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

SENATE . . . . . No. 901

The Commonwealth of Massachusetts

PRESENTED BY:

Pavel M. 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 to advance health equity.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	
Pavel M. Payano	*First Essex*	
Liz Miranda	*Second Suffolk*	
Manny Cruz	*7th Essex*	*2/11/2025*
Patricia D. Jehlen	*Second Middlesex*	*2/21/2025*
Sal N. DiDomenico	*Middlesex and Suffolk*	*2/21/2025*

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

SENATE . . . . . No. 901

By Mr. Payano, a petition (accompanied by bill, Senate, No. 901) of Pavel M. Payano, Liz Miranda, Manny Cruz, Patricia D. Jehlen and others for legislation to advance health equity. Health Care Financing.

The Commonwealth of Massachusetts

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

An Act to advance health equity.

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

SECTION 1. Section 17A of chapter 6 of the General Laws is hereby amended by inserting after "the secretary of energy and environmental affairs,", in line 4, the following words:- the secretary of equity,.

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

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

"Health equity", as defined in section 1 of chapter 6F.

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

"Priority population", a population that is disproportionately affected by health disparities.

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 16. Clause (ii) of said subsection (e) of said section 8 of said chapter 6D, as so appearing, is hereby amended by striking out, in line 58, “and any” and inserting in place thereof the following words:- , efforts to reduce health inequities experienced by priority populations, and any.

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

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

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

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

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

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

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

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

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

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

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

SECTION 24. a) There shall be a special commission to address areas of longstanding health inequities in the state by establishing benchmarks (i.e., specific, measurable targets) from which to measure statewide improvement. The commission shall consist of: the senate chair of the joint committee on health care financing who shall serve as co-chair; the house chair of the joint committee on health care financing who shall serve as co-chair; the senate chair of the joint committee on public health; the house chair of the joint committee on public health; the senate chair of the joint committee on racial equity, civil rights, and inclusion; the house chair of the

joint committee on racial equity, civil rights, and inclusion; the attorney general or a designee; the secretary of health and human services or a designee; the commissioner of public health or a designee; the executive director of the health policy commission or a designee; the executive director of the center for health information and analysis or a designee; 1 person with a professional record of health equity advocacy or expertise who shall be appointed by the senate president; 1 person with a professional record of health equity advocacy or expertise who shall be appointed by the speaker of the house of representatives; 1 person with a professional record of health equity advocacy or expertise who shall be appointed by the minority leader of the senate; 1 person with a professional record of health equity advocacy or expertise who shall be appointed by the minority leader of the house of representatives; 11 persons who shall be appointed by the governor, 1 of whom shall be a health economist, 1 of whom shall represent a high-Medicaid and low-income public payer disproportionate share hospital, 1 of whom shall represent a hospital with not more than 200 beds, 1 of whom shall represent a hospital with at least 800 staffed beds, 1 of whom shall have demonstrated expertise in representing the health care workforce as a leader in a labor organization, 1 of whom shall be a representative of an employer with not more than 50 employees, 1 of whom shall be a representative of an employer with more than 50 employees, 1 of whom shall have significant experience in the health equity sub-sector of the life sciences sector, 1 of whom shall be an expert in health and social services for children,1 of whom shall be an expert in health and social services for seniors, 1 of whom shall be an expert in healthcare and social services for persons with disabilities, and 1 of whom shall be a representative of a healthcare consumer advocacy organization; 1 person who shall be a representative of the Massachusetts Health and Hospital Association; 1 person who shall be a representative of the Massachusetts League of Community Health Centers; 1 person who shall be

a representative of the Massachusetts Association of Health Plans; 1 person who shall be a representative of Blue Cross Blue Shield of Massachusetts; 1 person who shall be a representative of the Massachusetts Medical Society; 1 person who shall be a representative of the Massachusetts Public Health Alliance; and 1 person who shall be a representative of the Health Equity Compact.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

g) By no later than sixteen months after enactment of this act, the commission shall complete the activities described in the preceding paragraphs and submit a final report to the Governor's office, the state legislature, and the health policy commission, which shall include, but not be limited to: the high-priority areas of health inequities in the state identified by the commission; the Health Equity Benchmarks drafted by the commission; the framework for driving and assessing state performance that promotes accountability with respect to achieving material progress in addressing health inequities in the state; and recommendations for operationalizing the Health Equity Benchmarks and the framework for driving and assessing state performance.

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

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

CHAPTER 6F

EXECUTIVE OFFICE OF EQUITY

Section 1. Definitions

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

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

"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.

"Office", executive office of equity.

"Secretary", secretary of equity.

"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 2. Establishment of office

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

Section 3. Principal agency of executive department; purposes

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

(a) 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;

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

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

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

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

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

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

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

The secretary, in consultation with each respective secretary of each Massachusetts executive office, shall appoint an undersecretary of equity to assist each other Massachusetts executive office in applying an equity lens in all aspects of agency decision making, including service delivery, program development, policy development, and budgeting. The secretary shall appoint an undersecretary of equity for administration and finance, an undersecretary of equity for education, an undersecretary of equity for energy and environmental affairs, an undersecretary of equity for health and human services, an undersecretary of equity for housing, an undersecretary of economic development, an undersecretary of equity for labor and workforce development, an undersecretary of equity for public safety and security, an undersecretary of equity for transportation, an undersecretary of equity for veterans affairs, and an undersecretary of equity for climate innovation and resilience. Each person appointed as an undersecretary shall have experience, and shall know the field or functions of such position.

The undersecretaries shall provide assistance to the executive offices by:

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

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

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

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

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

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

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

Section 5. Advisory board

(a) There shall be an advisory board to the executive office of equity. The advisory board shall consist of: 3 persons appointed by the governor; 3 persons appointed by the president of the senate; 3 persons appointed by the speaker of the house of representatives; 3 persons appointed by the Massachusetts Black and Latino Legislative Caucus; 1 person appointed by the Secretary of Administration and Finance who shall have expertise in economic matters; 1 person appointed by the Secretary of Education who shall have expertise in education matters; 1 person appointed by the Secretary of Energy and Environmental Affairs who shall have expertise in environmental justice; 1 person appointed by the Secretary of Health and Human Services who shall have expertise in health equity and the social determinants of health; 1 person appointed by the Secretary of Housing who shall have expertise in housing policy; 1 person appointed by the

Secretary of Economic Development who shall have expertise in economic development policy; 1 person appointed by the Secretary of Labor and Workforce Development who shall have expertise in labor and workforce development policy; 1 person appointed by the Secretary of Public Safety and Security who shall have expertise in criminal justice matters; 1 person appointed by the Secretary of Transportation who shall have expertise in transportation matters; 1 person appointed by the Secretary of Veterans Affairs who shall have expertise in matters related to veterans, and 1 person appointed by the Secretary of Office of Climate Innovation and Resilience who shall have experience in climate matters.

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

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

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

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

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

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

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

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

(b) Notwithstanding any general or special law to the contrary, the secretary, in collaboration with other secretaries in the governor's cabinet, shall publish and regularly update data dashboards on the executive office of equity's website. To the extent possible, all data dashboards shall include data able to be disaggregated by (1) gender; (2) race; (3) ethnicity; (4) geographic location; (5) age; (6) disability; (7) primary language; (8) occupation; and (9) any

other demographic information that the secretary deems important to understand inequities and disparities in the commonwealth.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(I) assessing ongoing discrimination and minority stressors against individuals and groups in populations that have experienced marginalization or oppression based upon race, gender, gender identity, gender expression, ethnicity, marital status, language, sexual orientation,

disability, and other factors, including discrimination that is based upon bias and negative attitudes of health professionals and providers;

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

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

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

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

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

Section 7. Annual Report

The secretary shall, on or before the first Wednesday in December of each year, submit a report to the governor, the president of the senate, the speaker of the house of representatives, the chair of the senate committee on ways and means, and the chair of the house committee on ways and means. Such report shall list and discuss the proposals which have been made and the accomplishments which have been achieved during the preceding two years towards advancing equity within the executive office of equity, each other executive office and throughout the

commonwealth. Said report shall contain a summary of the objectives of such proposals, their disposition, and such further recommendations for legislative or executive actions concerning these proposals or additional proposals as, in the judgment of the secretary, should be made to improve equity in the programs, services and business affairs of the commonwealth.

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

"Health equity", as defined in section 1 of chapter 6F.

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

"Priority population", as defined in section 1 of chapter 6D.

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

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

(7) develop a process to hold annual public hearings to obtain input relating to health equity research and analysis priorities from healthcare consumers in the commonwealth, and it shall be the goal of the council for such hearings to obtain input from priority populations, the

health disparities council under section 16O of chapter 6A, the division of medical assistance, and the department of public health. The council shall analyze the input received for the purposes of inclusion in the annual report described in section 16(a).

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

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

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

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

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

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

(2) To ensure that standards with respect to health equity data for accountable care organizations under MassHealth are incorporated into such regulations, the regulations shall specify standardized measures for data collection to: (A) standardize and strengthen social risk factors data collection, including race (including meaningful capture of multi-racial), ethnicity, language, disability, sexual orientation, gender identity, geographic location (including, for example, ZIP code, census tract, and/or primary city or town of residence), and health-related social needs; (B) maintain robust structures to identify and understand disparities, including through stratified reporting on key performance indicators; and (C) account for social determinants of health, including food insecurity, housing stability, and community violence.

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

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

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

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

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

(a) The center shall publish an annual report based on the information submitted under this chapter concerning health care provider, provider organization and private and public health care payer costs and cost trends, section 13 of chapter 6D relative to market power reviews and section 15 relative to quality data. The center shall compare the costs, cost trends, and expenditures with the health care cost growth benchmark established under section 9A of said chapter 6D, analyzed by regions of the commonwealth, and shall compare the costs, cost trends, and expenditures with the aggregate primary care and behavioral health expenditure targets established under section 9A of said chapter 6D, and shall detail: (1) baseline information about cost, price, quality, utilization and market power in the commonwealth’s health care system; (2) cost growth trends for care provided within and outside of accountable care organizations and patient-centered medical homes; (3) cost growth trends by provider sector, including but not limited to, hospitals, hospital systems, non-acute providers, pharmaceuticals, medical devices and durable medical equipment; provided, however, that any detailed cost growth trend in the pharmaceutical sector shall consider the effect of drug rebates and other price concessions in the aggregate without disclosure of any product or manufacturer-specific rebate or price concession information, and without limiting or otherwise affecting the confidential or proprietary nature of any rebate or price concession agreement; (4) factors that contribute to cost growth within the commonwealth’s health care system and to the relationship between provider costs and payer

premium rates; (5) primary care and behavioral health expenditure trends as compared to the aggregate baseline expenditures, as defined in section 1 of said chapter 6D; (6) the proportion of health care expenditures reimbursed under fee-for-service and alternative payment methodologies; (7) the impact of health care payment and delivery reform efforts on health care costs including, but not limited to, the development of limited and tiered networks, increased price transparency, increased utilization of electronic medical records and other health technology; (8) the impact of any assessments including, but not limited to, the health system benefit surcharge collected under section 68 of chapter 118E, on health insurance premiums; (9) trends in utilization of unnecessary or duplicative services, with particular emphasis on imaging and other high-cost services; (10) the prevalence and trends in adoption of alternative payment methodologies and impact of alternative payment methodologies on overall health care spending, insurance premiums and provider rates; (11) the development and status of provider organizations in the commonwealth including, but not limited to, acquisitions, mergers, consolidations and any evidence of excess consolidation or anti-competitive behavior by provider organizations; and (12) the impact of health care payment and delivery reform on the quality of care delivered in the commonwealth.

As part of its annual report, the center shall report on price variation between health care providers, by payer and provider type. The center's report shall include: (1) baseline information about price variation between health care providers by payer including, but not limited to, identifying providers or provider organizations that are paid more than 10 per cent above or more than 10 per cent below the average relative price and identifying payers which have entered into alternative payment contracts that vary by more than 10 per cent; (2) the annual change in price variation, by payer, among the payer's participating providers; (3) factors that contribute to price

variation in the commonwealth's health care system; (4) the impact of price variations on disproportionate share hospitals and other safety net providers; and (5) the impact of health reform efforts on price variation including, but not limited to, the impact of increased price transparency, increased prevalence of alternative payment contracts and increased prevalence of accountable care organizations and patient centered medical homes.

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

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

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

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

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

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

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

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

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

"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.

(b) There shall be established and set upon the books of the commonwealth a separate fund to be known as the Health Equity Zone Trust Fund to be expended, without further appropriation, by the department of public health. The fund shall consist of revenues collected by the commonwealth including: (1) any revenue from appropriations or other monies authorized by the general court and specifically designated to be credited to the fund; (2) any fines and penalties allocated to the fund under the General Laws; (3) any funds from public and private

sources such as gifts, grants and donations to further community-based prevention activities; (4) any interest earned on such revenues; and (5) any funds provided from other sources, including financial contributions from private organizations.

The department of public health shall establish a framework to incentivize private sector participation to implement the activities described in this section, that includes, but is not limited to, establishing a mechanism to facilitate financial contributions from private organizations to the Health Equity Zone Trust Fund to supplement public revenues allocated by the commonwealth, and the ability of private organizations to participate as part of a multi-sector partnership, consistent with subsection (e).

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

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

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

(e) The purpose of the Health Equity Zone Trust Fund is to enable the creation of so-called health equity zones, namely geographic areas where existing opportunities emerge and investments are made to address inequities in health outcomes. The Health Equity Zone Trust Fund will equip multi-sector partnerships which may include residents, businesses and other private sector stakeholders, community-organizations, and municipal agencies to identify and

create community determined solutions necessary to create just and fair conditions for health. The Health Equity Zone Trust Fund shall prioritize investment in the communities that have been systematically oppressed and where decades of disinvestment have created inequitable health outcomes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

“Cultural safety”, an examination by health care professionals of themselves and the potential impact of their own culture on clinical interactions and health care service delivery.

This requires individual health care professionals and health care organizations to acknowledge and address their own biases, attitudes, assumptions, stereotypes, prejudices, structures, and characteristics that may affect the quality of care provided. In doing so, cultural safety encompasses a critical consciousness where health care professionals and health care organizations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities, and as measured through progress towards achieving health equity. Cultural safety requires health care professionals and their associated health care organizations to influence health care to reduce bias and achieve equity within the workforce and working environment.

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

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

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

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

(2) By January 1, 2028, the department, in consultation with the board, shall adopt model rules establishing the minimum standards for continuing education programs meeting the requirements of this section. The department shall consult with patients and communities with lived experience of health inequities or racism in the health care system, relevant professional organizations, and the board in the development of these rules.

(3) The minimum standards must include instruction on skills to address the structural factors, such as bias, racism, ableism, and poverty, that manifest as health inequities. These skills include individual-level and system-level intervention, and self-reflection to assess how the licensee's social position can influence their relationship with patients and their communities. These skills enable a health care professional to care effectively for patients from diverse cultures, groups, and communities, varying in race, ethnicity, gender identity, sexuality, religion, age, ability, socioeconomic status, and other categories of identity. The courses must assess the licensee's ability to apply health equity concepts into practice. Course topics may include, but are not limited to: (A) strategies for recognizing patterns of health care disparities on an individual, institutional, and structural level and eliminating factors that influence them; (B) intercultural communication skills training, including how to work effectively with an interpreter and how communication styles differ across cultures; (C) implicit bias training to identify

strategies to reduce bias during assessment and diagnosis; (D) methods for addressing the emotional well-being of children and youth of diverse backgrounds; (E) ensuring equity and antiracism in care delivery pertaining to medical developments and emerging therapies; (F) structural competency training addressing five core competencies, which are: (i) recognizing the structures that shape clinical interactions; (ii) developing an extra clinical language of structure; (iii) rearticulating cultural formulations in structural terms; (iv) observing and imagining structural interventions; and (v) developing structural humility; (G) cultural safety training; and (H) providing effective care to individuals with disabilities and behavioral health diagnoses.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) The first sentence of the third paragraph of said section 410 of said chapter 159 is hereby amended by striking out "nursing homes and nursing home employees" and inserting in

place thereof the following words:- nursing homes, safety net hospitals, community health centers, other providers determined by the Corporation and employees of such entities.

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

SECTION 47. (a) Notwithstanding any general or special law to the contrary, the secretary of health and human services or designee shall, subject to appropriation, provide funding, in consultation with the secretary of equity and commissioner of public health, to safety net hospitals and community-based providers with a high Medicaid payer mix (as determined by the secretary) to advance health equity and to address disparities in resources for facilities serving priority populations who predominantly rely on Medicaid. In providing such funding, the secretary shall prioritize safety net 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 support may be used as the safety net hospital or community-based provider determines appropriate, including for such purposes as patient care operations, access, infrastructure, or capacity building.

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

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

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

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

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

(a) outreach methods and strategies;

(b) client and community assessment;

(c) effective communication;

(d) culturally-based communication and care;

(e) health education for behavior change;

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

(g) application of public health concepts and approaches;

(h) community capacity building;

(i) writing and technical communication skills; and

(j) patient navigation services.

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

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

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

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

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

SECTION 52. Notwithstanding any general or special law to the contrary, the group insurance commission public employee plans under Chapter 32A; the division of medical assistance under chapter 118E and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract to a Medicaid managed care organization or primary care clinician plan; insurance companies organized under Chapter 175; non-profit hospital service corporations organized under Chapter 176A; medical service corporations organized under chapter 176B; and health maintenance organizations organized under chapter 176G shall not decline to provide coverage and reimbursement for covered health care services solely on the basis that those services were

delivered by a certified community health worker, as defined by Section 259 of Chapter 112, employed by health care providers or provider groups, including but not limited, an acute care hospital, health system, community health center, school-based health center, community behavioral health center, community mental health center, or behavioral health community partner.

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

Provided however, the costs of providing competent interpreter services through sign and spoken languages by facilities licensed under section 19 of chapter 19 of the general laws or Section 51 of Chapter 111 of the general laws, shall be recognized and separately reimbursed by the division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third party contractors under contract to a division managed care organization or primary care clinician program.

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

SECTION 55. (a) Notwithstanding any general or special law to the contrary, the appointive boards and commissions of the commonwealth identified pursuant to subsection (b) shall, to the extent practicable, be composed of at least 50 percent women, and at least 25 percent

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

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

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

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

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

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

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

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

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

selected. The commissioner shall disclose the list of drugs selected by each entity annually on the division's website.

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

Section 83. (a) The office shall make Graduate Medical Education payments for primary care, including but not limited to internists, family medicine, pediatrics, and gerontology, behavioral health, maternal health, including obstetrics and gynecology, and other physician residency training in fields experiencing physician shortages, as determined by the secretary; provided, that said payments may support community-based training for other health professionals, including but not limited to, family medicine nurse practitioners, sexual and reproductive health practitioners, ophthalmologists, optometrists, dentists, and dental hygienists. Eligible recipients shall include community health centers and hospitals licensed in the Commonwealth. Payments shall take into consideration MassHealth utilization and primary care, behavioral health, and maternal health, including obstetrics and gynecology, and other physician residency training in fields experiencing physician shortages; provided further, that the executive office will prioritize placements at community-based settings, at organizations that serve a high public payer mix.

(b) No later than July 1, 2025, the secretary, in consultation with the executive office of administration and finance, shall identify an adequate amount of annual Medicaid graduate medical education funding necessary to fulfill the requirements of this section, as well as state and other funding sources for use for graduate medical education expenditures. The secretary

shall report its recommendations to the joint committee on healthcare finance and committees on ways and means.

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

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

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

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

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