealth; promoting access to equitable opportunities and resources that reduce disparities; and improving outcomes statewide across state government; developing and implementing equity impact analyses and creating and publishing health equity data that is disaggregated. New chapter defines terms utilized throughout the proposed legislation including: data dashboards, equity, health equity, social determinants of health.

EOE shall develop multi-year strategic plans to advance equity within each executive office and develop standards and data dashboards for the collection, analysis and public reporting of disaggregated data by race, ethnicity, language, disability, gender, income and other socio-demographic factors. EOE will do so in coordination with public and quasi-public entities, including HPC and CHIA. Other duties of EOE include creating outcome measures to determine the effectiveness of disparity reduction programs and services; and the development and implementation of equity impact analyses at the request of any constitutional, executive, or legislative office. The secretary of health equity to file an annual report and outlines the contents of the report.

SECTIONS 26, 27: of the proposed legislation amend section 1 of chapter 12C by inserting definitions for health equity and priority population, as established in the proposed legislation.

SECTION 28-31: Amends multiple sections of chapter 12 (CHIA) to ensure that CHIA's research and analysis reports and data collection include: barriers to health equity data collection, methods to engage priority populations, how workforce diversity affects care quality and access, ensuring the focus of health disparities and health equity for priority populations is included. Establishes a Chief Health Equity Officer role within CHIA to oversee and support initiatives aimed at reducing health disparities among priority populations. Requires CHIA's oversight council to hold annual hearings on health equity research and analysis, with feedback from priority populations and stakeholders. CHIA's annual report must include data and analysis.

SECTION 32: Inserts a new section into chapter 12C, proposed section 10A, directing CHIA to promulgate regulations, in consultation with DPH and MassHealth and in coordination with the executive office of equity, for the uniform reporting of data necessary to analyze health inequities experienced by priority populations.

SECTION 33: Amends section 11 of chapter 12C to apply existing timely reporting requirements and enforcement mechanisms to the data collected under new section 10A (inserted by this bill).

Summary Prepared by the House Staff of the Joint Committee on Health Care Financing

SECTION 34: Amends section 16 of chapter 12C to expand the data analyzed in CHIA's annual cost trends report to include data on the "aggregate primary care and behavioral health expenditure target" set by HPC under the proposed section 9A, publish the aggregate baseline expenditures, and include in its annual reports an analysis of the factors that may lead to health inequities for priority populations.

SECTION 35 of the proposed legislation amends section 2GGGG of chapter 29 to add to the approved uses of funding available through the Distressed Hospital Trust Fund proposals aiming to reduce identified disparities or otherwise advance equity in care delivery.

SECTION 36: Amends chapter 111 by inserting 2 new sections. Section 2K establishes a new Health Equity Zone Trust Fund. The DPH commissioner shall administer the fund and the commissioner in consult with the Health Equity Zone Advisory Board shall make expenditures from the fund. The Health Equity Zone Trust Fund shall enable the creation of newly defined "health equity zones" to address inequities in health outcomes. Not less than 85% of the Fund shall be awarded by a grant process to municipalities, community-based organizations, and regional-planning agencies that apply for the implementation, technical assistance, and evaluation of health equity activities. Section 2L establishes the Health Equity Zone Advisory Board to make recommendations to DPH concerning the administration and allocation of the Health Equity Zone Trust Fund established in section 2K. Health equity zones are defined as:

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

SECTIONS 37, 38: Amends section 25C of chapter 111 (DON approval process at DPH), requiring any DON application undergo a health equity assessment and directs DPH to consider the findings, and input from the EOE in its approval process.

SECTION 39: Adds health care workforce development language to specifically include individuals from priority populations, regardless of immigration status.

SECTION 40: Inserts new section, creating a requirement that all licensed healthcare professionals complete health equity training by 2028, covering topics such as cultural safety, structural competency, implicit bias, and anti-racism. The Department of Public Health and licensing boards must ensure training quality and accessibility, including a free course option.

SECTION 41, 42: Amends chapter 118E by inserting 2 new sections for comprehensive MassHealth (or equivalent) coverage for all children, youth, and adults who are ineligible due to immigration status. Coverage is required by January 1, 2027 and ensures access to health care regardless of federal action.

Section 16E establishes a program of comprehensive health coverage for children and young adults under the age of 21 who are residents of the Commonwealth and are not eligible for benefits under Title XIX or XXI of the Social Security Act or Section 9A of this chapter solely due to their immigration status. Children and young adults will be eligible to receive MassHealth benefits equivalent to the benefits available to people of like age and income under categorical and financial eligibility requirements established by the EOHHS under Title XIX and XXI. EOHHS will maximize federal financial participation but will not rely on the availability of the federal participation, for the benefits provided under this section.

Summary Prepared by the House Staff of the Joint Committee on Health Care Financing

Section 16F establishes a program of comprehensive health coverage for all other residents of the Commonwealth not covered under the new section 16E and who are not eligible for benefits under Title XIX or XXI of the Social Security Act or Section 9A of this chapter solely due to their immigration status. Such individuals will be eligible to receive MassHealth benefits equivalent to the benefits available to people of like age and income under categorical and financial eligibility requirements established by the EOHHS under Title XIX and XXI. EOHHS will maximize federal financial participation but will not rely on the availability of the federal participation, for the benefits provided under this section.

SECTION 43: Amends section 36, ch. 118E requiring institutional providers contracting to provide services through MassHealth implement measurable diversity, equity, and inclusion initiatives and expand mental health and wellness benefits for their employees.

SECTIONS 44, 45: Amends existing statute to extend workforce development funding and programs, previously limited to nursing homes, to include safety net hospitals, community health centers, and other essential providers. Retroactively repeals the sunset provision on the temporary, 2-year period of mandated telehealth rate parity for primary care and chronic care services authorized by chapter 260 of the Acts of 2020. The 2-year period of mandated rate parity for such services expired on December 31, 2022.

SECTION 46: Directs the DPH commissioner, in consult with the assistant secretary for MassHealth, to develop standardized, tiered, and stackable credentials for the certification of lower-wage positions funded by MassHealth. Intended to support career advancement and workforce development.

SECTION 47: Directs the EOHHS secretary in consult with the EOE secretary and DPH commissioner to provide funding to support safety net hospitals and community-based providers that serve populations with a high Medicaid payer mix, with the stated goal of advancing health equity and supporting facilities that disproportionately serve Medicaid patients. Priority funding will be given to hospitals that:

(1) Have a high Medicaid payer mix;
(2) Have an average statewide average acute hospital commercial relative price of less than 0.90 (as calculated by the center for health information and analysis); and
(3) Are not a part of a large health system (as determined by the secretary)Such funding, subject to legislative appropriation, may be used for operations, infrastructure, access, or capacity building. Access to funds is not contingent on federal participation, ensuring continued support regardless of federal reimbursement.

SECTION 48: Directs the assistant secretary for MassHealth to establish payment models that incentivize behavioral health, oral health and pharmacy services in primary care, within MassHealth programs.

SECTION 49: Amends section 259 of ch. 112 adding “patient navigation services” to the definition of core competencies. Core competencies are overlapping and mutually reinforcing skills and knowledge essential for effective community health work in core areas and include outreach methods and strategies, client and community assessment, effective communication, community capacity building, support, advocacy and coordination of care for clients.

SECTION 50: Adds new definition to section 259 of ch. 112 for “patient navigation services”.

SECTION 51: Strikes the third paragraph of section 260 ch. 112, removing the exemption that allowed both public and private insurers to refuse reimbursement for services delivered by community health workers.

SECTION 52 of the proposed legislation requires the appointing authorities to ensure that the memberships of the HPC, Office of Health Equity Advisory Board, Board of Registration in Medicine, Public Health Council,

and all DPH health profession boards of registration to be composed of at least 50% women and 25% Black, Indigenous, or other people of color.

SECTION 51: Repeals the third paragraph of Section 260 of Chapter 112, to support proposed section 52, to strengthen community health workers (CHWs') role in health care and support broader health equity goals by ensuring sustainable funding for services.

SECTION 52: Mandates that public and private insurers, including MassHealth contractors, cannot deny coverage or reimbursement for services solely because they are delivered by certified CHWs working in a variety of healthcare and community settings.

SECTION 53: Requires that costs for competent interpreter services in sign and spoken languages be recognized and reimbursed separately by MassHealth and its contracted insurers for licensed healthcare facilities.

SECTION 54: Extends the interpreter reimbursement mandate to all health insurance carriers and behavioral health managers, ensuring the carriers and behavioral health managers separately reimburse licensed facilities for the cost of qualified interpreter services.

SECTION 55: Requires specific appointed boards and commissions be composed of at least 50% women and at least 25% Black, Indigenous, or other people of color, to improve representation and equity in governance.

SECTION 56: Imposes an annual reporting requirement on insurers to disclose which prescription drugs are covered with no or limited cost-sharing. The state may reject drugs that do not meet required criteria and must publish this information online

SECTION 57: Establishes a Medicaid-funded Graduate Medical Education (GME) program supporting training in primary care and high-need specialties, especially in community-based and underserved settings. Initial payments begin by October 1, 2025, with a funding plan due by July 1, 2025.

SECTION 58: Specifies that Sections 5, 8, and 31 of the act shall become effective 90 days after passage.

SECTION 59: Establishes that sections 6, 7, 9-12, 34, 39, 42, 43, 45, 46, and 55 shall take effect 180 days after the act is passed.

SECTION 60: Delays the implementation of sections 29, 32, 33, and 48 to one year after the act's passage to allow time for preparation and compliance.

SECTION 61: Sets the effective date for section 23 as January 1, 2027, aligning with other long-term provisions in the legislation.