HEALTH EQUITY TASK FORCE

Final Report

Established by Chapter 93 of the Acts of 2020

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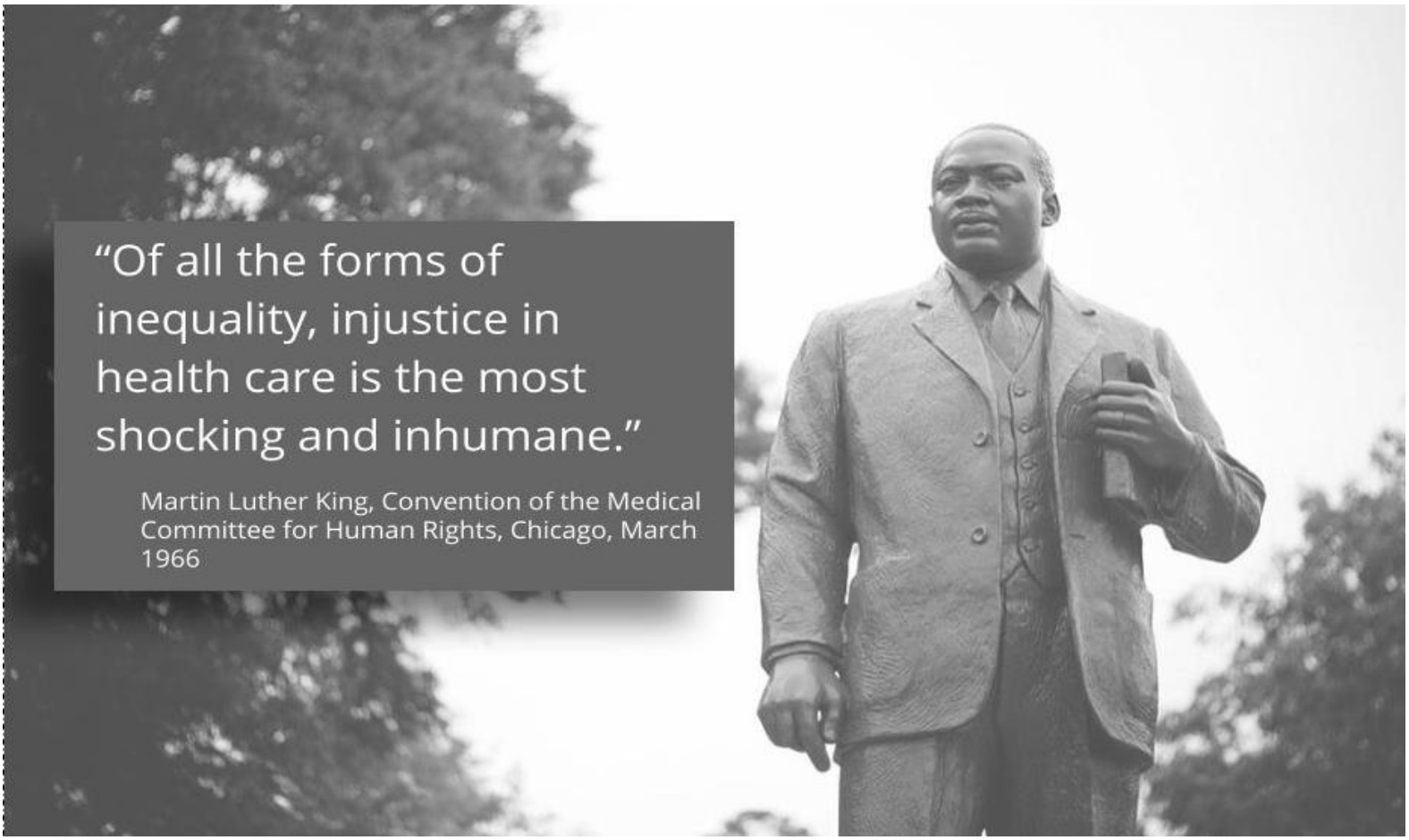


March 2021

We are pleased to submit this report with recommendations to the Massachusetts Legislature from the COVID-19 Health Equity Task Force, created by Chapter 93 of the Acts of 2020. We thank the Legislature for this important opportunity and Task Force Members for their dedicated work and contributions. We hope that these recommendations serve as a roadmap to address historic injustices that led to unequal burden of disease and death during COVID-19 for vulnerable populations.

If we had one guiding principle that we wish readers will take away from this report it is that ***equity must be the "North Star" for guiding every decision about the response to the COVID-19 pandemic.*** We have an opportunity to make significant progress to achieve this goal with the billions of dollars of new federal money coming to the state. We cannot afford to miss this opportunity.

2020 is a year that will forever be seared into the consciousness of Americans. Our nation's collective and longstanding refusal to acknowledge the devastating effects of racism on the health and longevity of Black and Brown people could no longer be sustained.

It is now well-known that Black and Brown members, along with other socially vulnerable members of our society, fared far worse in the COVID-19 pandemic with significantly higher rates of infection and death.[1] In the midst of that suffering, we were further confronted with pervasive racial injustices by the tragic murder of George Floyd and others.

The disparities in COVID-19 morbidity and mortality are the direct result of long-standing inequities in access to opportunities and resources for Black and Brown people. These inequities have manifested through racist policies such as those that banned Blacks from owning property and limited educational and all other

[1] https://www.bostonindicators.org/reports/report-website-pages/covid_indicators-x2/2020/december/persisting-covid-disparities

opportunities. The stress of living with ongoing racism has a dramatic impact on health and longevity leading to higher rates of disease.

COVID-19 has also revealed the vulnerabilities of groups such as persons with disabilities, older adults, and low-income people during a crisis. To achieve equity and remedy these historic injustices means that we need to take bold actions and place equity at the forefront of every decision. This report aims to provide a roadmap for doing so.

We are honored to serve as co-chairs of the COVID-19 Health Equity Task Force, created to study and make recommendations that address health disparities for a range of vulnerable populations, communities and providers during the COVID-19 pandemic. The charge included addressing all relevant factors.

The Task Force quickly decided that while it needed to respond to the immediate inequitable impacts of COVID-19, it also needed to address the underlying root causes to prevent such inequities in the future. We scanned the country to learn of best practices.

We are particularly proud of the recommendations that position Massachusetts to become an equity leader among states by building structures and systems that lift up equity within state government so that we are never in this place again. We do this by calling for the creation of a Cabinet level equity leader, an Equity in All Policies approach, and an After Action Review of the pandemic response with an equity lens, an equity analysis of how federal dollars are being invested, and more.

The Task Force received oral and written testimony from hundreds of individuals and organizations at three public hearings for which we are grateful. This participation and feedback provided critical lessons that are fundamental guiding principles of this report. Two stand out loud and clear.

First, is the need for the ***community to be a partner and have a voice*** with state and local government in every aspect of planning and implementation of COVID-19 response, and beyond. As one participant said, "nothing about us, without us."

The second is the need for ***actionable data.*** This data must be stratified (and disaggregated) by race, ethnicity, language, ability, sexual orientation, gender identity, age, and geographic location. The community must participate in deciding the most important data elements to be collected. The data must be relevant, transparent, and available to the public, in order to be a driver of change. As someone else said, "you can't change what you can't measure."

Finally, ***returning to the pre-pandemic "normal" is not an option.*** "Normal" created the conditions that led to these disparities. Massachusetts has received and will receive historic amounts of federal funds to recover. This provides us a unique opportunity to prioritize equity as we make decisions about how to invest those dollars. We must seize this opportunity to build a more equitable and resilient future for all. The time to act is now.

Sincerely,

Michael Curry, Esq.
Co-chair
Chief Executive Officer
Massachusetts League of Community Health Centers

Assaad Sayah, MD
Co-Chair
Chief Executive Officer
Cambridge Health Alliance

1. EXECUTIVE SUMMARY

BACKGROUND

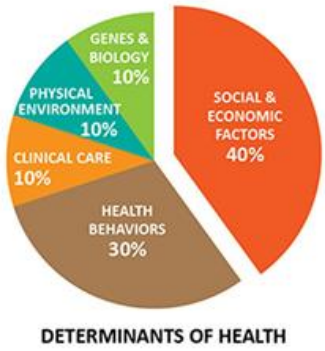
In June of 2020 the Massachusetts Legislature created the COVID-19 Health Equity Task Force in direct response to the well documented, egregious inequities in infection and death rates in communities of color, low-income communities and among vulnerable populations. Chapter 93 of the Acts of 2020, created the Task Force to,

> *"…study and make recommendations to the general court that address health disparities for underserved or underrepresented populations based on culture, race, ethnicity, language, disability, gender identity, sexual orientation, geographic location, including, but not limited to, gateway cities with hospitals dedicated to caring for patients who test positive for COVID-19, and age in the commonwealth during the COVID-19 pandemic." (Section 2A of Chapter 93 of the Acts of 2020)*

The Task Force was charged with developing recommendations including, but not limited to:

- Improving safety for populations at increased risk for COVID-19;
- Removing barriers and increasing access to quality and equitable health care services and treatment;
- Increasing access to personal protective equipment and COVID-19 testing, including diverse geographic locations;
- Providing informational materials in multiples languages on health care resources including, but not limited to prevention, testing, treatment and recovery; and
- Any other factors deemed relevant, including further study of the impact of health disparities.

The 16-member Task Force (see appendix 9) was chaired by Michael Curry, Esq, President and Chief Executive Officer of the Massachusetts League of Community Health Centers, and Assaad Sayah, MD, Chief Executive Officer of Cambridge Health Alliance. The Task Force met 17 times, all of which were open to the public, and held 3 public hearings to obtain feedback from the general public.[2] [3]



DETERMINANTS OF HEALTH

APPROACH

The Task Force quickly decided that while it needed to respond to the immediate inequitable impacts of COVID-19, it also needed to address the underlying root causes to prevent such inequities in the future. In particular, the Task Force recognized that to prevent future health inequities meant addressing the social determinants or factors that influence health.

This is because access to quality health care accounts for only 20% of health status. Social, economic, and environmental

[2] https://malegislature.gov/Commissions/Detail/512/Documents

[3] https://malegislature.gov/Commissions/Detail/512/Hearings

factors including where people live, work and spend time as well as the effects of racism account for the other 80%.

We know that there are wide gaps in income, wealth, education, neighborhood safety and other factors based on race and ethnicity in this country. An egregious example close to home is the wealth gap in Boston reported by the Federal Reserve's report The Color of Wealth. It shows the net worth of white Bostonians is $247,500 while the net worth of Black Bostonians is only $8.[4] **It is inequities like this one in wealth that lead directly to inequities in health.** Thus, the Task Force's recommendations address many of these social and economic factors, such as housing, income and food access that became a crisis during the pandemic.

Finally, key themes emerged over the course of the Task Force's deliberations and guided the recommendations. Among them, the voices of those most affected by this pandemic, Black and Brown people and those with other social vulnerabilities, must guide and inform decision-making and be engaged in carrying out solutions.

Also among the key themes was, "you can't fix what you can't measure." Throughout every aspect of these proceedings, the public identified the need for more granular and disaggregated data on race, ethnicity, language and other socio-demographic factors throughout every part of state government.

And finally, returning to the pre-pandemic "normal" is not an option. "Normal" created the conditions that led to these disparities. We must seize this opportunity to build a more equitable and resilient future for all.

HOW THESE RECOMMENDATIONS POSITION MASSACHUSETTS TO BECOME A NATIONAL LEADER ON EQUITY

The overarching theme of these recommendations is that ***equity must be the "North Star" for guiding every decision about the response to the COVID-19 pandemic, and beyond.*** With billions of federal dollars arriving as a result of the American Rescue Plan, we have a unique opportunity to make significant and enduring progress on achieving this goal. We cannot afford to miss this opportunity.

In the report that follows, the Task Force is proud to offer the recommendations that address the immediate and ongoing need for vaccine equity and COVID-19 response, as well as the many recommendations that address the housing, food and income crises faced by families. The recommendations that address long-standing underfunding of safety net and behavioral health care providers, as well as community health centers are also critical to securing the foundation of our health system.

But the real opportunity for sustainable change and for Massachusetts to become an equity leader among states is the set of recommendations regarding building structures and systems that lift up equity within state government so that we are never in this place again. Specifically, the Task Force recommends:

- ★ **CONDUCTING AN "AFTER-ACTION REVIEW" (AAR) WITH AN EQUITY LENS**

[4] file:///C:/Users/jaq0/Downloads/color-of-wealth.pdf

After Action Reviews (AAR) are standard practice in emergency management and evaluate what worked well and what could be improved. Is it well known in the field that disasters disproportionately affect low-income persons, people of color and other vulnerable populations, yet the field does not fully account for this.

Massachusetts has the opportunity to be the first in the nation to conduct this review with an equity lens guided by an appointed Commission and a participatory process. The findings of the Commission should be filed with Legislative and Administration leadership, and the Administration should be required to respond. The Legislature should act now to require this review.

The AAR should commence immediately with a review of the vaccine plan, be conducted on a rolling basis and completed within 12 months of the end of the public health emergency.

★ CREATING A CABINET-LEVEL EXECUTIVE OFFICE OF EQUITY AND A SECRETARY OF EQUITY, EQUITY OFFICES WITHIN EACH SECRETARIAT AND EQUITY ADVISORY BOARDS

The legislature should pass legislation now to ensure that equity is always central to the business of state government by creating and resourcing a cabinet level Executive Office of Equity led by a Secretary of Equity. The office should be charged with leading efforts toward equity, diversity and inclusion, including developing 3- to 5-year equity strategic plans.

The legislation should also create and resource equity offices within each secretariat with similar charges. There should be a central Equity Advisory Board and each secretariat should also have equity advisory boards.

★ THE CABINET AND SECRETARIAT EQUITY OFFICES SHOULD CREATE DATA DASHBOARDS TO MEASURE PROGRESS AND CREATE ACCOUNTABILITY

As part of the same legislation, the Task Force recommends that the Secretary of Equity create data dashboards stratified and disaggregated by race, ethnicity, language and other socio-demographic factors. The Task Force recommends modeling these dashboards on those created by the Hope Initiative that focus on opportunities within communities, rather than deficits.

★ DEVELOPING AND IMPLEMENTING AN EQUITY IN ALL POLICIES/EQUITY IMPACT ANALYSES

The Secretary would also be charged by the legislation to work with the Equity Advisory Board to develop an Equity in All Policies approach for evaluating the equity impacts of new policies and programs. The Task Force calls on the Administration to conduct the first **Equity Impact Analyses on how billions of federal recovery dollars are being invested in Massachusetts.**

The following is an outline of all recommendations in the report, organized by topic. Within each topic, each item is color-coded based on the need for immediate, intermediate and longer-term actions.
Immediate Action: by June 30th, 2021
Intermediate Action: by December 31st, 2021
Long-term Action: by December 31st, 2022

2. ONGOING RESPONSE TO COVID-19

2.1. PROMOTE VACCINE EQUITY

2.1.1. Equity should be the top criteria in every aspect of vaccine planning and delivery. To achieve equity, resources must be disproportionately directed to communities with the highest rates of infection, and social vulnerability. Local, trusted community organizations should be engaged in all aspects of vaccine delivery.

The state should prioritize delivery of vaccines to those communities with the highest rates of COVID-19 infection, as well as social vulnerability. The state had also announced plans to send 20 percent more vaccines to those communities but has yet to announce a plan to implement this allocation. It is critical that the Department of Public Health issue guidance on the distribution of the extra 20 percent of vaccine supply and spread the dosage among the various providers;

2.1.2. Reduce Technological Barriers to Vaccination Appointments and Increase Access by Providing Transportation

The vaccine rollout has depended heavily on computer access and savvy. While a phone line has been added, there needs to be neighborhood-based assistance to schedule vaccine appointments by working with local, community-based organizations and ambassadors/community health workers. There should be a screening process to assess for transportation barriers, and funding provided for safe transportation to vaccine sites.

2.1.3. Bring Vaccines to Vulnerable Populations, Rather than Expecting Them to Come to Vaccination Sites.

Community-based clinics, on-site clinics at places like public housing, in-home vaccination and mobile vans must be considered as methods to reduce barriers to vaccine access. In particular, on-site and mobile clinics could reach individuals residing in congregate housing, residential treatment and group home facilities.

2.1.4. Enhance the Massachusetts Department of Public Health's (MDPH) Public Education Campaign to Increase Vaccine Acceptance among Populations who are Hesitant.

The MDPH campaign should be culturally appropriate, in multiple languages, delivered by local, trusted community messengers, and tailored to address specific vulnerable populations. In addition to a statewide campaign, the campaign should include resourcing and empowering local, trusted community messengers to deliver culturally appropriate and tailored messages in multiple languages targeted to high-risk populations, including people of color, older adults, those with

underlying and chronic conditions and persons with disabilities.

2.1.5. MDPH should contract with local community and faith-based organizations to employ ambassadors or community health workers.

The Task Force recommends the creation of a statewide ambassador program through partnerships with local, trusted community-based organizations. Ambassadors are hired from the community, thus creating needed jobs and providing service in multiple languages. Their presence builds trust and serves as a bridge between the community, public health and the health care sectors. They **can** assist at clinics, link people to needed services, and participate in public messaging, outreach and education.

2.1.6. In addition to city and town, MDPH should include zip code and census tract along with demographics, and race and ethnicity in the COVID-19 vaccination and case data they publish weekly.

DPH publishes weekly COVID-19 vaccination and case data, stratified by race and ethnicity. MDPH should collect census tract data for cases and those receiving vaccines so that communities can map where outbreaks are occurring, where vaccinations are needed, and design tailored interventions.

2.2. CONTINUE AND ENHANCE THE STOP THE SPREAD CAMPAIGN

The state should continue and enhance the Stop the Spread campaign through calendar year 2021. Stop the Spread provides COVID-19 testing to anyone free of charge, and most sites are located in communities with high rates of infection.

Ambassadors or community health workers should be added to these sites to screen for social and economic needs and connect people to needed resources. This is also a place where people could be screened for chronic conditions and connected to health care. Many people have been unable to address these conditions during the COVID-19 pandemic. It is by offering these supports and resources that trust will be built and more people will become engaged in the process.

2.3. ADDRESS THE NEEDS OF VULNERABLE POPULATIONS

2.3.1. Essential Workers

The Task Force recommends that essential workers and others have access to emergency paid sick leave during the COVID-19 and future pandemics. At this writing, such a bill is in conference committee.

2.3.2. Older Adults

Older adults need access to vaccination that is more accessible including on site and in home vaccination; transportation to vaccination; and assistance with scheduling. Furthermore, the pandemic highlighted important investments and delivery system reforms needed in nursing homes and long-term care facilities in light of the significant incidence and high fatality rate of COVID-19 among residents of senior care. Policy measures should also be taken to support older adults living in their homes and community settings, like the PACE program.

2.3.3. Persons with Disabilities

Persons with disabilities need to be prioritized for vaccines if their disability puts them at higher risk for COVID-19, and they need similar supports as older adults above. It is imperative that the unique needs of persons with disabilities are incorporated in current and future pandemic planning. One such measure is promoting safety and mask wearing in buildings where a significant number of persons with disabilities and other at-risk populations live, particularly those in 40b housing.

2.3.4. Persons with Chronic or Underlying Medical Conditions

Persons with chronic and underlying medical conditions, many of which disproportionately affect persons of color, are at higher risk for COVID-19. They may also have been unable to address their underlying conditions during the pandemic. Special efforts should be made to reach out to these individuals with culturally appropriate education about the importance of vaccination to protect their health. These efforts would best be conducted by trusted, community-based organizations, faith-based organizations and other local entities that are known and trusted.

2.3.5. Incarcerated Persons

Per language in the FY'21 budget, Incarcerated persons, particularly those at high risk for COVID-19, and near the end of their terms and/or at low level of risk to the community should be released to reduce risk of exposure to COVID-19. Few have been afforded this opportunity. The Attorney General was also given the option of appointing an ombudsperson to oversee the implementation of this policy and is ready to act. The Task Force calls on the Administration to allow implementation of the budget language and the appointment of the ombudsperson. The Commonwealth should partner with justice-centered, social services agencies in transition planning. [In process]

2.4. FUND RESEARCH ON THE INTERMEDIATE AND LONG-TERMS EFFECTS OF COVID-19

The Task Force recommends that the Legislature and Administration collaborate to fund plans within the FY 22 state budget, and with federal funding and grants where possible, for research and monitoring of the intermediate and long-term effects of COVID-19. This research should be conducted on the health effects, including long-haul health, behavioral health effects, the socio-economic implications of the pandemic, and ongoing response and recovery needs.

3. STRENGTHENING ACCESS TO QUALITY, AFFORDABLE HEALTH CARE AND OTHER SERVICES

3.1. PROMOTE DIGITAL EQUITY AND INCLUSION

To close the digital divide will require more affordable broadband and higher speeds, access to devices and digital literacy. Digital access has been critical during this pandemic to access telehealth, for children to attend school and for adults to have access and information to services such as unemployment, income supports, food benefits, housing applications and more.

3.1.1. Promote Telehealth and Digital Equity for Patients

The Task Force supports legislation that would expand access to telehealth services to patients by increasing digital adoption and literacy, reducing financial barriers to accessing telehealth,

expanding reimbursement parity, and requiring a public-health oriented lens to assessments of telehealth impacts in the state. Specifically, legislation should establish pilot programs with aims to increase telehealth access via the provision of digital technology and digital literacy education. In addition, the Task Force supports legislative action to require insurers to cover interpreter services for telehealth patients with limited English proficiency or for those who are deaf or hard of hearing, waive co-pays during the pandemic, abolishing prior authorization for virtual care that would not be required for in-person care, and reimburse providers for virtual care on a par with in person care. The Health Policy Commission should stratify the data in its required reports on the impact of telehealth on cost and access by race, ethnicity and other socio-demographic factors, and determine the impact on social determinants.

3.1.2. The Massachusetts Department of Telecommunications and Cable Should Work with the Massachusetts Broadband Institute and the Broadband Providers in Massachusetts to Increase Minimum Download and Upload Speeds Provided at Affordable and Subsidized Prices.

During the pandemic households with multiple internet users often lost service because download and upload speeds were inadequate. This was challenging with children attempting to attend school remotely while parents simultaneously attempted to file for unemployment, for example. The Massachusetts Broadband Institute, the Massachusetts Department of Telecommunications and Cable and the Legislature should work to require companies to establish acceptable minimum speeds for service that is affordable and/or subsidized.

3.1.3. The Task Force Supports Legislation to Create a Funding Subsidy for Lifeline, a Federal Program that Supports Minimum Phone Service.

Massachusetts needs legislative action to provide a state wrap-around subsidy to the Lifeline program, a federal program that provides affordable mobile phones to eligible participants. Massachusetts is one of only 10 states that does not subsidize this program, which is currently very underutilized in this state.

3.1.4. Support and Funding for Community Interventions to Make Broadband Access and Digital Devices More Affordable, and to Provide Digital Literacy Education.

The Task force urges funding in the FY'22 budget for multi-sector community interventions to make broadband access and digital devices more affordable, and to provide digital literacy education. Across the state, digital alliances have launched local efforts to expand access to and education for use of digital services.

3.2. EXPAND HEALTH CARE COVERAGE FOR IMMIGRANT CHILDREN

3.2.1. Extend MassHealth CommonHealth Coverage for Immigrant Children with Disabilities

While over 98 percent of the Commonwealth's children have some form of health coverage, thousands of predominantly low-income children and young adults with disabilities, most of whom are undocumented immigrants, can only access safety net programs with strict limits on covered benefits. Legislation is urgently-needed to extend MassHealth CommonHealth to this population.

3.2.2. Expand MassHealth Coverage for All Eligible Children Regardless of Immigration Status

The ultimate goal is coverage of all children, regardless of immigration status. Toward this end, the Task Force calls for legislative action toward MassHealth coverage of all eligible children and youth, regardless of immigration status.

3.3. ADVANCE EQUITABLE RESOURCES FOR SAFETY NET HOSPITALS AND THE COMMUNITIES THEY SERVE

3.3.1. Require Commercial Rate Equity for Safety Net Hospitals and Providers as a Means to Reduce Racial and Ethnic Health Disparities

Safety net hospitals that provide care to a high proportion of Medicaid patients are not paid as much by commercial insurers for the same quality and level of services as non-safety net hospitals. This is despite the fact that safety nets serve low-income communities and the communities that have been disproportionately affected by COVID-19. Legislation is needed to require they receive at least the average commercial insurance reimbursement rates.

3.3.2. Enhance Funding for High Medicaid Safety Net Hospitals Under Medicaid Waiver Renewal

The Commonwealth is re-applying to the Centers for Medicaid and Medicare Services to renew the Medicaid 1115 Waiver. During its current term (2018-2022), this Waiver has provided supplemental payments to safety net providers and allowed for delivery system reform and innovations to achieve equity. The Task Force supports continued partnership between the Massachusetts Executive Office of Health and Human Services and safety net providers to enhance care through the renewed Waiver.

3.3.3. Sustain and Enhance Medicaid Rates for Safety Net Hospitals and Hospital-Licensed Health Centers

Sustaining Medicaid rates and reimbursement is fundamental to the care delivery of safety net health systems, including safety net hospitals and hospital-licensed health centers. Patients with public payers, including MassHealth, the Health Safety Net and others often account for 70-80% of the payer mix at these hospitals. As Massachusetts Medicaid policies are designed in the upcoming Medicaid Waiver Renewal and in the annual MassHealth Acute Hospital Request for Applications, reimbursement for safety net hospitals must be protected and enhanced.

3.3.4. Establish Equitable Global Payments/Budgets Under Alternative Payment Methods

Private health insurance spending is consistently lower on average for low-income members, who often reside in diverse communities, and higher on average for members residing in more affluent communities. This spending cannot be explained by health complexity.[5] The Task Force concurs

[5] Office of Attorney General, Examination of Health Care Costs Trends and Cost Drivers: 2011 Report for Annual Public Hearing, at page 27 [AGO 2011 report], available at http://www.mass.gov/ago/docs/healthcare/2011-hcctd.pdf

with the Office of the Attorney General's 2020 report finding that, "COVID-19 has increased the urgency of swiftly addressing this problem by reimagining how we value and pay for health care."[6]

3.4. STRENGTHEN COMMUNITY HEALTH CENTERS

3.4.1. Invest in Health Center Rate Adequacy to Drive Access

The Task Force heard testimony about the chronic underpayment and resulting financial distress that left health centers in Massachusetts particularly vulnerable to the sudden revenue collapse brought on by COVID-19. Federal and state relief stabilized the health center network, but the financial fragility of the health center network was exposed. The Task Force recommends significantly increasing Medicaid payment for Federally-Qualified Health Centers' comprehensive, all-inclusive model of care. Policymakers should also explore commercial rate adequacy for CHCs.

3.4.2. Support Health Centers in "Growing Their Own" Workforce

The Task Force recommends supporting health centers in "growing their own" workforce. The Commonwealth should take a multipronged approach to continuing and expanding these efforts, including through MassHealth financing mechanisms, pilot programs, 1115 Waiver investments, and enactment of the Community Health Center Transformation Fund as a tool to sustain these programs.

3.5. ADVANCE BEHAVIORAL HEALTH EQUITY

3.5.1. Respond to Urgent Behavioral Health-Related COVID-19 Needs and Strengthen the Behavioral Health Delivery System

COVID-19 has starkly exposed the pre-pandemic vulnerability in the behavioral health delivery system and gaps in the continuum of care. At the same time, the need for behavioral health care has increased substantially during the pandemic. This has created an urgent need to build on the meaningful initial steps by the Administration and Legislature for additional mental health and substance use disorder inpatient capacity to expedite further capacity along the behavioral health continuum of care, including for individuals awaiting Department of Mental Health Continuing Care Treatment, outpatient care, and culturally and linguistically appropriate mental health services for patients of all ages, especially for children and adolescents.

3.5.2. Address Behavioral Health Disparities Through a Multi-Agency/ Stakeholder Commission

The Task Force recommends a Multi-Agency/Stakeholder Commission to address the capacity of the behavioral health system and inequities that result, and to make recommendations for improvement. Behavioral health equity is a longstanding issue that will require concerted policy and societal efforts to address. Statewide, multi-agency, and cross-sector efforts in partnership with stakeholders are needed. Given the enormity of the task ahead, over multiple years, the Commission would meet not less than quarterly to map out the work, monitor progress on the

[6] Office of the Attorney General, *Building Toward Racial Justice and Equity in Health: A Call to Action, 2020 at page 21,* available at https://www.mass.gov/doc/building-toward-racial-justice-and-equity-in-health-a-call-to-action/download

pressing areas of recommendations in this report, issue publicly-available annual reports, and make legislative, regulatory or budgetary recommendations.

3.5.3. Develop Robust, Publicly Available Data on Behavioral Health Clinical, Demographic, and Disparities

There are disparities in access to behavioral health services across the Commonwealth depending on factors such as race/ethnicity, language, age, socioeconomic status, geography, sexual orientation, gender identity, and insurance. Yet, there is little data collected to analyze the issues and develop policy, program and resource responses. While there are recommendations for stratified data collection in section 7.4., the Task Force wants to emphasize the need to do so for persons with behavioral health diagnoses.

3.5.4. Invest in Behavioral Health Services, Including Integration with Physical Health

Behavioral health has been chronically underfunded (below the cost of care) by public and private payers. Legislation to require more sustainable behavioral health inpatient and outpatient payment rates is needed in public and private insurance. In addition, Medicaid, a predominant payer for people with behavioral health conditions, must improve its reimbursement methodology to recognize the costs of this care. Furthermore, resources should be available to integrate behavioral health within primary care and other health care services, and services such as brief consultations and recovery coaches should be reimbursed.

3.5.5. Achieve Behavioral Health Parity

The Task Force recommends legislative action toward full mental health parity in the 2021-2022 legislative session. This should include the enforcement of existing parity laws; address barriers to care such as preauthorization requirements; apply parity across payers; ensure compliance through regular market conduct examinations; enhance opportunities and resources for consumers to assert parity rights; establish network adequacy standards; and require parity of reimbursement rates for behavioral health providers and medical providers.

3.5.6. Invest in Lasting Behavioral Health Workforce Improvements

The Task Force calls for actions to support and expand the behavioral health workforce through a variety of targeted initiatives including but not limited to expanding the student loan repayment program to include both inpatient and community-based behavioral health providers and additional behavioral health professionals, scholarships, and workforce training programs. Emphasis should be placed on growth in the behavioral health workforce that reflects the racial, ethnic and cultural diversity of the population to be served. Additional reimbursement is a critical priority to be able to recruit, retain and adequately compensate a behavioral health workforce. The Task Force supports legislation and Administrative actions to include peer support, recovery coaches, community health workers, and family partners as covered benefits in commercial insurance and within the Medicaid program, supported by federal matching funds.

3.5.7. Improve Behavioral Health Treatment at the Intersection with the Justice System

Many people intersecting with the criminal justice system suffer from behavioral health conditions. The Task Force recommends: (1) investment in alternatives to law enforcement response to divert people in behavioral health crises; (2) continued education of law enforcement officers in de-escalation techniques when interacting with individuals experiencing behavioral health distress; (3) reduce trauma inflicted on persons who are incarcerated; and (4) vastly improve and coordinate the care of individuals upon release from the justice system.

3.6. SUPPORT, EXPAND, AND DIVERSIFY THE HEALTH CARE WORKFORCE

3.6.1. Deploy State Initiatives and Funding to Advance the Health Care Workforce and Career Ladder Opportunities

The Task Force recommends state funding and initiatives, including those federally-supported under the Medicaid 1115 Waiver renewal, to provide health care career and pipeline development, student loan-forgiveness, job training and mentoring programs as pathways for current and prospective members of the healthcare workforce. The Task Force also supports initiatives to improve the process and timeliness for the licensing of health care professionals to practice in Massachusetts, and livable wages for essential health care workers.

3.6.2. Activate the Commission Charged with Making Recommendations on Licensing and Practice for Foreign-Trained Health Professionals

There are an estimated 3,000 foreign-trained medical professionals in Massachusetts, including physicians, nurses, dentists and other health professionals. The rich resource of highly trained but underutilized foreign-trained health professionals would not only meet a critical need for providers, but also enhance the racial and ethnic diversity, and cultural and linguistic capacity of the health care workforce, an acute need even prior to the pandemic. Last year, legislation directed the Massachusetts Department of Public Health to form a commission to review licensing and practice for foreign-trained health professionals and make recommendations. The Commission has yet to meet. The Health Equity Task Force encourages the Governor to direct MDPH to activate this Commission as soon as possible.

3.6.3. Support Training and Initiatives that Increase Cultural Competency, Address Racism, and Uncover the Implicit Bias that is Currently Rooted in the Health System

Testimony was received by the Task Force about the need for training and initiatives that increase cultural competency, address racism, and uncover the implicit bias that is currently rooted in the health system. Funding for statewide collaboratives is needed to carry out this training.

3.7. ADVANCE MASSACHUSETTS MEDICAID OPPORTUNITIES TO ADDRESS HEALTH EQUITY

3.7.1. Promote Maternal Health by Extending Maternal Postpartum Care Coverage in MassHealth from the Current 60 days to 12 months and Adding Doula Services

Maternal mortality, particularly among Black women, is a growing health crisis in the United States. Medicaid plays an important role in improving maternal and perinatal outcomes, covering 35% of births in Massachusetts. The Task Force calls for legislative and administrative action to promote

maternal health through extending postpartum Medicaid Coverage from 60 days to 12 months and adding doula services as a covered benefit. The American Rescue Plan Act gives states the option for 5 years to extend postpartum Medicaid/CHIP coverage for 12 months through their Medicaid State Plan or Waiver. Massachusetts should be prepared to extend postpartum Medicaid coverage through this vehicle, or the Medicaid 1115 Waiver opportunity and add doula services as a covered benefit.[7]

3.7.2. Integrate Health Equity Initiatives in Medicaid 1115 Waiver, including Innovations for Health-Related Social Needs and "Flexible Services"

Massachusetts' current Waiver includes a provision for "flexible services" funding that is being used to assist members in MassHealth Accountable Care Organizations with nutrition and housing, with the goal of improving health outcomes and reducing costs. These programs need to be continued and expanded to include a broader variety of services that can be tailored to address the social and economic needs of individual patients.

3.7.3. Continue and Restore MassHealth Retroactive Coverage Beyond the Pandemic

While federal law allows for 90 days retroactive Medicaid coverage from the time a person applies, Massachusetts obtained a waiver to provide only 10 days of retroactive coverage. However, during the COVID-19 public health emergency, MassHealth has been providing at least 90 days of retroactive coverage. The Task Force calls on the Administration and the Legislature to take action to make permanent 90-day retroactive coverage in keeping with the federal Medicaid minimum standards of coverage.

3.7.4. Protect the Homes of Seniors and Persons with Disabilities with MassHealth through Estate Recovery Reform

Medicaid is the only public benefit program that requires the value of benefits to be recouped from a deceased enrollee's family. This is called "estate recovery" and includes the value of the family home. Estate recovery for nursing homes costs is federally mandated, but Massachusetts law goes beyond federal requirements to require estate recovery for the costs of all medical services after a MassHealth enrollee turns age 55. Maintaining home ownership can help combat intergenerational poverty and wealth inequality in communities of color. The Health Equity Task Force supports legislative action to reform MassHealth estate recovery, including but not limited to establishing that MassHealth would only recover for federally-mandated medical assistance, would establish hardship waivers, and provide information upfront to MassHealth members about estate recovery, among other necessary reforms. The federal Medicaid and CHIP Payment and Access Commission issued recent Medicaid estate recovery reform recommendations in this regard.

3.8. REMOVE COPAYMENT BARRIERS FOR AFFORDABLE MEDICATIONS AND CARE TO ADDRESS HEALTH DISPARITIES

3.8.1. Remove Copayments for Prescription Medications and Services to Prevent and Manage Chronic Health Conditions

[7] https://www.congress.gov/bill/117th-congress/house-bill/1319/text#toc-H7381B14964A940089896309B190791E0

High out-of-pocket costs and copayments for prescription drugs and medical visits can cause patients to forgo needed prescription medications and care. The Task Force encourages legislation that removes copayment barriers in insurance design for preventive care, and care and medications for chronic conditions.

3.8.2. Enhance Patient Assistance Programs for Medications to Treat Conditions that Disproportionately Impact People of Color and are Risk Factors for COVID-19 Complications.

The Task Force supports additional legislative approaches to addressing medication affordability, particularly to treat chronic conditions that disproportionately impact people of color and other vulnerable populations. such as expanded patient medication assistance programs.

3.9. IMPROVE ORAL HEALTH

Oral health is among the deepest disparities in communities of color, low-income communities, vulnerable age groups, people with disabilities, and underserved geographic regions.

3.9.1. Sustain Full Restoration of Adult Dental Care Coverage in MassHealth

Full dental coverage for adults on MassHealth has waxed and waned since 2002. Adult dental benefits are currently restored and the restoration needs to be sustained with adequate state budget funding as an important step to address oral health needs.

3.9.2. Establish an Oral Health Commission and Statewide Needs Assessment

The Task Force recommends legislation to create a Special Legislative Commission on Oral Health, chaired and convened by the Massachusetts Commissioner of Public Health. It should be charged with (1) conducting a statewide oral health status and needs assessment, and (2) developing recommendations to address gaps in access to oral health services.

3.9.3. Enable Dental Professionals to Serve as Vaccinators

The Massachusetts Board of Registration in Dentistry provided guidance that dentists and certain dental hygienists can administer COVID-19 vaccinations within their scope of practice. The Task Force supports this, and encourages the continuation of dental professionals to serve as vaccinators through post-pandemic guidance.

4. ADDRESS SOCIAL FACTORS IN HEALTH

Social and economic inequities are the primary drivers of inequities in health. Following are recommendations on the key social factors of health including food security, housing, transportation, language access, community safety for immigrants, and the environment.

4.1. INCREASE FOOD ACCESS AND SECURITY

Food insecurity in Massachusetts doubled during the pandemic, with a corresponding increase in demand on the emergency food system with a dramatic increase in racial and ethnic disparities during the pandemic.

4.1.1. Close the SNAP Gap

The SNAP Gap refers to the over 700,000 individuals who are MassHealth recipients and likely eligible for the Supplemental Nutrition Assistance Program (SNAP) but are not receiving the benefit. The Task Force encourages legislation that would create one application procedure for households to apply for MassHealth/Medicare Savings Program, SNAP and other benefits such as Transitional Assistance for Families with Dependent Children (TAFDC) or Emergency Aid for the Elderly, Disabled and Children (EAEDC), which would contribute to closing the gap.

4.1.2. Fully Fund the Healthy Incentives Program

The Healthy Incentives Program allows the 900,000 Massachusetts residents who rely on SNAP benefits to double the value of their benefit when they purchase fruits and vegetables from farmers' markets. The Task Force supports level funding at $13 Million for the Healthy Incentives Program in the FY'22 budget. The Governor has proposed a cut to $5 Million which falls short of the demand from families for healthy food, and hurts local farmers who provide this food to farmers' markets. (budget line-item 4400-1004)

4.1.3. Support Universal Free School Meals

During the pandemic, school meals became universally free to all students. The Task Force supports requiring all schools to continue to make these meals available to all students at no charge. At this reading, it seems that the American Rescue Plan Act will make this possible.

4.1.4. Support for the Massachusetts Hunger-Free Campus Initiative

Two national surveys from 2017 and 2018 indicate more than one-third of four-year college students, and nearly half of all community college students, faced food insecurity in the previous 30 days. The Hunger Free Campus Initiative, under the Massachusetts Department of Higher Education would address student food insecurity and hunger across all 29 public higher education campuses, by establishing offices to address hunger and offering grant funding for solutions.

4.1.5. Fund the Massachusetts Emergency Food Assistance Program to Support Increased Need for the Food Bank Coalition of Massachusetts

The Massachusetts Emergency Food Assistance Program supports the Food Bank Coalition of Massachusetts that provides food for a network of nearly 1,000 pantries, meal programs, shelters and mobile markets across the Commonwealth. Demand for this food has seen double-digit increases during the pandemic and there is no end in sight. The Governor has recommended the pre-pandemic funding level of $20 Million in his FY'22 budget, while the food banks indicate the need $30 Million to meet demand (budget line-item 2511–0105).

4.2. PROVIDE AND INCREASE EMERGENCY AND BASIC INCOME

Insufficient income is a long-standing challenge for the most disenfranchised in our state, and is a deeply rooted cause of multiple inequities, including inequities in health. During the pandemic, loss of income particularly impacted immigrants with no access to public benefits.

4.2.1. Provide Robust Funding for Emergency Cash Assistance in the Commonwealth's Fiscal Year 2022 Budget

The Emergency Cash Assistance Program provides state funding to community foundations to fund

families in need. The foundations are required to match state dollars. In other words, a $10 Million state allocation provides $20 Million in family support that particularly benefits undocumented persons not eligible for other supports.

4.2.2. Make Progress Toward Eliminating Deep Poverty

"Deep Poverty" is defined as half the federal poverty level ($900). In Massachusetts, those on public assistance receive significantly less than that ($593 pre-pandemic) and, until the pandemic, had not received an increase since 1988 and 1990, depending on the benefit. While there was a 10% pandemic increase, the Governor's FY'22 budget proposal is to roll that back for the new year. The Task Force opposes the roll back and supports 20% annual increases until the benefit reaches at least 50% of federal poverty.

4.2.3. Extend the State Earned Income Tax Credit to all Massachusetts Taxpayers

Workers who pay taxes using Individual Tax Identification Numbers are not eligible to receive a federal or state earned income tax credit (EITC). Legislation is needed so that all families who pay state taxes are eligible for the state EITC.

4.3. INCREASE HOUSING STABILITY BY PREVENTING EVICTIONS AND FORECLOSURES AND SUPPORTING EMERGENCY SHELTER

4.3.1. Assist Landlords, Homeowners and Tenants to Prevent Evictions and Foreclosures

The good news is that $360 Million new dollars are coming to Massachusetts from the federal government for emergency rental assistance, on top of a previous influx of $450 Million. These funds provide a tremendous opportunity to stabilize housing and address issues of equity.

There are major challenges of timing and organization to ensure that rental assistance funds are distributed as quickly as possible so that tenants are not evicted and to prevent foreclosures. The federal moratorium expires March 31 and the state's Eviction Diversion Initiative is funded through the end of this fiscal year. Access to the funds need to be simplified and flexible practices, like eliminating the current $10,000 cap implemented.

Legislation should be considered to prevent evictions until all parties have worked in good faith to explore and exhaust every alternative, including federal funds for tenants and landlords alike. Legislation should also be considered to prevent residential foreclosures by allowing payments due during the state of emergency to be deferred to the end of their loan terms.

4.3.2. Provide Legal Counsel in Eviction and Foreclosure Proceedings

Only 8% of tenants have legal representation at eviction proceedings, placing them at tremendous disadvantage. A pro-bono legal representation program for tenants and homeowners should be established by legislation and funded.

4.3.3. Seal Eviction Records

Once a tenant has an eviction proceeding on their record, it is extremely difficult to obtain housing, even if they were not found to be at fault. Eviction records should be sealed during proceedings,

three years after a finding and if the tenant was found without fault.

4.3.4. Increase Funding for the Emergency Shelter System

In some cases, additional funding was provided to shelters during the emergency. Not only should that funding be maintained, it should be increased in anticipation of growing demand. Additional resources should be made available to enroll families eligible for Emergency Assistance in the HomeBASE rehousing program (budget line-item 7004-0108) and to provide extensions to families that are timing out of HomeBASE before securing long-term affordable housing. Processes for entering the family shelter system need to be streamlined.

4.4. CREATE ACCESS AND INCLUSION FOR IMMIGRANTS

Our state is home to one of the diverse immigrant populations, with almost 600,000 residents with Limited English Proficiency, of which 40% speak Spanish.

4.4.1. Promote Language Access in State Agencies

Legislation is needed to require state agencies that engage with the public to provide oral and written language access. Currently, it is challenging for non-English speakers to apply for unemployment or other benefits. Agencies would be required to do periodic assessments of the languages spoken by their clients.

4.4.2. Protect the Civil Rights and Safety of all Massachusetts Residents

The Task Force supports protecting the civil rights and safety of all Massachusetts residents. The climate of fear experienced by many undocumented immigrants has important health and public health implications, especially in the COVID-19 response, testing, treatment, and vaccinations. Legislation under consideration to increase immigrants' sense of safety would prevent law enforcement from questioning persons about their immigration status, unless required by state or federal law, and require law enforcement to obtain written informed consent in multiple languages for any such questioning. [In process]

4.4.3. Promote Access to Driver's Licenses and Identification for All Massachusetts Residents

Policies should be advanced to allow all qualified state residents to obtain valid driver's licenses so that immigrant families can travel safely to their essential jobs, health care appointments, and schools especially in light of pandemic precautions. A driver's license provides official identification, allows people to drive for employment or health care, and reduces fear experienced by immigrants. [In process]

4.5. BUILD "COMMUNITIES OF OPPORTUNITY": PRIORITIZE INVESTMENT IN HISTORIC ENVIRONMENTAL JUSTICE COMMUNITIES HIGHLY IMPACTED BY COVID-19 AS AN EQUITY CATALYST

Studies and mapping show the connection between high rates of COVID-19 and environmental burdens carried by those same communities, known as environmental justice communities. The

Task Force recommends that the Massachusetts Department of Public Health and/or the recommended new Executive Office of Equity explore adoption of “Communities of Opportunity" or "Health Empowerment Communities or Zones'' as an approach for state investments to build the capacity of and empower communities. A first step toward environmental justice is support for legislation that would advance local garden agriculture programs that promote health, nutrition, jobs and a healthy environment.

5. STRENGTHEN THE LOCAL AND STATE PUBLIC HEALTH SYSTEM

The fact that public health is the responsibility of 351 different cities and towns in Massachusetts with varying resources and without clear guidance translates into a fragmented and inequitable response around the Commonwealth. Around the country these responsibilities typically reside within county government.

5.1. STRENGTHEN AND FUND THE LOCAL PUBLIC HEALTH SYSTEM

Massachusetts needs to support and strengthen local public health by providing funding, establishing professional standards and incentives for sharing functions regionally and by enacting legislation to implement the recommendations of the Special Commission on Local and Regional Public Health.

5.2. SUPPORT AND ELEVATE THE MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

The Task Force supports elevating the Massachusetts Department of Public Health (MDPH) to play a more integral role through the duration of this pandemic and into any future public health initiatives. To do so will require investments in MDPH to build a stronger foundation and infrastructure to enable more robust response.

6. INTEGRATE EQUITY AND RESILIENCE INTO EMERGENCY AND DISASTER PREPAREDNESS

6.1. ENACT LEGISLATION TO CREATE A COVID-19 AFTER ACTION REPORT WITH AN EQUITY LENS

The Legislature should enact legislation in the Spring of 2021 that requires an After Action Review (AAR) with an equity lens, an innovation on a standard practice in the field of emergency management and an opportunity for Massachusetts to lead the nation.

6.2. REQUIRE THE APPOINTMENT OF A COVID-19 AFTER ACTION EQUITY COMMISSION

The legislation should require the appointment of an COVID-19 After Action Equity Commission. The Commission should use standard AAR methods and integrate an equity framework into all aspects of the review.

6.3. APPOINT A DIVERSE AND REPRESENTATIVE COVID-19 AFTER ACTION EQUITY COMMISSION

The Commission should comprise representatives of: Appointees by the Governor, including but not limited to representatives of emergency management; legislative leadership; leaders from cities and

towns disproportionately impacted by COVID-19; the healthcare sector; essential businesses and workers, social services (housing/food) organizations, and diverse people with lived experience.

6.4. RETAIN THIRD-PARTY EXPERTS TO FACILITATE AND PRODUCE COVID-19 AFTER ACTION REVIEW

The AAR, under the guidance of the Commission, should be facilitated and produced by a third party/ies with expertise in emergency management, equity and participatory community processes.

6.5. INITIATE COVID-19 AFTER ACTION REVIEW IN THE SPRING 2021 TO BE UNDERTAKEN ON A ROLLING BASIS, STARTING WITH THE REVIEW OF THE VACCINE PLAN

The AAR should be initiated in Spring 2021 and completed on a rolling basis, beginning as soon as possible with review of the Vaccine Plan. The final comprehensive AAR should be completed within 12 months of the end of the public health emergency. Findings should be filed with leaders of the Administrative and Legislative branches, and a response required from the Administration within one month of a rolling review, and three months of the final report.

7. PRIORITIZE EQUITY IN STATE GOVERNMENT

While the charge of this Task Force is around Health Equity, we recognize that health is the net result of myriad social, economic and other factors, as well as racism. These factors, or "determinants of health," account for up to 80% of health status. Therefore, a focus on equity within economic development, housing, social services, education and many other responsibilities of government *are a prerequisite to achieving health equity.* This understanding informs the recommendations that follow.

7.1. ENACT LEGISLATION TO CREATE AND RESOURCE A CABINET-LEVEL EXECUTIVE OFFICE OF EQUITY

The Health Equity Task Force recommends that legislation be enacted to create and resource a cabinet-level Executive Office of Equity led by a Secretary of Equity. The Secretary of Equity would be charged with leading efforts toward equity, diversity and inclusion across all aspects of the executive branch of state government, including creating 3- to 5-year strategic plans, data dashboards and implementing an equity in all policies approach, working with an Equity Advisory Board. There will be a special -although not exclusive- obligation to address racial and ethnic equity, given this pandemic and our current racial reckoning.

7.2. ENACT LEGISLATIVE PROVISIONS TO CREATE AND RESOURCE OFFICES OF EQUITY WITHIN EVERY SECRETARIAT

The recommended legislation would also create and resource Offices of Equity within every Secretariat, charged with leading efforts toward equity, diversity and inclusion throughout that Secretariat, and coordinating with their peers across state government. Each Secretariat level office would develop strategic plans, create data dashboards and have an Equity Advisory Board.

7.3. CREATE PUBLICLY AVAILABLE DATA DASHBOARDS TO TRACK PROGRESS TOWARD EQUITY

The Office of Equity would create a set of high level and publicly available data dashboards to track overall progress toward equity. The Task Force recommends using the opportunity-based framework developed by the HOPE Initiative.

7.4. ADOPT STANDARD DATA COLLECTION PRACTICES CRITICAL TO MEASURING PROGRESS

The Task Force recommends that Massachusetts adopt standard and consistent demographic data collection practices at point of care, service and testing, and that to accomplish this it convenes key stakeholders.

7.5. REQUIRE AN EQUITY IN ALL POLICIES/EQUITY IMPACT ANALYSIS ON NEW POLICIES AND PROGRAMS

The Task Force recommends the legislation include a requirement for an Equity in All Policies/Equity Impact Analysis on new policies and programs. The Office of Equity will be responsible for developing regulations, tools and overseeing implementation.

7.6. EQUITY ADVISORY BOARD

The Executive Board would be guided by an external Equity Advisory Board, with diverse experts in the fields of equity and health equity, community Based organizations that address the social and economic factors that impact equity, and people from communities around the Commonwealth with lived experience.

8. CONCLUSION

8.1. CALL FOR AN EQUITY IMPACT ANALYSIS OF HOW FEDERAL FUNDS HAVE BEEN INVESTED IN MASSACHUSETTS AND A PLAN FOR FUTURE INVESTMENT

The federal government has already provided $71 Billion to Massachusetts for pandemic response, and another up to $12 Billion is slated to arrive with the passage of the American Rescue Plan Act. The Task Force calls for a comprehensive analysis of how these funds have been utilized to date, and a plan to use them to achieve equity going forward.

Many thanks to all who participated in the creation of this plan and to the Massachusetts State Legislature for providing this opportunity. This is an ambitious plan to guide the way toward achieving equity in our Commonwealth. **Now is the time.**

IMMEDIATE ACTION

2. ONGOING RESPONSE TO THE COVID-19 CRISIS

2.1. EQUITY SHOULD BE OUR "NORTH STAR" AND A KEY DRIVER OF AN ONGOING AND INTEGRATED RESPONSE TO THE COVID-19 PANDEMIC

COVID-19 has hit poor communities and communities of color disproportionately. If communities had less opportunity, fewer resources and suffered discrimination and racism pre-pandemic, they have been disproportionately devastated by the health and economic impacts of this public health crisis. Resources need to be directed to these communities accordingly, and these resources need to be designed, delivered and messaged in partnership with the communities most affected.

We recommend that the approach to a vaccination strategy be guided by the needs and interests of the communities. We must partner with communities in the design of all programs and services, and deliver to the community not only what we want them to have (vaccines) but also what they identify they need, including connection to food, shelter, medical care for underlying health conditions, and other essential services. It is only by demonstrating this level of respect and caring that trust in the system can be built, and we achieve the most effective and equitable outcome.

The Task Force would like to recognize the work of the Vaccine Equity Now! Coalition, led by several Task Force members, which calls for many of the same measures that follow in this report. While many decisions about the vaccine plan have already been made or are evolving, the key point, which will always be relevant, is that equity should be the first and guiding priority.

2.1.1. Equity should be the top criteria in every aspect of vaccine planning and delivery. To achieve equity, resources must be disproportionately directed to communities with the highest rates of infection. Local, trusted community-based organizations should be engaged in all aspects of vaccine siting, communications and delivery communications and delivery.

Vaccines need to be delivered to the communities that have been hit hardest. While it made sense to begin by prioritizing persons over age 75, average life expectancy in communities of color is lower, therefore the plan excluded a significant population from gaining immediate access to this life-saving vaccine and delayed deep penetration in communities most impacted. However, there is still time to apply principles of equity in current and future phases of vaccine delivery.

And while improving, communities of color are not currently being vaccinated at rates corresponding to their disproportionate COVID-19 case rates. As of March 11, according to the DPH weekly dashboard, of those who had received at least first doses, 71% were White, while 5% were Black, 5% Hispanic, and 4% Asian. While these rates are similar to percent of population over age 65 in each age group, they are not commensurate with the high infection rates within communities of color.

Mass vaccination sites like Gillette Stadium in Foxboro and Eastfield Mall in Springfield are important to have, but they are not accessible to those without transportation and they are not located in communities of color. Progress has been made, but much work remains to catch up so that vaccination sites adequately target those communities with the highest incidence of COVID-19. The Reggie Lewis site in Roxbury was an important addition to meet the needs of some Black and Brown neighborhoods of Boston, and the model of reserving spots on the schedule for the local community, and partnering with the Boston Black COVID-19 Coalition to conduct outreach is exemplary. That model needs to be spread statewide.

It is commendable that the state has begun targeting efforts to the 20 hardest hit communities for outreach and education, and equity efforts. However, the state had also announced plans to send 20 percent more vaccines to those communities but has yet to announce a plan to implement this allocation. It is critical that the Department of Public Health issue guidance on the distribution of the extra 20 percent and spread the dosage among the various providers (mass, health centers, hospitals, pharmacies, and community sites). In some cases, DPH may also need to provide technical assistance. Alternative methods for vaccine delivery, as described below, need to be implemented.

2.1.2. Reduce technological barriers to vaccine appointments and increase access by providing transportation.

Low resource communities face multiple barriers to technology. Broadband is not available in every neighborhood and when it is, it is often inadequate and/or not affordable (see section IV(A) *Promote Digital Equity and Inclusion*). Households may not be able to afford devices, and may lack computer literacy, particularly among older adults. The vaccine rollout has depended heavily on computer access and savvy. While a phone line has been added, there needs to be neighborhood-based assistance to schedule vaccine appointments by working with local, community-based organizations and ambassadors/community health workers. There should be a screening process to assess for transportation barriers, and funding provided for safe transportation to vaccine sites.

2.1.3. Bring vaccines to vulnerable populations, rather than expecting them to come to vaccination sites. Methods for vaccine delivery could include: mobile vans; onsite vaccination at congregate sites; in-home vaccination; and community-based vaccination clinics.

The Task Force heard much testimony on the need to bring vaccines to communities, rather than expecting people from vulnerable communities to come to the vaccine site. Community-based clinics, on-site clinics at places like public housing, faith-based organizations, community-based organizations and small businesses, as well as in-home vaccination and mobile vans must be considered as methods to reduce barriers to vaccine access. In particular, on-site and mobile clinics could reach individuals residing in congregate housing, residential treatment and group home facilities, such as those operating under contracts with the Massachusetts Department of Developmental Services, the Department of Mental Health, the Department of Children and Families, the Executive Office of Elder Affairs, the Department of Housing and Community Development, the Department of Youth Services, and the Department of Public Health.

2.1.4. Enhance the Massachusetts Department of Public Health's (MDPH) public education campaign to increase vaccine acceptance among populations who are hesitant. This campaign should be culturally appropriate, in multiple languages, delivered by local, trusted

community messengers, and tailored to address specific vulnerable populations.

The Massachusetts Department of Public Health is to be commended for launching a robust public education campaign to increase vaccine uptake in communities of color. In addition to a statewide campaign, the campaign should include resourcing and empowering local, trusted community messengers to deliver culturally appropriate and tailored messages in multiple languages targeted to high-risk populations, including people of color (especially targeting the Black and LatinX communities), older adults, those with underlying conditions and persons with disabilities. Campaign messages should also be culturally sensitive to encompass faith-based groups and small businesses.

Despite the urgency of this moment, the educational campaign will need to be prolonged. Many in the community are displaying "vaccine deliberation," as they wait and see the impact of vaccination on their peers. It may take them some time to decide that vaccination is the right choice for them. There should be ongoing education about how and where to get vaccinated.

Evidence shows that government agencies are particularly distrusted within communities of color. Personal doctors, as well as local, trusted community leaders could make a difference in building trust and reducing vaccine hesitancy. Current campaigns could further leverage this potential power and influence.

2.1.5. MDPH should contract with local community-based and faith-based organizations to employ ambassadors/community health workers who can assist at clinics, link people to needed services, and participate in public messaging, outreach and education.

The Boston Public Health Commission has created an “ambassador” program through a partnership with the Massachusetts Immigrant and Refugee Advocacy Coalition (MIRA). These ambassadors, similar to community health workers (CHWs), work in testing and vaccine sites, perform outreach and education, and connect people to needed resources. Ambassadors are hired from the community, thus creating needed jobs and providing service in multiple languages. Their presence builds trust and serves as a bridge between the community and public health and the health care sectors. Similarly, the state has partnered with the Massachusetts League of Community Health Centers to train and deploy community health workers into their respective communities.

The Task Force recommends the creation of a statewide ambassador/community health worker program through partnerships with local, trusted community-based organizations. Ambassadors and community health workers should reach out to people in community locations that are a part of their daily lives, including community-based organizations, churches, and small businesses. Staff need to be prioritized for vaccines, funded to have the equipment they need (iPads to schedule vaccine appointments, for example), and be paid a family-sustaining wage. It is also essential that future contracting for ambassadors, community health workers and communications campaigns be accessible to local, minority led non-profit organizations with familiarity and relationships in the community.

2.1.6. In addition to city and town, MDPH should include zip code and census tract along with demographics, race and ethnicity in the vaccination data they publish weekly.

DPH publishes weekly vaccination data, stratified by race and ethnicity. It would be extremely important to add city, town, zip code and census tract to this report. There is currently no way to determine where vaccines are being delivered, and if the residents of color in communities with high rates of infection are among the vaccinated. Even within high-risk communities, infection rates often cluster within certain neighborhoods and streets. Communities need to be able to map this data to determine where outbreaks are occurring and design tailored interventions.

Later in this report, the Task Force calls for more comprehensive health equity data throughout state government that is stratified by race, ethnicity, geography and more. The Task Force would like to call out the need for data on race, ethnicity, language and geography for patients hospitalized with COVID-19.

2.2. CONTINUE AND ENHANCE THE *STOP THE SPREAD CAMPAIGN* THROUGH AT LEAST CALENDAR YEAR 2021, INCLUDING TESTING, CONTACT TRACING AND ISOLATION HOUSING, AND ADDING AMBASSADORS/COMMUNITY HEALTH WORKERS AND HEALTH SCREENINGS FOR THOSE WITH CHRONIC, UNDERLYING CONDITIONS.

The state should continue and enhance the Stop the Spread campaign through calendar year 2021, if not longer. Stop the Spread provides COVID-19 testing to anyone free of charge and most sites are located in communities with high rates of infection. Ambassadors or community health workers, through partnerships with local community-based organizations, should be added to these sites to screen for social and economic needs and connect people to needed resources. This is also a place where people could be screened for chronic conditions, which disproportionately affect those vulnerable to COVID-19, and connected to ongoing health care and community-based organizations. Many people may have foregone health care for these conditions during COVID-19. It is by offering these supports and resources that trust will be built and more people will become engaged in the process.

As part of the continued and enhanced Stop the Spread program, continue to provide isolation housing for those needing quarantine, and consider adding low-cost non-congregate housing for those from the most impacted communities, the elderly, those with medical and mental health conditions, and homeless persons.

TESTIMONY RECEIVED IN SUPPORT OF RELEVANT MASSACHUSETTS LEGISLATION

SD699 / HD1283
An Act effectuating equity in COVID-19 vaccination
Sponsored by Sens. Sonia Chang Diaz and Rebecca Rausch & Reps. Liz Miranda and Mindy Domb

2.3. ADDRESS THE NEEDS OF VULNERABLE POPULATIONS, INCLUDING ESSENTIAL WORKERS, OLDER ADULTS, PERSONS WITH CHRONIC, UNDERLYING MEDICAL, BEHAVIORAL HEALTH AND CHRONIC HEALTH CONDITIONS, PERSONS WITH DISABILITIES, AND INCARCERATED PERSONS.

2.3.1. Essential Workers

Essential workers were on the front lines of this pandemic. They and others need an emergency sick leave benefit during a declared state of emergency or disaster. Essential workers often feel

obligated to attend work even when sick for fear of losing a job and because they cannot afford to lose a paycheck, thus fueling the spread of infection. If a worker can work from home, there is less risk to the public. However, many workers of color, who disproportionately have low-wage jobs, are essential workers and do not have that option. They may be compelled to work to keep their jobs and feed their families.

Massachusetts' Earned Sick Time law, passed by the voters in 2014, provides 40 hours of paid sick time yearly, but that sick time must be accumulated over time, and for thousands of workers this isn't enough to meet the scale and impact of this public health crisis. The federal Families First Coronavirus Response Act (FFCRA) provided 10 days of additional paid sick time for many workers last year, but it expired at the end of December 2020.

The Task Force is encouraged that the state Legislature is taking legislative action to establish a COVID-19 Emergency Paid Sick Leave Fund to reimburse eligible employers for providing employees with COVID-19 emergency paid sick leave through September 30, 2021 or until the $75 Million fund has been expended, whichever comes first. The legislation provides up to 40 hours of emergency paid sick leave for full-time employees (pro-rated for part-time employees) and also covers time off for isolation after exposure, to seek medical care or immunization and other related reasons.

Building on this promising development, the Task Force recommends ongoing monitoring of needs for future pandemic emergency paid sick leave beyond September 2021. The Task Force also recommends support to essential workers, as well as small businesses to assist them with income and other supports.

The Task Force also recommends exploring extended unemployment benefits for essential workers, short term disability for those with lingering effects of COVID-19, and re-employment assistance for those who lost jobs due to business closures, furloughs or layoffs.

TESTIMONY RECEIVED IN SUPPORT OF RELEVANT MASSACHUSETTS LEGISLATION

HD531 / SD386
An Act Relative to Emergency Paid Sick Leave
Sponsored by Reps. Paul Donato and Sean Garballey and Sen. Jason Lewis

PROMISING PRACTICES FROM OTHER STATES

According to the National Conference of State Legislatures, New York passed a law last year in which, "large employers must provide 14 days of paid sick leave for any quarantine or isolation order. Midsize employers and small employers with more than $1 Million must provide 5 days of sick leave. Small employers must provide job-protected, unpaid leave for the duration of any quarantine or isolation order. Any worker who does not receive 14 days of paid sick leave can apply for "quarantine leave" benefits and the state will provide eligible employees with full wage replacement benefits for up to 14 days using a combination of state Temporary Disability Insurance and Paid Family and Medical leave insurance benefits."[8]

[8] https://www.nysenate.gov/legislation/bills/2019/s8091

2.3.2. Older Adults

Older adults, particularly those living in long term care and skilled nursing facilities, suffered the highest fatality rates from COVID-19 of one in every five people living in senior care or over 8800 residents.[9] The residents of these facilities are more likely to be frail and physically vulnerable, and the workforce who cares for them is typically underpaid and comes from communities with high infection rates and high rates of social vulnerability. Older adults in the community often rely on homecare workers with similar backgrounds to stay in their homes. Both situations create a perfect storm for infection to spread and both groups deserve care and attention. Based on testimony received at public hearings, the Health Equity Task Force recommends:

- Transportation to vaccination sites for seniors, and assistance with scheduling
- Vaccination clinics at all senior public housing, and on-site vaccination for homebound and disabled seniors and adults, not requiring on-line scheduling.
- Nursing home and homecare workers have adequate PPE, and access to free testing.
- Investments and delivery system reforms in nursing homes and long-term care facilities
- Policy action through the Legislature and state Administration to support older adults living in their homes and community settings, such as encouraging and facilitating enrollment in PACE (Program of All-Inclusive Care for the Elderly) programs and other care models that support non-congregate living.

[9]https://www.bostonglobe.com/2021/03/20/metro/you-are-my-sunshine-nursing-homes-covid-19-vaccinations-bring-hope-amid-an-uncertain-future/

2.3.3. Persons with Disabilities

Persons with disabilities are at high risk for COVID-19, as was communicated in public testimony by persons with disabilities in the Health Equity Task Force hearings. The state's emergency/disaster planning does not take into account their unique needs and challenges. One woman described her ordeal, which resulted in her developing completely preventable major infections while attempting to obtain adequate supplies for the ventilator she depended on to survive,

The Health Equity Task Force recommends:

- Prioritizing eligibility for vaccines for persons with disabilities that put them at risk during the COVID-19 pandemic, and providing the necessary support to schedule vaccinations. Deliver vaccines in the community and at-home when necessary.
- Including the unique needs of persons with disabilities that put them at risk during the COVID-19 pandemic in current and future pandemic planning.
- Promoting safety and mask wearing in buildings where a significant number of persons with disabilities and other at-risk populations live, particularly those in 40b housing.

2.3.4. Persons with Chronic or Underlying Medical Conditions

Persons with chronic and underlying medical conditions, many of which disproportionately affects persons of color, are at higher risk for COVID-19. They may also have been unable to address their underlying conditions during the pandemic. Special efforts should be made to reach out to these individuals with culturally appropriate education about the importance of vaccination to protect their health. These efforts would best be conducted by trusted, community-based organizations, faith-based organizations and other local entities that are known and trusted. In B, Stop the Spread, the Task Force also recommended that these sites include screening and education around chronic conditions, as well as connection to ongoing health care.

2.3.5. Incarcerated Persons

The Task Force recommends that the Department of Corrections should immediately take steps to release from prison those persons who can be safely released and allow an ombudsperson appointed by the Attorney General to monitor the release program, consistent with the provisions in the FY'21 state budget law. The Commonwealth should apply for FEMA public assistance funding for non-congregate shelters for unhoused individuals returning from prison. The Commonwealth should partner with justice-centered, social services agencies as partners in transition planning.[10]

Infection rates in Massachusetts jails and Department of Correction facilities are very high. The Task Force received testimony that over a third of those incarcerated have been infected with COVID-19. In a study published last June, the rate of infection in Massachusetts prisons and jails was three times that of the general population. While the Administration is to be commended for prioritizing certain vulnerable populations in congregate settings for vaccination, such as those in homeless shelters and prisons, there is no substitute for depopulating congregate settings.

[10] https://www.fema.gov/news-release/20200722/coronavirus-covid-19-pandemic-non-congregate-sheltering

Presently, there are low rates of vaccine uptake among incarcerated people and staff, creating risk for people incarcerated and the community. In fact, fewer than 50% of correctional staff have been immunized. It is not enough to make the vaccine available to high-risk groups. Intentional and directed educational campaigns must be developed to build trust and reduce vaccine hesitancy using strategies of trusted voices, town hall meetings and distribution of information to every person either employed by or in the custody of the Department of Corrections. Finally, testing, with rapid results, must be available.

The state must monitor the progress in these correctional facilities and ensure greater accountability and transparency. In the last budget cycle (FY'21 budget line-item 8900-0001) language was included that required the following, "given the continued prevalence and threat of COVID-19 within Department of Correction facilities, the commissioner of correction shall release, transition to home confinement or furlough individuals in the care and custody of the department who can be safely released, transitioned to home confinement or furloughed with prioritization given to populations most vulnerable to serious medical outcomes associated with COVID-19 according to the Centers for Disease Control and Prevention's guidelines."

The language also calls for the appointment, for the duration of the pandemic, of an ombudsperson by the Attorney General's Office to provide accountability and information to support the health and safety of the incarcerated population, including progress of releases. The Task Force recommends that when an ombudsperson is appointed, they monitor appropriate and safe release placement.

To date, however, very few have been released and the Attorney General's appointee to the ombudsperson role has not begun their work with the Department of Corrections.

The Task Force is concerned that the ombudsperson role will remain vacant beyond the end of the fiscal year, which would lapse the mandate for this necessary accountability measure. We urge the Legislature to extend the term of the ombudsperson role during the FY'22 budget. Further delay of implementation of the state budget law language will lead to unnecessary exposures and deaths. Therefore, the Task Force calls for the swift and full implementation of the FY'21 budget language, and the consideration of legislation to make the oversight role of the Attorney General permanent. [In process]

PROMISING PRACTICES FROM OTHER STATES

*[In process]

TESTIMONY RECEIVED IN SUPPORT OF RELEVANT MASSACHUSETTS LEGISLATION

HD3265
An Act Relative to Decarceration and COVID-19
Sponsored by Rep. Lindsay Sabadosa

2.4. FUND RESEARCH ON THE INTERMEDIATE AND LONG-TERM EFFECTS OF COVID-19

The Task Force recommends that the Legislature and Administration collaborate to establish and fund plans within the FY'22 state budget for research and monitoring of the intermediate and long-term effects of COVID-19. This should include research conducted on the health effects, including long-haul health, behavioral health effects, the socio-economic implications of the pandemic, and ongoing response and recovery needs. This research and monitoring should be analyzed using disaggregated population characteristics referenced in section 7.3.

Federal funding for these research initiatives, through the National Institutes of Health (NIH) or other opportunities should be explored. NIH recently announced a major initiative to identify the causes of "long-haul" COVID-19, and the means of prevention and treatment. "Long-haul" is defined as those who have not recovered fully over a period of a few weeks. Symptoms can persist for months and range from fatigue, shortness of breath, "brain fog", sleep disorders, fevers, gastrointestinal symptoms, anxiety, and depression.[11] Toward this end, NIH recently issued an initial series of research opportunities announcements for the Post-Acute Sequelae of SARS-COV-2 Infection (PASC) Initiative.[12]

[11] https://www.nih.gov/about-nih/who-we-are/nih-director/statements/nih-launches-new-initiative-study-long-covid
[12] https://covid19.nih.gov/funding/open-funding-opportunities

IMMEDIATE AND INTERMEDIATE ACTION

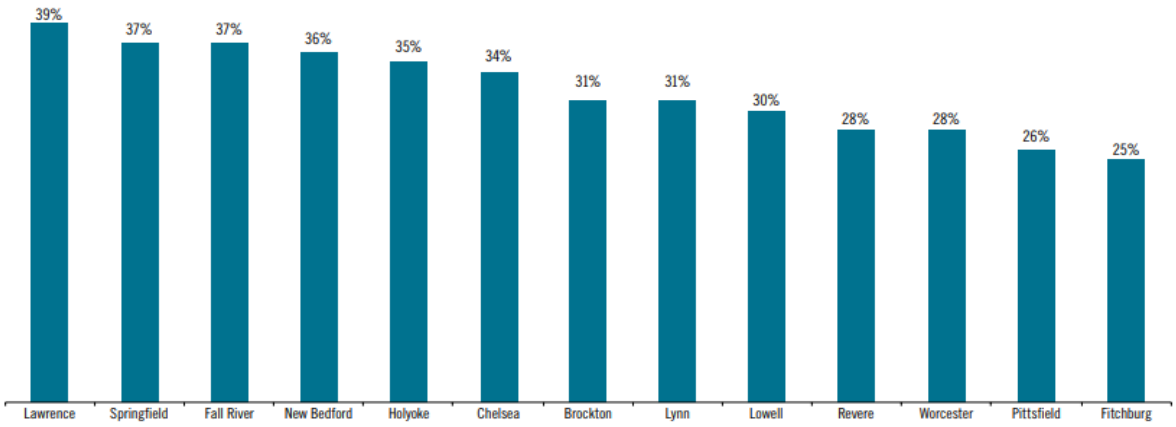
3. STRENGTHENING ACCESS TO QUALITY, AFFORDABLE HEALTH CARE AND OTHER SERVICES

3.1. DIGITAL EQUITY AND INCLUSION

While the digital divide has been long-standing, it became a chasm during COVID-19. Geographic gaps in broadband availability, insufficient broadband capacity of available products, affordability, access to devices and digital literacy are all significant barriers to digital access with disproportionate impact in low-income communities and communities of color. During the spring COVID-19 surge, many people across the Commonwealth accessed health care through telehealth, but this was not an option for many low-income people and people of color. Digital barriers also had a significant impact on accessing a host of services and benefits necessary to address social determinants of health including unemployment, education, income and food benefits, housing applications and more.

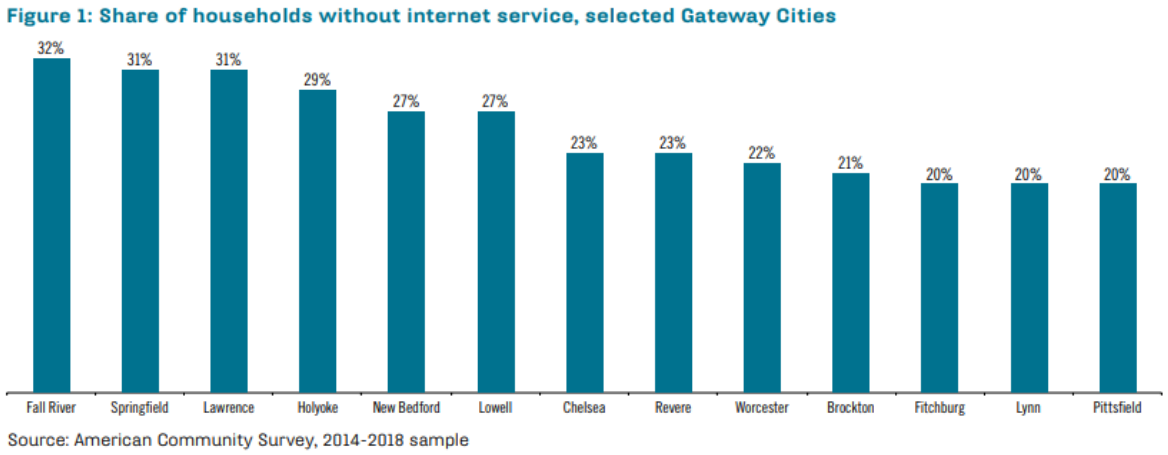
According to *Going For Growth: Promoting Digital Equity in Massachusetts Gateway Cities,* a policy brief by the MassINC Gateway Cities Innovation Institute, about 25 percent of Gateway City households did not have internet service at home pre-pandemic, and another 10 percent depended on unstable connections such as a mobile phone. Contrast this with Federal Communications Commission data from 2018 showing that more than 97.9 percent of Massachusetts residents live in places where broadband runs under the street, indicating that not all households can afford internet services. Census data also shows that 18 percent of households in Massachusetts did not have a laptop or desktop computer in 2018. In Gateway Cities, the share was much larger, with 28 percent of households lacking such devices.[13]

Figure 3: Share of households without computers, selected Gateway Cities



Source: American Community Survey, 2014-2018 sample

[13] https://2gaiae1lifzt2tsfgr2vil6c-wpengine.netdna-ssl.com/wp-content/uploads/2020/12/MassINC-Digital-Divide-Policy-Brief.pdf



Charts cited from *Going For Growth: Promoting Digital Equity in Massachusetts Gateway Cities* by the MassINC Gateway Cities Innovation Institute, November 2020

3.1.1. Support Measures to Promote Telehealth and Digital Equity for Patients

During the pandemic, the Governor issued an emergency order requiring insurers to cover telehealth, and waiving many barriers to telehealth, particularly by creating parity in reimbursement rates between virtual and in-person visits. This resulted in a tremendous surge in the use of telehealth for those who could access it. Telehealth holds the promise to reduce barriers to health care for those with limitations of time due to work or other responsibilities, child care and/or transportation.

Massachusetts also made great strides forward at the end of the last legislative session with the passage of Chapter 260 of the Acts of 2020, which vastly improved and made more permanent access to telehealth. Among the provisions of the bill are coverage parity across all payers, a definition of telehealth including but not limited to audio (telephone) - of great benefit to those without devices - permanent reimbursement parity for behavioral health and two years of reimbursement parity for other services at which time the Health Policy Commission will issue a report on the impact of telehealth on access and cost. However, as one presenter at a Health Equity Task Force meeting stated, “the gains in Chapter 260 are only as good as how equitably they are implemented.”

A new bill has been filed by the tMed Coalition to advance this progress further. The bill would expand access to telehealth services to patients by increasing digital adoption and literacy, reducing financial barriers to accessing telehealth, expanding reimbursement parity, and requiring a public-health oriented lens to assessments of telehealth impacts in the state.

The legislation directs the Health Policy Commission (HPC) to establish two programs—a Digital Bridge Pilot Program and a Digital Health Navigator Tech Literacy Pilot Program with aims to increase telehealth access via the provision of digital technology and digital literacy education. The bill would require insurers to cover interpreter services for telehealth patients with limited English proficiency or for those who are deaf or hard of hearing. It would prohibit insurers from collecting co-pays for telehealth services for the duration of the public health emergency (PHE) and for 90 days after. It would prohibit insurers from imposing prior-authorization requirements on medically necessary visits that do not apply to in-office visits.

Building upon Chapter 260 of the Acts of 2020, the bill would extend reimbursement for primary care and chronic disease management (defined to include COVID-19 and its long-term effects and certain pediatric diseases) to be on-par with reimbursement rates for in-office services. The bill would also direct the HPC to incorporate an assessment of the impact of telehealth on social determinants of health when studying the impact of telehealth in Massachusetts.

Testimony Received in Support of Relevant Massachusetts Legislation

HD2533 / SD2099
An Act relative to telehealth and digital equity for patients
Sponsored by Rep. Thomas Golden and Sen. Adam Gomez

3.1.2. The Massachusetts Broadband Institute, the Massachusetts Department of Telecommunications and Cable and the Legislature should work with the broadband providers in Massachusetts to increase minimum download and upload speeds provided at affordable and subsidized prices.

The Massachusetts Broadband Institute along with the cable companies launched several initiatives during the COVID-19 pandemic, including internet access for job seekers, contracts with school departments to offer access and devices to their students, low-cost access to many families, and more. These initiatives are to be commended and there is more work to be done.[14]

Among the issues that need to be resolved is the definition of broadband internet speed. During the pandemic households with multiple users often lost service due to inadequate broadband speeds. This was challenging with children attempting to attend school remotely while parents simultaneously attempting to file for unemployment, for example.

The Federal Communications Commission has a definition for broadband internet speed (25 Mbps download and 3 Mbps upload) that many experts think is inadequate. Iowa states that communities with access to less than that are "unserved," while Missouri defines communities without 25Mbps/3Mbps as underserved. It is progress that Comcast Essentials will almost double these speeds by March 1 (50Mbps/5Mbps). The Massachusetts Broadband Institute, the Massachusetts Department of Telecommunications and Cable and the Legislature should work to require companies to establish acceptable minimum speeds for service that is affordable and/or subsidized.

3.1.3. Support Legislation to Create a Funding Subsidy for Lifeline, a Federal Program that Supports Minimum Phone Service

LifeLine is a federal program that subsidizes phone service for low-income individuals. The Federal Communications Commission pays carriers $9.25 per household per month to provide minimum services. The program is dramatically underutilized in Massachusetts, with only about 100,000 participants, or 18% of those eligible. One reason for this is that Massachusetts is one of only 10

[14] https://broadband.masstech.org/

states in the country that does not provide a matching subsidy.

California boasts the most utilized LifeLine program and provides the greatest subsidy. For Massachusetts to do this would require the statutory authority of the Massachusetts Department of Telecommunications and Cable to be broadened to create this program and to negotiate with the carriers. Following this broadened authority, the Department would need to negotiate with the two current Lifeline carriers in Massachusetts on the appropriate state subsidy to get Lifeline customers unlimited minutes and text messages during the state of emergency, and adequate minutes and capacity beyond.

The Department of Transitional Assistance had previously started negotiations to share their database with the federal Lifeline administrator. By sharing this information, the Commonwealth could more than double Lifeline enrollment at no additional cost to the state. This could expedite the enrollment of more than twice the current number of enrollees.

3.1.4. Support and Funding for Community Interventions to Make Broadband Access and Digital Devices More Affordable, and to Provide Digital Literacy Education.

The Health Equity Task Force heard several presentations about communities taking the initiative to address digital equity locally. Following are two local initiatives from which lessons can be drawn by other Massachusetts communities. Each of these examples would have benefited from state funds to support and/or leverage additional private resources.

PROMISING PRACTICES FROM OTHER STATES

RHODE ISLAND

ONE Neighborhood Builders, a community development corporation in Providence, Rhode Island, raised $250,000 to provide free wireless mesh internet coverage to 3,000 households in Olneyville, the lowest income neighborhood in the City, for the next five years. It required significant public-private partnership. The biggest challenge was to educate the community and overcome their fears of getting trapped into paying for it and/or having personal data stolen. They energetically engaged with the community to do so.[15]

REGIONAL APPROACHES

The Essex County Community Foundation undertook a county-wide study and then convened key stakeholders from across the county to map the problem and develop a menu of potential partnership solutions, ranging from municipal broadband to public wifi, to subsidized accounts, free devices. Each of these initiatives would require public and private funding. The Digital Equity Alliance of Western Massachusetts works on similar issues with a range of community partners. In particular, they worked to address the significant digital equity gap over the past year for students in Springfield Public Schools.[16,17]

3.2. EXPANDING HEALTHCARE COVERAGE FOR IMMIGRANT CHILDREN

3.2.1. Extend MassHealth CommonHealth Coverage for Immigrant Children with Disabilities

[15] https://oneneighborhoodbuilders.org/author/michelle-cheng/
[16] https://www.eccf.org/wp-content/uploads/2020/10/ECCF-Digital-Divide-Report_English.pdf
[17] https://sites.google.com/view/digitalequityalliance/home?authuser=0

The Task Force recommends passing legislation in the Spring of 2021 to provide MassHealth CommonHealth coverage to all children and youth with disabilities and the highest health care needs, as an urgent first step in expanding coverage to all immigrant children regardless of immigration status.

While over 98 percent of the Commonwealth's children have some form of health coverage, **thousands** of predominantly low-income children and young adults with disabilities can only access safety net programs with strict limits on covered benefits. These safety net programs, such as the Children's Medical Security Plan and Health Safety Net, do **not** cover important services that people with disabilities, complex medical and/or behavioral health conditions need, such as intensive behavioral health care and medical supplies like wheelchairs or specialized formulas.

Therefore, legislation is urgently-needed to extend MassHealth CommonHealth to this population by building on an existing approach in Massachusetts to use state funding to cover certain children with disabilities with "Permanent Residence Under Color of Law" (PRUCOL) status.

"CommonHealth" was specifically designed to provide services to individuals with disabilities, with a focus in recent decades to ensure that people can get the care they need in the least restrictive setting – at home and in the community.

The care for this population is concentrated with safety net hospitals and community health centers, who often face financial constraints in carrying out their mission to care for all due to the lack of comprehensive coverage for immigrant populations. Expanding MassHealth coverage is also beneficial from the standpoint of additional community-based providers and their patients. The Health Safety Net Fund, an important safety net program for the uninsured, does not include all services and provider types.

3.2.2. Expand MassHealth Coverage for All Eligible Children Regardless of Immigration Status

The Task Force calls for a progression of legislative action toward MassHealth coverage of all eligible children and youth, regardless of immigration status. This is a major health equity barrier that will make a significant difference in the health and well-being for this underserved population.

Both of these legislative actions would need to be accompanied by outreach and education to immigrant communities on eligibility and enrollment via trusted, community-based messengers including safety net and other healthcare providers. The public charge rule, which has been overturned by the current federal Administration, had a chilling effect on immigrants' willingness to accept benefits, even those they were eligible for out of fear of identification and implications on future immigration applications. As noted below, at least 6 other states have adopted a comprehensive Medicaid coverage approach for **all** children regardless of immigration status.

PROMISING PRACTICES FROM OTHER STATES

Other states including New York, California, Illinois, Washington, Oregon and Washington D.C. have gone further to extend comprehensive Medicaid coverage to all such children who are otherwise eligible, regardless of immigration status. The Health Equity Task Force encourages action to adopt this comprehensive approach as part of the progression of legislation for universal coverage for children of all backgrounds in Massachusetts.

Testimony Received in Support of Relevant Massachusetts Legislation

HD2945 / SD1909
An Act to ensure equitable access to health coverage for children with disabilities
Sponsored by Rep. David M. Rogers and Sen. Sal N. DiDomenico

HD2932 / SD1908
An Act to ensure equitable health coverage for children
Sponsored by Rep. David M. Rogers and Sen. Sal N. Domenico

3.3. ADVANCE EQUITABLE RESOURCES FOR SAFETY NET HOSPITALS AND THE COMMUNITIES THEY SERVE

The authorizing statute for the Task Force recognizes the role of safety net hospitals dedicated to caring for patients who test positive for COVID-19 in gateway cities.

Safety net hospitals and health systems, the predominant acute care and community health care providers in gateway communities, play a vital role in both ongoing health care and the local COVID-19 response. These hospitals, located in cities with the highest rates of COVID-19, experienced disproportionate surges in COVID-19 patients. The unequal surge is further evidence of the relationship between health status and the attendant economic factors and social vulnerability. The recent Attorney General's report *Building Toward Racial Justice and Equity in Health* recognized that "the disproportionate impact of COVID-19 on communities of color amplifies the longstanding need to change how health care resources are allocated, starting with payments to providers who care for underserved populations."[18]

Bold policy action is needed. Over the past decade, Massachusetts policymakers have required annual reporting on the statewide variation in commercial health insurance rates across hospitals and providers. This has provided an important baseline of data. However, public reporting alone has not changed the market-based insurance tactics and pervasive commercial rate inequities that continue to exist for the same quality and level of services, especially to the highest Medicaid safety net hospitals and others.[19] The pandemic's disproportionate impacts in poor and diverse communities have laid bare these inequities and call for structural action and accountability. Resources matter - to improve the health and care for populations with higher need.

In addition to the vital role of Medicaid and public payers, concerted action by commercial health insurers to achieve equitable rates for safety net hospitals and health systems is part of the paradigm that must shift toward greater investment (not below average rates) in diverse and lower-income communities, to reverse resource deficits compounded over the years.

3.3.1. Require Commercial Rate Equity for Safety Net Hospitals as a Means to Reduce Racial and Ethnic Health Disparities

Safety net hospitals that care for a high proportion of patients with Medicaid are paid less than

[18] Office of the Attorney General, *Building Toward Racial Justice and Equity in Health: A Call to Action, 2020* at page 19, available at https://www.mass.gov/doc/building-toward-racial-justice-and-equity-in-health-a-call-to-action/download
[19] https://www.chiamass.gov/relative-price-and-provider-price-variation/

other hospitals by commercial insurers.[20] Disparities in critical resources, particularly when need is higher, threaten access to care in low resource communities.

Inequitable rates, including by commercial insurance plans and in alternative payment models and global payments, contribute to the disparities in resources across communities. Legislative action to ensure equitable commercial insurance rates for high Medicaid safety net hospitals is now more imperative than ever.

The Task Force recommends legislative action in the 2021-2022 session to require commercial health plans, within their existing budgets, to pay high Medicaid safety net hospitals the statewide average relative price. Legislation should require that commercial carriers annually certify and provide evidence to the Massachusetts Division of Insurance that each high Medicaid safety net acute hospital's rates meet a minimum threshold of the carrier's statewide average commercial relative price.

Testimony Received in Support of Relevant Massachusetts Legislation

SD261 / HD1436
An Act to reduce racial and ethnic health disparities through commercial rate equity for safety net hospitals
Sponsored by Sen. Sal N. DiDomenico and Rep. Frank A. Moran and Rep. David M. Rogers

3.3.2. Enhance Funding for High Medicaid Safety Net Hospitals in Medicaid Waiver Renewal

The Task Force commends the Administration and MassHealth for its proactive funding support of safety net hospitals/providers during the pandemic. The Medicaid Waiver is a crucial vehicle for the state and federal government to continue to support safety net hospitals, particularly those with the highest concentration of Medicaid and low-income patient care they provide. During the current term (2018 - 2022), the Medicaid Waiver provides supplemental payments for safety net hospitals to ensure continued access to care for Medicaid and low-income uninsured individuals as well as other dedicated funding to support delivery system reforms and innovations integral to accountable care.

Authorization for this important funding for safety net providers must be renewed for fiscal year 2023 going forward through the Commonwealth's Medicaid Waiver 1115 Renewal. The Massachusetts Executive Office of Health and Human Services (EOHHS) has identified as one of its key goals for the next waiver renewal to, "sustainably support the Commonwealth's safety net – including level, predictable funding for safety net providers, with a continued linkage to accountable care."[21]

The Task Force encourages the continued partnership of EOHHS and safety net health systems and hospitals to enhance safety net hospital supplemental funding, including for new state-federal investments led by safety net health systems to advance care delivery and health equity.

[20] https://www.chiamass.gov/assets/docs/r/pubs/2020/S-RP-Final-Results-CY-2018.pdf
[21] https://www.mass.gov/doc/section-1115-listening-session-1/download

3.3.3. Invest in Sustaining Medicaid Rates for Safety Net Hospitals and Hospital-Licensed Health Centers

Sustaining Medicaid rates and reimbursement is fundamental to the care delivery of safety net health systems, including safety net hospitals, hospital-licensed health centers, and affiliated providers. Patients with public payers, including MassHealth, the Health Safety Net and others often account for 70-80% of the payer mix at these hospitals.

The Task Force recognizes the important step enacted by the Legislature and currently being implemented by EOHHS for a five percent enhancement to inpatient and outpatient Medicaid reimbursement for two years for certain hospitals in Section 63 of Chapter 260 of the Acts of 2020. This is an important foundation upon which to build future reimbursement policies that meet the financial requirements of safety net hospitals that care predominantly for diverse, low-income and vulnerable populations.

As Massachusetts Medicaid policies are designed in the upcoming Medicaid Waiver Renewal and in the annual MassHealth Acute Hospital Request for Applications, reimbursement for safety net hospitals must be protected and enhanced. Several current policies under consideration, such as global budgets for primary care and changes to behavioral health and pharmacy programs, must embed and build upon current reimbursement for hospital-licensed health centers and 340B pharmacies.

3.3.4. Establish Equitable Global Payments/Budgets under Alternative Payment Methods

Important research by the Office of the Attorney General shows that total medical spending is not equitable across communities and providers. The Office of the Attorney General's report documents a troubling relationship between income, health status and adjusted medical spending. Private health insurance spending is consistently lower on average for low-income members, who often reside in diverse communities, and higher on average for members residing in more affluent communities.

These spending inequities cannot be explained by health complexity,[22] but rather are a product of both services utilization and higher relative payment rates to providers serving higher-income communities.[23,24] These historic inequities are incorporated in alternative payment models and global budgets that often set lower overall budgets for the care of diverse and lower-income populations. The significant variation in global budgets established by insurers (both commercial and public payers including MassHealth) means that some doctors and health systems have more resources to care for their patients compared to others with a similar risk-adjusted panel of patients.

This practice needs to be reset so that there are equitable budgets. Additional resources are essential to advance health equity and address the greater social vulnerability of populations served by safety net health systems and providers. These greater needs are not fully captured and reflected

[22] Office of Attorney General, Examination of Health Care Costs Trends and Cost Drivers: 2011 Report for Annual Public Hearing, at page 27 [AGO 2011 report], available at http://www.mass.gov/ago/docs/healthcare/2011-hcctd.pdf
[23] AGO 2011 Report at page 31.
[24] https://www.mass.gov/doc/presentation-office-of-the-attorney-general-day-one/download slide 10

in the traditional risk adjustment models.[25] The Task Force concurs with the Office of the Attorney General's 2020 report finding that, "COVID-19 has increased the urgency of swiftly addressing this problem by reimagining how we value and pay for health care."[26]

3.4. STRENGTHEN COMMUNITY HEALTH CENTERS

3.4.1. Invest in Community Health Center Rate Adequacy to Drive Access

Community health centers (CHCs) serve as the primary care safety net for the Commonwealth, caring for more than one million patients a year or one in seven state residents. Massachusetts Federally-Qualified Health Centers (FQHCs) predominantly serve patients who are low-income (84%), racial or ethnic minorities (67%), and best served in a language other than English (40%). By law and mission, FQHCs are located in Medically Underserved Areas or serve Medically Underserved Populations and are open to all, regardless of ability to pay. The vast majority of health center patients are publicly insured, subsidized, or uninsured.

The taskforce heard testimony about the chronic underpayment and resulting financial distress that left health centers in Massachusetts particularly vulnerable to the sudden revenue collapse brought on by COVID-19 and the suspension of primary care services. Federal and state relief stabilized the health center network and enabled them to remain viable and respond to the pandemic while continuing to care for their patients, but the financial fragility of the health center network was exposed.

The need to increase payment for the services CHCs offer was recognized in both the Governor's health care legislation last legislative session, which called for thirty percent (30%) increases in primary care and behavioral health payment across all payers, including MassHealth , and the Attorney General's health equity report, entitled *Building Toward Racial Justice and Equity in Health: A Call to Action*, which called for fair and adequate payment for safety net providers, and specifically for community health centers in Medicaid.

Fair payment for health centers in Medicaid is not only good policy, but also an expectation under federal law. Increasing health centers' MassHealth payment will help to stabilize this critical network, but also catalyze growth in those services that improve health in the communities where the greatest inequities exist.

In addition, because health centers employ members of the diverse communities they serve, increased reimbursement will result in better pay and stimulate growth in these areas. Importantly to the task force, improved rates should also produce increased access to medical, behavioral, and oral health services. That means more community members served, shorter wait times for appointments, better retention of providers, improved outcomes, and reduced inequity for communities of color. The Task Force recommends significantly increasing Medicaid payment for Federally-Qualified Health Centers' comprehensive, all-inclusive model of care. Policymakers should also understand and make progress on commercial rate adequacy for community health centers.

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[25] Office of Attorney General, Commonwealth of Massachusetts, Examination of Health Care Cost Trends and Cost Drivers 2015 Report at page 29, available at https://www.mass.gov/doc/september-2015-examination-of-health-care-cost-trends-and-cost-drivers/download

[26] Office of the Attorney General, *Building Toward Racial Justice and Equity in Health: A Call to Action, 2020 at page 21,* available at https://www.mass.gov/doc/building-toward-racial-justice-and-equity-in-health-a-call-to-action/download

3.4.2. Support Health Centers in "Growing Their Own" Workforce

Health centers have a long history of developing career ladder and advanced health professional training programs, both through the support of the state government and public-private partnerships. Training by and in health centers: expands access to care; produces providers with more experience serving diverse populations, who are more likely to serve in underserved communities after training; and catalyzes economic empowerment and better paying jobs for local employees of health centers.

The state's current Medicaid 1115 Waiver has included historic investments in primary care and behavioral health workforce development programs. However, as the current Waiver approaches its end and the next waiver proposal is in development, policymakers must explore all options to ensure that there is a robust, racially and ethnically diverse, and well-trained pipeline of health care workers.

To that end, the Task Force recommends supporting health centers in "growing their own" workforce through training and retention efforts. The Commonwealth should take a multipronged approach to continuing and expanding these efforts, including through MassHealth financing mechanisms, pilot programs, 1115 Waiver investments, and enactment of the Community Health Center Transformation Fund as a tool to sustain these programs. Examples include:

- Nurse Practitioner residency training at health centers, including Family Medicine and Psychiatric Nurse Practitioners;
- Reestablishment of Medicaid Graduate Medical Education (GME) with a focus on health center-based residency slots;
- Loan repayment for health center providers with service commitment; and
- Career ladder programs for Community Health Workers, Medical Assistants, Social Workers and other behavioral health clinicians and other positions.

Testimony Received in Support of Relevant Massachusetts Legislation

HD1454 / SD789
An Act Promoting Workforce Development and Provider Retention at Community Health Centers
Sponsored by Rep. Mary S. Keefe and Sen. John F. Keenan

HD1461 / SD463
An Act to Promote Graduate Medical Education
Sponsored by Rep. Frank A. Moran and Sen. Jason M. Lewis

HD913 / SD515
An Act Relative to the Primary Care Workforce Development and Loan Repayment Grant Program at Community Health Centers
Sponsored by Rep. Thomas M. Stanley and Sen. Sonia Chang-Diaz

3.5. ADVANCE BEHAVIORAL HEALTH EQUITY

The COVID-19 pandemic layered additional challenges onto an already fragile behavioral health system that has led to a current crisis situation. The Commonwealth has taken important steps to respond to the behavioral health aspects of the COVID-19 pandemic; however, persistent challenges and historical health inequities have been exacerbated and must be addressed.

Approximately half a million adults in the Commonwealth are living with serious and debilitating psychological distress, according to an analysis of the Medical Expenditure Panel Survey conducted by the Health Equity Research Lab. Of this group, only about 40 percent of Blacks and Latinos, and 30 percent of Asians received any type of mental health treatment. This means that 60,000 - 70,000 racially/ethnically diverse adults in Massachusetts with serious psychological distress are disconnected from any type of mental health treatment.[27]

Racially and ethnically diverse populations living with mental illness are more likely to have persistent and severe mental illness than their white counterparts.[28] As well as diverse people living with mental illness are more likely to be arrested and incarcerated than their white counterparts. Many people of color are receiving behavioral health treatment in correctional facilities, as one testimony referenced as "a second behavioral healthcare system for people of color."[29]

As detailed below, a range of matters - from race and ethnicity to language, age, sexual orientation and gender identity, socioeconomic status, geography, insurance policies and reimbursement, and workforce development - must be acknowledged and addressed in order to advance equity in behavioral healthcare.

3.5.1. Respond to Urgent Behavioral Health-Related COVID-19 Needs and Strengthen the Behavioral Health Delivery System

COVID-19 has starkly exposed the pre-pandemic vulnerability in the behavioral health delivery system and gaps in the continuum of care for persons in need of behavioral health services. At the same time, the need for behavioral health care has increased substantially during the pandemic.[30] This has created an urgent need for additional mental health and substance use disorder inpatient

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[27] Equity Research Lab's analysis of nationally representative Medical Expenditure Panel Survey applied to 2020 U.S. Census figures of the non-institutionalized adult population sizes of racial and ethnic groups in Massachusetts. Updated analysis adapted from Cook, B. L., Zuvekas, S. H., Carson, N., Wayne, G. F., Vesper, A., & McGuire, T. G. (2014). Assessing racial/ethnic disparities in treatment across episodes of mental health care. Health services research, 49(1), 206-229. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3844061/
Alegría, M., Cook, B., Loder, S., Doonan, M. (2014). *The Time is Now: Tackling Racial and Ethnic Disparities in Mental and Behavioral Health Services in Massachusetts*, Issue Brief, Massachusetts Health Policy Forum, December 11, 2014.

[28] Williams, D. R., Gonzalez, H. M., Neighbors, H., Nesse, R., Abelson, J. M., Sweetman, J., & Jackson, J. S. (2007). Prevalence and distribution of major depressive disorder in African Americans, Caribbean Blacks, and Non-Hispanic Whites: Results from the National Survey of American Life. *Archives of general psychiatry*, *64*(3), 305-315.
Breslau, J., Kendler, K. S., Su, M., Gaxiola-Aguilar, S., & Kessler, R. C. (2005). Lifetime risk and persistence of psychiatric disorders across ethnic groups in the United States. *Psychological medicine*, *35*(3), 317.

[29] Thompson, Melissa, Kimberly Barsamian Kahn, Jean McMahon, and Madeline O'Neil. "Mental illness, race, and policing." In *The Politics of Policing: Between Force and Legitimacy*. Emerald Group Publishing Limited, 2016.

[30] The Implications of COVID-19 for Mental Health and Substance Use, Issue Brief published by the Kaiser Family Foundation, February 21, 2021, available at: https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

capacity, outpatient care, and culturally and linguistically appropriate mental health services for patients of all ages, and especially for children and adolescents.

Significant emergency department boarding for patients awaiting psychiatric inpatient care placement is a major area of current state focus. As a result of the pandemic, the length of time behavioral health patients wait in an emergency department for an inpatient placement has increased substantially. Often patients present at an emergency department with psychiatric needs and end up waiting days for a behavioral health level of care placement; a situation referred to as emergency department boarding.

Patients turn to emergency department resources because of the acuity of their psychiatric and/or co-occurring conditions and/or a lack of community-based levels of care. This can be related to deficiencies in other parts of the behavioral health continuum of care (i.e., emergency response systems and/or community resources that could potentially help prevent emergencies). Furthermore, the current trend also reflects increased need for inpatient psychiatry treatment, especially among children and youth, and the loss of nearly 270 inpatient psychiatry beds due to facility closures and reduced bed capacity due to COVID-19 precautions. As of February 2021, there are up to 300 - 400 patients daily boarding in emergency departments across the state awaiting an inpatient psychiatry placement.[31] At the same time, there is an increase in high acuity patients.

In light of the continued and urgent need, the Administration, supported by the Legislature, has launched important incentive funding and enhanced MassHealth per diem rates to encourage expanded and new behavioral health inpatient capacity, including for youth and adults. Hospitals have committed more than 200 inpatient beds across the spectrum of youth, adults, and older adults.[32]The enhanced MassHealth rates for incremental inpatient psychiatry bed capacity are presently time-limited. The enhanced MassHealth rates for new adult inpatient bed capacity are proposed for one-year, and the enhanced MassHealth rates for new child and youth inpatient bed capacity are proposed for up to three years. Long-term funding support beyond this time horizon is needed to sustain these essential services.

In addition to the steps to expand acute inpatient behavioral health capacity, urgent action is needed to enhance the Department of Mental Health (DMH) capacity to provide long-term treatment. The Task Force learned that approximately 100 DMH clients are “stuck” in acute inpatient behavioral health units, some for more than 6 months awaiting admission to DMH Continuing Care Treatment. This long-standing problem appears to be heightened during the pandemic.

Strengthening the community-based treatment system is also important to ensure that treatment across the care continuum is available to those who need it. Community residential capacity is also urgently needed, which can be supported in part through continued and increased funding for the DMH Rental Subsidy Program. This supported housing program helps DMH clients transition to the community via affordable housing, where clinical and social services are provided to support their tenancy, wellness, and recovery.

Many behavioral health providers indicated that direct provider funding is needed to support the increased costs associated with the COVID-19 pandemic, including for workforce needs and staffing shortages, enhanced coordination and technical assistance for Personal Protective Equipment (PPE)

[31] Massachusetts Department of Mental Health and MassHealth updates via trade organization meetings
[32] Massachusetts EOHHS briefing on Behavioral Health Roadmap, February 24, 2021

acquisition, infection control, surveillance testing and vaccination efforts by behavioral health programs. During this time of intense need, supplemental funding for behavioral health staff could help prevent turnover and help fill current job openings for behavioral health workers, sitters and clinical staff.

The behavioral health system must be better equipped and designed to include appropriate inpatient placements (inclusive of new inpatient and community-based acute treatment capacity as well as partial hospitalization programs) and a more robust outpatient system including crisis stabilization services for children:

- Children/adolescents with co-occurring behavioral health/ autism spectrum disorder (ASD)/ intellectual and developmental disabilities (IDD);
- Children/adolescents with co-occurring behavioral health/chronic medical conditions;
- Department of Children and Families-involved youth with serious behavioral health conditions;
- Children exhibiting aggressive/assaultive behaviors; and
- Young children through age 6 in need of outpatient care after discharge from higher levels of inpatient care.

Long-term behavioral health impacts of the COVID-19 pandemic must be monitored to guide proportionate state response.

In February 2021, the Baker Administration announced a *Roadmap for Behavioral Health Reform: Ensuring the Right Treatment When and Where People Need It*.[33] The Task Force welcomes this development and the further details that are forthcoming as part of the crucial and timely policy response to strengthen the behavioral health system across the Administration, the Legislature, stakeholders, and providers.

3.5.2. Address Health Disparities for People with Behavioral Health Concerns through a Multi-Agency/Stakeholder Commission

Behavioral health equity is a longstanding issue that will require concerted policy and societal efforts to address. Statewide, multi-agency, and cross-sector efforts in partnership with stakeholders are needed. Given the enormity of the task ahead, over multiple years, the Task Force recommends a Multi-Agency and Stakeholder Commission to Address Behavioral Health Disparities to map out the work and monitor progress on the pressing areas of recommendations in this report. The Commission shall meet not less than quarterly and issue publicly-available annual reports tracking progress and making legislative, regulatory or budgetary recommendations.

In addition to the topics of behavioral health equity outlined in this report, focus areas for the Commission should include but not be limited to:

- Improving access to, and the quality of, culturally competent behavioral health services including (i) the need for greater racial, ethnic and linguistic diversity within the behavioral

[33]Roadmap for Behavioral Health Reform: Ensuring the right treatment when and where people need it, Massachusetts Executive Office of Health and Human Services; https://www.mass.gov/doc/roadmap-for-behavioral-health-reform-ensuring-the-right-treatment-when-and-where-people-need-it/download

health workforce; (ii) the role of gender, gender identity, race, ethnicity, linguistic barriers, status as a client of the department of children and families, status as an incarcerated or formerly incarcerated individual, including justice-involved youth and emerging adults, status as a veteran, status as an individual with post-traumatic stress disorder, status as an aging adult, sexual orientation and social determinants of health regarding behavioral health needs; and (iii) any other factors that create disparities in access and quality within the existing behavioral health service delivery system, including stigma, transportation and cost; and

- Developing a set of evidence-based prevention and early intervention initiatives, given their impact on the onset and progression of behavioral health conditions including those that arise and/or become evident during the adolescent and young adult years.

The Commission to address health disparities for individuals with behavioral health conditions should include representation from:

- State agencies (such as Massachusetts Department of Mental Health, Department of Public Health and its Bureau of Substance Addiction Services, MassHealth, Department of Children and Families, Executive Office of Elder Affairs, and the Executive Office of Public Safety and Security);
- The Legislature (such as the Chairs of the Joint Committee on Mental Health, Substance Use and Recovery and the Chairs or designees of the Massachusetts Black and Latino Legislative Caucus and the Massachusetts Asian American Legislative Caucus);
- Health and behavioral health system (representing the outpatient and inpatient continuum of care including primary care-behavioral health integration and school-based mental health);
- Persons and families with lived experience;
- Racial/ethnic equity advocacy groups and linguistic equity advocacy groups;
- Behavioral health advocacy and trade organizations;
- Organizations providing services for individuals with housing insecurity;
- Criminal justice/legal system; and
- Organization serving the health care needs of the lesbian, gay, bisexual, transgender, queer and questioning community.

Testimony Received in Support of Relevant Massachusetts Legislation

SD2133
An Act addressing barriers to care for mental health
Sponsored by Sen. Julian Cyr

3.5.3. Develop Robust, Publicly Available Data on Behavioral Health Clinical, Demographic, and Disparities in the Commonwealth

Disparities in access to behavioral health services across the Commonwealth vary based on factors such as race/ethnicity, language, age, socioeconomic status, geography, sexual orientation, gender identity, and insurance. However, there is little data collected to analyze the issues and develop

policy, program and resource responses. While there are recommendations for stratified data collection in section VIII(D), the Task Force emphasizes the need to do so for persons with behavioral health diagnoses.

Robust clinical and access data stratified by demographic factors is foundational to improving behavioral health services, access, and outcomes. The data should include rates of evidence-based screening in primary care and other settings for depression, substance use disorder, and other behavioral health conditions and data on whether patients who screened positively received the follow-up care they needed.

3.5.4. Invest in Resources and Funding for Behavioral Health Services, Including Integration of Behavioral Health and Physical Health

Behavioral health has been chronically underfunded (below the cost of care) by public and private payers. This overall lack of resources makes it difficult to sustain behavioral health services let alone expand them to meet growing and complex needs. New and sustained investments are needed. For instance, the Administration's investments (with legislative support) for new inpatient psychiatry capacity through enhanced MassHealth per diem reimbursement for new inpatient bed days is time-limited. Permanent and enduring funding is needed.

Legislation to require more sustainable behavioral health inpatient and outpatient payment rates is needed in public and private insurance. In addition, Medicaid, a predominant payer for people with behavioral health conditions, must improve its reimbursement methodology to recognize the costs of this care. Every MassHealth managed care product should be transparent about their behavioral health rates and be accountable for their adequacy in covering the costs of care for Medicaid populations. Regular rate reviews must be incorporated for MassHealth reimbursement.

Furthermore, an important way of improving overall health, access, and health disparities is the integration of behavioral health and physical health care services, particularly in primary care. This model can facilitate evidence-based screening for mental health and substance use disorder and connect individuals to care often within the same primary care setting. In addition, there are promising behavioral health home models that integrate primary care into specialty behavioral health settings to make sure that individuals with serious mental health concerns are also receiving health screenings and care.

It is important that care delivery and payment models adequately reimburse for these services, including many integrated functions that are not presently reimbursed in the insurance system, such as brief consultations by and introductions to behavioral health clinicians in the primary care setting and care management for mental health and substance use disorder treatment including medication-assisted treatment for opioid use disorder.

Integral to tracking investments in behavioral health is by adopting policies such as those proposed for the Commonwealth's health care cost trends process, supported by the Center for Health Information and Analysis and the Health Policy Commission, to tracking behavioral health expenditures as part of its annual cost trends reporting and hearing process.

TESTIMONY RECEIVED IN SUPPORT OF RELEVANT MASSACHUSETTS LEGISLATION

HD3139

An Act to strengthen and expand access to behavioral healthcare
Sponsored by Rep. Marjorie C. Decker

HD3840
An Act providing equitable access to behavioral health services for MassHealth consumers
Sponsored by Rep. Elizabeth A. Malia

HD446
An Act to require equitable payment from the Commonwealth
Sponsored by Rep. Ruth B. Balser

HD2519
An Act requiring reimbursement for the costs of providing competent interpreter services
Sponsored by Rep. Gerard J. Cassidy

SD1416
An Act to increase investment in behavioral health care in the Commonwealth
Sponsored by Sen. Cindy F. Friedman

SD1063 / HD2023
An Act relative to applied behavioral health clinic rates
Sponsored by Rep. James J. O'Day and Sen. John F. Keenan

HD3880
An Act to create a thriving public health response for adolescents
Sponsored by Rep. Marjorie C. Decker

3.5.5. Achieve Behavioral Health Parity

There remains a stark lack of parity between behavioral health and physical health insurance coverage. While the concept of "parity" is part of federal and state laws, it has been challenging to enforce. And these barriers are especially pronounced for low-income and diverse populations.

Examples of disparities between the two include the requirement for prior authorization for many behavioral health services, reimbursement - with behavioral health paid significantly less, the comprehensiveness - or lack thereof - of covered benefits, and limited access to some providers who are "out of network." Benefit access is not equivalent across insurances. For instance, commercially-insured individuals do not necessarily have access to crisis mental health services, residential rehabilitation services, recovery coaching or peer support. Within MassHealth, some members have access to services such as intensive outpatient programs and structured outpatient addiction programs, while others do not. Many behavioral health providers do not presently participate in certain insurance products.

The Task Force recommends legislative action toward full mental health parity in the 2021-2022 legislative session. This should include the enforcement of existing parity laws; address barriers created by insurers including preauthorization requirements so that medical necessity determinations are made by the treating clinician; apply parity across payers; ensure compliance through regular market conduct examinations; enhance opportunities and resources for consumers to assert parity rights; establish network adequacy standards; and require parity of reimbursement rates for behavioral health providers and medical providers.

TESTIMONY RECEIVED IN SUPPORT OF RELEVANT MASSACHUSETTS LEGISLATION

SD2089
An Act relative to mental health parity implementation
Sponsored by Senator Cindy F. Friedman

SD1565
An Act removing preauthorization requirements for mental health acute treatment
Sponsored by Sen. Cindy F. Friedman

HD2245
An Act to further define medical necessity determinations
Sponsored by Rep. Kay Khan

SD1785
An Act for medical necessity fairness
Sponsored by Sen. John Cronin

HD3587 / SD1789
An Act for supportive care for serious mental illness
Sponsored by Rep. Marjorie C. Decker and Sen. John Cronin

HD3898 / SD1024
An Act to remove administrative barriers to behavioral health services
Sponsored by Rep. Elizabeth A. Malia and Sen. John F. Keenan

SD576 / HD3849
An Act providing access to patient protection services for MassHealth consumers
Sponsored by Rep. Elizabeth A. Malia and Sen. John F. Keenan

SD577 / HD3840
An Act providing equitable access to behavioral health services for MassHealth consumers
Sponsored by Rep. Elizabeth A. Malia and Sen. John F. Keenan

HD3880
An Act to create a thriving public health response for adolescents
Sponsored by Rep. Marjorie C. Decker

3.5.6. Invest in Lasting Behavioral Health Workforce Improvements

The ability to recruit and retain qualified behavioral health staff is among the greatest impediments to improving behavioral health access. The shortages in key behavioral health workforce positions warrant concerted action. These shortages are in all levels of the behavioral health workforce including behavioral health workers, registered nurses, clinical nurse specialists, licensed practical nurses, behavioral health associates providing one-on-one “sitter” care, social workers, psychiatrists, recovery coaches, care managers, and direct care counselors.

The Task Force calls for improvement to support and expand the behavioral health workforce through a variety of targeted initiatives. These include but are not limited to significant expansion of the student loan repayment program (including under the Medicaid 1115 Waiver) to include both inpatient and community-based behavioral health providers and additional behavioral health profession types, scholarships, and workforce training programs.

Emphasis should be placed on growth in the behavioral health workforce to meet the needs across the continuum of care and that is reflective of the racial and cultural diversity of the population with the ability to meet cultural and linguistic needs. Removing financial and other barriers to education would support people entering behavioral health careers and continuing their professional development.

Partnerships with universities and community colleges are integral to expanding and diversifying the behavioral health workforce. Graduate medical education funding is necessary for the training of future physicians and psychiatrists, including child and geriatric psychiatrists which are in shortage. A step in the direction would be to re-initiate Medicaid graduate medical education funding for psychiatrists. A promising workforce pipeline pilot to encourage a culturally, ethnically and linguistically diverse behavioral health workforce through collaboration between colleges and behavioral health providers was recently adopted as part of the FY'21 state budget law within budget line-item 4513-2020.

Additional reimbursement is a critical priority to be able to recruit and retain a behavioral health workforce. Pay must be increased for certain positions like mental health workers and differentials paid for hard to fill shifts. Testimony suggested creating a fund that hospitals could access for adding staff to meet fully licensed bed capacity; the fund could have safeguards to be used only when a hospital has had to close a unit or is unable to open a new unit due to staffing. Additional testimony was received about support needed to address staff vacancies across the entire behavioral health system.

Peer support, recovery coaches, community health workers, and family partners, who play critical roles in helping patients and families engage in behavioral health care should be added as covered benefits in Medicaid, supported by federal matching funds, and in commercial insurance. The Task Force supports legislation and Administrative actions to add these services as covered benefits in commercial insurance and within the Medicaid program, with federal matching funds.[34] [35] [36]

Furthermore, expanding the behavioral health workforce is also a matter of lessening the administrative complexities of insurance for providers so that more of them will participate, building on the recent legislative progress requiring a uniform credentialing form. A relevant study authorized within the FY'21 state budget law (budget line-item 4513-2020) has great promise to provide informative variables about the availability of culturally competent behavioral health providers within networks of both public and private health care payers. It will also identify potential barriers to care for underserved cultural, ethnic, linguistic, and other populations in the community; geographic challenges to access culturally competent providers; and training opportunities for providers to most effectively serve diverse populations.

TESTIMONY RECEIVED IN SUPPORT OF RELEVANT MASSACHUSETTS LEGISLATION

HD3139

An Act to strengthen and expand access to behavioral healthcare

[34]https://www.macpac.gov/wp-content/uploads/2019/07/Recovery-Support-Services-for-Medicaid-Beneficiaries-with-a-Substance-Use-Disorder.pdf

[35] https://www.medicaid.gov/sites/default/files/2019-12/clarifying-guidance-support-policy.pdf

[36] https://www.nashp.org/wp-content/uploads/2019/11/SUD-Scan-findgs-final-11.21.19.pdf

Sponsored by Rep. Marjorie C. Decker

SD1259
An Act establishing a behavioral health workforce center
Sponsored by Sen. John F. Keenan

HD1936 / SD689
An Act relative to recovery coach licensure
Sponsored by Reps. James J. O'Day and Elizabeth A. Malia and Sen. John F. Keenan

3.5.7. Improve Behavioral Health Treatment at the Intersection with the Justice System

A multi-faceted strategy is recommended to effectively reduce health disparities among individuals with behavioral health conditions intersecting with the criminal justice system.

First, there should be investment in alternatives to law enforcement response to people in behavioral health crises and those in need of treatment services. Co-responder programs, such as partnerships between behavioral health professionals and the police, should be bolstered and built upon. There are promising models around the country, including those in Oregon and Missouri described below, that successfully divert the police from situations that require mental health intervention. This should be coupled with continued education of law enforcement officers in de-escalation techniques when interacting with individuals experiencing behavioral health distress.

Second, with policy changes, the existing emergency response system could better triage people in behavioral health crises away from law enforcement and to behavioral health care and the services described above. Several legislative proposals, including those noted below, merit consideration to improve the 911 system to better include behavioral health emergencies and to integrate the federal 988 system.

Third, policy efforts are needed to reduce trauma inflicted on persons who are incarcerated, addressing the documented harm to individuals with behavioral health conditions within the prison system. Fourth, there is an opportunity to vastly improve and coordinate the care of individuals upon release from the justice system.

PROMISING PRACTICES FROM OTHER STATES

OREGON

Eugene, Oregon has successfully implemented an innovative community mental health partnership with the Eugene Police Department that has been in place for nearly 30 years and is integrated in the community. The Crisis Assistance Helping Out On The Streets (CAHOOTS) is a mobile crisis intervention program in which behavioral health personnel provide primary and joint response, diverting 5 - 8% of calls from police for situations that require behavioral health intervention. CAHOOTS personnel often provide initial contact and transport for people with substance use and/or mental health concerns and transport for necessary non-emergency medical care.[37]

[37] https://www.eugene-or.gov/4508/CAHOOTS

Each team consists of a medic (either a nurse or an EMT) and a crisis worker experienced in the mental health field. CAHOOTS provides immediate stabilization in case of urgent medical need or psychological crisis, assessment, information, referral, advocacy and transportation to the next step in treatment as needed. Services include but are not limited to:

- Crisis Counseling
- Suicide Prevention, Assessment, and Intervention
- Conflict Resolution and Mediation
- Grief and loss
- Substance Abuse
- Housing Crisis
- First Aid and Non-Emergency Medical Care
- Resource Connection and Referrals
- Transportation to Services.[38]

MISSOURI

Missouri's Community Mental Health Liaison (CMHL) program launched in 2013 as part of the Strengthening Mental Health Initiative. Thirty-one CMHLs employed by community behavioral health organizations work across the state to assist law enforcement and courts to link individuals with behavioral health needs to appropriate treatment and follow-up.

The goal is to form better community partnerships between Community Mental Health Centers, law enforcement, and courts to save valuable resources that might otherwise be expended on unnecessary jail, prison, and hospital stays and to improve outcomes for individuals with behavioral health issues.[39]

TESTIMONY RECEIVED IN SUPPORT OF RELEVANT MASSACHUSETTS LEGISLATION

1. Investment in alternatives to law enforcement response to people in behavioral health crisis and those in need of treatment services:

HD672
An Act ensuring access to addiction services
Sponsored by Rep. Ruth B. Balser

HD670 / SD587
An Act to require health care coverage for emergency psychiatric services
Sponsored by Reps. Ruth B. Balser and Thomas M. Stanley and Sen. Cindy F. Friedman

HD3807
An Act to Create Alternatives for Community Emergency Services (ACES)
Sponsored by Rep. Lindsay N. Sabadosa

HD2692 / SD2065
An Act to better coordinate suicide prevention services, behavioral health crisis care and emergency services through 988 implementation
Sponsored by Rep. Marjorie C. Decker and Sen. Julian Cyr

SD585
An Act relative to establishing a criminal justice and community support trust fund

[38] https://whitebirdclinic.org/cahoots/
[39] Missouri Community Mental Health Liaison Fact Sheet: https://www.mocoalition.org/community-mental-health-liaison https://41e56e24-d282-42b5-b0f1-f16abf1bc04b.filesusr.com/ugd/6dadf9_4fff4740c18e4801bb7a973e66d99dc8.pdf

Sponsored by Sen. Cindy F. Friedman

Line-Item 4000-0300
Create and fund a network of restoration centers with funding in the FY'22 state budget

2. Make existing emergency response system better able to triage people in behavioral health crisis away from law enforcement:

HD3884 / SD2036
An Act to enhance 911 operations for behavioral health crisis response
Sponsored by Rep. Brandy Fluker Oakley and Sen. Julian Cyr

3. Reduce trauma inflicted on incarcerated person, addressing the documented harm to individuals with behavioral health conditions:

SD568 / HD430
An Act to transfer Bridgewater State Hospital from the Department of Corrections to the Department of Mental Health
Sponsored by Rep. Ruth B. Balser and Sen. Cynthia Stone Creem

SD415 / HD3269
An Act to provide criminal justice reform protections to all prisoners in segregated confinement
Sponsored by Rep. Liz Miranda and Sen. James B. Eldridge

SD2386 / HD3974
An Act to ensure the constitutional rights and human dignity of prisoners on mental health watch
Sponsored by Rep. Brandy Fluker Oakley and Sen. James B. Eldridge

3.6. SUPPORT, EXPAND, AND DIVERSIFY THE HEALTH CARE WORKFORCE TO REFLECT THE POPULATION

The Task Force expresses its deep gratitude and respect for the extraordinary work of healthcare professionals at all levels for the care and compassion they have provided throughout the pandemic. At the same time, the COVID-19 pandemic has amplified stressors faced by the healthcare workforce including staffing shortages, the need to diversify the workforce to reflect the population, to support racially, ethnically, and linguistically competent care, to assist patients with new healthcare modalities including telehealth, and to compensate staff appropriately.

During the pandemic, we have seen significant percentages of staff leaving healthcare positions for industries with higher pay. Substantial testimony was received by the Task Force about the need for additional investments in rates of hospital and provider payment, especially for behavioral health providers, nurses, allied health professionals and other health professionals. According to some behavioral health organizations, the ability to recruit and retain qualified staff remains among the greatest challenges faced by behavioral health providers, slowing down improvements to behavioral health access.

3.6.1. Deploy State Initiatives and Funding to Advance the Healthcare Workforce and Create Career Ladders

The Task Force recommends state funding and initiatives, including those federally-supported under the Medicaid 1115 Waiver renewal, to provide health care career and pipeline development, student loan-forgiveness, job training and mentoring programs as pathways for current and prospective

members of the healthcare workforce, with an emphasis on doing so for healthcare clinicians and professionals from diverse backgrounds and with multilingual capabilities.

Testimony was offered suggesting a Request for Information to gain input on health care professions, shortages, and vacancies at all levels and recommended strategies, potential state or regional programs, investments, and/or barriers to be addressed. This should be accompanied by an annual for bi-annual review of key workforce needs thereafter.

Furthermore, several important initiatives to improve the process and timeliness for the licensing of healthcare professionals to practice in Massachusetts were brought to the attention of the Task Force. Examples include legislation to require the Board of Registration in Medicine to process physician licensure applications within 90 days; to make recommendations to facilitate interstate medical practice (with implications for telehealth); and to authorize Massachusetts to enter into the Nurse Licensure Compact, allowing a nurse to have one license in their state of residency and to practice in other states, subject to the nurse practice law and regulations of each state.

Testimony was also received about livable wages (including for nursing home, home health, behavioral health, among other workforce members) and other employment supports for essential health care workers.

TESTIMONY RECEIVED IN SUPPORT OF RELEVANT MASSACHUSETTS LEGISLATION

HD1988/ SD671
An Act relative to nurse licensure compact in Massachusetts
Sponsored by Rep. Kay Khan and Sen. Joseph A. Boncore

HD3380/ SD1220
An Act to ensure timely physician licensure
Sponsored by Rep. Jon Santiago and Sen. Adam G. Hinds

HD2533/ SD2099
An Act relative to telehealth and digital equity for patients (Sections 27 and 28)
Sponsored by Rep. Thomas A. Golden, Jr. and Sen. Adam Gomez

3.6.2. Activate the Commission Charged with Making Recommendations on Licensing and Practice for Foreign-Trained Health Professionals

There are an estimated 3,000 foreign-trained medical professionals in Massachusetts, including physicians, nurses, dentists and other health professionals. The challenge for physicians is they must complete a three-year residency in the US, within five years of graduating from medical school to qualify to sit for a test for their license. Other professions have similar barriers. This is a high bar for people who are often in the country as refugees and immigrants with few personal resources.

The rich resource of highly trained but underutilized foreign-trained health professionals would not only meet a critical need for providers, but also enhance the racial and ethnic diversity, and cultural and linguistic capacity of the health care workforce, acute needs even prior to the pandemic.

During COVID-19, there was a desperate need for medical personnel and a modest change was made in the requirements. Governor Baker issued an executive order that allowed the Board of Registration in Medicine to license foreign-trained physicians who had completed two years of a US

accredited training program. New York issued a similar executive order that required one year of such training. This was important progress, and more is needed.[40]

Last year, legislation passed that directed the Massachusetts Department of Public Health to form a commission to review licensing and practice for foreign trained health professionals and make recommendations. In fact, this is the second time the Commonwealth has attempted this approach. In 2014, Governor Deval Patrick also formed a commission. The current Commission has not yet been convened. The Health Equity Task Force understands that MDPH has been fully consumed with responding to the COVID-19 crisis. The Health Equity Task Force encourages the Governor to direct

PROMISING PRACTICES FROM OTHER STATES

Minnesota

After creating a Task Force that submitted a set of recommendations, Minnesota launched the International Medical Assistance Program. It is implemented through community-based organizations, residency program providers, and other stakeholders. Community based organizations provide career guidance and support, funding assistance for testing fees, interview preparation, and general support so its participants can become "residency ready." The University of Minnesota offers a clinical assessment as well as a rigorous nine-month clinical experience program to further assist IMGs in meeting residency requirements. Last, but not least, the IMG assistance program offers funding for residency spots dedicated to IMGs in primary care. Participants selected in the dedicated IMG residency spots must sign a commitment to work in a rural or urban high-need area and pay fifteen thousand dollars into the program once they join the workforce. The program is administered through the Minnesota Department of Health.[42]

Arkansas

In 2019 Arkansas enacted SB 456, a bill requiring that the academic licensee practice under the supervision of a faculty member licensed by the Arkansas State Medical Board, adding a supervised clinical element to the existing academic license. An IMG who practices medicine under an academic license for a period of two consecutive years is eligible for an active, unrestricted license to practice medicine in the state, without needing to complete a U.S. residency.[43]

Additional state policy options put together by WES, Global Talent Bridge, a non-profit "dedicated to helping skilled immigrants fully utilize their talents and education in Canada and the United States."[44]

3.6.3. Support Training and Initiatives that Increase Cultural Competency, Address Racism, and Uncover the Implicit Bias in Health Care

Testimony was received by the Task Force about the need for training and initiatives that increase cultural competency, address racism, and uncover the implicit bias that is currently rooted in the health system. The Task Force heard testimony from many individuals and families, of diverse racial and ethnic backgrounds, abilities, diagnoses, and gender identity, about the challenges they have faced within the health system that should be addressed through the training and other initiatives across the statewide healthcare system. Funding for statewide collaboratives is needed to carry out this training.

[40] https://www.mass.gov/doc/april-9-2020-foreign-medical-doctors/download

[41] https://budget.digital.mass.gov/summary/fy20/outside-section/section-102-special-commission-on-foreign-trained-medical-professional-licensure

[42] https://www.health.state.mn.us/facilities/ruralhealth/img/index.html

[43] https://www.arkleg.state.ar.us/Acts/Document?type=pdf&act=701&ddBienniumSession=2019%2F2019R

[44] https://www.imprintproject.org/wp-content/uploads/2020/09/Removing-Barriers-to-Practice-State-Policy-Options.pdf

Not only have these challenges led to the health disparities addressed in this report, they have fostered distrust in the healthcare system. As a step towards preparing for the future and building trust between structurally marginalized communities and the healthcare system, a process of sustained community engagement by all aspects of the public and private healthcare and public health systems is suggested.

3.7. ADVANCE HEALTH EQUITY THROUGH MASSACHUSETTS MEDICAID

Massachusetts is preparing its Medicaid 1115 Waiver demonstration renewal proposal to the federal government in the Spring of 2021 for submission in the summer of 2021. Medicaid 1115 demonstration Waivers provide federal flexibility for state Medicaid programs to test innovations that support the goals of the Medicaid program, including improving health care outcomes and reducing costs.[45]

Massachusetts has been leading the nation both in coverage expansions and in implementing new population health models through the MassHealth Accountable Care Organization (ACO) program, which covers approximately 1.3 million MassHealth members. Overall, MassHealth provides essential health care coverage to 2 million members, including 800,000 low- and moderate-income adults (40% of all members), 680,000 low- and moderate-income children (35% of all members) and 293,000 people with disabilities and 191,000 seniors (combined, 25% of all members).[46]

The Medicaid Waiver and accompanying Medicaid policies are an opportunity to attain federal support for extending postpartum Medicaid coverage and adding doula services, improving health equity, funding health-related social needs, and continuing retroactive MassHealth coverage beyond the pandemic. Please see the behavioral health section of this report for recommendations to add or augment peer support, recovery coaches, community health workers, and family partners as MassHealth covered benefits. Other Medicaid policies such as those affecting estate recovery for low-income seniors and persons with disabilities call out for reform using an equity lens.

3.7.1. Promote Maternal Health by Extending Maternal Postpartum Care Coverage in MassHealth from the current 60 Days to 12 Months and Adding Doula Services

Maternal mortality is a growing health crisis in the United States. A recent 2020 study by the Commonwealth Fund reports that the United States has the highest maternal mortality rate among developed countries. Multiple factors contribute to this including access to maternity care providers and comprehensive postpartum supports.[47]

While the majority of pregnancy-related deaths are preventable, increasing maternal death is a great cause of concern. Women of color are disproportionately impacted; and they are more likely than white women to die or experience serious illness and injury due to pregnancy-related causes. Black women have pregnancy-related mortality nearly three times higher than the rate for white women.[48]

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[45] https://www.mass.gov/doc/section-1115-listening-session-1/download

[46] https://www.mass.gov/doc/executive-office-of-health-human-services-governor-bakers-fy2022-budget-proposal-january-27/download

[47] https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries

[48] https://www.kff.org/report-section/racial-disparities-in-maternal-and-infant-health-an-overview-issue-brief/

Medicaid plays an important role in improving maternal and perinatal outcomes. In Massachusetts, MassHealth covers 35% of births. Massachusetts has expanded MassHealth to more low-income residents, including pregnant and postpartum women. Yet, some postpartum women experience disruptions in coverage and care under current eligibility rules, leading to delays in identifying and treating pressing health challenges. Pregnancy-associated mortality increased 33% in Massachusetts between 2012 and 2014, the latest time period for which publicly available data is available.

Timely postpartum visits provide an opportunity to address chronic health conditions, such as diabetes and hypertension; mental health status, including postpartum depression; and substance use disorders.[49]

The Task Force calls for legislative and administrative action to promote maternal health through extending postpartum Medicaid Coverage from 60 days to 12 months and adding coverage of doula services. The Task Force calls for timely planning by the Administration and the Legislature to direct MassHealth to obtain federal authorization to extend postpartum coverage from the current 60 days to 12 months and adding doula services as a covered benefit. A goal of the legislation would be to ensure that immigrants would also get the same postpartum coverage extension in Medicaid coverage.

Under current federal rules, pregnant and postpartum women who are eligible for Medicaid on the basis of their pregnancy only receive coverage during their pregnancy and 60 days postpartum. This timeframe is not sufficient to address the medical and socio-emotional needs of the postpartum period. Continuous coverage is paramount during this critical time, impacting the long-term health and well-being of pregnant and postpartum women, their families and their communities.

Doula services encompass physical, emotional, and informational support, but not medical care, for pregnant women, surrogates, foster care parents and adoptive parents during and after pregnancy, labor, childbirth, miscarriage, stillbirth or loss. This may include accompanying pregnant individuals to health care and social services appointments and connecting them to community-based and state- and federally-funded resources, including those which address needs within the social determinants of health.

Of note, there is a promising recent development at the federal level passed in the American Rescue Plan Act of 2021, recently signed into law, that gives states the option for 5 years to extend postpartum Medicaid/CHIP coverage for 12 months through their Medicaid State Plan or waiver thereof.[50] This provision goes into effect at least one year after passage of the law, likely available to states in April 2022. Massachusetts should be prepared to explore postpartum Medicaid coverage through this vehicle, or the upcoming Medicaid 1115 Waiver opportunity, which will be filed with the federal government in the summer of 2021. Medicaid coverage for doula services should be pursued at the same time.

Private insurers should review their postpartum coverage to make sure it recognizes coverage for conditions that extend beyond 90 days. The Task Force also received testimony about geographic access barriers to maternal health care.

[49] https://www.medicaid.gov/state-overviews/scorecard/postpartum-care/index.html
[50] Public Law No: 117-2, Sections 9812 and 9822 https://www.congress.gov/bill/117th-congress/house-bill/1319/

PROMISING PRACTICES FROM OTHER STATES

POSTPARTUM COVERAGE

There are presently two approaches states can take to implement an extension of postpartum coverage from 60 days to 12 months: through the use of state-only funds or through a Medicaid Section 1115 Waiver. Note that the recently passed federal American Rescue Plan Act (Public Law No: 117-2) gives states this option of extending postpartum coverage to 12 months through their Medicaid State Plan.

Extending Medicaid coverage to postpartum women beyond 60 days is emerging as a key state strategy to address the maternal mortality crisis, according to analysis prepared by the National Academy for State Health Policy.[51]

At least 24 states have taken steps to consider legislation, budget, and federal proposals to extend postpartum coverage. An interactive map and chart summarize proposed and approved legislation since 2018, Medicaid Waivers, financial estimates, and other initiatives designed to extend coverage during the postpartum period. Under the Families First Coronavirus Response Act, Medicaid enrollees who typically lose coverage after 60 days postpartum cannot be disenrolled until the end of the month in which the public emergency period ends. Several states have taken the step of filing Medicaid 1115 Waivers to extend postpartum Medicaid coverage including South Carolina, Georgia, Illinois, Indiana, Missouri, New Jersey, and Tennessee.

DOULA SERVICES

Several states, including Minnesota, Oregon and New Jersey, include Medicaid coverage for doula services. Under federal law, state Medicaid programs must cover a set of mandatory benefits, and states can also opt to offer optional benefits within federal guidelines. Several state Medicaid agencies have chosen to cover doula services as an optional benefit.[52]

OREGON

Oregon's Medicaid program has covered doula services as a preventive service since 2017.[53] The Oregon Health Authority covers two prenatal and two postpartum sessions and doula support during labor and delivery.

MINNESOTA

Minnesota's Medicaid program has covered doula services as an extended service since 2014.[54] It includes up to seven sessions with a doula, which include prenatal and postpartum support as well as during labor and delivery.

NEW JERSEY

New Jersey announced that its Medicaid program, known as NJ FamilyCare, will cover doula services effective January 1, 2021.[55] [56]

TESTIMONY RECEIVED IN SUPPORT OF RELEVANT MASSACHUSETTS LEGISLATION

HD2470/ SD1929

[51] https://www.nashp.org/view-each-states-efforts-to-extend-medicaid-coverage-to-postpartum-women/
[52] https://www.nashp.org/four-state-strategies-to-employ-doulas-to-improve-maternal-health-and-birth-outcomes-in-medicaid/#toggle-id-4
[53] https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OR/OR-17-0006.pdf
[54] https://mn.gov/dhs/assets/14-07-spa_tcm1053-270737.pdf
[55] https://www.nj.gov/governor/news/news/562021/20210202b.shtml
[56] https://www.medicaid.gov/Medicaid/spa/downloads/NJ-20-0011.pdf

An Act relative to expanding equitable access to maternal postpartum care
Sponsored by Rep. Liz Miranda and Sen. Joan B. Lovely

HD2776/ SD1931
An Act relative to Medicaid coverage for doula services
Sponsored by Reps. Liz Miranda and Lindsay N. Sabadosa and Sen. Joan B. Lovely

3.7.2. Integrate Health Equity Initiatives in Medicaid 1115 Waiver, including Innovations for Health-Related Social Needs and "Flexible Services"

The Medicaid Waiver renewal is an opportunity to advance health equity, including measures and initiatives to expand care and address social factors in health. Massachusetts' current Waiver includes a provision for "flexible services" funding that is being used to assist members and test whether MassHealth Accountable Care Organizations can improve members' health outcomes and reduce total costs of care through targeted evidence-based programs that address nutrition and housing needs. There is substantial support for continuing and building on this program.

Consistent with Massachusetts experience this Medicaid Waiver term, there is an opportunity to further advance initiatives toward whole person care, including more integration of supported housing options. Promising practices from other states' Medicaid demonstration programs should be considered in Massachusetts.

PROMISING PRACTICES FROM OTHER STATES

CALIFORNIA

California's Medicaid Waiver, "Medi-Cal 2020 Waiver", initiated Whole Person Care (WPC) Pilots and is currently operating under an extension through December 2021. The state received authority and up to $1.5 billion in federal funds to pilot an innovative new approach to engaging and treating Medicaid beneficiaries who are high-utilizers of the health care system or present complex physical, behavioral, or social needs. Under this initiative, California counties and other local entities were provided the opportunity to develop and implement their own WPC pilot programs within certain parameters. The pilots are designed to coordinate physical health, behavioral health, and social services (e.g., housing supports) for one or more of the designated target populations, which include high utilizers with two or more chronic conditions, individuals who are homeless or at risk of homelessness, or individuals with a behavioral health condition or substance use disorder.[57] [58] [59]

OREGON

Since 2012, Oregon has fostered partnerships between its Medicaid accountable care organizations (called coordinated care organizations or CCOs) and community-based organizations (CBOs). These CCO/CBO partnerships have helped reduce health inequities by addressing both individual CCO members' social needs and community social determinants of health.

Recently, Oregon launched a five-year, second phase of its CCO program, called CCO 2.0, recognizing that many things affect health outside of the doctor's office. CCOs will increase their investments in strategies to address social determinants of health and health equity. CCOs will build stronger relationships with members, nonprofit organizations, hospitals, schools, and local public health departments. CCOs will align goals at the state and local level to improve health outcomes and advance health equity. Oregon is developing measurement and evaluation strategies to increase understanding of spending

[57] https://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx
[58] https://caph.org/wp-content/uploads/2019/04/wpc-4.11.19.pdf
[59] https://caph.org/wp-content/uploads/2018/05/WPC-Brochure-7.20.2018.pdf

in this area and track outcomes.[60][61] Recommended policies will:

- Increase strategic spending by CCOs on social determinants of health, health equity and disparities in communities, including encouraging effective community partnerships
- Increase CCO financial support of non-clinical and public health providers
- Align community health assessment and community health improvement plans to increase impact
- Strengthen meaningful engagement of tribes, diverse members, and community advisory councils
- Build CCOs' organizational capacity to advance health equity
- Increase the integration and use of traditional health workers.

3.7.3. Continue and Restore MassHealth Retroactive Coverage Beyond the Pandemic

While federal law allows for 90 days retroactive Medicaid coverage from the time a person applies, Massachusetts has obtained a waiver to provide only 10 days of retroactive coverage. However, during the COVID-19 public health emergency, MassHealth has been providing at least 90 days of retroactive coverage. The Task Force calls on the Administration and the Legislature to take action to make permanent 90-day retroactive coverage prior to the date of the application for MassHealth coverage. This is in keeping with the federal Medicaid minimum standards of coverage.

TESTIMONY RECEIVED IN SUPPORT OF RELEVANT MASSACHUSETTS LEGISLATION

HD4089
An Act to restore the effective date of MassHealth coverage for new applicants
Sponsored by Rep. Carolyn C. Dykema

SD1993
An Act relative to effective date of MassHealth coverage for new applicants under age 65
Sponsored by Sen. Joseph A. Boncore

3.7.4. Protect the Homes of Seniors and Persons with Disabilities with MassHealth through Estate Recovery Reform

Health starts with housing. The Task Force views Medicaid estate recovery reform legislation as crucial to protecting the homes of seniors and persons with disabilities with MassHealth. Reform is needed to address the disproportionate effect of estate recovery on the lowest income Medicaid beneficiaries. A home is often the only asset a person has to hand down to their children and grandchildren. When the state captures this asset, it contributes to and exacerbates the intergenerational racial and ethnic wealth gap.

Medicaid is the only public benefit program that requires the value of benefits to be recouped from a deceased enrollee's family, called "estate recovery". Estate recovery for nursing homes costs is federally mandated, but Massachusetts law goes beyond federal requirements to require estate recovery for the costs of all medical services after a MassHealth enrollee turns age 55.

[60] https://www.nashp.org/oregons-community-care-organization-2-0-fosters-community-partnerships-to-address-social-determinants-of-health/
[61] https://www.oregon.gov/oha/OHPB/CCODocuments/2018-OHA-CCO-2.0-Report-Executive-Summary.PDF

After a MassHealth recipient passes away, the agency seeks repayment of the medical expenses paid for that individual if that individual leaves a probate estate. Over 80% of the amount MassHealth recovers for itself and the federal government comes from sale of the family home.

Current state law also fails to require adequate notice to MassHealth members and applicants about estate recovery. Few people know that Medicaid estate recovery is triggered by turning age 55,[62] not only by entering a nursing home. Most MassHealth members have incomes under 100% of the federal poverty level ($12,888 for one in 2021), and those 65 and over have countable assets of $2000 or less ($3000 for a couple).

One of the few assets of value that MassHealth does not count for people age 65 and older living in the community is the family home.[63] Seniors and people with disabilities want their homes to benefit their families. Maintaining home ownership can help combat intergenerational poverty and wealth inequality in communities of color. The Task Force supports legislative action to reform MassHealth estate recovery, including but not limited to establishing that MassHealth will only recover for federally-mandated medical assistance, establish hardship waivers, and provide information upfront to MassHealth members about estate recovery, among other necessary reforms.

Easing the burden of Medicaid estate recovery to promote equity is also a recommendation of the federal Medicaid and CHIP Payment and Access Commission in its recent in-depth examination of the topic.[64]

TESTIMONY RECEIVED IN SUPPORT OF RELEVANT MASSACHUSETTS LEGISLATION

SD1031 / HD1408
An Act protecting the homes of seniors and disabled people on MassHealth
Sponsored by Rep. Christine P. Barber and Sen. Joanne M. Comerford

3.8. REMOVE COPAYMENT AND OTHER BARRIERS TO AFFORDABLE MEDICATIONS AND CARE

High out-of-pocket costs and copayments for prescription drugs and medical visits can cause patients to forgo needed prescription medications and care. Research demonstrates that cost-sharing prevents people from accessing high-value care, and the impact is particularly pronounced for low-income consumers. Conversely, initiatives that eliminate cost barriers for patients by covering costs for screening and treatment in combination with patient navigation, can improve health outcomes for certain conditions like colorectal cancer and breast cancer.[65] [66]

[62] See Massachusetts General Law 118E, 31(b)(3)
[63] See 130 CMR 520.008(A)
[64] Medicaid and CHIP Payment and Access Commission (MACPAC), Report to Congress on Medicaid and CHIP, Chapter 3, Medicaid Estate Recovery: Improving Policy and Promoting Equity, (March 2021) available at https://www.macpac.gov/publication/medicaid-estate-recovery-improvingpolicy-and-promoting-equity/
[65] https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/
[66] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3661932/

The Task Force commends and aligns with the recent Attorney General's *Building toward Racial Justice and Equity in Health* report's recommendation to address affordability of cost-sharing as an equity priority for diverse people and low-income communities.

The Attorney General's report recommends opportunities such as insurance plans temporarily reducing cost-sharing for: (1) primary care and behavioral health visits during the pandemic and (2) medications for chronic conditions linked to COVID-19 complications. The report further recommends that the Health Policy Commission and Health Connector study longer-term strategies to address access barriers due to cost sharing to promote equitable access to services.[67]

3.8.1. Remove Copayments for Prescription Medications and Services to Prevent and Manage Chronic Health Conditions and for Preventive Care

Improving access to prescription drugs and health care services for chronic health conditions and for preventive care is a health equity issue. High out-of-pocket costs and copayments can be a barrier to care and medications, especially for persons with chronic health conditions, communities of color, and low-income communities. During the COVID-19 pandemic, people of color and others with underlying chronic health conditions are more susceptible to COVID-19 complications. Removing barriers to care, such as out-of-pocket costs to affordable medications and health care services, is an important way to curb racial and other inequities, particularly related to preventive care, wellness, and chronic conditions. Removing barriers to care for chronic conditions is also cost effective by fostering ambulatory sensitive care instead of at a later stage in treatment. This is especially key for chronic conditions, such as diabetes, asthma/COPD, hypertension and heart disease, substance use and opioid use disorder, certain mental health conditions, among others.

The Task Force encourages legislation that shifts toward a wellness system in part by removing copayment barriers in insurance design for preventive care and care and medications for chronic conditions. This will advance overall health and important health equity opportunities relative to the disproportionate burden of chronic conditions.

TESTIMONY RECEIVED IN SUPPORT OF RELEVANT MASSACHUSETTS LEGISLATION

HD2708 / SD1716
An Act to Ensure Affordable Care
Sponsored by Rep. Christine P. Barber and Sen. John F. Keenan

3.8.2. Enhance Patient Assistance Programs for Medications to Treat Conditions that Disproportionately Impact People of Color and Are Risk Factors for COVID-19 Complications

The Task Force supports legislative approaches such as expanded patient medication assistance programs to complement legislation to remove cost-sharing barriers to necessary prescriptions medications. This could make a difference for people who rely on medications, such as insulin, asthma inhalers, and other medications, to treat chronic conditions that disproportionately impact people of color and other vulnerable populations. These chronic health conditions are also risk factors for increased COVID-19 complications. Other legislative provisions could ensure consumers

[67] https://www.mass.gov/doc/building-toward-racial-justice-and-equity-in-health-a-call-to-actin/download

know their lowest cost options for their prescriptions at the pharmacy.

TESTIMONY RECEIVED IN SUPPORT OF RELEVANT MASSACHUSETTS LEGISLATION

HD2948
An Act to ensure prescription drug cost transparency and affordability
Sponsored by Reps. Christine P. Barber and Jon Santiago

SD2217
An Act relative to pharmaceutical access, costs and transparency
Sponsored by Sen. Cindy F. Friedman

3.9. IMPROVE ORAL HEALTH

Oral health is among the deepest disparities in communities of color, low-income communities, vulnerable age groups, people with disabilities, and underserved geographic regions. Integral to overall health, poor oral health can significantly affect an individual's physical, mental, and financial health.

Lower-income people and people of color are more likely to have unmet dental needs. Poor oral health is connected to higher risk for diabetes, cardiovascular disease and stroke, complications in pregnancy and childbirth, adverse mental health outcomes, and other conditions.[68] One in five working-age adults does not get needed dental care. Black adults are 68% more likely to have an unmet dental need than white adults. Latino adults are 52% more likely than white adults to report difficulty performing at work due to poor oral health.[69]

Among people with COVID-19, those with poor oral health and chronic larger amounts of pathogenic oral bacteria associated with poor oral health, have poorer outcomes and more severe COVID-19 complications.[70] [71]

3.9.1. Sustain Full Restoration of Adult Dental Care Coverage in MassHealth

Oral health is a critical component of overall health care, yet full dental coverage for adults on MassHealth has waxed and waned since 2002, making access to dental coverage and services uncertain for many Massachusetts residents. Adult dental benefits are currently restored and the restoration needs to be sustained with adequate state budget funding as an important step to address oral health needs.

Underserved communities across the state have historically faced the greatest barriers to accessing dental care. Black and Latino families are more likely to have unmet needs for medical or dental care. In Massachusetts, 15 percent of low-income adults say their mouth and teeth are in poor condition. Those with family incomes at or below 138 percent FPL were less likely than all other

[68] https://www.dentaquestpartnership.org/system/files/Impacts%20Beyond%20The%20Mouth_0.pdf
[69] https://www.dentaquestpartnership.org/system/files/New%20NHANES%20Oral%20Health%20Data%20Reflect%20Barriers%20%26%20Inequalities.pdf
[70] https://www.nature.com/articles/s41415-020-1747-8
[71] https://www.dentaquestpartnership.org/vap-oral-health

income groups to report a dental visit (56% versus 82% of individuals at higher income levels). Furthermore, 18 percent of adults reported an unmet need for dental care.[72] [73]

3.9.2. Establish an Oral Health Commission and Statewide Needs Assessment

Massachusetts' data on oral health needs and access to care is outdated, hindering the ability to understand the challenges and the policy solutions needed to ensure equitable access to dental services. The first step is to get an accurate picture of the oral health needs of residents across the state.

Therefore, the Task Force recommends legislation to create a Special Legislative Commission on Oral Health (SLCOH), chaired and staffed by the Massachusetts Commissioner of Public Health. The SLCOH should be charged with: (1) conducting a statewide oral health status and needs assessment to get an accurate picture of the oral health needs of Massachusetts residents and (2) developing recommendations to address gaps in access to oral health services and to improve the overall health status of residents including pediatric, adult, and older adult populations. Innovative programs should be highlighted.

TESTIMONY RECEIVED IN SUPPORT OF RELEVANT MASSACHUSETTS LEGISLATION

HD2962 / SD1526
An Act to establish an oral health commission and needs assessment
Sponsored by Rep. Kate Hogan and Sen. Harriette L. Chandler

3.9.3. Support Dental Professionals to Serve as Vaccinators

Oral health, and oral health providers, play an important role in health for underserved populations during and beyond the COVID-19 pandemic, including the overture to be part of vaccination efforts. The Massachusetts Board of Registration in Dentistry issued a clarification that administering COVID-19 vaccinations is within the scope of practice of dentists and permitted dental hygienists.[74]

The Task Force supports action to direct the:

- Massachusetts Department of Public Health to continually review and update effective and easy-to-use resources – training materials, checklists, etc. – for dental practices to serve as vaccination sites with dental professionals administering vaccines during the current public health crisis; and
- Massachusetts Board of Registration of Dentistry to develop and issue guidelines post-pandemic emergency, that build on the COVID-19 guidance noted above, to allow dentists and permitted dental hygienists to administer certain vaccinations in support of public health goals and improved access to vaccinations for their patients.

[72] https://www.ada.org/en/science-research/health-policy-institute/oral-health-and-well-being/Massachusetts-facts
[73] https://www.mass.gov/doc/oral-health-brief
[74]https://www.mass.gov/info-details/massachusetts-covid-19-vaccine-program-mcvp-overview#who-can-administer-the-covid-19-vaccine?-

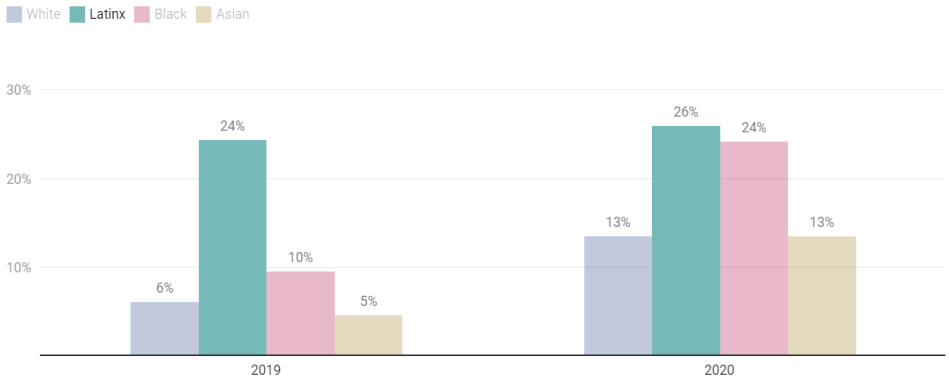
4. SOCIAL AND ECONOMIC FACTORS THAT IMPACT HEALTH

Social and economic inequities are the primary drivers of inequities in health. Following are recommendations on the key social factors of health including food security, housing, transportation, language access, community safety for immigrants, and environmental justice.

4.1. INCREASE FOOD ACCESS AND SECURITY

Food insecurity has been concentrated in Latinx and Black communities, who have been hardest hit by the pandemic.

Share of the population 18+ indicating low or very low food security by race/ethnicity, Massachusetts.



Graphic cited from: *Food Insecurity Has Doubled During the Pandemic: Data, Insights and Policy Solutions.*[75]

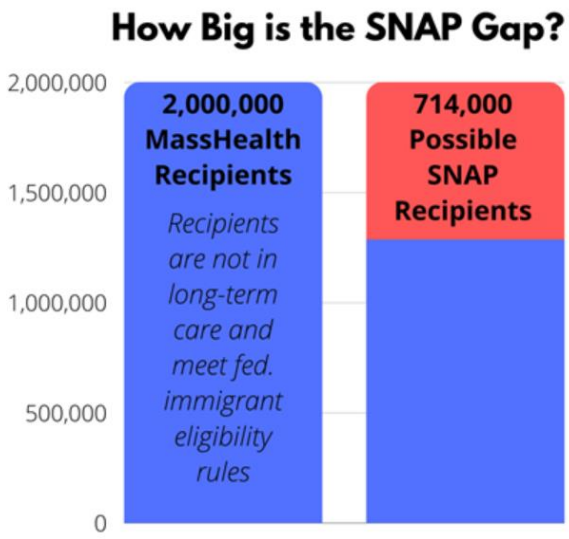
Food insecurity in Massachusetts doubled during the pandemic from 8% to almost 17%, according to a report from The Boston Indicators Project, with a corresponding increase in demand on the emergency food system. That report also documents persistent disparities in rates of

[75] https://www.bostonindicators.org/reports/report-website-pages/covid_indicators-x2/2020/october/food-insecurity#:~:text=Despite%20the%20fact%20that%20Massachusetts,in%20Massachusetts%20were%20food%20insecure.

food insecurity between racial and ethnic groups, with a dramatic increase for most and a widening of that gap during the pandemic.

Another report from Feeding America documents that during the pandemic, Massachusetts had the highest rate of increase in food insecurity in the country (59%), with one in five children living in a food insecure household, an increase of 102%. Norfolk County had the highest rate of increase in food insecurity for children in the country (163%).[76]

4.1.1. Close the SNAP Gap



The SNAP Gap refers to the over 700,000 individuals who are MassHealth recipients and likely eligible for the Supplemental Nutrition Assistance Program (SNAP) but are not receiving the benefit.[77] These benefits could make the critical difference in helping families put food on the table, yet people are often unaware of what they are eligible for and/or overwhelmed with the processes to apply.

Currently families have to apply for these and other benefits that provide income through separate and unrelated processes. Often when families apply for one benefit, they are not aware of the availability of another benefit. The Task Force encourages legislation that would create one application procedure for households to apply for SNAP as well as MassHealth/Medicare Savings Program, and Transitional Assistance for Families with Dependent Children (TAFDC) or Emergency Aid for the Elderly, Disabled and Children (EAEDC).

A common application would reduce duplicate data collection thus increasing the efficiency of state government, improve access to desperately needed cash assistance for families, and increase access to 100% federally-funded nutrition which has documented benefits in improving health.

TESTIMONY RECEIVED IN SUPPORT OF RELEVANT MASSACHUSETTS LEGISLATION

HD1500 / SD1015
An Act to Streamline the Process to Access Critical Public Health and Safety Net Programs through Common Applications
Sponsored by Sen. DiDomenico and Rep. Jay Livingstone

4.1.2. Fully Fund The Healthy Incentives Program (HIP)

This program allows Massachusetts residents who rely on SNAP benefits to feed themselves and their families each month, to double the value of their SNAP benefit when they purchase fruits and

[76] https://www.feedingamerica.org/sites/default/files/2020-10/Brief_Local%20Impact_10.2020_0.pd
[77] Graphic cited from: Massachusetts Legal Service https://www.masslegalservices.org/content/its-time-finally-close-massachusetts-snap-gap-and-expand-common-apps-2021

vegetables from farmers' markets. Fruits and vegetables are often omitted from the shopping list of SNAP recipients because they can be expensive. The incentive allows SNAP recipients to make the choice to include fresh fruits and vegetables on their shopping lists. The program is administered by the Massachusetts Department of Agricultural Resources and the Massachusetts Department of Public Health.

The Task Force supports a $13 Million allocation for HIP in the FY'22 budget. This is the amount included in the final FY'21 budget, yet the Governor's budget has proposed a cut that would reduce the total amount to $5 Million, which falls short of the demand from families for healthy food, and hurts local farmers who provide this food to Farmer's Markets. (budget line-item 4400-1004)

TESTIMONY RECEIVED IN SUPPORT OF RELEVANT MASSACHUSETTS LEGISLATION

SD1179
An Act relative to an agricultural healthy incentives program
Sponsored by Sen. Anne Gobi

4.1.3. The Task Force Recommends Making School Meals Universal as Part of the Feed Kids Campaign

During the pandemic, school meals became universally free to all students. The Task Force supports requiring all schools to continue to make these meals available to all students at no charge. At this reading, it appears that the American Rescue Plan will make this possible.

Research shows when a child is well fed, they perform better in school, are at lower risk for obesity, and adjust to social situations better. Additionally, by making meal access universal, we help remove stigma around economic status and family situation—creating a more equitable and just educational environment. It is estimated that up to 50,000 children would benefit daily from this policy.[78]

TESTIMONY RECEIVED IN SUPPORT OF RELEVANT MASSACHUSETTS LEGISLATION

HD1161 / SD519
An Act relative to universal school meals
Sponsored by Rep. Andres Vargas and Sen. Sal N. DiDomenico

4.1.4. The Task Force Supports the Massachusetts Hunger-Free Campus Initiative

Two national surveys from 2017 and 2018 indicate more than one-third of four-year college students, and nearly half of all community college students, faced food insecurity in the previous 30 days. Many of these students are the first generation in their families to attend college, are immigrants or their parents are immigrants.

The Hunger Free Campus Initiative, under the Massachusetts Department of Higher Education (MDHE) would address student food insecurity and hunger across all 29 public higher education

[78] https://feedkidsma.org/about-the-bill

campuses. MDHE will establish an office to support institutions of public higher education, with the goal of building the capacity of colleges to address student food insecurity. The office would also administer a grant program to these colleges to promote food security among students.

TESTIMONY RECEIVED IN SUPPORT OF RELEVANT MASSACHUSETTS LEGISLATION

HD453 / SD1477
An Act establishing the Massachusetts Hunger-Free Campus Initiative
Sponsored by Rep. Andres Vargas and Sen. Harriette Chandler

4.1.5. Fund the Massachusetts Emergency Food Assistance Program to Support Increased Need for the Food Bank Coalition of Massachusetts

The Massachusetts Emergency Food Assistance Program (MEFAP) supports the Food Bank Coalition of Massachusetts that provides food for a network of nearly 1,000 pantries, meal programs, shelters and mobile markets across the Commonwealth. Demand for this food has seen double-digit increases during the pandemic and there is no end in sight. The Governor has recommended the pre-pandemic funding level of $20 Million in his FY'22 budget proposal while the food banks are advocating for $30 Million to meet demand (budget line-item 2511–0105). The Task Force supports the need for the higher budget amount.

4.2. PROVIDE AND INCREASE EMERGENCY AND BASIC INCOME THROUGH EMERGENCY CASH ASSISTANCE, AN INCREASE IN PUBLIC BENEFITS AND ACCESS TO EARNED INCOME TAX CREDITS FOR ALL TAXPAYING FAMILIES.

4.2.1. The Task Force recommends Robust Funding for Emergency Cash Assistance in the Commonwealth's Fiscal Year 2022 Budget

Insufficient income is a long-standing challenge for the most disenfranchised in our state, and is a deeply rooted cause of multiple inequities, including health inequities. During the pandemic, loss of income particularly impacted immigrants with no access to public benefits. According to the MIRA Coalition's community survey conducted in August, 59 percent of immigrant households reported reliance on food or cash assistance; among households with undocumented members, the share was 77.8 percent. Three in five such households reported housing insecurity. (budget line-item 7002-2022)

This was partially possible because the Commonwealth launched the emergency cash assistance program last summer. This funding supported the Community Foundations Grant Program for COVID-19, managed by the Executive Office for Housing and Economic Development, specifically for emergency cash assistance to our most impacted state residents, especially those without access to federal or state assistance. The program funds community foundations who partner with trusted, local community organizations to provide assistance to families most in need. The Community Foundations are expected to match the state funding dollar for dollar. Thus, a $10 Million allocation from the state results in $20 Million in cash assistance for vulnerable persons and families. The Task Force supports $10 million of state funding for this program in FY'22.

4.2.2. The Task Force Supports Progress Toward Eliminating Deep Poverty

The federal government defines "deep poverty" as half the federal poverty level. A family of three with a monthly income of less than about $900 would be considered in deep poverty. In Massachusetts, the maximum Emergency Aid to the Elderly, Disabled and Children (EAEDC) and Transitional Aid to Families with Dependent Children (TAFDC) those families could receive was $593 pre-pandemic per month. The Commonwealth's Fiscal Year 2021 budget provided a 10 percent increase from January through June of 2021. Shockingly, this was the first increase for TAFDC since 2000, and the first for EAEDC since 1998. The Governor is proposing to roll back that increase to pre-pandemic levels in the FY '22 budget.

At minimum, the Task Force strongly supports efforts to: (1) maintain the 10 percent benefit increase; (2) continue to increase benefits by 20 percent annually until they are at least at 50 percent of the federal poverty level, and; (3) continue to increase benefits through cost-of-living increases so that they remain at a minimum of 50 percent of federal poverty. This would benefit about 29,000 families.

There are at least eight states with higher benefits than Massachusetts, including Connecticut ($698 a month maximum for a family of three), Vermont (increasing to $700 in August), New York ($789), and New Hampshire ($1066).[79]

TESTIMONY RECEIVED IN SUPPORT OF RELEVANT MASSACHUSETTS LEGISLATION

HD1158 / SD430
An Act to Lift Kids Out of Deep Poverty
Sponsored by Rep. Marjorie C. Decker and Sen. Sal N. DiDomenico

4.2.3. The Task Force supports Extending the State Earned Income Tax Credit to All Taxpayers in Massachusetts

Many immigrant taxpayers who work, pay taxes, and file federal and state tax returns are not eligible for social security numbers, so they file their returns using Individual Tax Identification Numbers (ITINs). In 2018, the Department of Revenue received 30,821 returns from taxpayers with ITINs, of which 24,427 reported annual income under $50,000. Every one of these filers paid their share of state and federal income tax.

Under current law, only those Massachusetts residents who have social security numbers can receive the state earned income credit. In a comparison of two families, both earning $35,000/year and both raising two children, the family in which all members have a social security number will receive $3,390 from state and federal credits, including $785 from the state. The other family may have children with social security numbers, but if both parents, or even one of them has an ITIN, they will receive zero. The state EITC should be available to all families who pay state taxes.

TESTIMONY RECEIVED IN SUPPORT OF RELEVANT MASSACHUSETTS LEGISLATION

HD1992 / SD1886
An Act to Increase Family Stabilization Through the Earned Income Tax Credit
Sponsored by Reps. Marjorie C. Decker and Andres Vargas and Sen. Sal N. DiDomenico

[79] https://www.liftourkidsma.org/

4.3. INCREASE HOUSING STABILITY BY PREVENTING EVICTIONS AND FORECLOSURES, AND SUPPORTING EMERGENCY SHELTER

In the wake of COVID-19 and its prolonged economic effects, the Task Force received resounding testimony about the emergent need for housing stabilization and eviction and foreclosure prevention efforts.

The Massachusetts moratorium on evictions and foreclosures, which provided important protections, ended on October 17, 2020. The Governor is to be commended for replacing it with the COVID-19 Eviction Diversion Initiative funded through Fiscal Year 2021. That initiative includes: $100 Million in emergency rental assistance through the Residential Assistance for Families in Transition program (RAFT); up to $12.3 Million to provide tenants and landlords with access to legal services around eviction and foreclosure proceedings; and almost $50 Million for post-eviction rapid rehousing. The Biden Administration has stepped in with an executive order extending the federal eviction moratorium until March 31. In other words, all protections are removed by June 30, 2021.

However, through the American Rescue Plan, $362 Million is coming to Massachusetts for emergency rental assistance, and additional funds to prevent mortgage foreclosures and provide emergency assistance. The influx of these funds holds the potential to prevent a massive housing crisis. However, the funds must be directed to where they are most needed, and underlying factors must be addressed to prevent future housing crises when emergency funds expire.

4.3.1. Assist Landlords, Homeowners and Tenants to Prevent COVID-19 Evictions and Foreclosures

The Commonwealth received $450 Million in emergency rental assistance funds through the CARES Act in 2020, some of which has already been expended, and is about to receive an additional $362 Million for rental assistance and more for other housing-related purposes through the American Rescue Plan. The Commonwealth has the opportunity to distribute these funds equitably and efficiently. These funds could supplement and extend existing rental assistance and mortgage foreclosure prevention programs, including Rental Assistance for Families in Transition (RAFT), HomeBASE, Alternative Housing Voucher Program (AHVP), the Massachusetts Rental Voucher Program (MRVP), Emergency Rental and Mortgage Assistance (ERMA) and other housing stabilization and homelessness prevention programs.

Tenants and homeowners, including elderly persons and persons with disabilities, across Massachusetts are experiencing unprecedented financial distress. It is critical that the Massachusetts Department of Housing and Community Development (MDHCD) establish guidelines for distribution of these funds so that they benefit the tenants and homeowners at greatest risk of housing instability, homelessness, and utility shut-off as soon as possible. To accomplish this, the guidelines should further prioritize vulnerable populations, simplify the process, and add flexibility to the administration and allocation of funds.

The Task Force recommends that MDHCD prioritize funding for those communities with the highest COVID-19 infection rates per 100,000. There is clear evidence of increased housing instability and risk of displacement in these communities.

In addition, a portion of the emergency rental assistance funds should be used to stabilize families timing out of the HomeBASE program, which provides families in emergency shelter funds for up to a year to make the transition to permanent housing. Such funds should be targeted to HomeBASE participants in good standing in housing, whose benefits are set to expire and would otherwise likely face eviction. This would help ensure that these children and families do not face the trauma of experiencing homelessness again.

The Task Force recommends simplification of processes for people to obtain assistance for housing. Current processes are creating a barrier. For example, applicants are required to provide complex documentation to prove 'hardship', 'housing instability', and 'risk of homelessness.' The Commonwealth should accept self-certification to the greatest extent possible. This is particularly important for those who work in the cash economy who were among the hardest hit by the pandemic. Communication about the application process should be simplified, available in applicants' primary languages, and automated to allow applicants to check on the status of an application.

Finally, the Commonwealth should adopt flexible practices to ensure that funds are quickly distributed to those in greatest need, including providing funds directly to tenants when a landlord refuses to accept such funds; eliminating the current $10,000 cap on rental or mortgage arrears payments, particularly for those from hard hit communities; allowing for "bulk" payments to large landlords; funding municipal rental assistance programs; and allowing for existing state RAFT and ERMA funds to play a more robust role in preventing foreclosures.

The Task Force recommends policies that would prevent actions for "COVID-19" evictions or foreclosure until parties have worked in good faith to explore and exhaust every alternative. Measures should be included to prevent residential foreclosures for payments due during the state of emergency, and allow homeowners the same terms as federal lenders, including putting missed mortgage, interest, and escrow payments to the end of the loan term.

TESTIMONY RECEIVED IN SUPPORT OF RELEVANT MASSACHUSETTS LEGISLATION

HD3030 / SD1802
Enact An Act to prevent COVID-19 evictions and foreclosures and promote an equitable housing recovery
Sponsored by Reps. Frank Morgan and Kevin Honan and Sen. Patricia Jehlen

4.3.2. Promoting Housing Stability and Preventing Homelessness by Providing Legal Counsel in Eviction and Foreclosure Proceedings

Only 8 percent of tenants facing eviction have legal representation when they head to court, placing them at a huge disadvantage. During the emergency, there has been a pilot program to provide legal services to tenants facing evictions or other hearings. The pilot is funded through the Massachusetts Legal Assistance Corporation which subcontracts to local community-based organizations for services. This program should be continued with income eligibility guidelines created. The goal is to equalize the playing field and to stabilize housing for vulnerable families.

TESTIMONY RECEIVED IN SUPPORT OF RELEVANT MASSACHUSETTS LEGISLATION

HD2441 / SD1906

An Act promoting housing stability and homelessness prevention to provide right to counsel in evictions and foreclosure proceedings
Sponsored by Rep. David Rogers and Sen. Sal DiDomenico

4.3.3. Seal Eviction Records at Appropriate Times

Once a tenant has an eviction proceeding on their record, it is extremely difficult to obtain housing, even if they were not found to be at fault. When records became available online in 2013, landlords made it a habit to check eviction records, making housing all the more difficult for vulnerable families to obtain. This has a vastly disproportionate effect on families of color, particularly female headed households.

A January 2020 report from the ACLU found Black renters in Massachusetts are 2.4 times more likely to have an eviction case filed against them than others. The report also found, "black women are more likely to be denied housing due to prior eviction filings, even when they won." A June 2020 report from MIT and City Life/Vida Urbana shows that 70 percent of eviction filings in Boston are in majority-minority communities, despite only half of the city's rental housing being in those communities.[80]

Eviction records should be sealed as soon as proceedings are filed, while they are pending, and until or unless an allegation is proven. No-fault evictions should be sealed and non-payment and fault eviction cases should be publicly available only when there is a judgment against the tenant, or there is an agreement for judgment and the tenant has actually been evicted. All eviction records should be sealed after 3 years and a process should be developed to seal records for good cause before the 3-year point and when tenants satisfy their judgments or agreements.

TESTIMONY RECEIVED IN SUPPORT OF RELEVANT MASSACHUSETTS LEGISLATION

HD1889 / SD798
An Act promoting housing opportunity and mobility through eviction sealing (HOMES)
Sponsored by Rep. Michael Moran and Sen. Joseph Boncore

4.3.4. Increase Funding for and Access to the Emergency Shelter system

During the pandemic, families and individuals experiencing homelessness were often offered only congregate shelter when they had an emergency housing need. This was obviously dangerous during a pandemic. Funding from the Federal Emergency Management Agency allows for 100 percent federal reimbursement for non-congregate shelter during the pandemic, and the Massachusetts Emergency Management Agency and the Massachusetts Department of Housing and Community Development are urged to make these options available to as many people experiencing homelessness as possible.

The process for entering the Emergency Assistance family shelter system (budget line-item 7004-0101) desperately needs to be streamlined. Currently, the process relies on the person in need of shelter reaching someone on the phone and providing documentation electronically, both of which

[80] https://www.bostonglobe.com/2021/02/16/opinion/baker-should-seal-eviction-records-give-residents-second-chance/

are often challenging to accomplish. The Task Force recommends the creation of an ombudsperson to assist families in applying for emergency shelter and in retaining shelter benefits, and the removal of the shelter exclusion for families reapplying for shelter within 12 months of a previous shelter stay.

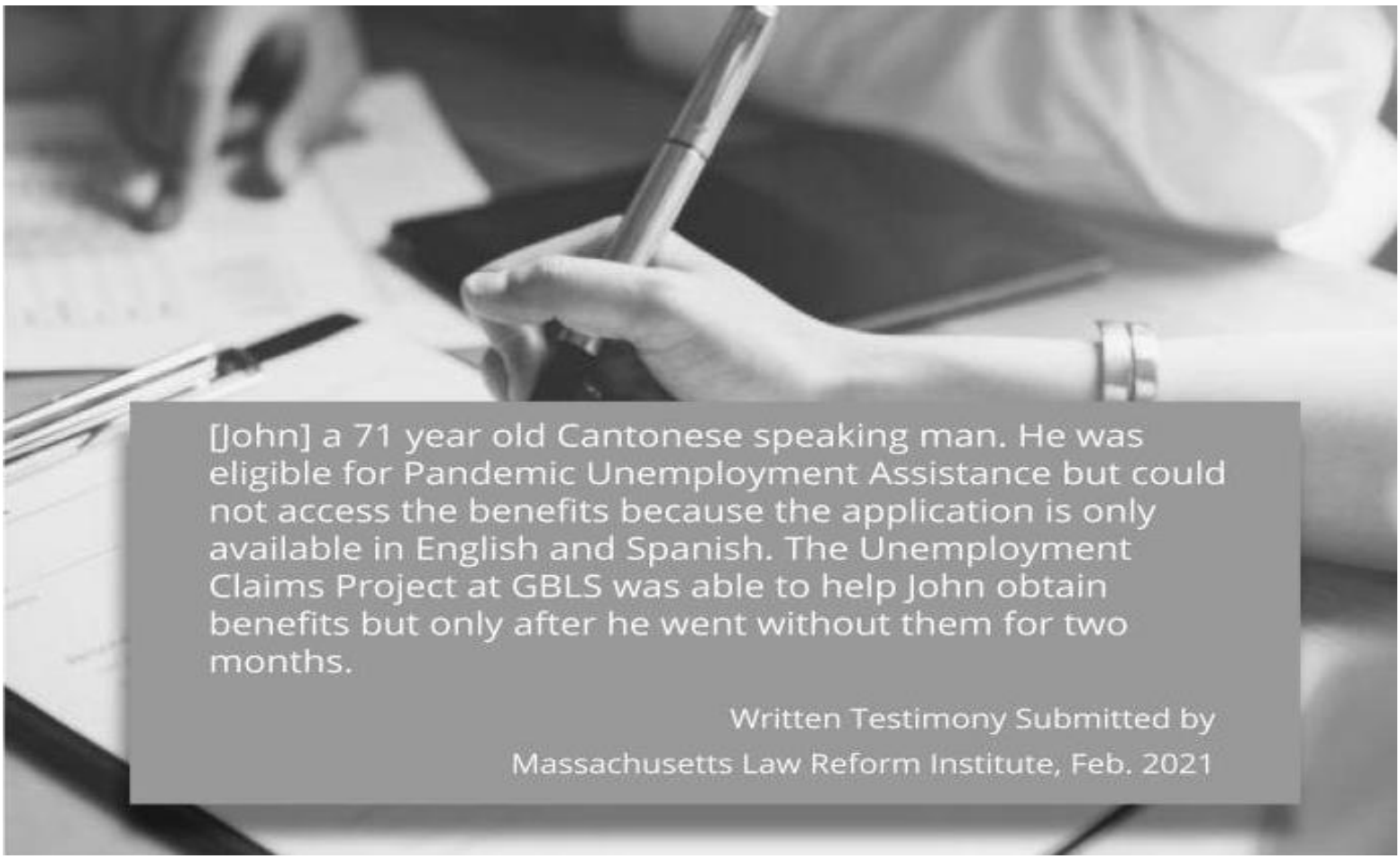
The family shelter program and single adult emergency shelter program (budget line-item 7004-0102) have been maximally taxed this past year. They have had to work to decompress shelters, prevent infections and keep staff safe. They are anticipating the potential for a major and significant need for their services during a prolonged recovery. Despite the influx of federal funds, so many families and individuals have lost businesses, income and employment that the need for shelter services could grow exponentially.

In some cases, additional funding was provided to shelters during the emergency. Not only should that funding be maintained, it should be increased in anticipation of growing demand and increased costs to address safety concerns. These investments in shelter and related rehousing programs are especially critical as the state navigates the pandemic and recovery.

4.4. CREATE ACCESS AND INCLUSION FOR IMMIGRANTS THROUGH LANGUAGE ACCESS, DRIVERS' LICENSES AND CIVIL RIGHTS

COVID-19 hit communities with large numbers of immigrants the hardest. According to MIRA Coalition, the Massachusetts organization that advocates on behalf of immigrants and refugees, "more than one-sixth of Massachusetts residents are foreign-born: almost 1.2 Million people, or 17.4 percent of the population." The communities with the highest percentage of their residents who are immigrants are: Chelsea (45%), Malden (43%), Everett (43%), Lawrence (41%), Revere (39%), Lynn (37%), Quincy (33%) and Randolph (32%).[81]It is no surprise that many of these same communities had the highest rates of COVID-19 infection statewide.

[81] https://miracoalition.org/get-the-facts/massachusetts-reports-data/



4.4.1. Promote Language Access in State Agencies

Our state is home to one of the most diverse immigrant populations in the country - nearly 600,000 people are Limited English Proficient (LEP) - and only forty percent of those individuals speak Spanish, indicating that the remaining sixty percent speak a multitude of other languages. While efforts have been made to communicate in multiple languages during the pandemic, much remains to be done.

The Task Force supports requiring public facing state agencies to provide oral and written language access to those they serve. State agencies should be required to create, implement and update targeted language access, including an assessment of languages spoken by their clients, with timelines and periodic reporting to the Legislature. The agencies should conduct periodic comprehensive training to staff on the importance of language access, how to work with interpreters and protocols on steps to take when dealing with an LEP individual.

Non-English speakers cannot easily access health information about COVID-19, and they cannot apply for benefits to meet their basic needs such as food (SNAP), housing, health care, unemployment and cash assistance, and cannot read notices that they have to re-apply to continue benefits.

The Task Force recommends that state agencies immediately adjust their telephone answering systems to provide short recorded greetings in multiple languages indicating which telephone key to press for each language. The multiple language greeting choices should be the very first in the

queue of greetings. While a language menu is frequently available, it follows a long message in English, often discouraging the caller before they get there.

TESTIMONY RECEIVED IN SUPPORT OF RELEVANT MASSACHUSETTS LEGISLATION

HD3674 / SD2251
Act Relative to Language Access and Inclusion
Sponsored by Reps. Adrian Madaro and Carlos Gonzalez and Sen. Sal DiDomenico

PROMISING PRACTICES FROM OTHER STATES

HAWAII

Legislation sets out requirements for state funded agencies regarding oral and written language services, requires each agency to establish language access plans and designate a language access coordinator, sets out requirements regarding translation of public hearings, and establishes a Language Access Office and Advisory Council.[82]

MARYLAND

Among the provisions of this legislation are a requirement that state agencies (over several years) take reasonable steps to provide equal access to public services for LEP individuals. It directs identified state agencies to translate "vital documents" (defined as all applications, or informational materials, notices, and complaint forms) into the language spoken by LEP population that constitutes 3 percent of the overall population within the geographic area served by a local office and to provide oral language services (which must be through face-to-face, in-house oral language services if contact between the agency and individuals with limited English proficiency is on a weekly or more frequent basis)

The legislation also requires equal access versions of government websites for any language spoken by limited English proficient populations that constitutes at least 0.5% of the overall population within the State. Finally, it calls for oversight and technical assistance to state agencies by the Department of Human Services, Office of the Attorney General and the Department of Information Technology.[83]

4.4.2. Protect the Civil Rights and Safety of All Massachusetts Residents

Undocumented immigrants are afraid to come forward for health care and other necessary services due to a climate of fear, including fear of being identified and detained by Immigration and Customs Enforcement. This has implications related to the public health response to COVID-19, testing, treatment, and vaccinations.

The Task Force supports protecting the civil rights and safety of all Massachusetts residents. Legislation under consideration to increase immigrants' sense of safety would prevent law enforcement from questioning persons about their immigration status, unless required by state or federal law, and require law enforcement to obtain written informed consent in multiple languages for any such questioning. Such actions would increase the health and safety of undocumented immigrants, thus positively affecting the health of their families and communities.[84] [In process]

[82] https://health.hawaii.gov/ola/files/2016/12/CHAPTER-321C-January-2015.pdf
[83] https://www.peoples-law.org/maryland-language-access-law-your-right-interpretation-and-translation
[84] https://www.miracoalition.org/wp-content/uploads/2021/02/SCA-factsheet-2021-1.pdf

TESTIMONY RECEIVED IN SUPPORT OF RELEVANT MASSACHUSETTS LEGISLATION

HD1165 / SD532
An Act to Protect the Civil Rights and Safety of all Massachusetts Residents
Sponsored by Sen. James B. Eldridge and Reps. Ruth Balser and Liz Miranda

4.4.3. Transportation: Access to Driver's Licenses and Identification for all Massachusetts Residents

All qualified state residents should be able to apply for a standard Massachusetts driver's license or identification card, regardless of immigrant status, while keeping our Commonwealth in full compliance with REAL ID requirements.

Having a valid ID would increase the comfort and reduce the fear of immigrants, particularly undocumented immigrants, to access health care, including vaccination, and other supportive services. If people can drive, they will also reduce their risk of exposure to the spread of infection on public transportation during the COVID-19 pandemic. And driving would increase the economic options available to workers and families to get to work, take their children to the doctor, or buy groceries. Public transportation is far too limited, particularly in the western part of the state.[85] [In process]

PROMISING PRACTICES FROM OTHER STATES

There is bipartisan support for driver's license legislation across the U.S. Sixteen states, the District of Columbia and Puerto Rico already allow residents the right to apply for driver's licenses regardless of immigration status, including our neighbors New York, Vermont and Connecticut. New Jersey and Virginia passed similar legislation, as did states with Republican governors – in Utah, Nevada and New Mexico. The following link provides a complete summary of these bills by state.[86]

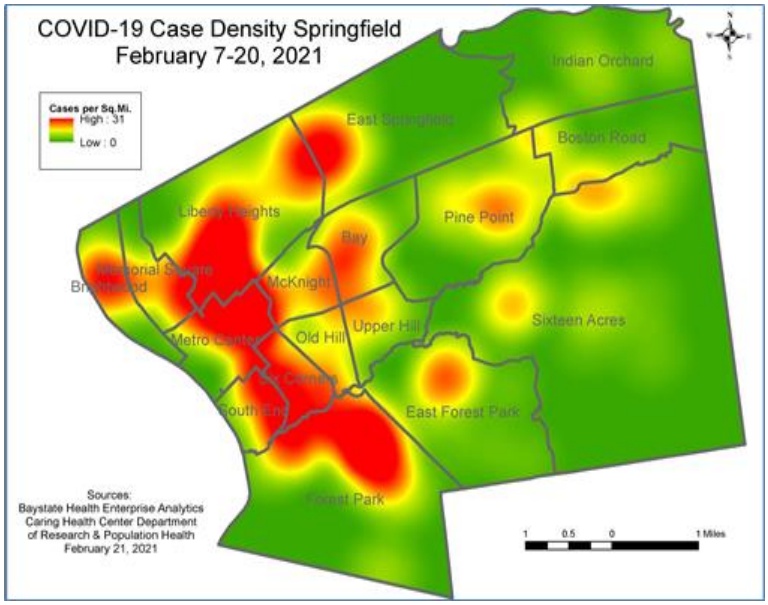
TESTIMONY RECEIVED IN SUPPORT OF RELEVANT MASSACHUSETTS LEGISLATION

HD44 / SD273
An Act relative to work and family mobility during and subsequent to the COVID-19 emergency
Sponsored by Reps. Tricia Farley-Bouvier and Christine Barber and Sen. Brendan Crighton

4.5. BUILD "COMMUNITIES OF OPPORTUNITY" BY PRIORITIZING INVESTMENT IN ENVIRONMENTAL JUSTICE COMMUNITIES HIGHLY IMPACTED BY COVID-19

Studies and mapping by CRESSH (Center for Research on Environmental and Social Stressors in Housing Across the Life Course) show the connection between high rates of COVID-19 and environmental burdens carried by those same communities, known as environmental justice (EJ) communities. CRESSH finds that the "burden of COVID-19 is falling unequally across Massachusetts communities based on vulnerability across multiple dimensions including health, economic, social,

[85] https://drive.google.com/drive/folders/1M761ssafO0bnzNu8onbRF0cttESUz4Ov
[86] https://www.ncsl.org/research/immigration/states-offering-driver-s-licenses-to-immigrants.aspx

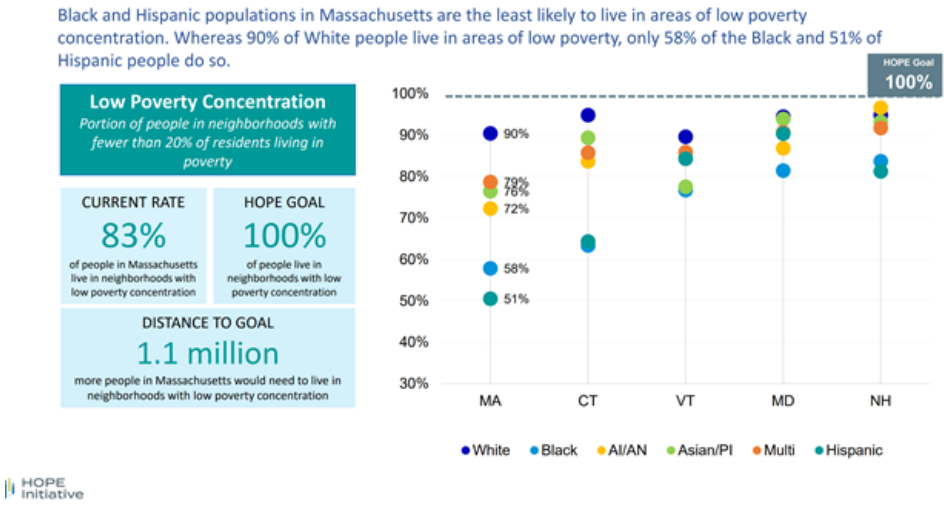


language, isolation, race/ethnicity, housing density and environmental factors.[87] The Task Force received testimony that supports these findings, which are common in Gateway Communities.

Modeling in Springfield's neighborhoods, conducted by Baystate Health's COVID-19 Mitigation Team, highlights disproportionately high rates of infections in traditionally underserved communities. Neighborhood-level maps (zip code is too large and at times too demographically and economically diverse) show a concentrated COVID-19 pattern in EJ populations and neighborhoods, defined through spatial epidemiological analysis as places of very high-risk.

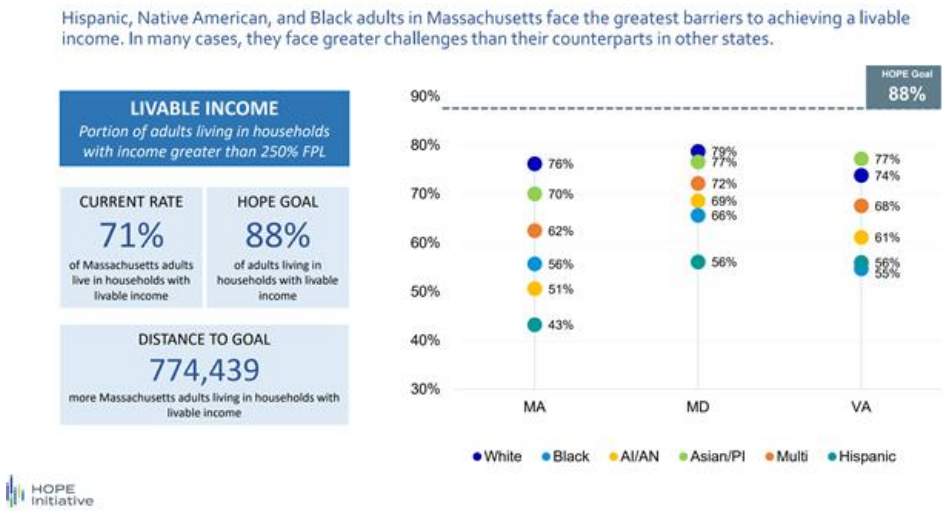
A report of the Kirwan Institute for the Study of Race and Ethnicity at The Ohio State University, entitled "The Geography of Opportunity: Building Communities of Opportunity in Massachusetts," identifies that low-income communities, and particularly racial and ethnic populations, are isolated from the essential opportunity structures needed to thrive. Neighborhood conditions (high quality education, a healthy and safe environment, sustainable employment, housing stability, etc.) play a substantial role in the life outcomes of residents."[88]

The HOPE Initiative observed that Black and Hispanic populations in Massachusetts are the least likely to live in areas of low poverty, pointing to greater racialized isolation or segregation from high opportunity communities when compared to other states. Further, the HOPE Initiative similarly found less



[87] https://sites.sph.harvard.edu/cressh/community-engagement-core/covid-19-community-resources/
[88] https://kirwaninstitute.osu.edu/research/geography-opportunity-building-communities-opportunity-massachusetts http://www.kirwaninstitute.osu.edu/reports/2009/01_2009_GeographyofOpportunityMassachusetts.pdf

access to livable income, reflecting the importance of addressing opportunity gaps so all residents flourish and can achieve their full potential.[89]



The Task Force recommends that the Massachusetts Department of Public Health and/or the recommended new Executive Office of Equity explore adoption of “Communities of Opportunity" or "Health Empowerment Communities or Zones" (see Public Health section) as an approach for state investments to build the capacity of and empower communities. Uplifting equity, health, and opportunity for all Massachusetts communities and residents starts by driving equity action in communities where the greatest gaps exist.

A first step toward environmental justice and community opportunity plans is legislation that would advance local garden agriculture programs that promote health, nutrition, jobs and a healthy environment.

TESTIMONY RECEIVED IN SUPPORT OF RELEVANT MASSACHUSETTS LEGISLATION

HD3246 / SD1581
An Act relative to food justice with jobs to establish a Garden Agriculture Program
Sponsored by Rep. Adrian Madaro and Sen. Joseph Boncore

[89] https://www.hopeinitiative.org/state/massachusetts

ACTING NOW TO PREPARE FOR THE FUTURE

5. STRENGTHEN THE PUBLIC HEALTH SYSTEM

5.1. SUPPORT AND STRENGTHEN LOCAL PUBLIC HEALTH

Local public health officials have stepped up to respond to this pandemic amid significant challenges and constraints and deserve our utmost appreciation. But they have been operating with one hand tied behind their backs with limited funding, staffing and other resources. *The fact that public health is the responsibility of 351 different cities and towns with varying resources and without clear guidance translates into a fragmented and inequitable response around the Commonwealth.* Around the country these responsibilities typically reside within county government. Massachusetts lacks a strong county government structure.

These challenges are well-documented and solutions have been proposed. The Special Commission on Local and Regional Public Health issued its report in June of 2019 (pre-COVID-19). According to the executive summary of the report,

> *Massachusetts is unique in the country in that it has a board of health for each of its 351 cities and towns and a long and proud history of home rule. Its tiny, stand-alone boards of health, many formed over a century ago, stand in contrast to the county or regional organization of local public health authorities in most other states. Their budgets, often bare bones, are the sole responsibility of individual cities and towns with no dedicated state funding. Their ever-expanding duties are determined by a patchwork of state laws and regulations in addition to local ordinances and by-laws. They report to numerous officials, yet there are few systems in place to assess their performance and no benchmarks for their overall success.*

The Executive Summary continues with key findings, including:

- Many Massachusetts cities and towns are unable to meet statutory requirements and even more lack the capacity to meet rigorous national public health standards.
- Because Massachusetts lacks a comprehensive system to collect local public health data, there is limited capacity to measure local public health system performance and to use local data to plan public health improvements.

A high-level summary of the Commission's recommendations includes[90]:

- Elevate the standards for and improve the performance of local public health departments.
- Increase cross-jurisdictional sharing of public health services to strengthen the service delivery capabilities of local public health departments.
- Explore improvements in the current platforms to report, analyze, and interpret data.

[90] https://www.mass.gov/doc/executive-summary-blueprint-for-public-health-excellence-0/download

- Set education and training standards for local public health officials and staff and expand access to professional development.
- Commit appropriate (state) resources for the local public health system changes proposed by the Commission.

The Task Force strongly supports measures to strengthen and streamline local public health. We cannot face another public health crisis with the fractured, inequitable and underfunded system we have. The Task Force urges MDPH to implement the findings of the Special Commission as soon as possible, and urges the Legislature to enact time-sensitive legislation this session to codify these recommendations in law. New investments of funds must accompany the modernization and improvements in the local and regional public health system.

In the meantime, federal COVID-19 funds could be deployed to accelerate the transition to a strengthened local and regional public health system. These resources should be allocated according to the needs of cities and towns, as measured by equity based on infection rates, socio-economic factors including poverty, race and ethnicity in burden of disease.

In addition, the Task Force recommends that incentives be incorporated for the local public health system to establish community advisory groups and processes (reflective of the community) to encourage collaboration and the input of diverse community representatives.

TESTIMONY RECEIVED IN SUPPORT OF RELEVANT MASSACHUSETTS LEGISLATION

HD1712 / SD1067

An Act relative to accelerating improvements to the local and regional public health system to address disparities in the delivery of public health services

Sponsored by Reps. Hannah Kane and Denise C. Garlic and Sen. Joanne Comerford

5.2. MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

Public Health has been underfunded for decades at the national, state and local levels, leaving us vulnerable and exposed to the devastating impacts of this pandemic. The Massachusetts Department of Public Health (MDPH) is deeply committed to health equity and to addressing the social determinants of health, but does so with the same limited resources as their peers across the country.

Over the past decade or more, MDPH successfully obtained federal funds to backfill gaps and cuts in their budget. While they are to be commended for these efforts, the grants further exacerbated a "silo" approach to public health. This limited the ability of the agency to holistically assess health needs across the population and to direct resources appropriately. Programs were driven by the funding source, instead of the needs. It is time to address this.

MDPH has a critical role to play in pandemic preparedness and response, particularly through the Office of Preparedness and Emergency Management (OPEM), which provides planning and management of public health disasters. The central role of MDPH, through OPEM and other divisions, should have been more elevated in the COVID-19 pandemic response and within the COVID-19 Command Center structure. The Task Force recognizes the vital role of public health in a pandemic response and supports elevating MDPH to play a more integral role through the duration

of this pandemic and into any future public health threats. The Task Force also supports building the overall capacity of MDPH to carry out prevention and intervention policies and programs to achieve health equity on an ongoing basis.

To do this, MDPH needs funding for data collection, analysis, reporting and surveillance, not only for a disaster but also for a host of public health indicators. All of these should be stratified by race, ethnicity and other socio-demographic factors and disaggregated within each category (see Data Dashboards within Prioritizing Equity in State Government).

MDPH needs funding for robust prevention and early intervention programs that braid resources together to build community assets and prevent poor and inequitable health outcomes. MDPH needs the capacity to work across state agencies, as public health is inextricably linked to the social factors in health such as food, housing, the environment and beyond.

MDPH needs funding to build local capacity to address public health issues. That includes building local and regional capacity to carry out basic public health functions as well as pandemic responses. It also includes resources to empower local communities to address their own public health concerns as Rhode Island and California have done (see promising practices below).

According to *The Impact of Chronic Underfunding on America's Public Health System: Trends, Risks, and Recommendations, 2020* from Trust for American's Health the core capabilities of a robust public health system include[91]:

- Increased funding to strengthen the public health infrastructure and workforce, including modernizing the system's data and surveillance capacities.
- Safeguarding and improving Americans' health by investing in chronic disease prevention and the prevention of substance misuse and suicide.
- Improving emergency preparedness, including preparation for weather-related events and infectious disease outbreaks.
- Addressing the social determinants of health and advancing health equity.

The Task Force urges legislative and administrative actions to empower the Massachusetts Department of Public Health to robustly carry out these functions.

PROMISING PRACTICES FROM OTHER STATES

RHODE ISLAND

Rhode Island provides funding to 10 Health Equity Zones. Essentially, those Zones are collaboratives of key local leaders and organizations that identify and address the issues of greatest concern to them. The Rhode Island Department of Public Health provides not only funding but also training, technical assistance, evaluation and overall support to create healthier communities.[92]

[91] https://www.tfah.org/report-details/publichealthfunding2020/
[92] https://health.ri.gov/programs/detail.php?pgm_id=1108

6. INTEGRATE EQUITY AND RESILIENCE INTO EMERGENCY AND DISASTER PREPAREDNESS

6.1. THE LEGISLATURE SHOULD ENACT LEGISLATION IN THE SPRING OF 2021 THAT REQUIRES AN AFTER ACTION REVIEW (AAR) WITH AN EQUITY LENS, AN INNOVATION ON A STANDARD PRACTICE IN THE FIELD OF EMERGENCY MANAGEMENT AND AN OPPORTUNITY FOR MASSACHUSETTS TO LEAD THE NATION.

It is well known throughout the disaster literature that vulnerable populations bear the disproportionate burden of devastation when disaster strikes. Hurricanes Katrina and Maria are prime examples. COVID-19 is often referenced as a "national Katrina" in light of its foreseeable disproportionate impacts on vulnerable people, notably those of diverse backgrounds. Yet, the field of disaster and emergency planning and preparedness does not yet fully recognize and incorporate that reality into their planning. Across the field of emergency preparedness, issues of equity can be peripheral, not central and core, to everything about preparing for, responding to and recovering from emergencies and disasters.

Equity should be the "North Star," a central and driving consideration in all aspects of the field. The planning should consider the unique needs of the populations including, race, ethnicity, language, disability, gender, sexual orientation and identification, age, social and economic vulnerability and other considerations.

To this end, the Task Force recommends that the Legislature enact legislation in the Spring of 2021 that requires an After Action Review (AAR), using an equity and resilience lens, an innovation on a standard practice and an opportunity for Massachusetts to lead the nation.

An AAR is a standard practice accepted by organizations ranging from The World Health Organization (WHO), to FEMA to the Department of Homeland Security and more. According to WHO an AAR is a "qualitative review of actions taken as a means of identifying and documenting best practices demonstrated and challenges encountered during the response to the event or the implementation of the project."

The AAR is an important management tool for continuous performance improvement and learning. It is a basic quality improvement practice familiar to many in healthcare and business. It is designed to capture what went well, best practices, and future opportunities for improvement. Such practices intentionally avoid blame and instead treat opportunities for improvement as learning and growth.[93] In fact, AARs were conducted following the Boston Marathon bombing, one on the overall emergency response and one on the public health aspects of the response.[94,95]

The typical AAR is conducted by an independent third party, often an emergency management consultant. There are standard practices for how to conduct an AAR from the various emergency management agencies including the National Incident Management System (NIMS) and the Homeland Security Exercise and Evaluation Program (HSEEP). Typical methods include key

[93] https://www.who.int/ihr/procedures/after-action-review/en/
[94] https://www.mass.gov/doc/after-action-report-for-the-response-to-the-2013-boston-marathon-bombings/download
[95] https://delvalle.bphc.org/mod/wiki/view.php?pageid=63

stakeholder interviews, surveys of additional key stakeholders and document review. While AAR's may be standard practice, **what is not standard is to conduct them with an equity lens and to be more inclusive where possible.**

6.2. THE LEGISLATION SHOULD REQUIRE THE APPOINTMENT OF A COVID-19 AFTER ACTION, EQUITY, AND RESILIENCE COMMISSION. THE AAR SHOULD BE INITIATED IN THE SPRING OF 2021 AND CONDUCTED ON A ROLLING BASIS UNTIL COMPLETE WITHIN 12 MONTHS OF THE END OF THE PUBLIC HEALTH EMERGENCY.

Creating a Commission to oversee the AAR is somewhat different from the usual methods emergency management agencies utilize to conduct an assessment. Those methods typically are overseen by internal committees and seek only arms-length community and stakeholder input through interviews and surveys. The Task Force believes that this pandemic has had such a historic and far-reaching impact, that a different and more inclusive statewide approach augmented with an equity and resilience lens, is warranted. If we have learned anything, it is that the way we usually do business must change. There is precedent, however. After 9/11, the President appointed a 9/11 Commission to do an AAR and make recommendations. We think that COVID-19 rises to at least this level.

The Commission, with the guidance of the facilitator, should begin their work with assessing potential frameworks to evaluate all actions with an equity lens and making a selection. It is critical that this framework be fully integrated and embedded into all aspects of the review, and not a separate, add-on section of the review. Equity must be prominent in every decision. Potential equity frameworks could include, but not be limited to "Targeted Universalism," a method for setting universal goals that may require different resources and approaches for different populations to achieve those goals. It is often used in making policy and program decisions.[96]

6.3. THE COMMISSION SHOULD COMPRISE REPRESENTATIVES OF: APPOINTEES BY THE GOVERNOR, INCLUDING BUT NOT LIMITED TO REPRESENTATIVES OF EMERGENCY MANAGEMENT; LEGISLATIVE LEADERSHIP AND APPOINTEES; LEADERS FROM CITIES AND TOWNS DISPROPORTIONATELY IMPACTED BY COVID-19; THE HEALTHCARE SECTOR; ESSENTIAL BUSINESSES AND WORKERS, SOCIAL SERVICES (HOUSING/FOOD) ORGANIZATIONS, AND PEOPLE WITH LIVED EXPERIENCE.

The Commission should include representatives of the executive branch appointed by the Governor including but not limited to the Massachusetts COVID-19 Command Center, the Massachusetts Emergency Management Agency, the Massachusetts Department of Public Health; legislative leadership, including appointees from the House Speaker and Senate President, including but not limited to representatives of the Joint Committee on Racial Equity, Civil Rights and Inclusion and the Joint COVID-19 and Emergency Preparedness and Management); city and town leaders from disproportionately impacted communities including emergency managers and public health personnel; representatives across the healthcare continuum of care, long-term care and congregate setting;, essential businesses and workers; social services and those organizations addressing social

[96] https://belonging.berkeley.edu/targeteduniversalism

determinants of health including but not limited to housing and food. The Commission should also include broad sector representation including business and labor.

6.4. THE AAR, UNDER THE GUIDANCE OF THE COMMISSION, SHOULD BE FACILITATED AND PRODUCED BY A THIRD PARTY/IES WITH EXPERTISE IN EMERGENCY MANAGEMENT, EQUITY AND PARTICIPATORY COMMUNITY PROCESSES.

Legislation should provide resources to the Commission to contract with an outside third party to facilitate the process and produce the report. Essential to a request for proposals for this vendor is that they have significant expertise in emergency management, equity and participatory processes. To achieve this may require a joint or "teamed" contract with multiple parties each holding pieces of the expertise but cooperating together in one process.

With the facilitators' help, the Commission will design a process that builds on standard AAR methods, and encourage inclusive and representative public participation to the greatest extent possible.

The legislation should direct the Commission to design methods that allow for additional community input, including but not limited to public hearings and open meetings, recognizing that some of the business of the Commission may include items that must remain confidential for security purposes. A major theme in public hearings of the Task Force was that people felt that all processes needed to be public and transparent. Input should be sought from diverse constituents across the Commonwealth.

6.5. THE AAR SHOULD BE CONDUCTED ON A ROLLING BASIS, BEGINNING AS SOON AS POSSIBLE WITH A REVIEW OF THE VACCINE PLAN. ADDITIONAL PHASES WILL BE DETERMINED BY THE COMMISSION, AND THE FINAL COMPREHENSIVE AAR SHOULD BE COMPLETED WITHIN 12 MONTHS OF THE END OF THE PUBLIC HEALTH EMERGENCY. REPORTS WILL BE FILED WITH LEADERS OF THE ADMINISTRATIVE AND LEGISLATIVE BRANCHES, AND A RESPONSE REQUIRED FROM THE ADMINISTRATION WITHIN ONE MONTH OF A ROLLING REVIEW, AND THREE MONTHS OF THE FINAL REPORT.

There is an urgent need to begin the AAR process immediately, focused on quickly learning lessons about the vaccine plan and amending that plan as soon as possible. This rolling and phased AAR process is a common practice so that learning can rapidly be incorporated into future phases of the emergency response and recovery. Additional phases will be determined by the Commission, and the final comprehensive AAR should be completed within 12 months of the end of the public health emergency.

The Commission will file their AAR reports with actionable recommendations with the Governor, Speaker of the House, the Senate President, the Joint Committee on Racial Equity, Civil Rights and Inclusion, and with the Joint COVID-19 and Emergency Preparedness and Management, and post the report on the public website.

AAR's run the risk of being completed and then filed away on a shelf. The next time an emergency or disaster occurs, the risk is that the same lessons are learned all over again. To prevent this from happening, the Task Force strongly recommends that the Legislature create an obligation for the Administration to file a response to the AAR, specifically stating point by point how they will amend

the statewide Comprehensive Emergency Management Plan to incorporate the recommendations of the AAR, particularly regarding equity.

The legislation should require the Administration to respond to the recommendations within one month of the phased AAR reports and within three months of the completion of the overall AAR.

The response to the AAR should include the corresponding resources necessary, including identified funding streams, where available, including the use of federal monies.

PROMISING PRACTICES FROM OTHER STATES

KIRKLAND, WASHINGTON

AAR's on the COVID-19 pandemic response have already been undertaken in some localities, are occurring on a rolling basis, and are being developed in some states around the country. The City of Kirkland, WA, where the first nursing home outbreak occurred, completed an AAR on the city's initial response last spring. The report focuses on improving the city's response to future pandemics and emergencies. It was conducted by a third-party consultant and uses the standard methods of document review, stakeholder interviews and surveys. It does not incorporate an equity lens.[97]

OREGON

A similar COVID-19 AAR is underway on a rolling basis in Oregon and relies on similar methods. The state retained an emergency management consultant to conduct the review.[98]

IOWA

Iowa is presently in the midst of procuring a vendor to plan, develop and manage a multi-step AAR and associated Improvement Plan (IP) based on the emergency management effort of the State of Iowa in response to the pandemic. The AAR and IP will provide data to document strengths and areas for improvement for preparedness and response efforts associated with pandemics and other disasters.[99]

7. Prioritize Equity in State Government

7.1. THE HEALTH EQUITY TASK FORCE RECOMMENDS THAT LEGISLATION BE ENACTED TO CREATE AND RESOURCE A CABINET LEVEL EXECUTIVE OFFICE OF EQUITY LED BY A SECRETARY OF EQUITY CHARGED WITH LEADING EFFORTS TOWARD EQUITY, DIVERSITY AND INCLUSION ACROSS ALL ASPECTS OF THE EXECUTIVE BRANCH OF STATE GOVERNMENT, INCLUDING CREATING STRATEGIC PLANS AND DATA DASHBOARDS, AND IMPLEMENTING AN EQUITY IN ALL POLICIES APPROACH, GUIDED BY AN EQUITY ADVISORY BOARD.

To promote opportunity and equity, address systemic drivers of inequity and root out racism will require a large-scale and intentional effort to drive system, policy, budget and program change throughout state government. While the charge of this Task Force is around Health Equity, we recognize that health is the net result of myriad social, economic and other factors, as well as racism. These factors, or "determinants" of health", account for up to 80% of health status.

[97] https://www.kirklandwa.gov/files/sharedassets/public/fire/emergency-mgmt/plans/kirkland-covid-19-initial-aar-11-2020.pdf
[98] https://olis.oregonlegislature.gov/liz/2019l1/Downloads/CommitteeMeetingDocument/22757
[99] https://ibdopportunities.iowa.gov/Home/BidInfo?bidID=339972bd-8e21-4800-99ad-767187f9b9dc

Therefore, a focus on equity within economic development, housing, social services, education and many other responsibilities of government are a prerequisite to achieving health equity.

A word on the definition of equity. The Legislature charged the Health Equity Task Force with making recommendations "to the general court that address health disparities for underserved or underrepresented populations based on culture, race, ethnicity, language, disability, gender identity, sexual orientation, geographic location, including, but not limited to, gateway cities with hospitals dedicated to caring for patients who test positive for COVID-19, and age in the commonwealth during the COVID-19 pandemic." (Section 2A of Chapter 93 of the Acts of 2020).

The Task Force takes that charge seriously and the Secretary of Equity would have responsibility for all residents of the Commonwealth. There would however, be a special obligation to address racial and ethnic equity given the disproportionate impact the pandemic has had on Black and Brown communities, and the racial reckoning our country is currently engaged in. The Secretary would work closely with others in state government with responsibilities for other populations and would include them in strategic planning, data monitoring and within the Interagency Council on equity.

The Secretary of Equity, in consultation with the legislative branch, Attorney General and an Equity Advisory Board, would be responsible for developing an overall equity strategic plan for the executive branch of state government, overseeing the Departmental strategic plans through an Interagency Equity Working Group, creating data dashboards, implementing the Equity In All Policies/Equity Impact Analysis policy and working collaboratively with the Equity Advisory Board.

TESTIMONY RECEIVED IN SUPPORT OF RELEVANT MASSACHUSETTS LEGISLATION

SD2026 / HD 3551
An Act establishing health equity at all levels in government
Sponsored by Sen. Joanne Comerford and Rep. Elizabeth Miranda

7.2. THE LEGISLATION WOULD ALSO CREATE AND RESOURCE OFFICES OF EQUITY WITHIN EVERY SECRETARIAT, CHARGED WITH LEADING EFFORTS TOWARD EQUITY, DIVERSITY AND INCLUSION THROUGHOUT THAT SECRETARIAT, AND COORDINATING WITH THEIR PEERS ACROSS STATE GOVERNMENT. EACH SECRETARIAT LEVEL OFFICE SHOULD ALSO HAVE AN EQUITY ADVISORY BOARD.

The legislation would create and resource equity offices within each executive office of the administrative branch of state government. These offices, in conjunction with the departmental Equity Advisory Boards, and in consultation with relevant legislative committees, would be responsible for working across the Secretariat to develop 3-to-5-year strategic plans, data collection and dashboards, and the implementation of the Equity Impact Analysis. They would also be charged with inter-agency initiatives where relevant. While accountable to the Secretary of their Executive Office, they would have matrixed accountability to the Secretary of Equity.

The Executive Office of Equity would provide technical assistance/training to agencies to complete agency strategic plans, dashboards, and foster a diverse, inclusive, and culturally sensitive workforce that delivers culturally sensitive services.

The Task Force acknowledges the important 2018 budget law provision in Section 16AA of Chapter 6A of the General Laws that established an office of health equity reporting directly to the Secretary

of the Executive Office of Health and Human Services. The legislation was implemented somewhat differently than written, with the creation of the Office of Health Equity within the Massachusetts Department of Public Health. The original intent of this legislative approach could serve as a foundation upon which to build equity firmly into all executive branch secretariats with additional specificity about responsibilities, accountability, advisory structures, resources, stature and reporting relationships, and collaboration across branches of government.

PROMISING PRACTICES FROM OTHER STATES

WASHINGTON

In April of 2020, Washington state enacted Chapter 332 of the Laws of 2020 (House Bill 1783) to create the nation's first Office of Equity. The Office sits within the Governor's Office for the purpose of promoting access to equitable opportunities and resources that reduce disparities, and improve outcomes statewide across state government. The Office is charged with developing a five-year strategic plan and assisting state agencies in doing likewise. The director is appointed by and reports to the Governor with advice and consent of the Senate. The office is charged with:[100]

- Assisting state agencies in applying an equity lens in all aspects of agency decision making, including service delivery, program development, policy development, and budgeting
- Community outreach and engagement
- Training on maintaining a diverse, inclusive, and culturally sensitive workforce
- Data maintenance and establishing performance metrics
- Performance accountability to equity plans and measures

VIRGINIA

Governor Ralph Northam appointed a cabinet level Chief Diversity Officer. According to a press release from the Governor's Office, "As the Director of Diversity, Equity, and Inclusion in the Commonwealth of Virginia, Dr. Underwood will develop a sustainable framework to promote inclusive practices across Virginia state government; implement a measurable, strategic plan to address systemic inequities in state government practices; and facilitate ways to turn feedback from state employees, external stakeholders, and community leaders into concrete equity policy."
The CDO is also charged with creating The ONE Virginia Plan, a strategic plan for achieving diversity, equity and inclusion across more than 100 state agencies. This year, the CDO has chaired the COVID-19 Equity Leadership Task Force. There is a Multi-Agency Health Equity Working Group as well as an Office of Health Equity within the Virginia Department of Health. There is no statutory mandate to create or sustain this position.[101]

7.3. THE OFFICE OF EQUITY WOULD CREATE A SET OF HIGH LEVEL AND PUBLICLY AVAILABLE DATA DASHBOARDS TO TRACK OVERALL PROGRESS TOWARD EQUITY. THE TASK FORCE RECOMMENDS USING THE OPPORTUNITY-BASED FRAMEWORK DEVELOPED BY THE HOPE INITIATIVE.

Since the passage of Chapter 93, data collection and reporting on COVID-19 has improved. The Department of Public Health now stratifies data by race, ethnicity, gender and other factors, and provides community-level data on rates of infection. This is important progress in the midst of a pandemic, and continuing progress is vital to guiding ongoing COVID-19 response and vaccination efforts from an equity perspective. As we look to the future, the Task Force heard much testimony on the need for more specific equity data collection, not only on COVID-19, but also on a range of

[100] http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/House/1783-S2.SL.pdf#page=1
[101] https://www.governor.virginia.gov/newsroom/all-releases/2019/september/headline-846422-en.html

health status indicators. As many stated, ”You cannot address what you can’t measure.” Thus, the recommendations for data dashboards are a leading priority.

The Task Force recommends that the Secretary of Equity look to the data dashboard model created by the Hope Initiative that focuses on opportunities within communities, rather than deficits. There are also important lessons to learn from the state of Connecticut (see box below).

7.4. THE TASK FORCE RECOMMENDS THAT MASSACHUSETTS ADOPT STANDARD AND CONSISTENT DEMOGRAPHIC DATA COLLECTION PRACTICES AT POINT OF CARE, SERVICE AND TESTING, AND THAT TO ACCOMPLISH THIS IT CONVENES KEY STAKEHOLDERS.

In designing those dashboards, one of the most vexing issues is data collection. The collection of accurate and comprehensive data at the front end - the point of care, service, or testing - is a vital prerequisite to accurate and comprehensive data at the back end - public reporting. The Task Force heard much testimony about the need to disaggregate the data and include additional categories. The categories of Black, Hispanic and Asian, for example, encompass multitudes of different cultures, languages and customs, making it difficult to tailor interventions. In addition, the Task Force heard compelling testimony to collect and report data reporting for persons with psychiatric diagnoses stratified by socio-demographic factors. This is an important endeavor that must also take into account patient privacy considerations and requirements.

As part of these initiatives, it is integral to train staff in best practices for collecting this information in a respectful manner. Providers do not routinely ask about sexual orientation or identity, ability, or occupation and place of employment. While some of this data is mandatory at the point of contact tracing, others are not. The challenge is to create a system where this information is requested by providers, payers and the public health and social service systems routinely and in a consistent and respectful manner.

To that end, the Task Force recommends that the Secretary of Equity convene key stakeholders to study and recommend best practices for collecting demographic data from patients at the point of care or testing, starting in the health care sector. The convening should include providers, payers, consumer advocates, relevant state agencies (HPC, CHIA, DPH, EOHHS) data experts and others. The group should consider and recommend best practices for data collection for at least the following groups:

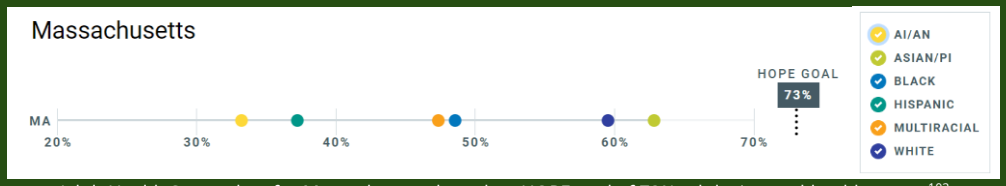
- Race (including meaningful capture of “multi-racial”)
- Ethnicity
- Country of familial origin
- Language including language in which person prefers to receive health care as well as primary language spoken in the home
- Sexual orientation
- Gender Identify
- Disability
- Occupation and place of employment (for reportable communicable diseases)
- Zip code or census tract
- Religious affiliation.

PROMISING PRACTICES ON DATA DASHBOARDS

THE HOPE INITIATIVE

The Health Opportunity and Equity (HOPE) Initiative presented their model dashboards to the Task Force. HOPE is funded by the Robert Wood Johnson Foundation (RWJF), and led by the National Collaborative for Health Equity and the Texas Health Institute in partnership with Virginia Commonwealth University's Center on Society and Health. HOPE sets benchmarks and tracks 27 indicators by race, ethnicity, and socioeconomic status. The indicators measure Social and Economic Factors, Community & Safety, Physical Environment, Access to Healthcare, and Health Outcomes. This dashboard has data for every state in the country. Notable about these dashboards is that they focus on opportunities rather than deficits, and on conditions that are modifiable by policy change. They exclude health behaviors since those are driven by the social and economic factors where people live, work and spend time.[102]

Also notable from HOPE, is the Massachusetts dashboard. They stressed in their presentation that while Massachusetts overall performs well on a host of key indicators, that masks the fact that the white majority does extremely well, while Black and Brown residents frequently perform below their counterparts around the country. That means that even though Massachusetts overall does well on certain indicators, the disparities in the state are significant compared to peers around the country. For example, while Massachusetts is 8th in the nation in overall health status, we are 24th in social and economic factors which disproportionately affect people of color and 46th in physical environment.



Adult Health Status data for Massachusetts based on HOPE goal of 73% adults in good health status.[103]

CONNECTICUT

The Connecticut Office of Health Strategy also presented at the February 2 Task Force meeting. They are leading the way as a state with the development of data dashboards with the goal of aligning public health, provider and payer measures. Connecticut has developed a Healthy Connecticut 2020 Dashboard. It is based on the State Health Improvement Plan and the CDC Healthy People 2020 goals, and measures a series of indicators drawn from the Institute of Medicine's Leading Health Indicators. Data is stratified by race and ethnicity wherever possible.

Of particular interest, Connecticut encountered the challenge of the quality of the demographic data collected at the point of care. The Connecticut Health Foundation brought the Cambridge-based Institute for Healthcare Improvement to Connecticut to facilitate a process with multiple stakeholders around what data should be collected. Of note, they are filing legislation to clarify and standardize race, ethnicity and language data collection for health care providers required to connect to the State-wide Health Information Exchange.[104,105]

CALIFORNIA

Regarding the collection of data on sexual orientation and gender identity, in September 2020 through Chapter 183 of the Acts of 2020, California became the first state in the nation to require the collection of sexual orientation and gender identity data for all reportable diseases, including COVID-19. The burden to

[102] https://www.nationalcollaborative.org/our-programs/hope-initiative-project/
[103] https://www.hopeinitiative.org/state/massachusetts
[104] C G A (ct.gov)
[105] https://portal.ct.gov/en/DPH/State-Health-Planning/Healthy-Connecticut/Healthy-Connecticut-2020-Performance-Dashboard

collect this data lies on the provider (if the information is known) and the health officer (local/county public health officials).[106]

7.5. THE TASK FORCE RECOMMENDS THE LEGISLATION INCLUDE A REQUIREMENT FOR AN EQUITY IN ALL POLICIES/EQUITY IMPACT ANALYSIS ON NEW POLICIES AND PROGRAMS.

There is an opportunity for Massachusetts to build on an existing model and create a bold new approach for rooting out systemic inequity. Multiple jurisdictions (see Promising Practices below) around the country have used Health in All Policies approaches to analyze the health impacts of everything from transportation projects to building developments. Now is the time to innovate on and evolve this practice and implement an equity in all policies approach.

Health in All Policies requires analyses of issues not typically thought of as related to health, including social, economic, environmental, housing, transportation and other issues, as well as the more obvious health and human service issues. An equity in all policies approach would require the same. As we know, health is created through equitable access to economic, social and behavioral resources and opportunities and thus these resources must be assessed to achieve health equity. The goal is to embed analysis of equity into all decision-making so that it becomes the routine way of doing business.

Critical to the success of such processes is a clear mandate through legislation or other means. There must be clear processes and tools for policy evaluation. One method to be considered for conducting these analyses would be contracting with academic institutions, as recommended in the HEALING Bill (Health Equity In All Levels In Government) cited in the blue box above. There must also be adequate resources for this policy to succeed.

An equity impact analysis could be triggered by a request from any member of the Legislature, or the executive branch. The Office of Equity will be responsible for developing regulations, tools and overseeing implementation. The Equity Advisory Board will approve final proposals for doing so.

PROMISING PRACTICES FROM OTHER STATES

CALIFORNIA

California's Health in All Policies program is an example for Massachusetts to learn from and adapt as it develops its own innovative, cutting-edge model focused on *equity.* A case study of California is cited in the Public Health Institute report. Executive Order S-04-10 created the Health in All Policies Task Force charged with identifying "priority programs, policies, and strategies to improve the health of Californians while advancing the goals of improving air and water quality, protecting natural resources and agricultural lands, increasing the availability of affordable housing, improving infrastructure systems, promoting public health, planning sustainable communities, and meeting the climate change goals." The Attorney General sits on the Task Force, along with officers of 18 other California state agencies, departments, and offices.[107,108]

WASHINGTON

[106] https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB932
[107] https://oag.ca.gov/environment/communities/policies
[108] https://sgc.ca.gov/programs/hiap/

In Washington state, legislation established the Washington State Governor's Interagency Council on Health Disparities and dictates that the council's action plan must address a number of specific diseases, health issues, and behaviors. These include diabetes, infant mortality, HIV/AIDS, breast cancer, sudden infant death syndrome, mental health, and the immunization rates of children and senior citizens. In Washington State, the governor or any legislator can request that the Board of Health complete a Health Impact Review on the impacts of legislation on health disparities.[109]

SEATTLE, WA

Seattle has a comprehensive commitment to addressing structural racism. As part of that commitment, they developed the attached tool to assess the impact of new policies and programs on equity.[110]

7.6. EQUITY ADVISORY BOARD

The Executive Office would be guided by an external Equity Advisory Board, with diverse experts in the fields of equity and health equity, community-based organizations that address the social and economic factors that impact equity, and people from communities around the Commonwealth with lived experience. The Equity Advisory Board should have 25 to 30 members who represent the diverse Commonwealth and are appointed by the Governor, the Speaker of the House, the Senate President, and the Attorney General. The chairs of the joint committees on Racial Equity, Civil Rights and Inclusion should be considered for appointment. Among the organizations that should also be considered are community health centers; a safety net hospital; an immigrant advocacy organization, along with health care consumers, housing, food, child advocacy and other organizations representing social factors in health, as well as health equity policy experts. This Board will approve the Commonwealth's equity strategic plan, have input and final approval of Data Dashboards, and approve the Equity in All Policies implementation plan and monitor results of all.

PROMISING PRACTICES FROM OTHER STATES

CALIFORNIA

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WASHINGTON

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[109] https://healthequity.wa.gov/

[110] https://www.seattle.gov/Documents/Departments/RSJI/Racial%20Equity%20Toolkit_FINAL_August2012_with%20new%20cncl%20districts(0).pdf

[111] https://oag.ca.gov/environment/communities/policies https://sgc.ca.gov/programs/hiap/

Seattle has a comprehensive commitment to addressing structural racism. As part of that commitment, they developed the attached tool to assess the impact of new policies and programs on equity.[112]

8. CONCLUSION

8.1. CALL FOR AN EQUITY IMPACT ANALYSIS OF HOW FEDERAL FUNDS HAVE BEEN INVESTED IN MASSACHUSETTS AND A PLAN FOR FUTURE INVESTMENT

This is a comprehensive roadmap to address the disproportionate impacts of COVID-19 on racial and ethnic groups, and other vulnerable populations and communities through the pandemic. It also seeks to put the Commonwealth on a path toward addressing underlying, root causes of these inequities and to prevent them in the future. The goal of this roadmap is to ensure that equity is front and center in all decisions by the state government going forward.

Needless to say, these recommendations will require commitment and resources for substantial funds to be implemented. The federal government has already provided $71 Billion for pandemic response, and another approximately $12 Billion is slated to arrive through the American Rescue Plan. While there are many requirements on these funds, and the Commonwealth is to be commended for publicly posting related information, **there has been no comprehensive analysis of the equity impact of these funds.**

For example, are these funds going to the communities and populations hardest hit by this pandemic? Are they targeted to address barriers to vaccines for vulnerable populations? And how can these funds serve as an essential bridge to a stronger, more equitable future? These are just a few of the questions that need to be examined.

This Task Force calls for such an **equity impact analysis** of funds that have already been expended, and an **equity plan for all unspent balances and future new funds** the Commonwealth may receive. It is often said that you can tell an entity's priorities by looking at their budget. Let's make it clear in the Commonwealth's budget plans, that equity is priority number one.

[112] https://www.seattle.gov/Documents/Departments/RSJI/Racial%20Equity%20Toolkit_FINAL_August2012_with%20new%20cncl%20districts(0).pd

APPENDICES

9. TASK FORCE MEMBERS

Senate Appointees	House Appointees
Michael Curry, Esq. **Task Force Co-Chair** *President & CEO, Massachusetts League of Community Health Centers*	**Dr. Assaad Sayah** **Task-Force Co-Chair** *CEO, Cambridge Health Alliance; Commissioner of Public Health, City of Cambridge; Assistant Professor, Harvard Medical School*
Senator Julian Cyr	**Rep. Jose Tosado** (term through January 2021)
Senator Sonia Chang-Diaz	**Dr. Kiame Mahaniah** *CEO, Lynn Community Health Center*
Dr. Milagros Abreu *Executive Director, President and Founder of The Latino Health Insurance Program*	**Dr. Myechia Minter-Jordan** *President & CEO, DentaQuest Partnership for Oral Health Advancement and Catalyst Institute*
Dr. Cassandra Pierre *Infectious Disease Physician and Assistant Professor of Medicine at Boston University*	**Jeffrey Sanchez** *Lecturer, Center for Public Health Leadership, TH Chan School of Public Health; Senior Advisor, Rasky Partners*
Dr. Frank Robinson *Vice President, Public Health, Baystate Health*	**Beverly Stables** *Health Care Policy Analyst for House Minority Leader Bradley H. Jones, Jr.*
Hirak Shah *Legal Counsel for Senate Minority Leader Bruce Tarr*	**Rep. Carlos González**
	Rep. Liz Miranda (term commenced in February 2021)
Rep. Chynah Tyler *Chair of the MA Black and Latino Legislative Caucus*	**Representative Donald H. Wong** *Chair of the MA Asian-American Legislative Caucus*

10. LEGISLATIVE CHARGE OF THE HEALTH EQUITY TASK FORCE

Chapter 93 of the Acts of 2020:
https://malegislature.gov/Laws/SessionLaws/Acts/2020/Chapter93

SECTION 2. (a) Notwithstanding any general or special law to the contrary, there shall be a task force to study and make recommendations to the general court that address health disparities for underserved or underrepresented populations based on culture, race, ethnicity, language, disability, gender identity, sexual orientation, geographic location, including, but not limited to, gateway cities with hospitals dedicated to caring for patients who test positive for COVID-19, and age in the commonwealth during the COVID-19 pandemic.(b) The recommendations shall include, but shall not be limited to, ways to: (1) improve safety for populations at increased risk for COVID-19, which may include, but shall not be limited to: (i) employees of businesses and organizations defined as providing "COVID-19 Essential Services" under the governor's March 23, 2020 emergency order; (ii) individuals residing in congregate housing and group home facilities, including, but not limited to, those operating under contracts with the department of developmental services, the department of mental health, the department of children and families, executive office of elder affairs, the department of housing and community development, the department of youth services, or the department of public health; (iii) inmates confined to a house of correction or state prison; (iv) individuals with serious underlying medical conditions linked to increased risk of severe illness from COVID-19 according to the federal Centers for Disease Control and Prevention; and (v) individuals residing in municipalities or neighborhoods disproportionately impacted by COVID-19;

SECTION 2. (b) (1) (cont.) (2) remove barriers and increase access to quality and equitable health care services and treatment; (3) increase access to medical supplies; (4) increase access to testing for COVID-19, including identifying ways to ensure that testing occurs in diverse geographic locations throughout the commonwealth; (5) provide informational materials to underserved or underrepresented populations in multiple languages on available and affordable health care resources in the commonwealth, including, but not limited to, prevention, testing, treatment and recovery; and (6) address any other factor the task force deems relevant to address health disparities for underserved or underrepresented populations based on culture, race, ethnicity, language, disability, gender identity, sexual orientation, geographic location and age in the commonwealth during the COVID-19 pandemic. As part of its recommendations, the task force may recommend the further study of the impact of disparities on populations not subject to this study.

(c) The task force shall consist of: 6 members appointed by the senate president, not more than 2 of whom shall be members of the senate; 6 members appointed by the speaker of the house of representatives, not more than 2 of whom shall be members of the house of representatives; 1 member appointed by the minority leader of the senate; 1 member appointed by the minority leader of the house of representatives; the chair of the Massachusetts Asian-American Legislative Caucus or a designee; and the chair of the Massachusetts Black and Latino Legislative Caucus or a designee. Task force membership shall reflect diverse representation in the commonwealth including, but not limited to, diverse cultures, races, ethnicities, languages, disabilities, gender identities, sexual orientations, geographic locations and ages. Appointees of the senate president, speaker of the house, minority leader of the senate and minority leader of the house who are not members of the general court shall be knowledgeable in public health or healthcare. When making appointments, the senate president, speaker of the house, minority leader of the senate and minority leader of the house shall give consideration to individuals who have experience addressing

disparities in underserved or underrepresented populations based on culture, race, ethnicity, language, disability, gender identity, sexual orientation, geographic location and age or who work in the healthcare system with a diverse patient population. Two members of the task force shall be elected by a majority of the task force membership to serve as co-chairs; provided, however, that neither member shall be a member of the general court. The task force may consult with the office of health equity to inform its work. The office of health equity shall provide requested information to the task force upon request.

(d) The task force shall file its recommendations with the clerks of the house of representatives and the senate and the house and senate committees on ways and means not later than August 1, 2020 *[date amended by section 70 of Chapter 227 of the Acts of 2020].*

(e) The task force shall file an interim report describing any initial recommendations and issues requiring further study with the clerks of the house of representatives and the senate and the house and senate committees on ways and means not later than June 30, 2020; provided, however, that the task force may file earlier interim recommendations if deemed advisable or additional interim recommendations between June 30, 2020 and August 1, 2020 *[date amended by section 71 of Chapter 227 of the Acts of 2020]*.

(f) The task force shall hold at least 1 public hearing and accept public comment before filing its interim report under subsection (e) and shall hold not less than 2 additional public hearings and accept public comment before filing its final report under subsection (d); provided, however, that the task force may hold virtual public hearings if it is in the interest of public health.

SECTION 3. Notwithstanding any general or special law to the contrary, the department of correction and each house of correction shall provide to the department of public health any data necessary to implement sections 1 and 2.

SECTION 4. Notwithstanding any general or special law to the contrary, the department of public health may enter into interagency agreements with other state agencies to facilitate the collection of data requested pursuant to this act.

SECTION 5. Sections 1 and 3 to 4, inclusive, are hereby repealed.

SECTION 6. The governor shall certify in writing to the state secretary when the department of public health has not received a report of a positive test of COVID-19 in the commonwealth within the preceding 30 days.

SECTION 7. Section 5 shall take effect upon the certification required by section 6.

Approved, June 7, 2020.

11. HEALTH EQUITY TASK FORCE INTERIM REPORT

Health Equity Task Force Interim Report: Report SD.3081 (malegislature.gov) and Report HD.5415 (malegislature.gov)

Interim Report of the Health Equity Task Force (pursuant to §2 of Chapter 93 of the Acts of 2020) to study and make recommendations to the General Court that address health disparities for underserved or underrepresented populations during the COVID-19 pandemic

COVER LETTER
October 15, 2020

To the Honorable Michael D. Hurley
Clerk of the Senate
State House, Room 335
Boston, MA 02133

To the Honorable Steven T. James
Clerk of the House of Representatives
State House, Room 145
Boston, MA 02133

Dear Mr. Hurley and Mr. James:

Please find attached the Interim Report of the Health Equity Task Force (pursuant to §2 of Chapter 93 of the Acts of 2020, which is attached to this letter as a description of the legislative mandate vested in the Health Equity Task Force).

The Task Force is charged to study and make recommendations that will promote an equitable COVID-19 response and address troubling health inequities by learning from experiences to date. Drawing on the significant work done by others, the Task Force has an ultimate goal of making progress on longstanding structural inequities and improvements in ongoing and future pandemic response efforts, which will be a focus of a future Final Report. Health disparities are not new, but have been amplified in the COVID-19 pandemic and its economic aftermath.

Based on extensive stakeholder input of approximately 100 organizations and individuals thus far, this Interim Report is issued to provide timely considerations for state policy makers about immediate needs in the ongoing COVID-19 response, as we face the possibility of a second surge. To that end, the Interim Report highlights key priorities for the FY 2021 state budget and policy action expected this Fall.

Respectfully,

Michael Curry, Esq. Task Force Co-Chair, Deputy CEO and General Counsel at Massachusetts League of Community Health Centers

Dr. Assaad Sayah, Task Force Co-Chair, CEO, Cambridge Health Alliance; Commissioner of Public Health, City of Cambridge; Assistant Professor, Harvard Medical School

Senate Appointees

Senator Sonia Chang-Diaz

Senator Julian Cyr*

Dr. Milagros Abreu, Executive Director, President and Founder of The Latino Health Insurance Program

Dr. Cassandra Pierre, Infectious Diseases Physician and Assistant Professor of Medicine at Boston University

Dr. Frank Robinson, Vice President, Public Health Baystate Health

Hirak Shah, Legal Counsel for Senate Minority Leader Bruce Tarr

Chair of the MA Black and Latino Legislative Caucus
Representative Carlos González

House Appointees

Representative Chynah Tyler

Representative José F. Tosado

Dr. Kiame Mahaniah, CEO, Lynn Community Health Center

Dr. Myechia Minter-Jordan, President & CEO, DentaQuest Partnership for Oral Health Advancement and Catalyst Institute

Jeffrey Sanchez, Lecturer, Center for Public Health Leadership, TH Chan School of Public Health; Senior Advisor, Rasky Partners

Beverly Stables, Health Care Policy Analyst for House Minority Leader Bradley H. Jones, Jr.

Chair of the MA Asian-American Legislative Caucus
Representative Donald H. Wong

*Senator Cyr voted to approve the Health Equity Interim Report, noting his recusal on the report's telehealth provisions related to his service on the pending Health Care Conference Committee and on Appendix IV of the Interim Report.