MASSACHUSETTS
HEALTH POLICY COMMISSION

HPC Board Meeting

October 23, 2025

Agenda

UP NEXT: Call to Order

Approval of Minutes **(VOTE)**

2025 Health Care Cost Trends Hearing

Health Care Transformation and Innovation: Investment Programs

HPC DataPoints Issue #31, "*When the Closest Pharmacy is Too Far: Mapping Pharmacy Deserts in Massachusetts*"

Select Findings from the 2025 Health Care Cost Trends Report Chartpack

Administration and Finance

Executive Director's Report

Adjourn

Agenda

Call to Order

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VOTE

Approval of Minutes from September 18, 2025, Board Meeting

MOTION

That the Commission hereby approves the minutes of the Commission meeting held on September 18, 2025, as presented.

Agenda

Call to Order

Approval of Minutes **(VOTE)**

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The HPC employs four core strategies to realize its vision of better care, better health, and lower costs for all people of the Commonwealth.

MARKET OVERSIGHT

Monitor and intervene when necessary to assure market performance

CONVENE

Bring together stakeholder community to influence their actions on a topic or problem

RESEARCH AND REPORT

Investigate, analyze, and report trends and insights

PARTNER

Engage with individuals, groups, and organizations to achieve mutual goals

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2025 HEALTH CARE COST TRENDS HEARING

Working Together to Safeguard the Commonwealth's Commitment to Health Care Affordability, Access, and Equity

SAVE THE DATE

Wednesday
NOVEMBER 12, 2025
Registration and Breakfast: 8:30AM

SUFFOLK UNIVERSITY
LAW SCHOOL
120 Tremont Street, Boston

MASSACHUSETTS
HEALTH POLICY COMMISSION

2025 Health Care Cost Trends Hearing Agenda

Working Together to Safeguard the Commonwealth's Commitment to Health Care Affordability, Access, and Equity

Registration and Breakfast	8:30 AM
Call to Order and Welcome	9:00 AM
Opening Remarks from Massachusetts Leaders	9:15 AM
Panel 1: A Call to Action: Community and Clinician Voices on Threats to Access, Affordability, and Equity	9:45 AM
Presentation: Federal Policy Landscape: Impacts on Health Coverage in Massachusetts Audrey Shelto, President and CEO, Blue Cross Blue Shield of Massachusetts Foundation	10:30 AM
Panel 2: State Policy Response to Federal Action: Preserving Health Care Access and Equity • **Michael Curry**, President and CEO, Massachusetts League of Community Health Centers; Co-Founder, Health Equity Compact • **Michael Lauf**, President and CEO, Cape Cod Healthcare; Board Chair, Massachusetts Health and Hospital Association • **Michael Levine**, Undersecretary for MassHealth, Executive Office of Health and Human Services • **Audrey Morse Gasteier**, Executive Director, Massachusetts Health Connector • **Amy Rosenthal**, Executive Director, Health Care For All	11:00 AM
Lunch Break	12:15 PM
Panel 3: Innovation Insights: Transforming Care through the Hospital at Home Programs • **Danny Metzger-Traber**, Vice President, Strategic Business Operations, Mass General Brigham Healthcare at Home • **Constantinos Michaelidis, MD**, Medical Director, UMass Memorial Health Hospital at Home Program	12:45 PM

Agenda subject to change.

2025 Health Care Cost Trends Hearing Agenda (continued)

Research Presentation: Health Care Cost Trends in Massachusetts and the Imperative to Advance Affordability David Seltz, Executive Director, Health Policy Commission	1:15 PM
Panel 4: Pharmaceutical Market Trends: Balancing Innovation and Sustainability • **Sarah Emond,** President and CEO, Institute for Clinical and Economic Review • **Patrick Gilligan,** President and CEO, Point32Health • **Marissa Schlaifer**, Vice President, Policy and Regulatory Affairs, OptumRx • **Tracy Sims,** Executive Director of Corporate Affairs, Eli Lilly and Company • **Matthew Veno,** Executive Director, Group Insurance Commission	1:30 PM
Panel 5: Moving Forward Together: How CEOs are Maintaining a Focus on Affordability in a Time of Uncertainty • **Doug Howgate,** President, Massachusetts Taxpayers Foundation • **Sarah Iselin,** President and CEO, Blue Cross Blue Shield of Massachusetts • **Manny Lopes,** President and CEO, Fallon Health • **Kevin Tabb, MD,** President and CEO, Beth Israel Lahey Health	2:45 PM
Reflections and Discussion	4:00 PM
Public Testimony For more information and to sign up to testify, visit: masshpc.gov/2025-cth	4:15 PM
Adjournment	4:30 PM

The HPC required 50 health care market participants to submit written testimony before the 2025 Cost Trends Hearing.

- In partnership with the Office of the Attorney General, the HPC requires pre-filed testimony (PFT) annually to engage with a broad range of Massachusetts health care market participants, in addition to the witnesses called to testify in-person.
  - Chapters 342 and 343 of the Acts of 2024 required **additional market participants** to provide public testimony.

Health care entities are asked address topics such as:

- Recent and ongoing federal policy changes
- Workforce challenges
- Investments in and access to primary care
- Prescription drug spending trends
- Direct-to-consumer prescription drug programs
- Access to biosimilars
- Private equity involvement in Massachusetts health care
- Health care affordability

- PFT responses are due Friday, October 31, 2025, and will be posted on the testimony webpage of the HPC's website as they are submitted.

25 Providers

9 Payers

7 Pharmaceutical Manufacturers

4 Pharmacy Benefit Managers

3 Significant Equity Investors

1 Management Services Org.

1 Real Estate Investment Trust

Registration and Details

Location:
Suffolk University Law School
120 Tremont Street, Boston

- The hearing will also be livestreamed on the HPC's website.

Time:
Registration and Breakfast begins at 8:30 AM

Registration is required for in-person attendance. Register on the 2025 Health Care Cost Trends Hearing webpage on the HPC's website.

Register Here

masshpc.gov/cth-2025-register

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Health Care Transformation and Innovation: Investment Programs

UP NEXT: The HPC's Investment Programs Over Time

Hypertensive Disorders Equitably Addressed through Remote Technology for Birthing People (HEART-BP)

Promoting Appropriate Transitions to Home (PATHways)

Goals of HPC Investment Programs

Respond to pressing health care challenges

Since its inception, the HPC has leveraged investment programs to address emerging issues in health care such as the opioid epidemic, rising costs, and unmet health-related social needs.

Test models with promise of advancing care quality, access, and equity at lower cost

The HPC designs programs from an existing evidence base and incorporates novel solutions to determine whether and how care models improve care access, quality, and equity at a lower cost.

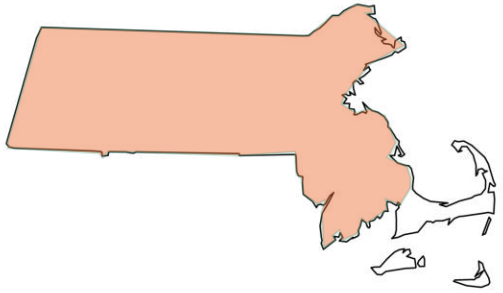
Promote policy priorities that have real patient and community impact

The HPC leverages learnings from investment programs to inform the broader policy landscape, ensuring Massachusetts strategic priorities reflect the voices of patients and communities they're designed to serve.

Ten Years of Care Delivery Transformation Across Massachusetts

200,000+

Lives impacted across six investment programs.

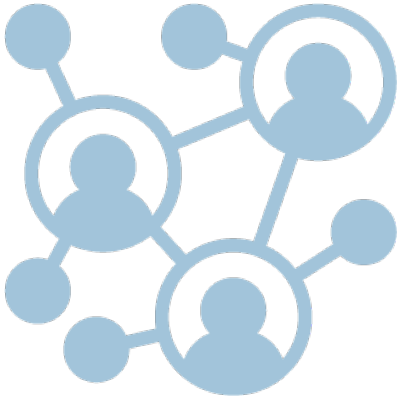


46

Unique Awardees, spanning nearly the entire Commonwealth

$90+ Million

Awarded by the HPC to investment program recipients.



99

Individual Awards made to fund innovative care delivery programs.

Key Themes Across Programs

- WORKFORCE
- COMMUNITY ENGAGEMENT
- PARTNERSHIPS
- HEALTH-RELATED SOCIAL NEEDS
- STIGMA REDUCTION
- PATIENT EXPERIENCE
- CARE IN THE COMMUNITY
- HEALTH EQUITY
- EARNING PATIENT TRUST
- DATA COLLECTION
- INNOVATION
- COMMUNITY NETWORKS

Key Themes Across Programs

WORKFORCE

STIGMA REDUCTION

EARNING PATIENT TRUST

DATA COLLECTION

INNOVATION

COMMUNITY NETWORKS

> “Anecdotally, we could say why patients were being readmitted. Through [this HPC investment], we now have that data to back it up. We can go to our community partners and say, ‘Okay, you seem to have a higher readmission rate,’ and work with them to identify why. We really have that data.”
>
> **Hospital Staff**

Key Themes Across Programs

"We are reaching people who would otherwise not be receiving care. They face barriers related to transportation in very rural counties or anything associated with stigma, shame or fear … [teleBH] removes those barriers and that is huge."

Hospital Staff

HEALTH-RELATED SOCIAL NEEDS

STIGMA REDUCTION

COMMUNITY

HEALTH EQUITY

EARNING PATIENT TRUST

DATA COLLECTION

INNOVATION

COMMUNITY NETWORKS

Key Themes Across Programs

WORKFORCE

STIGMA REDUCTION

EARNING PATIENT TRUST

DATA COLLECTION

INNOVATION

COMMUNITY NETWORKS

"During the screening process, many patients specifically ask whether the doulas are Black and cite a preference for receiving care from doulas who look like them and share their background and experiences. It is evident that being able to share and relate to similar background and experiences in life as well as health care settings is important to creating meaningful relationships."

Hospital Staff

Key Themes Across Programs

WORKFORCE

COMMUNITY ENGAGEMENT

STIGMA REDUCTION

PATIENT EXPERIENCE

EARNING PATIENT TRUST

DATA COLLECTION

"She did a great job representing me…if I didn't understand something she would inform my doctors or explain things to me. Just her presence…she didn't take no for an answer. There was one nurse that was kind of rude…my doula was my advocate, she was really there for me, and she spoke up for me. I'm glad the doula was there to have my back. The doctors and nurses – after my doula spoke up for me, they understood, and some of them did apologize."

Program Patient

The Last Decade of HPC Investment Programs

Program Total	$70M	$11.3M	$10M	$2.5M	$1.46M	$500K
Program	CHART	HCII	SHIFT-Care	MassUP	C4SEN	BESIDE
	Community Hospital Acceleration Revitalization and Transformation	Health Care Innovation Investments	Sustainable Health Care Innovations Fostering Transformation	Moving Massachusetts Upstream	Cost-Effective Coordinated Care for Caregivers and Substance Exposed Newborns	Birth Equity and Support through the Inclusion of Doula Expertise
Launch Year	2014	2016	2018	2020	2021	2021
Current Phase	COMPLETE			IN EVALUATION AND DISSEMINATION		

Current HPC Investment Program Portfolio

Anticipated Program Total	$1.5M	$1.47M
Program	 HEART-BP	 PATHways
	Hypertensive Disorders Equitably Addressed with Remote Technology for Birthing People	Promoting Appropriate Transitions to Home
Launch Year	2025	2026
Current Phase	UNDERWAY	IN DEVELOPMENT

Health Care Transformation and Innovation: Investment Programs

The HPC's Investment Programs Over Time

UP NEXT: Hypertensive Disorders Equitably Addressed through Remote Technology for Birthing People (HEART-BP)

Promoting Appropriate Transitions to Home (PATHways)

HEART-BP Investment Program Background

DPH Review of Maternal Health Services, November 2023

Hypertensive Disorders of Pregnancy

- Hypertensive disorders of pregnancy complicate approximately 10% of all pregnancies.
- Complications from hypertensive disorders of pregnancy are a leading cause of SMM and postpartum readmissions.
- More than half of maternal deaths occur during the postpartum period, defined as up to a year after delivery.

Remote Blood Pressure Monitoring

- The Massachusetts Department of Public Health recommendation re: Innovating through Telehealth and Remote Blood Pressure Monitoring:
  - "DPH will work with hospitals to implement remote blood pressure monitoring programs across all hospitals in MA. EOHHS will work with public and private interested parties to support health insurance coverage of remote monitoring services."

HEART-BP Investment Program Aims

1. Support Awardees in making high-quality, patient-centered RBPM programs available to appropriate patients for a minimum of 6 weeks postpartum.
2. Improve access to care, experience of care, and outcomes for birthing people experiencing HDP.
3. Ensure that Awardees address the presence of or potential for inequities in access, outcomes, and experience in all elements of the Program.
4. Reduce avoidable readmissions and ED visits associated with HDP to support both the clinical and the business case for RBPM.
5. Capture Program insights that can inform development of sustainable, scalable RBPM programs across the Commonwealth by collecting data on relevant processes, outcomes, experience, and avoided costs.

HEART-BP Investment Program Overview

$1.5 Million

The HPC is investing $1.5 million in funding for the HEART-BP Investment Program.

30 Months

The program's Period of Performance will be 30 months, comprising a Planning Period of six months and a 24-month Implementation Period.

5 Awards

The HPC awarded funding of up to $300,000 each to four hospitals and one community health center:

- Berkshire Medical Center
- Beverly Hospital
- Heywood Hospital
- Edward M. Kennedy Community Health Center
- Signature Healthcare Brockton Hospital

Health Care Transformation and Innovation: Investment Programs

The HPC's Investment Programs Over Time

Hypertensive Disorders Equitably Addressed through Remote Technology for Birthing People (HEART-BP)

UP NEXT: Promoting Appropriate Transitions to Home (PATHways)

PATHways Background: Data consistently demonstrate the need for timely, successful discharge to a home setting.

Systemic barriers create challenges and delays for successful discharge

- According to **MHA Data from the Transitions from Acute Care to Post Acute Care Task Force**, on average, each day more than 2,000 patients statewide remain hospitalized despite being medically ready for discharge.[1]
- **HPC analysis of CHIA data** shows extra long lengths of stay (> 30 days) are increasing as a proportion of hospital stays and account for half of the growth in bed days since 2016.[2]
- The **2025 Massachusetts Transitions from Acute Care to Post Acute Care Task Force** report recommends the Hospital to Home Partnership Program be made permanent.[3]

Hospital to Home Partnership Program: Leveraging ASAPs to facilitate successful discharge

- There are 24 Aging Services Access Points (ASAPs) across the Commonwealth, all contracted with the Executive Office of Aging & Independence, which provide programs and services specifically designed to support adults aged 60 and older, and their caregivers.
- Support in these areas, especially when initiated pre-discharge and in partnership with hospitals, are shown to expedite and facilitate successful discharge to home and community settings.

HPC builds upon AGE's successful hospital-to-home discharge program with PATHways investment program opportunity

Original Program from Executive Office of Aging & Independence (AGE)

- AGE previously implemented the **Hospital to Home Partnership Program**, whereby Acute Care Hospitals partnered with ASAPs to embed a Home and Community Based Services (HCBS) liaison within hospitals to facilitate successful discharge to home and community settings. This program was supported by ARPA dollars.

HPC's PATHways Program in Partnership with AGE

- In the absence of additional funding to support these partnerships, the HPC proposes to provide bridge funding for new and existing programs at eligible community hospitals.
- This funding intends to fill a gap in the resources needed to support these essential partnerships and make the case for long-term sustainability, as recommended by the *Massachusetts Transitions from Acute Care to Post Acute Care Task Force*.

PATHways – Promoting Appropriate Transitions to Home

- This investment program will support the position of a **Home and Community-Based Services (HCBS) Hospital Liaison** embedded within the hospital setting. This position will connect individuals to programs and community services to **support a more efficient discharge to the community or home setting.**
- The program will fund **partnerships between ASAPs and hospitals** to continue or establish this model of care.

PATHways aims to:

- Support and/or sustain partnerships between ASAP and hospitals
- Support institutional (e.g., skilled nursing facility) diversion and hospital discharge directly to home and community-based settings
- Collect qualitative and quantitative evidence to advance the case for sustaining partnerships between ASAPs and hospitals

PATHways Investment Program Opportunity and Eligibility (Draft)

Funding: Total Program $2.1 million

- Up to 7 awards of $210,000 each from HPC funding
- Additional $90,000 to be contributed in-kind from each hospital for a total program cost of $300,000 per Awardee

Applicants

- Aging Service Access Points (ASAPs) in partnership with eligible acute care community hospitals in Massachusetts

Timeline

- Period of performance: 2 years

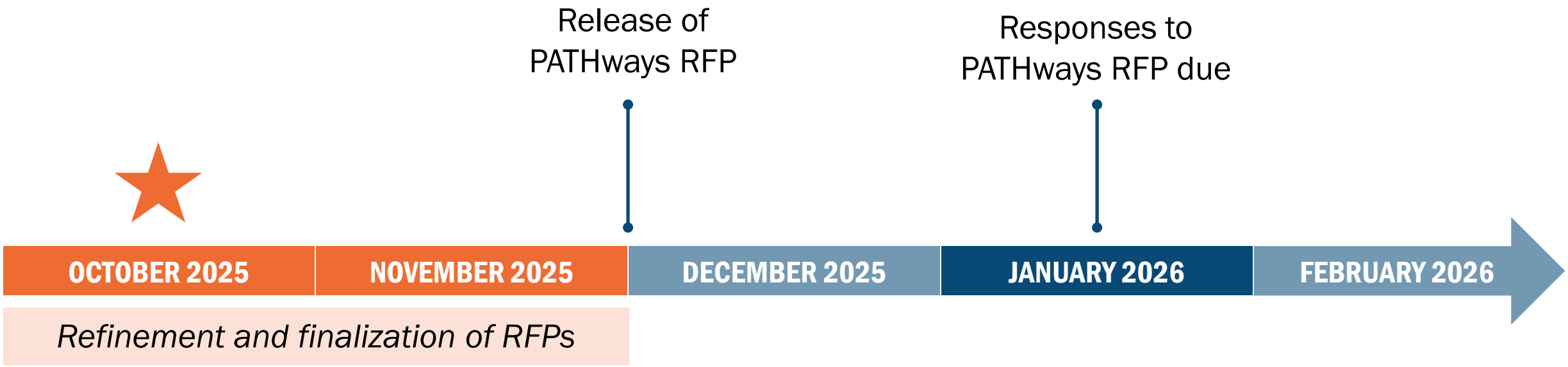
State Partnership

- The HPC will fund and implement PATHways in partnership with the Executive Office of Aging and Independence (AGE)

Program Launch: 2026

List of eligible hospitals may be found as Attachment A Exhibit 2 on the HEART-BP Request for Responses bid solicitation here. Subject to change upon release of the request for proposals for this opportunity.

New Investment Program Timeline (Draft)



All dates are approximate

As we move forward with drafting the RFP for PATHways, what else should we consider?

1. How can we best promote these new opportunities?
2. Are there additional partnerships we should explore for either program implementation or evaluation?
3. Where do you see alignment with ongoing work in the Commonwealth?

Agenda

Call to Order

Approval of Minutes **(VOTE)**

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Research Presentation: Pharmacy Deserts in Massachusetts

UP NEXT: Background on Pharmacy Deserts and Impact of Closures

Definitions and Data Sources

Results

Background

- Pharmacies provide prescription drugs, over-the-counter medications and certain preventive services, serving as a vital part of the health care continuum for patients.
- Pharmacy closures have been found to be **associated with negative health effects**, such as clinically significant declines in adherence to cardiovascular medications among older adults.[1]
- Pharmacy closures are the result of complex and evolving dynamics in the pharmaceutical supply chain and in the wider retail economy. **Independent pharmacies** face particular financial pressures due to their **lack of economies of scale.**
- A study that examined pharmacy deserts nationwide found that 46% of U.S. counties have at least one pharmacy desert, and that such deserts are **significantly more common in high social vulnerability areas**.[2]

1. Qato DM, Alexander GC, Chakraborty A, Guadamuz JS, Jackson JW. Association between pharmacy closures and adherence to cardiovascular medications among older US adults. JAMA network open. 2019 Apr 5;2(4):e192606-.
2. Catalano G, Khan MM, Chatzipanagiotou OP, Pawlik TM. Pharmacy accessibility and social vulnerability. JAMA Network Open. 2024 Aug 1;7(8):e2429755-.

Literature Definitions of Pharmacy Deserts

Qato et al. (2014) studied neighborhoods in Chicago, defining a desert as a census tract where:

- 33% or more of the population **more than a mile** from a pharmacy, OR
- 33% or more of the population with **low vehicle access** and **more than half a mile** from a pharmacy.

Guadamuz et al. (2021) focused their analysis on the 30 largest U.S. cities and defined a desert as census tracts:

- distance to the nearest pharmacy was **1.0 mile or more OR**
- **0.5 mile or more, low income** and **low vehicle access**

Wittenauer et al. (2024) conducted a national analysis using:

- 33% of its population living more than **1 mile** from the pharmacy for urban areas, more than **5 miles** for suburban areas, and more than **10 miles** for rural areas. Additional considerations for low-income areas.

1. Guadamuz et al. (2021). “Fewer Pharmacies In Black And Hispanic/Latino Neighborhoods Compared With White Or Diverse Neighborhoods, 2007–15.” Health Affairs. https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01699
2. Wisseh et al. (2021). ”Social Determinants of Pharmacy Deserts in Los Angeles County.” Journal of Racial and Ethnic Health Disparities. https://pmc.ncbi.nlm.nih.gov/articles/PMC8076330/
3. Qato et al. (2014). "‘Pharmacy Deserts’ Are Prevalent In Chicago’s Predominantly Minority Communities, Raising Medication Access Concerns.“ Health Affairs. https://www.healthaffairs.org/doi/10.1377/hlthaff.2013.1397

Research Presentation: Pharmacy Deserts in Massachusetts

Background on Pharmacy Deserts and Impact of Closures

UP NEXT: Definitions and Data Sources

Results

Definitions and Data Sources

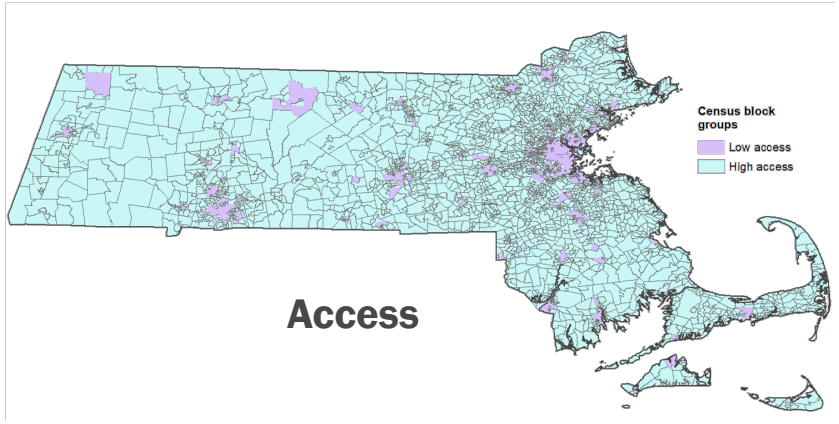
- **Pharmacy license data** from the EOHHS license verification site:
  - All active retail pharmacy licenses in 2025 (and historical data)
  - Active status identified primarily with last renewal and expiration date
  - **Excluded:** compounding, specialty, other and provider-based pharmacies not open to the general public
- The HPC considered five types of pharmacies for this analysis:
  - Large chain (e.g., CVS, Walgreens)
  - Grocery-based (e.g., Stop & Shop, Big Y)
  - Small chain and independent (e.g., Eaton Apothecary, Louis and Clark)
  - Mass-merchant (e.g., Walmart, Costco)
  - Provider-based and open to the general public (i.e., co-located and operated by hospitals and other providers)

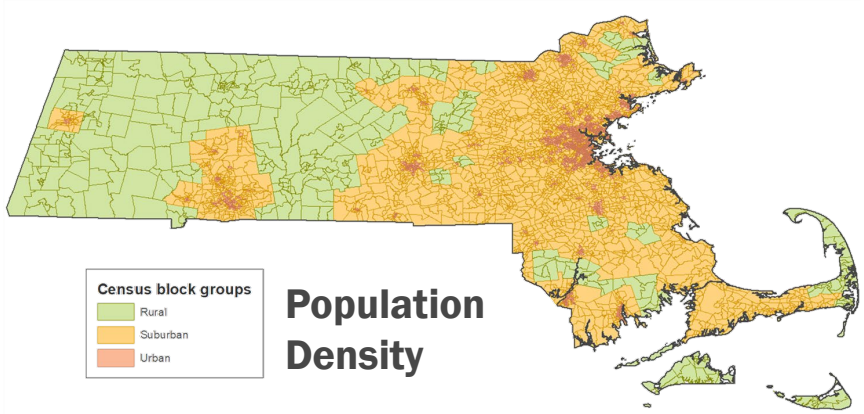
Source: EOHHS Massachusetts Health Professions License Verification site. Latest update: June 16, 2025. https://checkahealthlicense.mass.gov/

Definitions and Data Sources

HPC Pharmacy Desert definition[1]:

- Census block group is defined as a pharmacy desert if **nearest pharmacy is more than:**
  - Rural block groups[2] (DPH definition of rural): **5 miles**
  - Suburban block groups (pop < 5,000 per sq mile): **2 miles**
  - Urban block groups (pop > 5,000 per sq mile): **1 mile**
- Additional allowance for "low-access" areas (either vehicle ownership below state average or high poverty rates, defined as 20% of households below FPL): **the distance criteria are halved**.
- Near-desert definition: only one pharmacy within radius (excludes block groups already identified as a pharmacy desert).

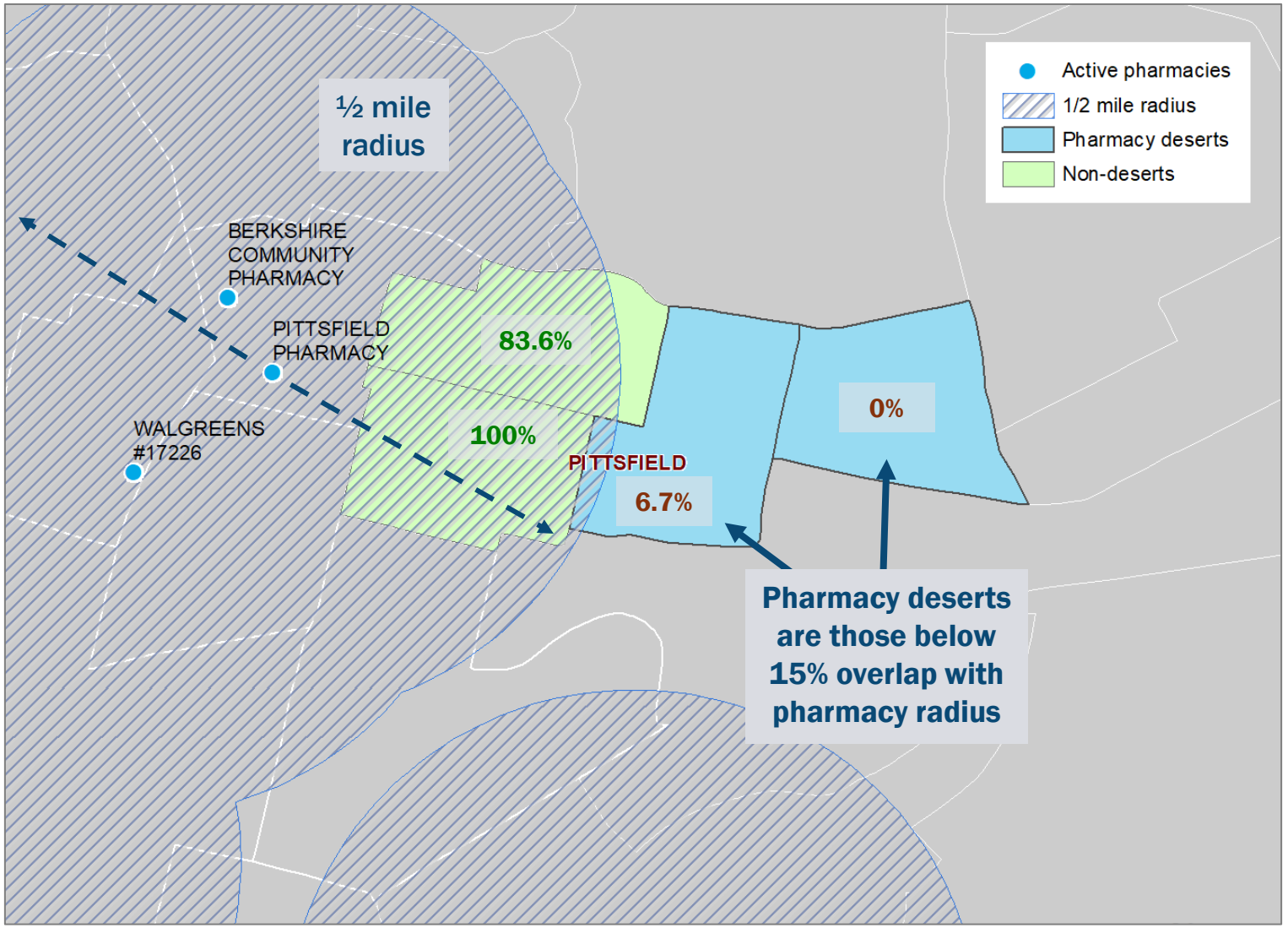




Notes: Rurality is assigned at the municipal level which are then associated with census tracts. All mapping conducted in ArcMap 10.8/ArcGIS Pro. Population data is based on 2020 Census block groups. Sociodemographic and transportation-related characteristics from the 2023 American Community Survey 5-year estimates. Analysis is conducted at the block group level..
Source: State Office of Rural Health (2023). "Rural Definition." https://www.mass.gov/info-details/state-office-of-rural-health-rural-definition. American Community Survey (ACS), 2023 5-year estimates.

1. See, for example, Guadamuz et al. (2021). "Fewer Pharmacies In Black And Hispanic/Latino Neighborhoods Compared With White Or Diverse Neighborhoods, 2007–15." Health Affairs. www.healthaffairs.org/doi/10.1377/hlthaff.2020.01699
2. Census block groups are smaller than census tracts. They are ideally composed of about 1,000 persons, in contrast to Census tracts which are about 4,000 persons.

Illustration of HPC Pharmacy Desert Definition



Factors Affecting Generalizability and Interpretation

- Assumes that all persons are **equally distributed** across a given block group.
- All distances are **as-the-crow-flies** and does not capture distance travelled along a road network to reach the pharmacy (i.e., drive times).
- Some ACS characteristics are measured at the census tract level and do not have same the level of granularity as those at the block group level.
- The state's definition of rural is defined at the municipal level. As such, rurality is not assessed for each underlying census tract or block group individually.
- The HPC can only identify active status as well as openings and closing within a two-year time window (licenses are renewed for two years)

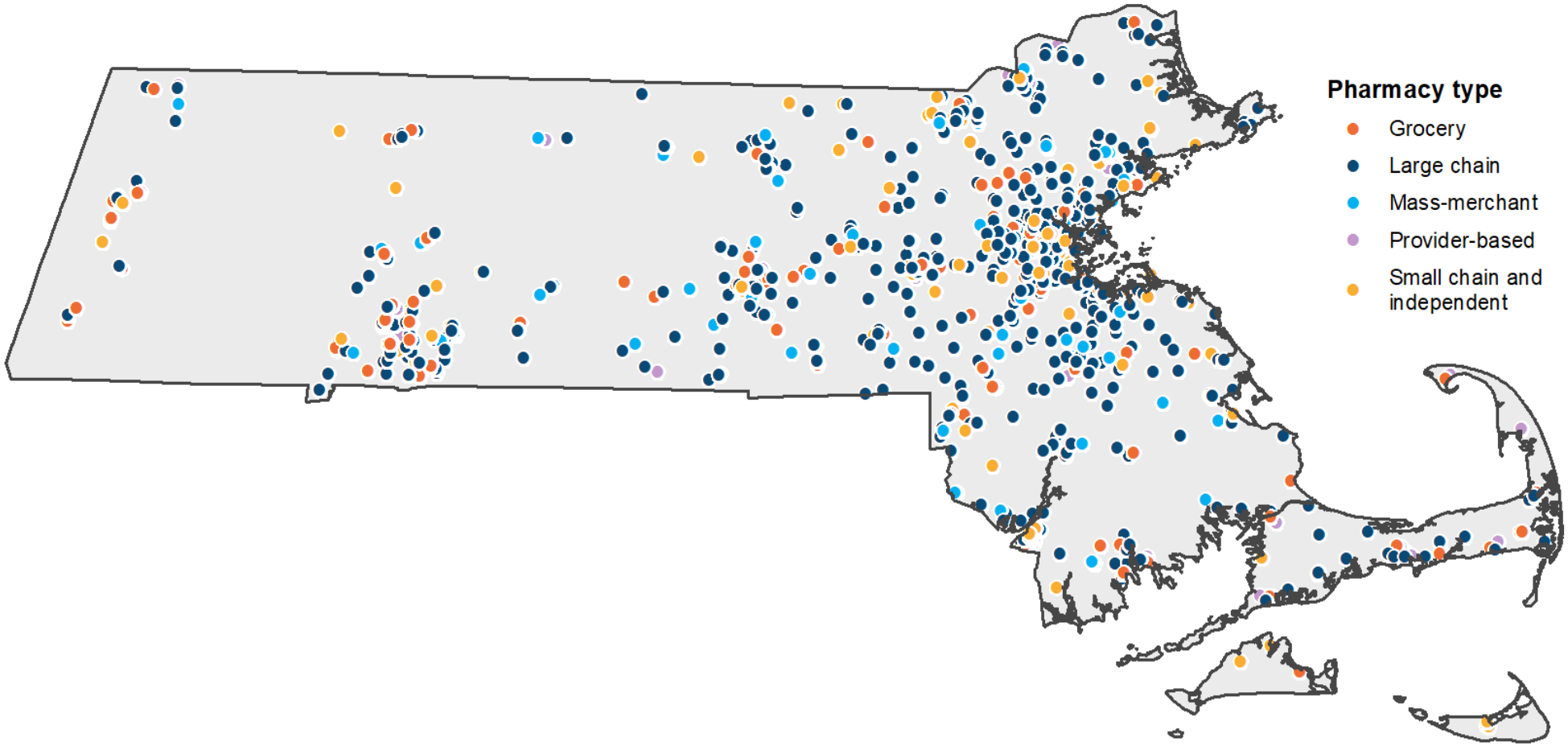
Research Presentation: Pharmacy Deserts in Massachusetts

Background on Pharmacy Deserts and Impact of Closures

Definitions and Data Sources

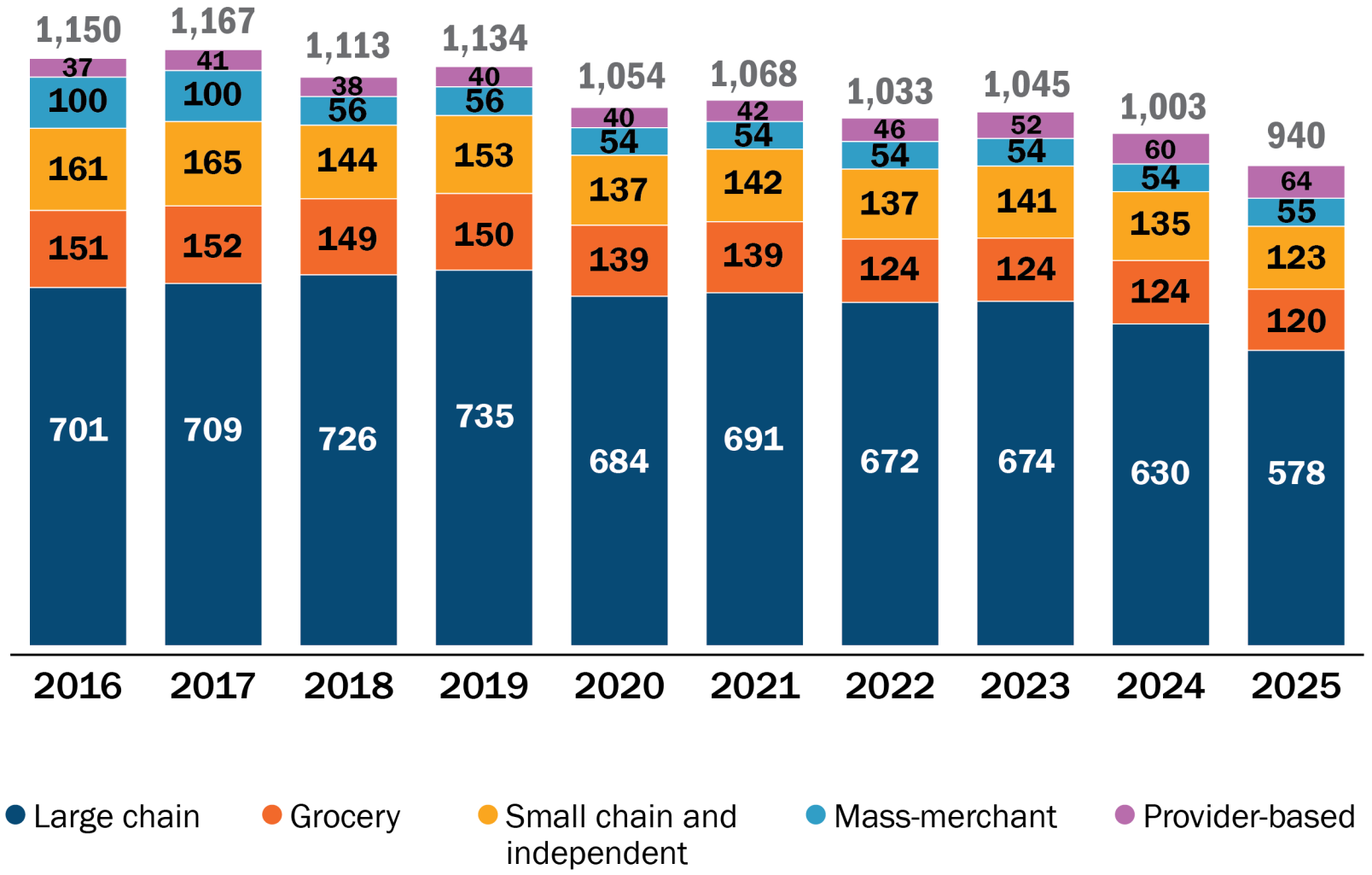
UP NEXT: Results

As of 2025, there are 940 active retail pharmacies in Massachusetts.



Notes: Pharmacy Categories developed for DataPoints #25 on flu vaccines. All mapping and geocoding conducted in ArcMap 10.8/ArcGIS Pro. Geocoding using the MassGIS master address database and latest address locator. Conducted using the NAD1983 geographic coordinate system.
Source: EOHHS Massachusetts Health Professions License Verification site. Latest update: June 16, 2025. https://checkahealthlicense.mass.gov/

The number of pharmacies in Massachusetts has declined by nearly 200 (17%) since 2019, mostly due to closures of chain pharmacies.



From 2016 to 2025:

Provider-based nearly doubled during this time

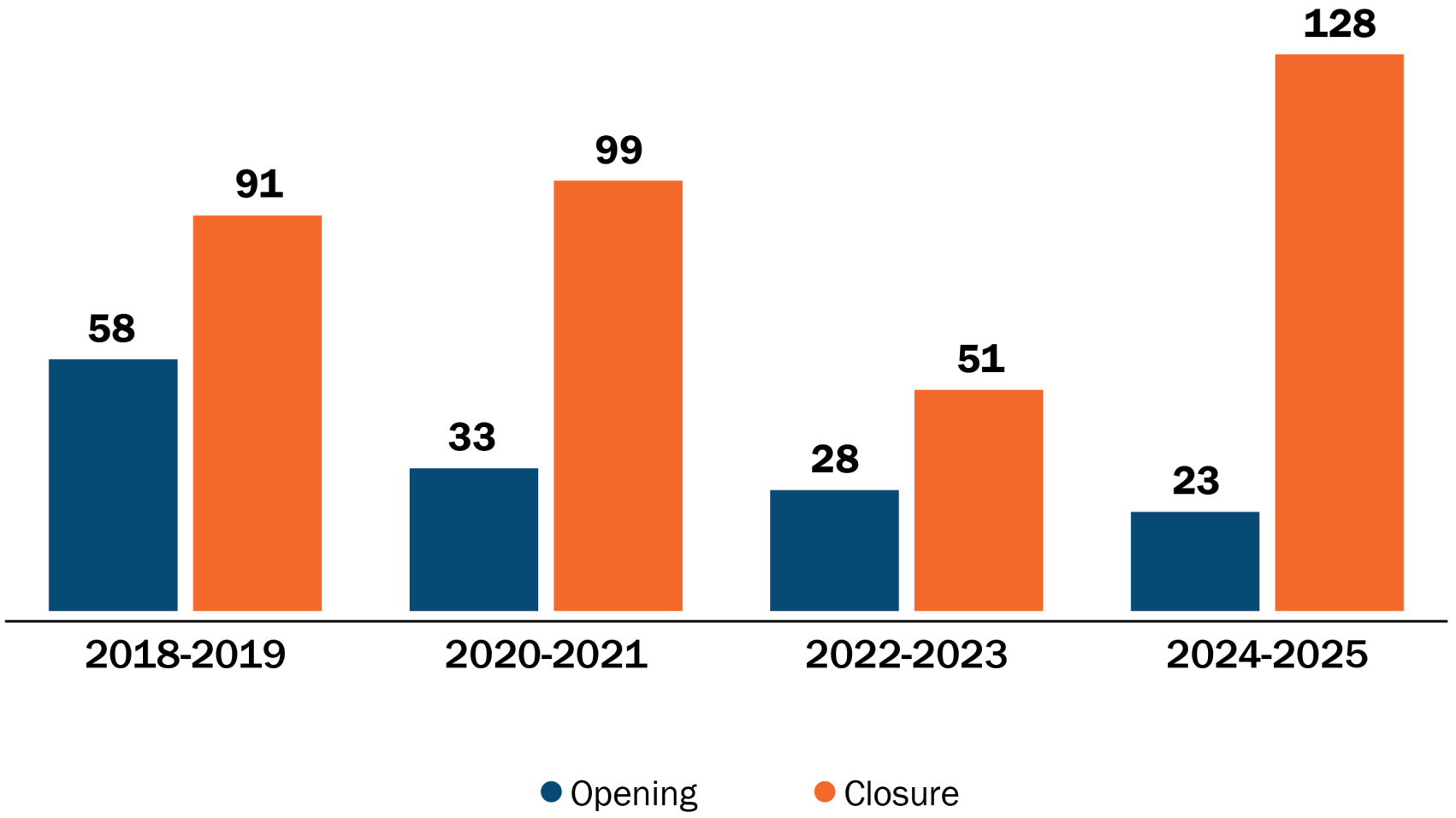
Mass-merchants shrunk the most (-45%)

Small chain and independent and **Grocery-based** saw similar declines in relative terms (about -20%)

Large chains lost the most in absolute terms (-123)

Source: EOHHS Massachusetts Health Professions License Verification site. Latest update: June 16, 2025. https://checkahealthlicense.mass.gov/

There have been 142 openings and 369 closures since 2016 (net -227). The largest number of closures occurred during the 2024-2025 period.

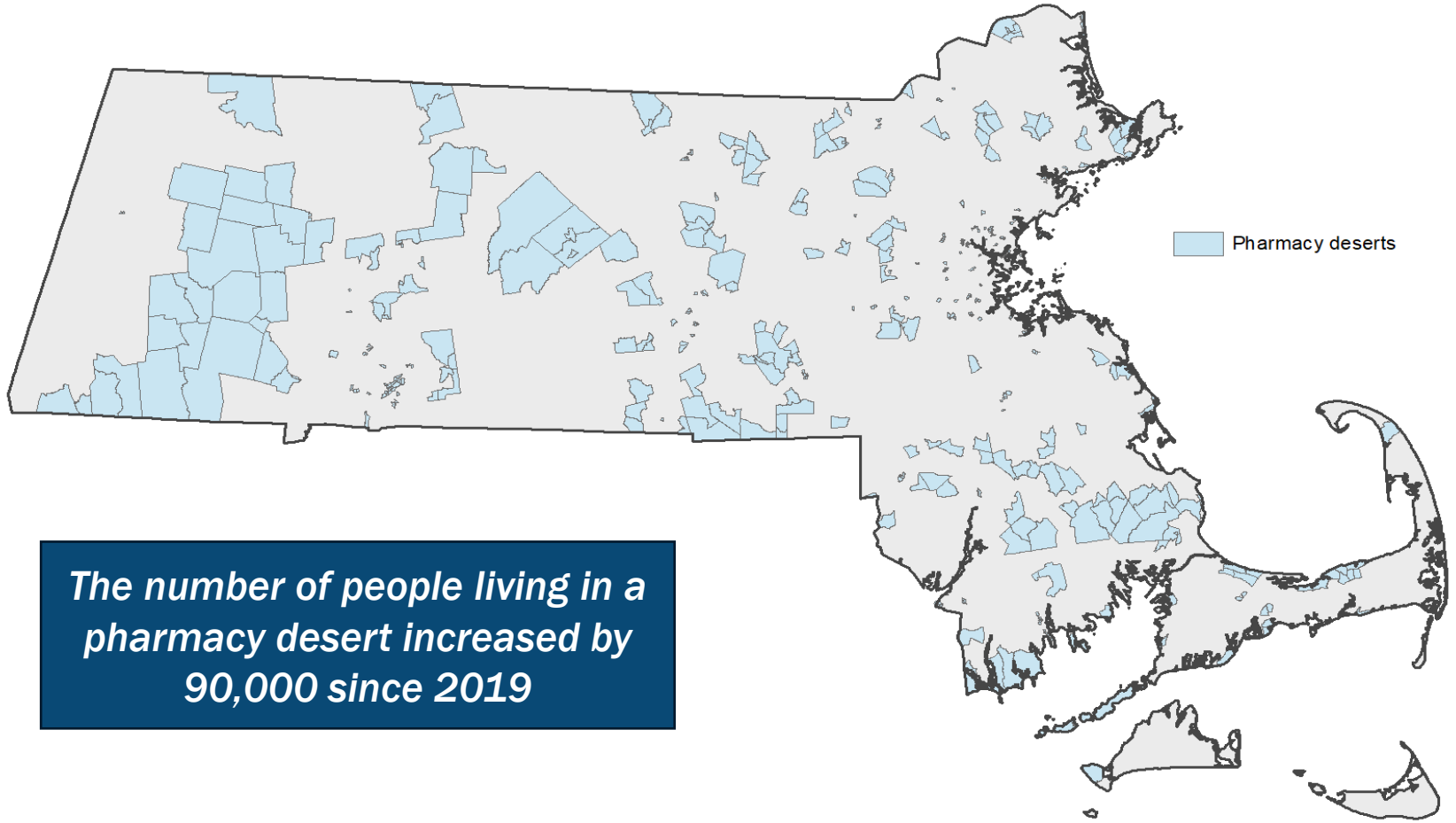


Notes: Pharmacy licenses expire every other year on December 31st. A closure is only observed when the license reaches the expiration date with no subsequent renewal. We are reporting openings and closings in two-year groups.
Source: EOHHS Massachusetts Health Professions License Verification site. Latest update: June 16, 2025. https://checkahealthlicense.mass.gov/

Chain and independent pharmacies saw the most closures in 2024 and 2025, while provider-based pharmacies had the most openings.

Notes: Pharmacy licenses expire every other year on December 31st. A closure is only observed when the license reaches the expiration date with no subsequent renewal. We are reporting openings and closings in two-year groups.
Source: EOHHS Massachusetts Health Professions License Verification site. Latest update: June 16, 2025. https://checkahealthlicense.mass.gov/

As of 2025, 432 of 5,109 block groups constitute a pharmacy desert. These deserts include about 580,000 people, or 8.3% of the Massachusetts population.



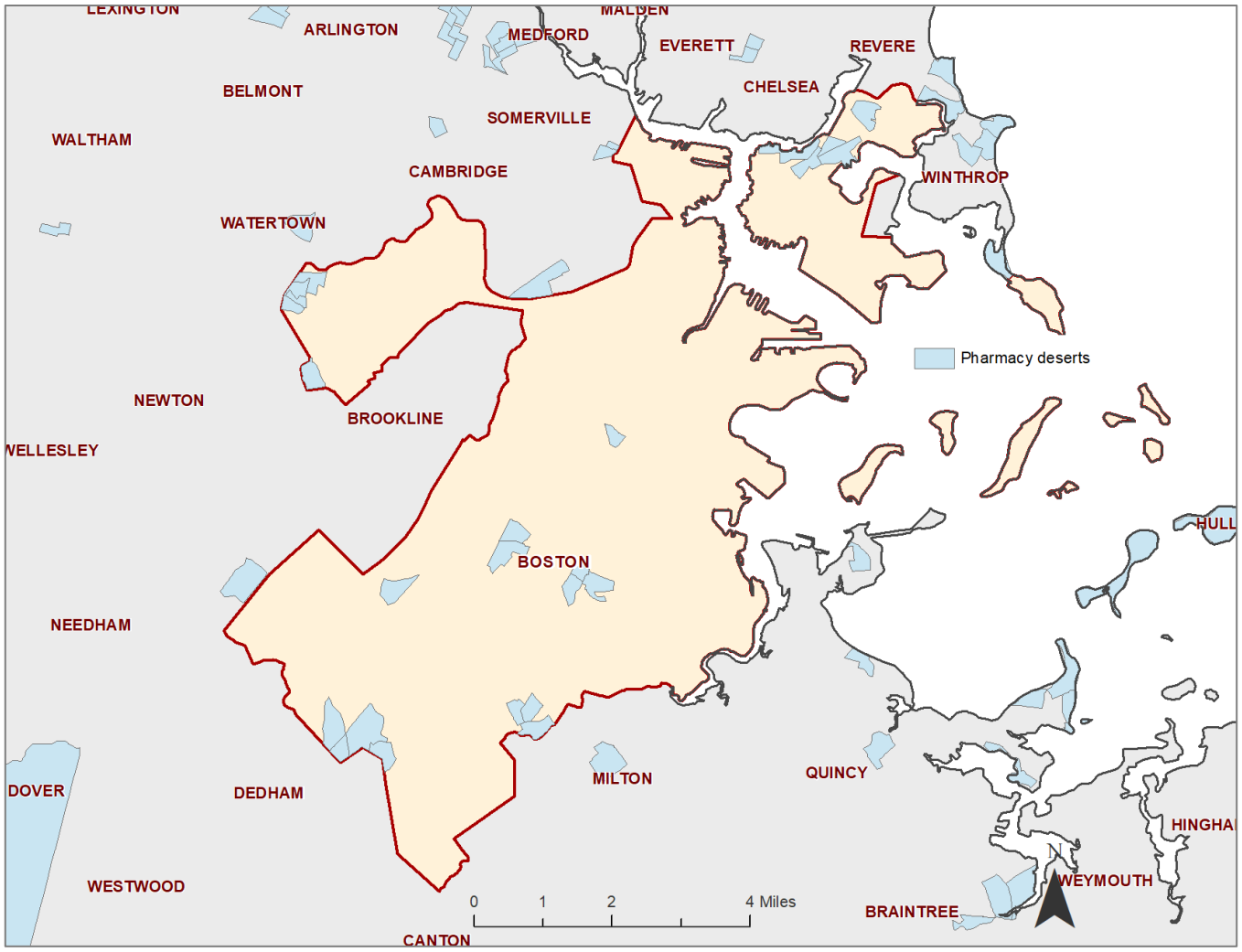
The number of people living in a pharmacy desert increased by 90,000 since 2019

Pharmacy Deserts in Massachusetts: 432

- Rural: 43
- Suburban: 187
- Urban: 202

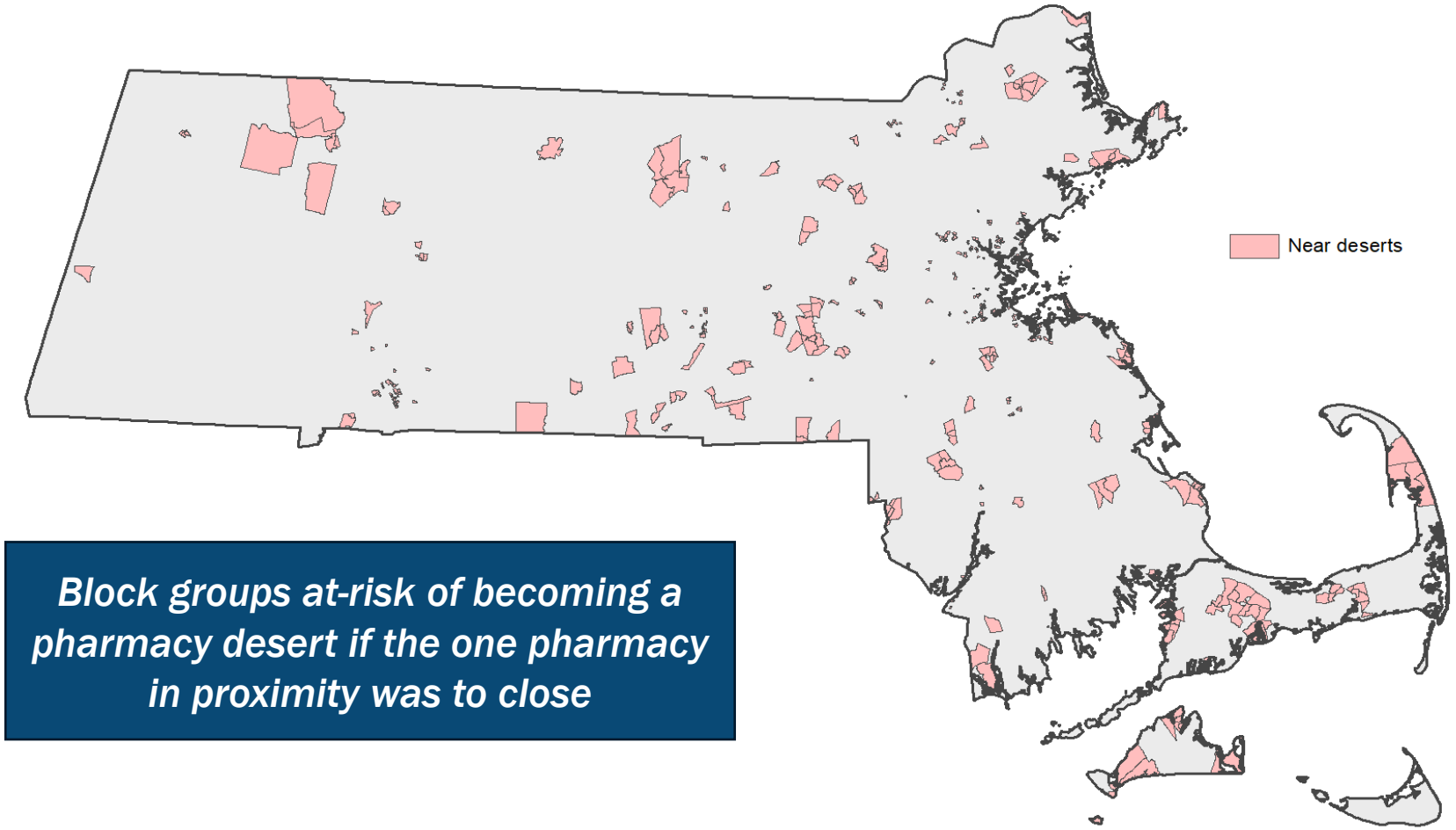
Notes: All mapping and geocoding conducted in ArcMap 10.8/ArcGIS Pro. Conducted using the NAD1983 geographic coordinate system. Population data is based on 2020 Census block groups.
Source: EOHHS Massachusetts Health Professions License Verification site. Latest update: June 16, 2025. https://checkahealthlicense.mass.gov/. State Office of Rural Health (2023). "Rural Definition." https://www.mass.gov/info-details/state-office-of-rural-health-rural-definition. American Community Survey (ACS), 2023 5-year estimates.

Spotlight: Pharmacy Deserts in the Greater Boston Area



Notes: All mapping and geocoding conducted in ArcMap 10.8/ArcGIS Pro. Conducted using the NAD1983 geographic coordinate system. Population data is based on 2020 Census block groups.
Source: EOHHS Massachusetts Health Professions License Verification site. Latest update: June 16, 2025. https://checkahealthlicense.mass.gov/. State Office of Rural Health (2023). "Rural Definition." https://www.mass.gov/info-details/state-office-of-rural-health-rural-definition. American Community Survey (ACS), 2023 5-year estimates.

416 of 5,109 block groups are at-risk of becoming a pharmacy desert. These include about 525,000 people, or 7.5% of the Massachusetts population.



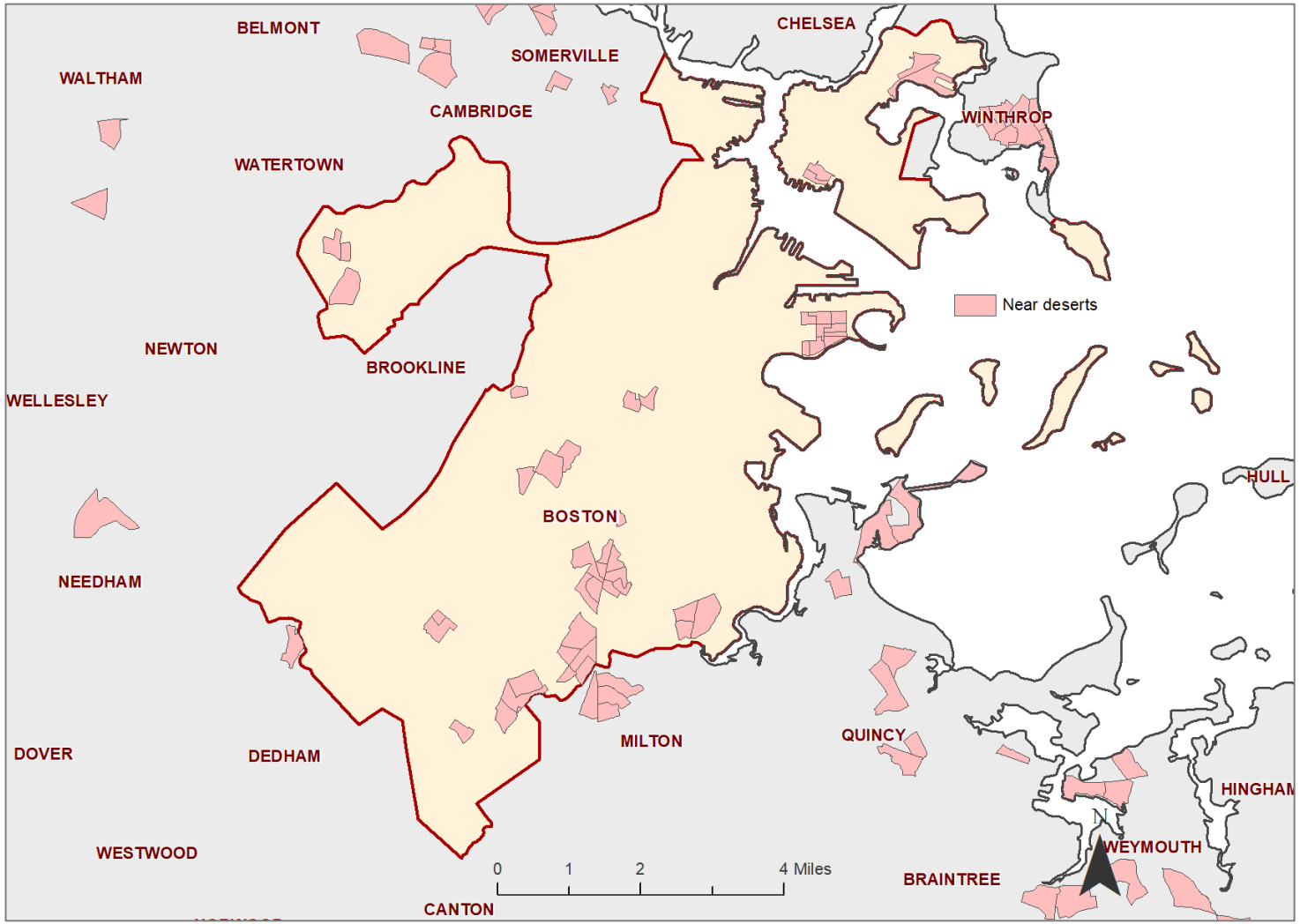
Block groups at-risk of becoming a pharmacy desert if the one pharmacy in proximity was to close

"Near-deserts" in Massachusetts: 416

- Rural: 26
- Suburban: 162
- Urban: 228

Notes: All mapping and geocoding conducted in ArcMap 10.8/ArcGIS Pro. Conducted using the NAD1983 geographic coordinate system. Population data is based on 2020 Census block groups.
Source: EOHHS Massachusetts Health Professions License Verification site. Latest update: June 16, 2025. https://checkahealthlicense.mass.gov/. State Office of Rural Health (2023). "Rural Definition." https://www.mass.gov/info-details/state-office-of-rural-health-rural-definition. American Community Survey (ACS), 2023 5-year estimates.

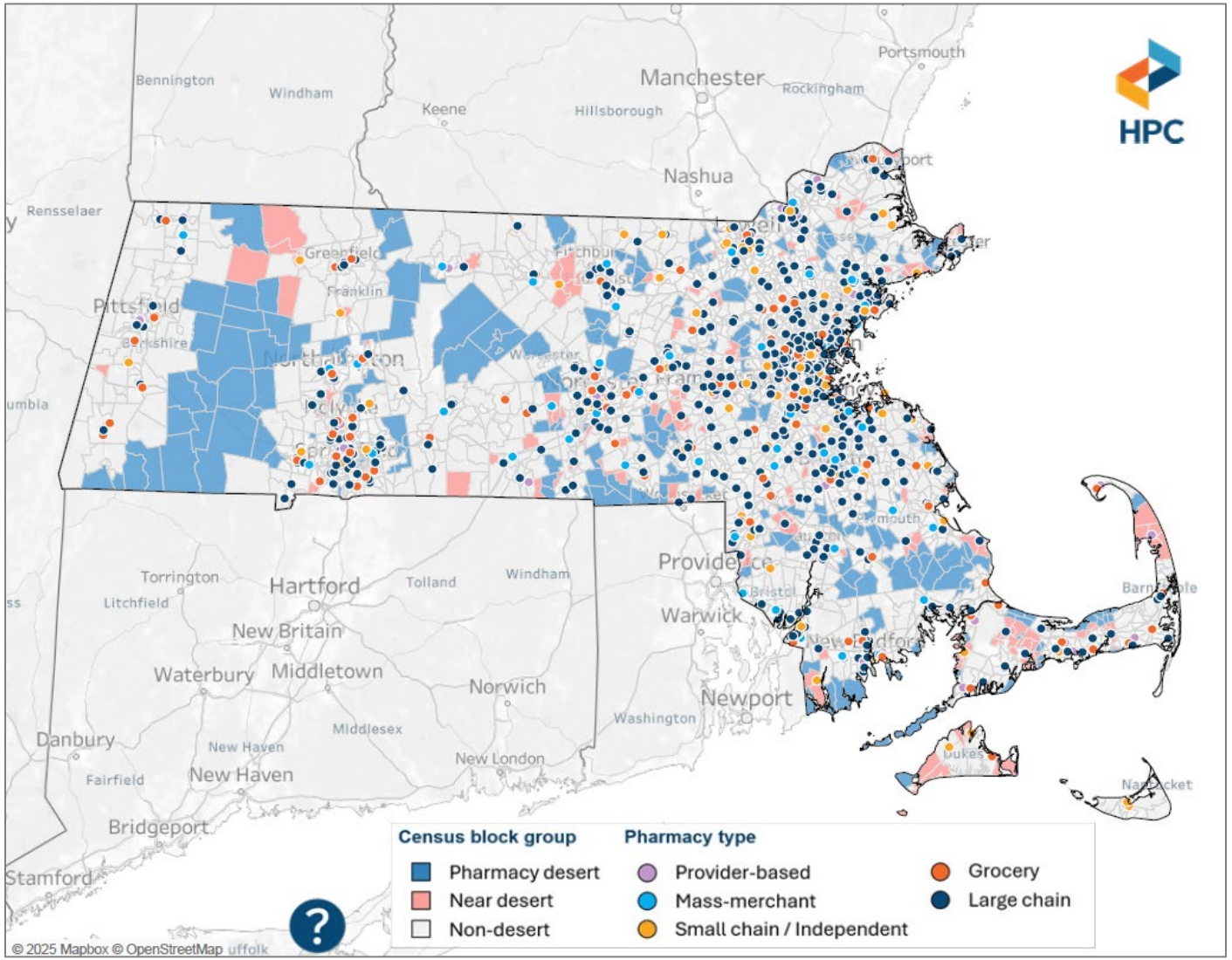
Spotlight: Areas At-Risk of Becoming a Pharmacy Desert in the Greater Boston Area



Notes: All mapping and geocoding conducted in ArcMap 10.8/ArcGIS Pro. Conducted using the NAD1983 geographic coordinate system. Population data is based on 2020 Census block groups.
Source: EOHHS Massachusetts Health Professions License Verification site. Latest update: June 16, 2025. https://checkahealthlicense.mass.gov/. State Office of Rural Health (2023). "Rural Definition." https://www.mass.gov/info-details/state-office-of-rural-health-rural-definition. American Community Survey (ACS), 2023 5-year estimates.

Pharmacy Deserts, "Near-Deserts," and Active Pharmacies, 2025

Combined, more than 1 million Massachusetts residents live in a pharmacy desert or in an area at risk of becoming one, more than 15% of the total population



Notes: All mapping and geocoding conducted in ArcMap 10.8/ArcGIS Pro. Conducted using the NAD1983 geographic coordinate system. Population data is based on 2020 Census block groups.
Source: EOHHS Massachusetts Health Professions License Verification site. Latest update: June 16, 2025. https://checkahealthlicense.mass.gov/. State Office of Rural Health (2023). "Rural Definition." https://www.mass.gov/info-details/state-office-of-rural-health-rural-definition. American Community Survey (ACS), 2023 5-year estimates.

Block Group Characteristics at Different Levels of Population Density, 2023

Pharmacy deserts vs. non-deserts

	Category	No. of block groups	Population	Area in sq. miles	Pop per sq. mile	Share of households without a vehicle	Share of households below the FPL	Share non-white	Share of population above 65	Median income
Rural	Non-desert	398 (85.2% of rural total)	523,870	7.41	784.6	5.0%	4.7%	11.3%	22.3%	$109,241
	"Near-desert"	26 (5.6% of rural total)	25,166	8.47	834.0	8.3%	5.4%	10.8%	28.3%	$82,685
	Pharmacy desert	43 (9.2% of rural total	46,399	25.48	119.8	3.5%	4.6%	7.5%	24.5%	$101,789
Suburban	Non-desert	2,113 (85.8% of suburban total)	3,125,274	1.72	1,989.6	5.7%	4.6%	20.9%	19.9%	$129,115
	"Near-desert"	162 (6.6% of suburban total)	230,350	2.29	1,222.7	4.5%	3.8%	15.2%	20.0%	$132,250
	Pharmacy desert	187 (7.6% of suburban total)	288,798	4.48	794.7	3.6%	3.1%	12.8%	21.6%	$142,098
Urban	Non-desert	1,750 (80.3% of urban total)	2,272,099	0.13	19,533.5	21.2%	10.8%	44.7%	13.8%	$100,635
	"Near-desert"	228 (10.5 of urban total)	270,444	0.12	15,599.7	18.9%	11.7%	48.8%	14.7%	$89,912
	Pharmacy desert	202 (9.3% of urban total)	247,517	0.14	12,876.5	19.1%	12.3%	43.6%	13.8%	$85,089

Notes: Population data is based on 2020 Census block groups.
Source: State Office of Rural Health (2023). "Rural Definition." https://www.mass.gov/info-details/state-office-of-rural-health-rural-definition. American Community Survey (ACS), 2023 5-year estimates.

- Urban deserts tend to be in lower-income areas within urban regions.
- Deserts tend to have lower population density.

Conclusions

- Pharmacy closures, and the deserts that can result, can threaten access and exacerbate existing disparities. **The number of pharmacies in Massachusetts declined by 17% (nearly 200 pharmacies) from 2019 to 2025**.

- **8.3% of Massachusetts residents, or about 580,000 people, live in a pharmacy desert as of 2025**. This is an increase of roughly **90,000** people since 2019.
  - Many of the newly created pharmacy deserts were in some of the state's largest cities, such as Springfield (6), Boston (5), New Bedford (5), and Worcester (6).

- **Another 7.5% of residents, about 525,000 people, live in an area that would be a desert if the sole pharmacy in their area closed**.

- Timely policy action is needed to increase and sustain equitable pharmacy access in the Commonwealth.

- The HPC plans to utilize its new Offices of Pharmaceutical Policy and Analysis (OPPA) and Health Resource Planning (OHRP) to continue examining trends in pharmacy deserts in Massachusetts in the coming months.

Agenda

Call to Order

Approval of Minutes **(VOTE)**

2025 Health Care Cost Trends Hearing

Health Care Transformation and Innovation: Investment Programs

HPC DataPoints Issue #31, "*When the Closest Pharmacy is Too Far: Mapping Pharmacy Deserts in Massachusetts*"

UP NEXT: Select Findings from the 2025 Health Care Cost Trends Report Chartpack

Administration and Finance

Executive Director's Report

Adjourn

2025 Health Care Cost Trends Report: Outline

- **Massachusetts Spending Performance and Affordability of Care** *Findings presented at the Benchmark Hearing on March 13, 2025*
- **Focus on Affordability: Improving Affordability and Predictability in Cost Sharing** *Findings presented at the HPC Board meeting on June 5, 2025*
- **Chartpacks** *Select findings presented today (October 23, 2025 Board meeting)*
  - Primary Care and Behavioral Health
  - Price Trends and Variation
  - Hospital and Post-Acute Care Utilization
  - Provider Organization Performance Variation
- **Policy Recommendations**

UP NEXT: Primary Care and Behavioral Health Spending and Utilization in Massachusetts

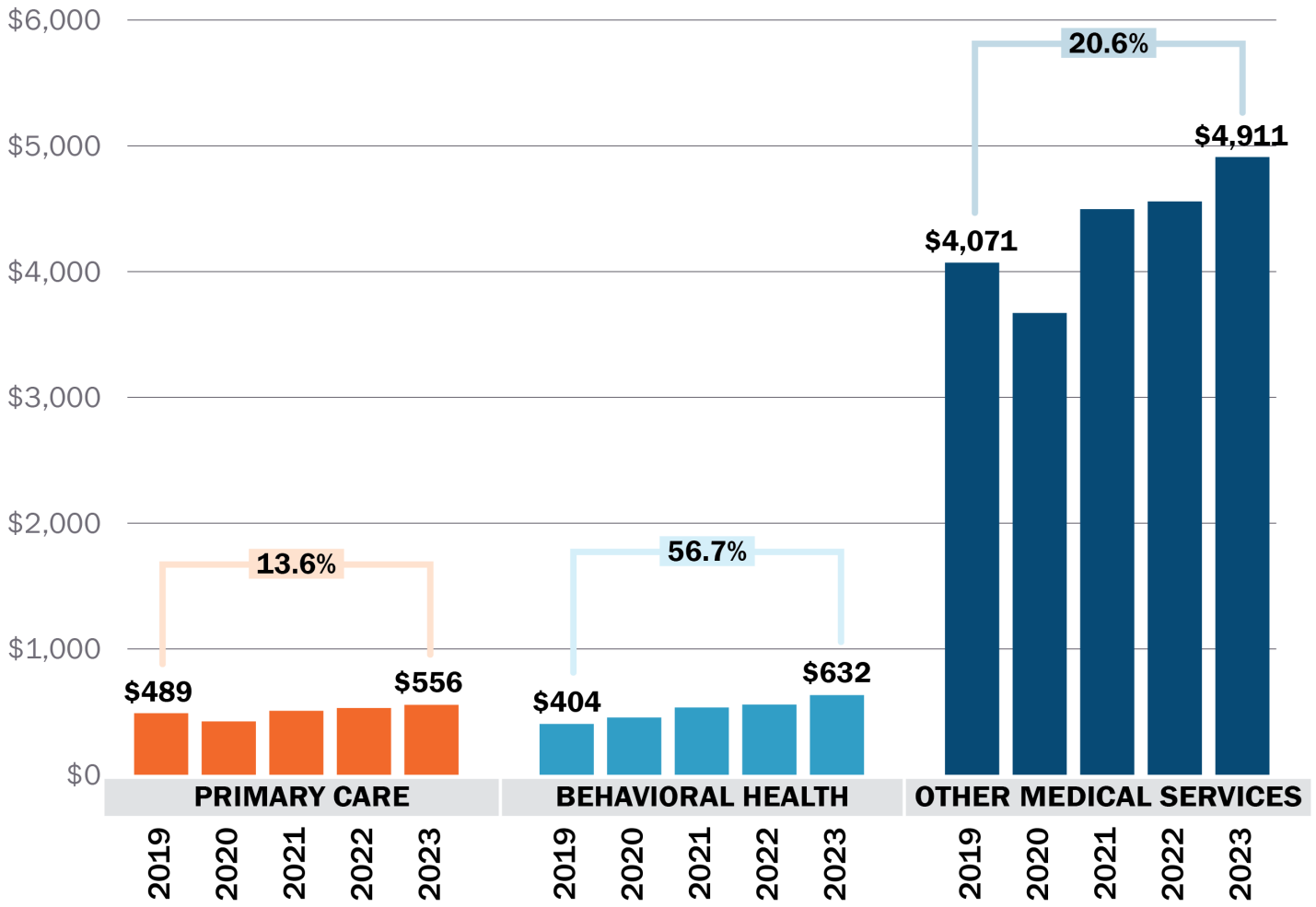
Commercial Price Trends

Hospital and Post-Acute Care Utilization

Provider Organization Performance Variation

From 2019 to 2023, spending on primary care declined as a share of total medical spending in Massachusetts.

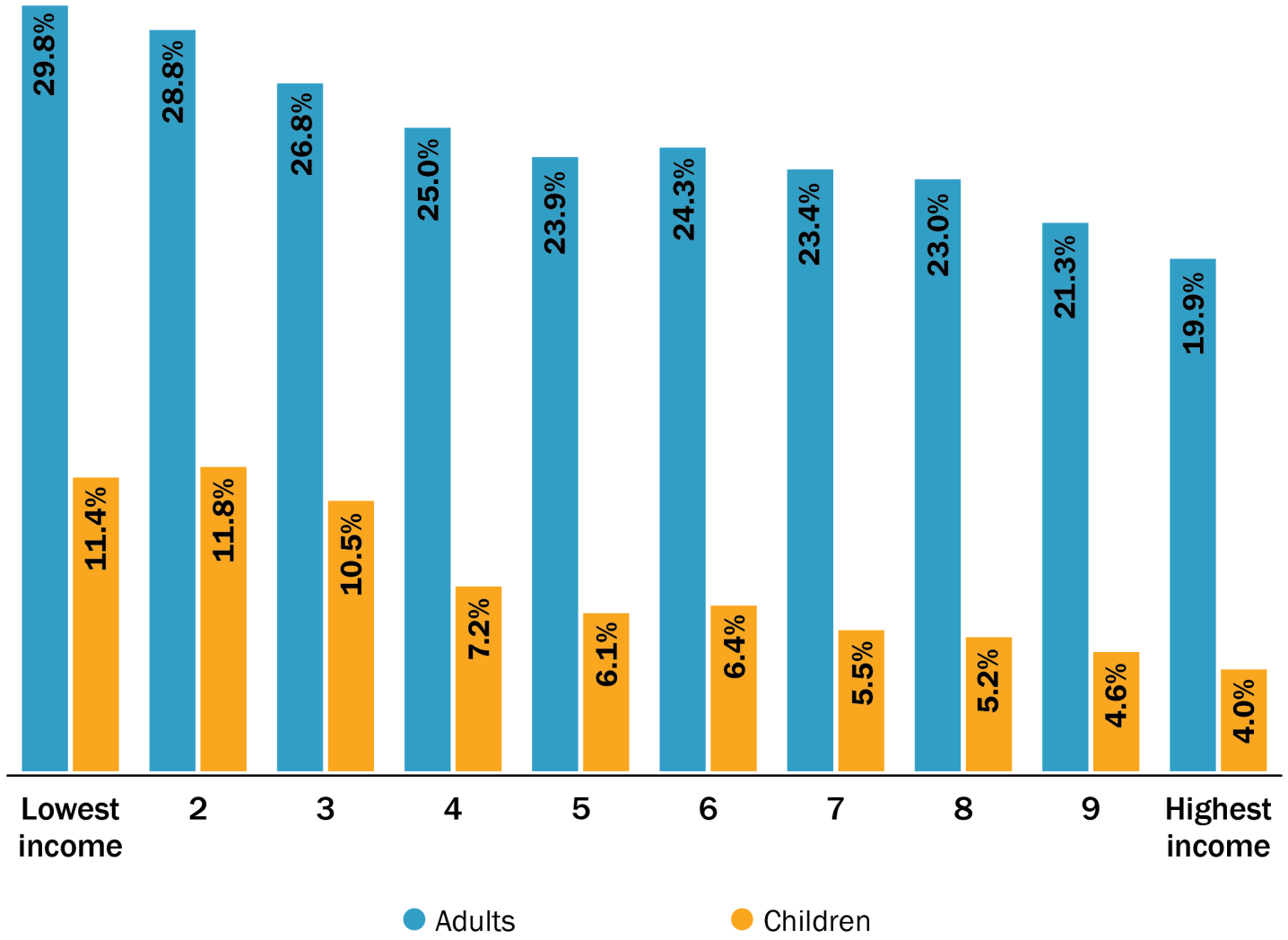
Annual Spending Per Commercial Member for Each Category Of Care Shown, 2019-2023



Notes: Analysis restricted to members under age 65. Visits with a primary care provider and a principal behavioral health diagnosis were categorized as primary care.
Sources: HPC analysis of Center for Health Information and Analysis (CHIA) All-Payer Claims Database V2023, 2019-2023.

Commercially-insured children living in lower income areas were more than twice as likely to have no primary care visits in a year as children in the higher income areas.

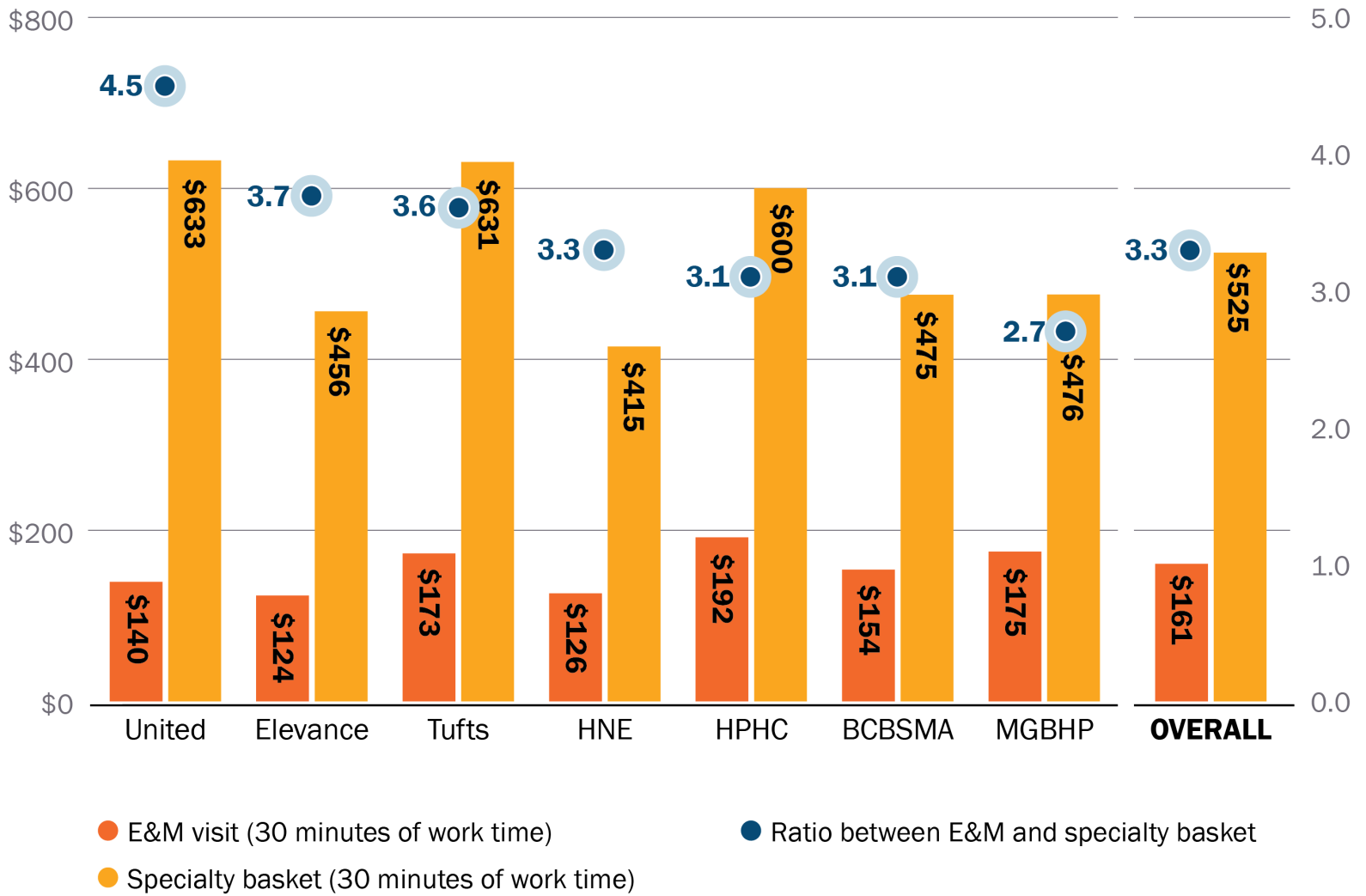
Percentage of Commercially-insured Residents With No Primary Care Visits
By Income of their Zip Code, Adults and Children, 2023



Notes: Analysis restricted to members under age 65 with full year medical and prescription drug coverage. Children are defined as those under age 18. Income groupings represent population-weighted deciles based on median income of zip code sourced from U.S. Census Bureau American Community Survey 5-year estimates.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2023, 2023

The average payment for common specialty services is more than three times greater than the average payment for an E&M visit representing the same amount of work time.

Average Payment for 30 Minutes of Time For Common Specialty Services and for an Evaluation and Management Visit of Similar Time, By Payer



Notes: E&M = evaluation & management visit. "E&M visit" reflects average allowed amount for a 20-minute E&M visit with an established patient (CPT 99213) (30 minutes of work). "Specialty basket" reflects average of average prices paid for select specialty procedures performed in an ambulatory setting (30 minutes of work).
Source: HPC analysis of Massachusetts All-Payer Claims Database, 2023

Research Presentation: 2025 Health Care Cost Trends Report Chartpack

Primary Care and Behavioral Health Spending and Utilization in Massachusetts

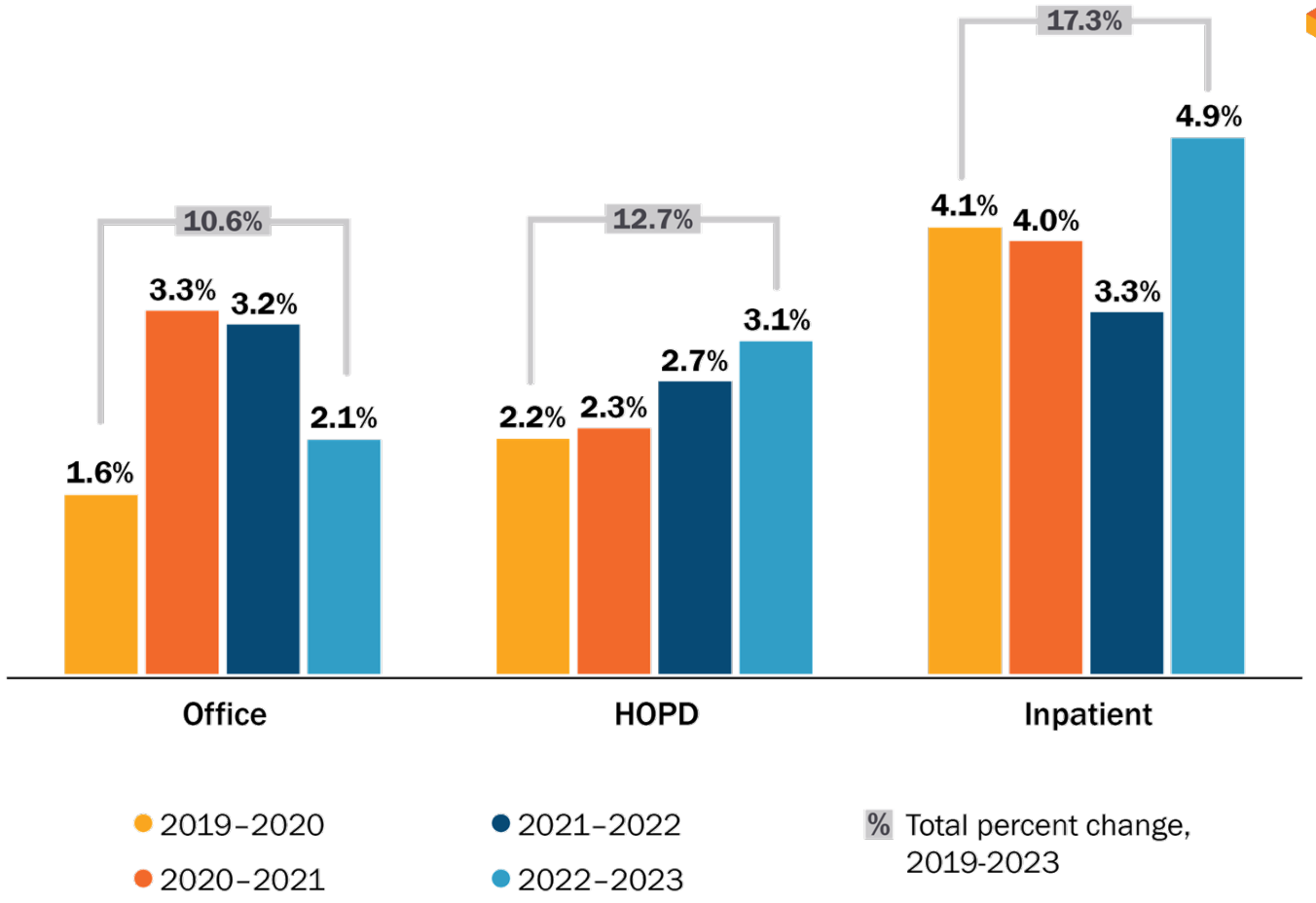
UP NEXT: Commercial Price Trends

Hospital and Post-Acute Care Utilization

Provider Organization Performance Variation

Commercial prices per encounter grew between 2% and 5% in all settings in 2023.

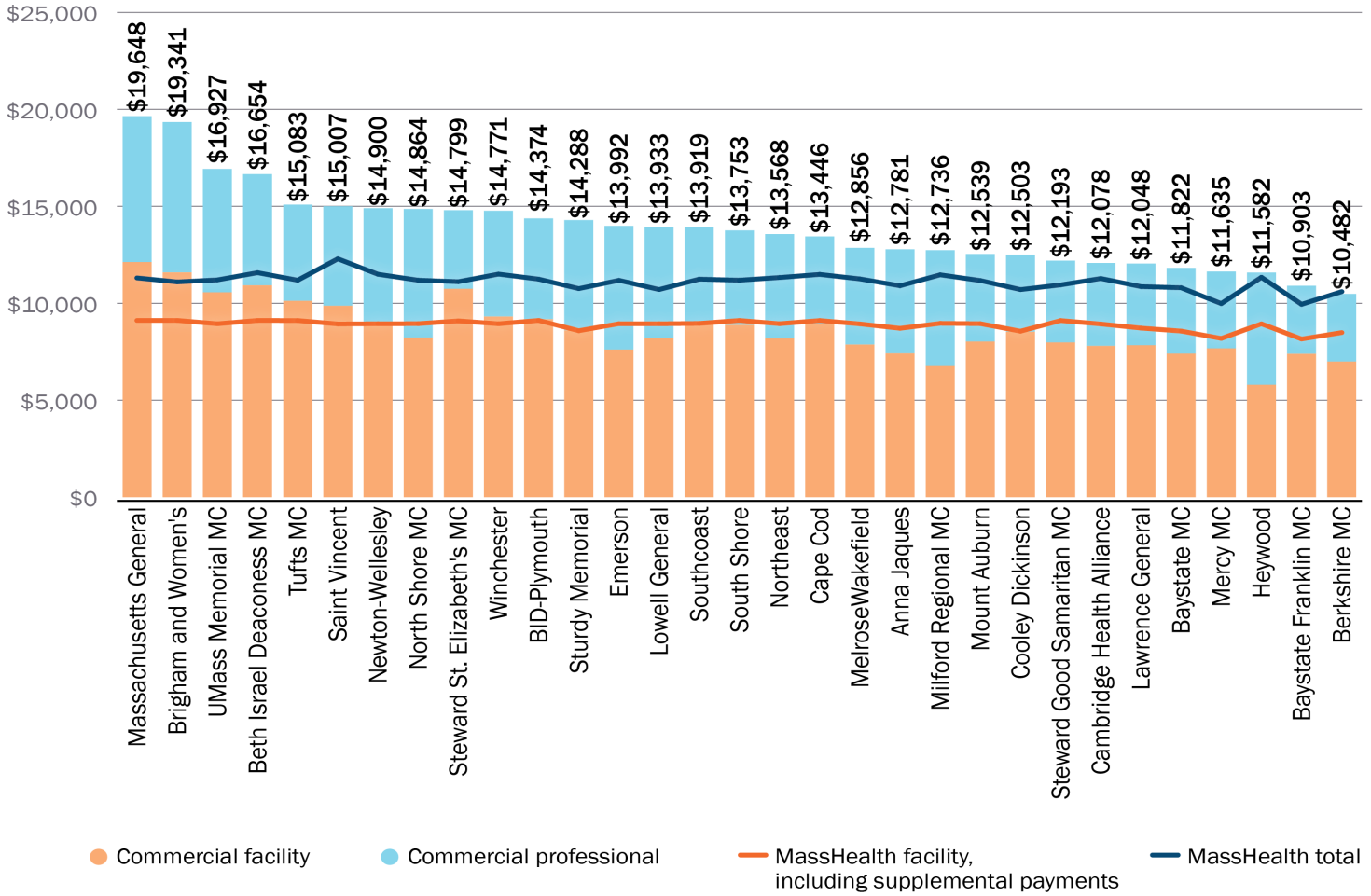
Average Price Increase Among All Services For Each Category and Year, 2019-2023



Notes: HOPD = hospital outpatient department. Price growth includes both facility and professional spending, where applicable. For all sites, price growth in a given period (e.g., 2019-2020) is equal to the sum of spending for all procedure codes in the more contemporary year (e.g., 2020) divided by the sum of the product of the average price in the earlier year (e.g., 2019) and total utilization in the more contemporary year for all procedure codes. Only procedure codes that were billed in both years in each period were included. Procedure codes with fewer than 20 encounters in either year during the period were excluded. For administered drugs and physical therapy services, unit prices were evaluated. Administered drug claims billed by UnitedHealthcare were excluded due to coding anomalies. Inpatient price growth excludes newborns, mental health, and substance use disorder (SUD) discharges. Inpatient price growth reflects change in payment per inpatient stay divided by APR-DRG weight (case-mix adjusted). Payment growth for inpatient stays include all services provided during the hospital stay. HOPD spending increase does not match HOPD index due to differences in methodology.
Sources: HPC analysis of Center for Health Information and Analysis (CHIA) All-Payer Claims Database V2023, 2019-2023

The average commercial price (including facility and professional components) for low-complexity vaginal delivery ranged from $10,482 to $19,648 across hospitals.

Commercial and MassHealth Inpatient Prices for Low-Complexity Vaginal Delivery by Hospital, 2023

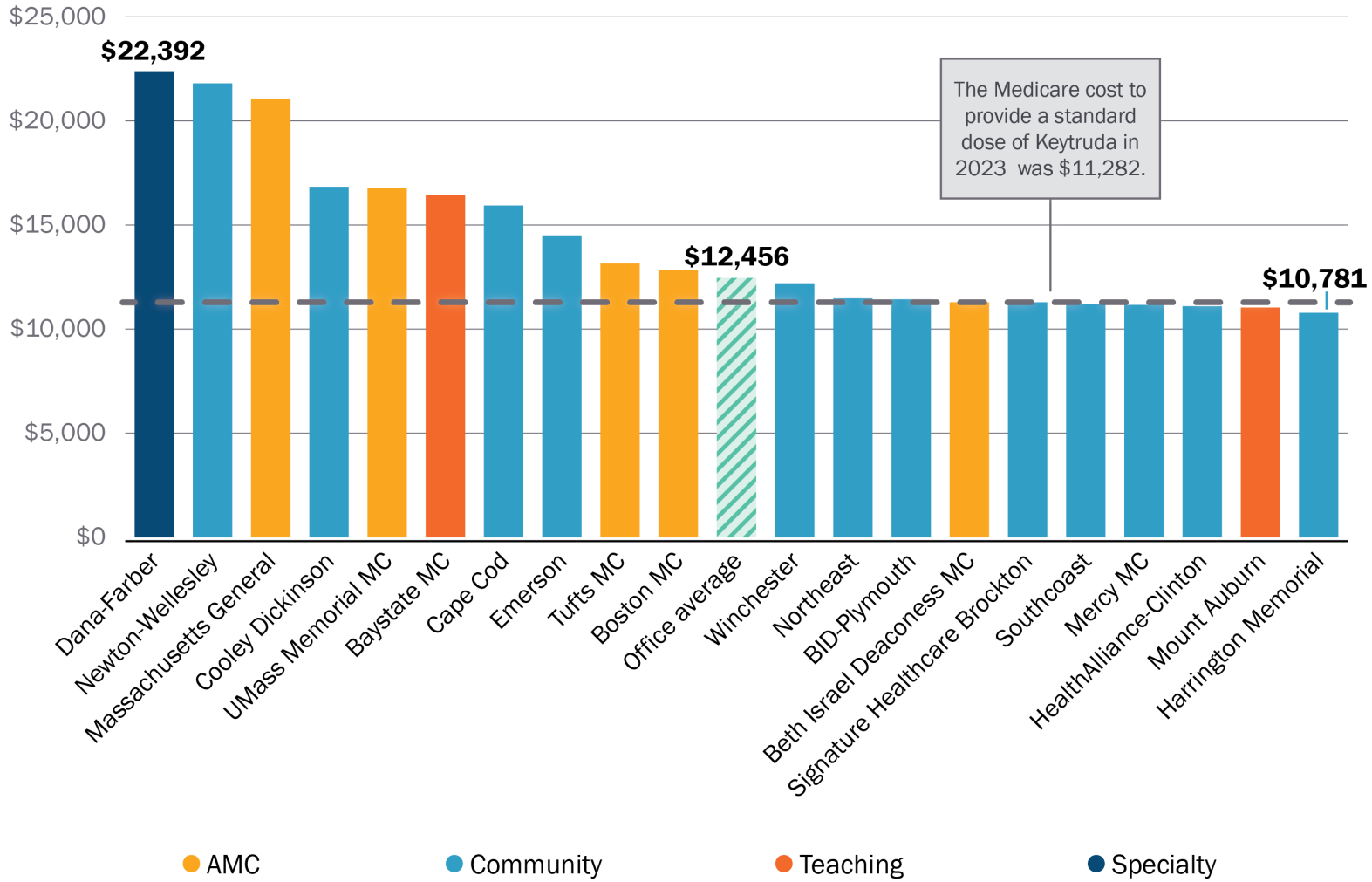


Notes: Analysis included commercial stays with APR-DRG 560, weighted average of prices for severity levels 1 and 2, in hospitals with at least 30 observations in the CHIA All-Payer Claims Database. Stays that are outliers in payment or length of stay, as well as transfers, are excluded from the estimation of comparable prices. The MassHealth facility rate is estimated using MassHealth payment rules for fiscal year 2023 and 2024, depending on the date of service, while MassHealth professional payments is estimated using actual professional payments to MassHealth patients based on APCD data. MassHealth supplemental payments only include rate add-on payments per discharge and do not include other types of supplemental payments. The research findings included within this report were produced using the Solventum™ (previously 3M) APR DRG Software.

Sources: HPC analysis of Center for Health Information and Analysis (CHIA) All-Payer Claims Database V2023, 2023

The average price for a standard dose of Keytruda administered through a clinical setting varied by a factor of 2:1 across providers.

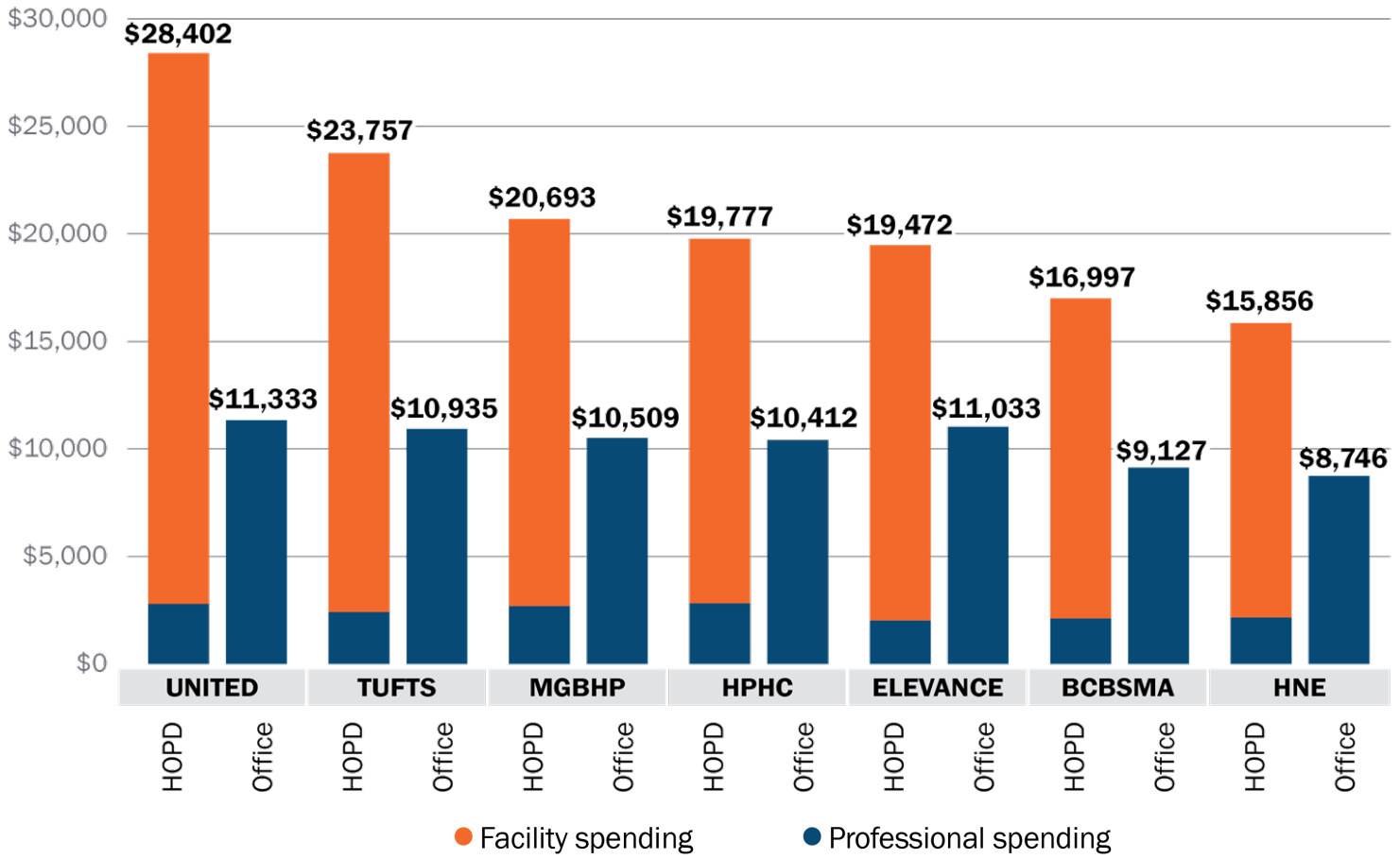
Average Price Received By Hospital From All Commercial Payers for a Standard Dose of Keytruda



Notes: Facilities listed are limited to those with at least 20 commercial encounters delivered in 2023. Prices reflect encounters (same person, same date of service, same procedure code) to capture the potential for both facility and professional claims billed on the same day. The price shown is for a standard dose of Keytruda (200 mg or 200 billable units). Data are for Keytruda (CPT J9271, 'Injection, pembrolizumab, 1 mg').
Sources: HPC analysis of Center for Health Information and Analysis (CHIA) All-Payer Claims Database v2023, 2023

There is variation among payers in how much more was paid for a basket of "crossover" procedures when performed in a HOPD compared to an office setting.

Average Payment For a Basket Of 25 Crossover Procedures (E.G. PT Evaluation, Mammography, Lipid Panel) by Payer and by Setting in Which the Procedures Occur



Notes: Crossover services are defined as services that can be provided safely at both hospital outpatient sites and office-based sites, see technical appendix for details. Only the top 25 services by total statewide volume are included in the index. For each payer-setting combination the same 25 procedure codes are evaluated using a fixed statewide volume (computed using 2023 data) and payer-setting specific average prices in 2023 for each procedure code. Each payer-setting combination has at least 20 encounters for each procedure code. Elevance Health was formerly Anthem.

Sources: HPC analysis of Center for Health Information and Analysis (CHIA) All-Payer Claims Database V2023, 2023

Research Presentation: 2025 Health Care Cost Trends Report Chartpack

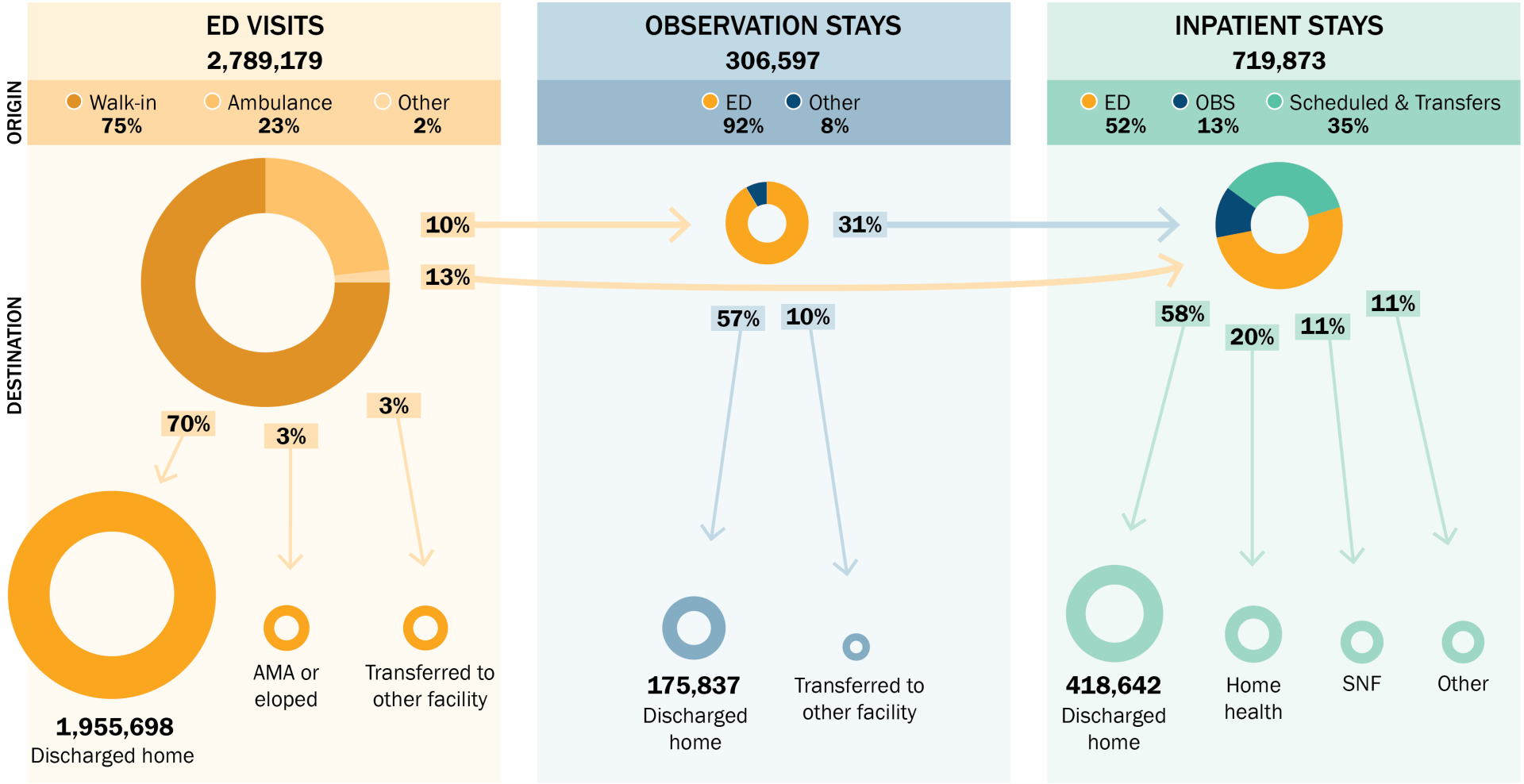
Primary Care and Behavioral Health Spending and Utilization in Massachusetts

Commercial Price Trends

UP NEXT: Hospital and Post-Acute Care Utilization

Provider Organization Performance Variation

Patient Pathways Through the Hospital, 2024

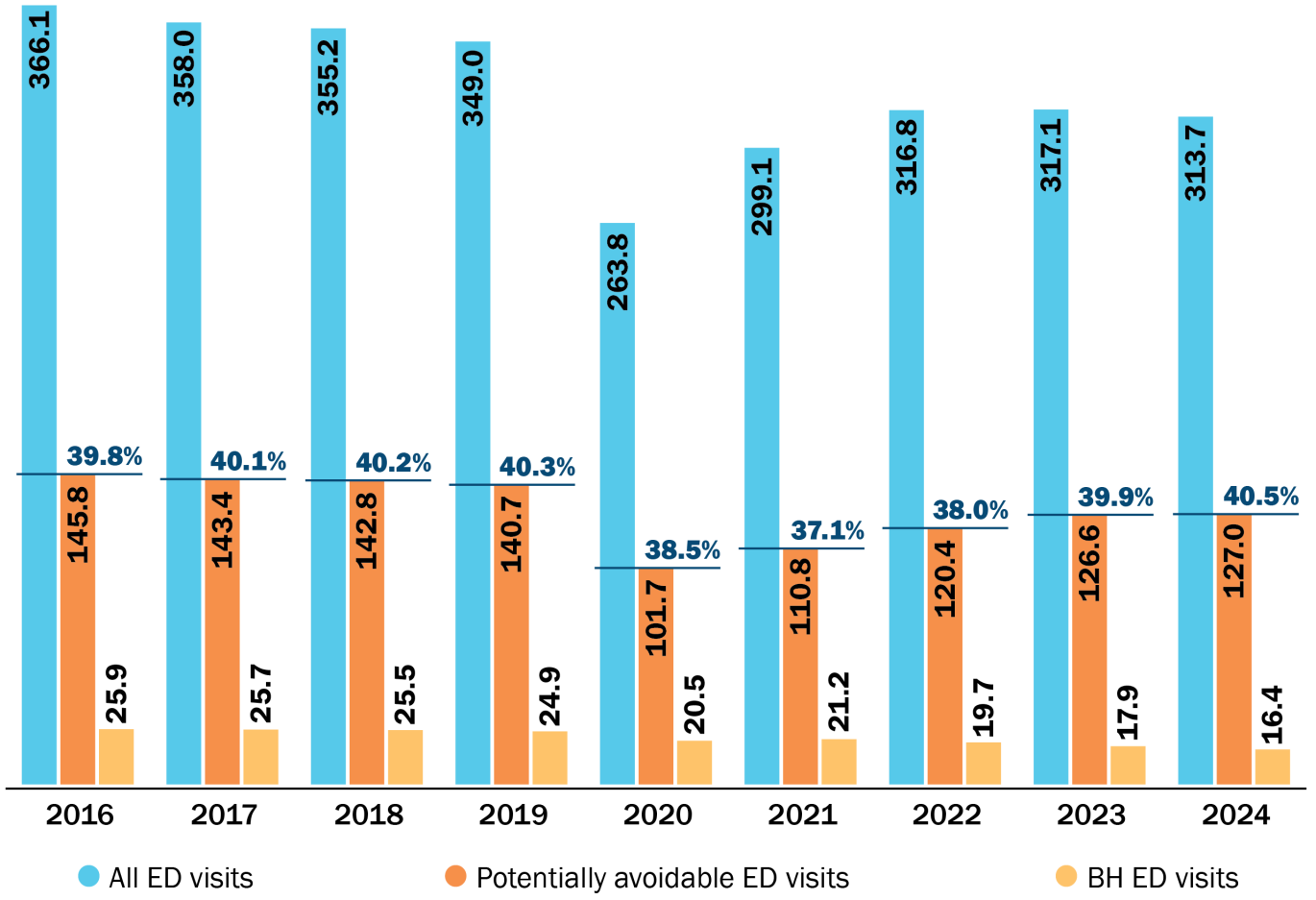


Notes: Ambulance transport category includes ambulance and helicopter; non-ambulance and non-walk-in transport category includes law enforcement and "other". Against medical advice destination category includes against medical advice and eloped. Emergency department visits identified using both emergency department and inpatient data. Transport information only available for ED visits identified in emergency department data (i.e., not admitted to observation or inpatient). Visits at specialty hospitals and "hospital at home" programs are excluded, as well as visits at two hospitals with incomplete data during the study period (Metrowest Medical Center, Framingham; and St. Vincent Hospital).

Sources: HPC analysis of Center for Health Information and Analysis (CHIA) Emergency Department Discharge, Outpatient Observation, and Hospital Inpatient Discharge Databases FY2020 to FY2024, preliminary FY2025.

While the total number of ED visits decreased slightly between 2023 and 2024, the share that were potentially avoidable increased.

Number Of "Treat And Release" Total, Avoidable, and Behavioral-health Related Emergency Department Visits per 1,000 Massachusetts Residents

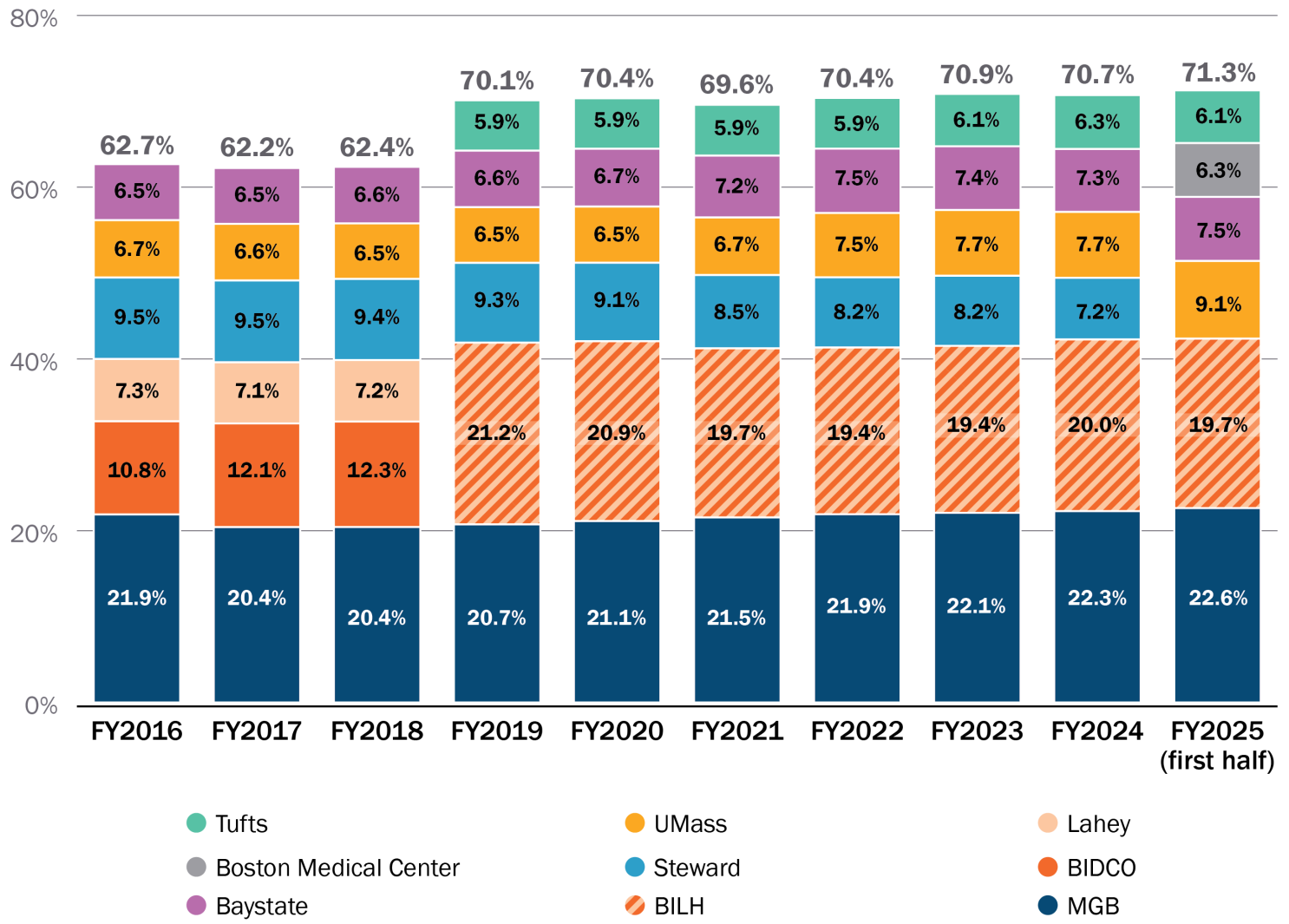


Notes: Data only include ED visits that did not result in an inpatient admission. Avoidable ED visits are based on the Billings algorithm, which classifies an ED visit into the following categories: Emergent - ED care needed and not avoidable; Emergent - ED care needed but avoidable; Emergent - primary care treatable; and Non-emergent - primary care treatable. "Avoidable" is defined here as ED visits that were emergent - primary care treatable or non-emergent - primary care treatable. Behavioral health ED visits were identified based on a principal diagnosis related to mental health and/or substance use disorder using the Clinical Classifications Revised Software (CCSR) diagnostic classifications. To improve classification rate, diagnosis codes unclassified by the Billings algorithm were truncated and shortened codes were re-classified. See technical appendix for details.

Sources: HPC analysis of Center for Health Information and Analysis (CHIA) Emergency Department Discharge Database FY2016 – FY2023, preliminary FY2024 and FY2025.

In the first half of FY2025 (after the dissolution of Steward Healthcare), the share of inpatient general acute services provided at the six largest health systems increased slightly to 71.3%.

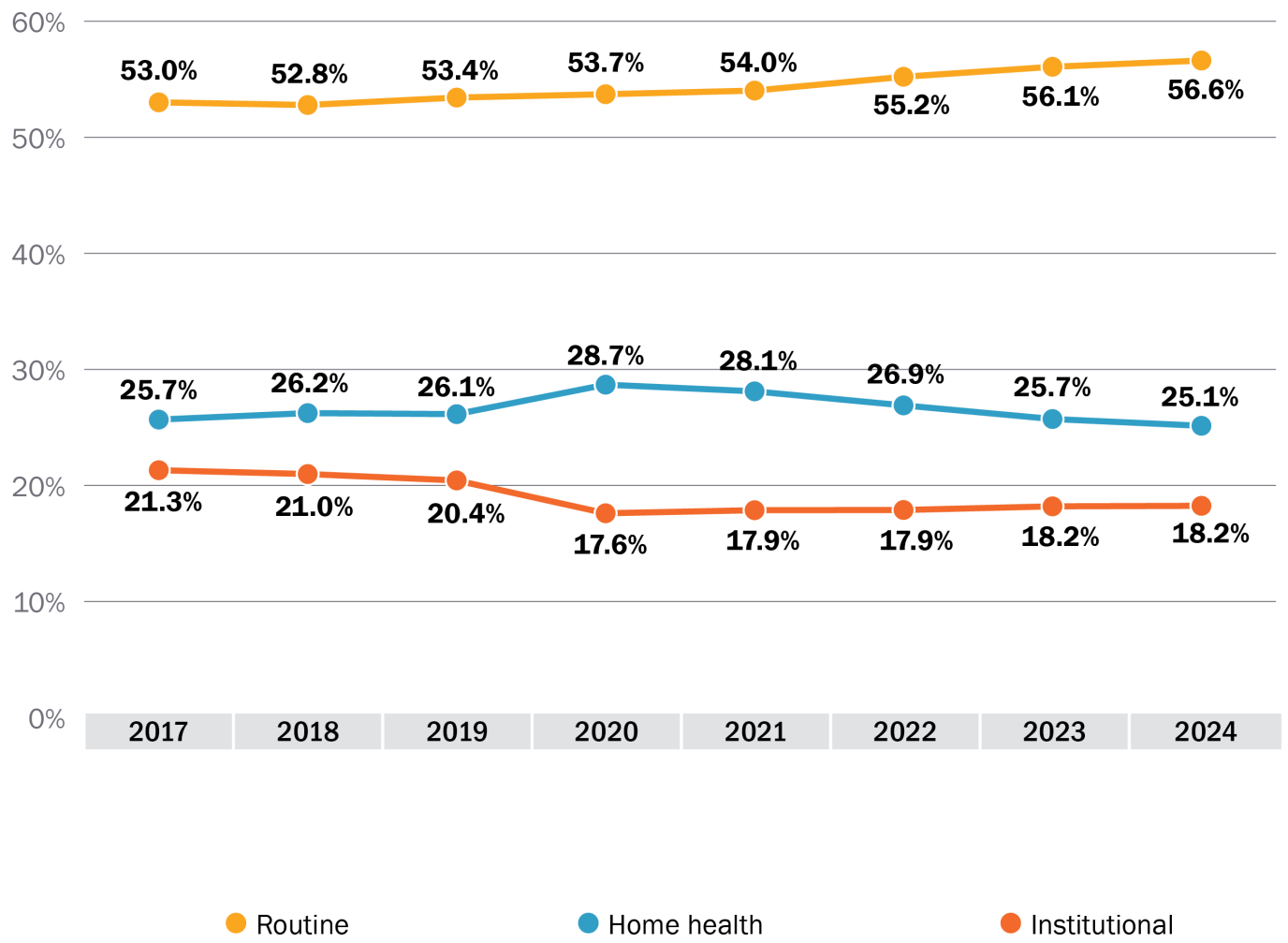
Percentage of Inpatient Stays Occurring in the 6 Largest Hospital Systems



Notes: Partners HealthCare changed its name to Mass General Brigham (MGB) in 2019. FY 2019 reflects the formation of Beth Israel Lahey Health (BILH) following the merger of Beth Israel Deaconess and Lahey Health systems. Inpatient care is measured in hospital discharges for general acute care services.
Sources: HPC analysis of Center for Health Information and Analysis (CHIA) hospital discharge dataset (HDD) FY2016-2025

The share of inpatient stays discharged to home health declined from 2020 to 2024 and is now below pre-pandemic levels.

Share of Inpatient Stays Discharged to Each Setting, 2017-2024



Notes: Out of state residents and those under 18 are excluded. Institutional post-acute care settings include skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals. Rates adjusted to control for age, sex, and changes in the mix of diagnosis-related groups (DRGs) over time. Specialty hospitals, except New England Baptist, were excluded. One hospital with at least one quarter of missing data (Mercy MC) was excluded for the entire study period. See technical appendix for details.
Sources: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database (HIDD), FY2017 to FY2024, preliminary FY2025.

Research Presentation: 2025 Health Care Cost Trends Report Chartpack

Primary Care and Behavioral Health Spending and Utilization in Massachusetts

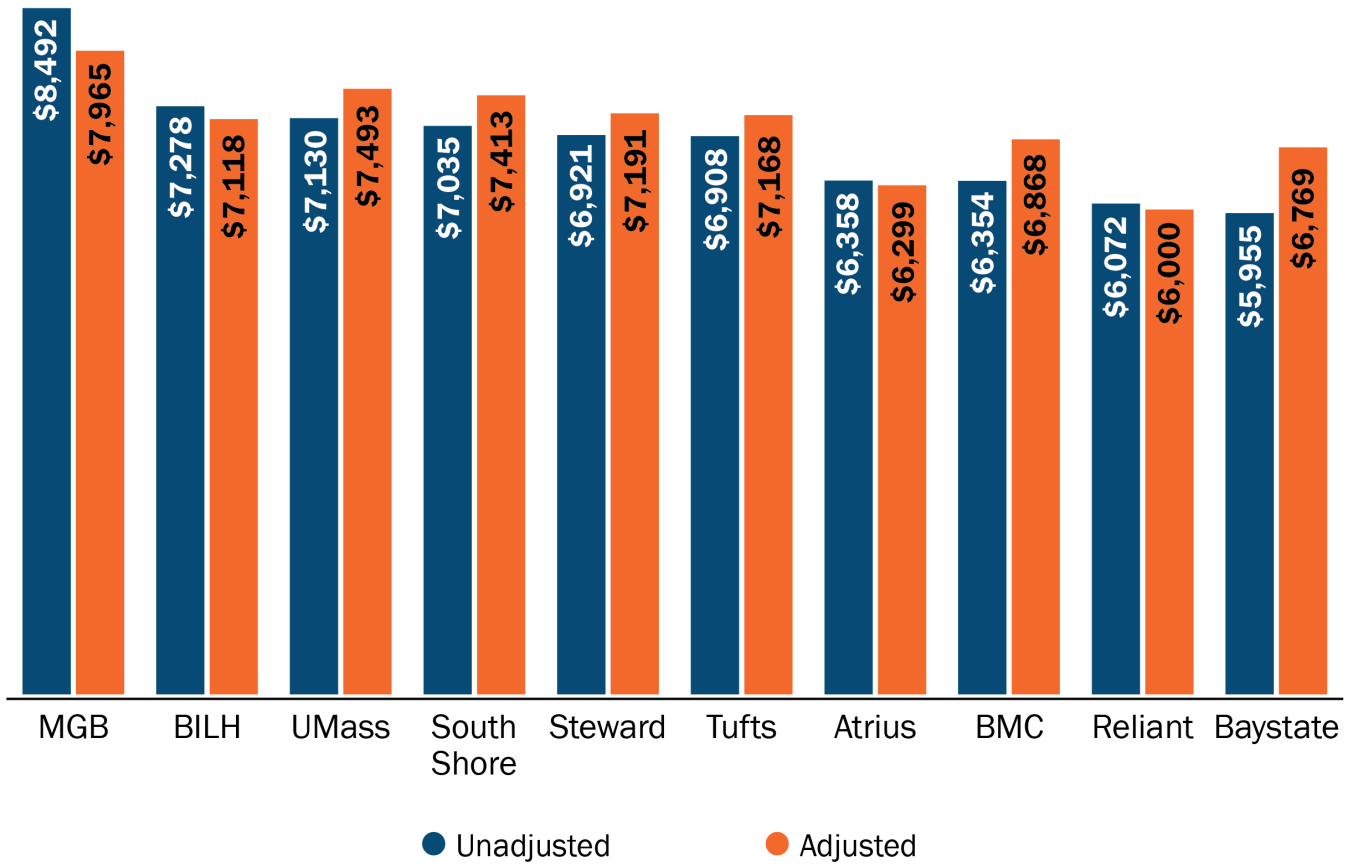
Commercial Price Trends

Hospital and Post-Acute Care Utilization

UP NEXT: Provider Organization Performance Variation

Unadjusted and adjusted average annual medical spending (excluding prescription drug spending) for patients varies across provider organizations.

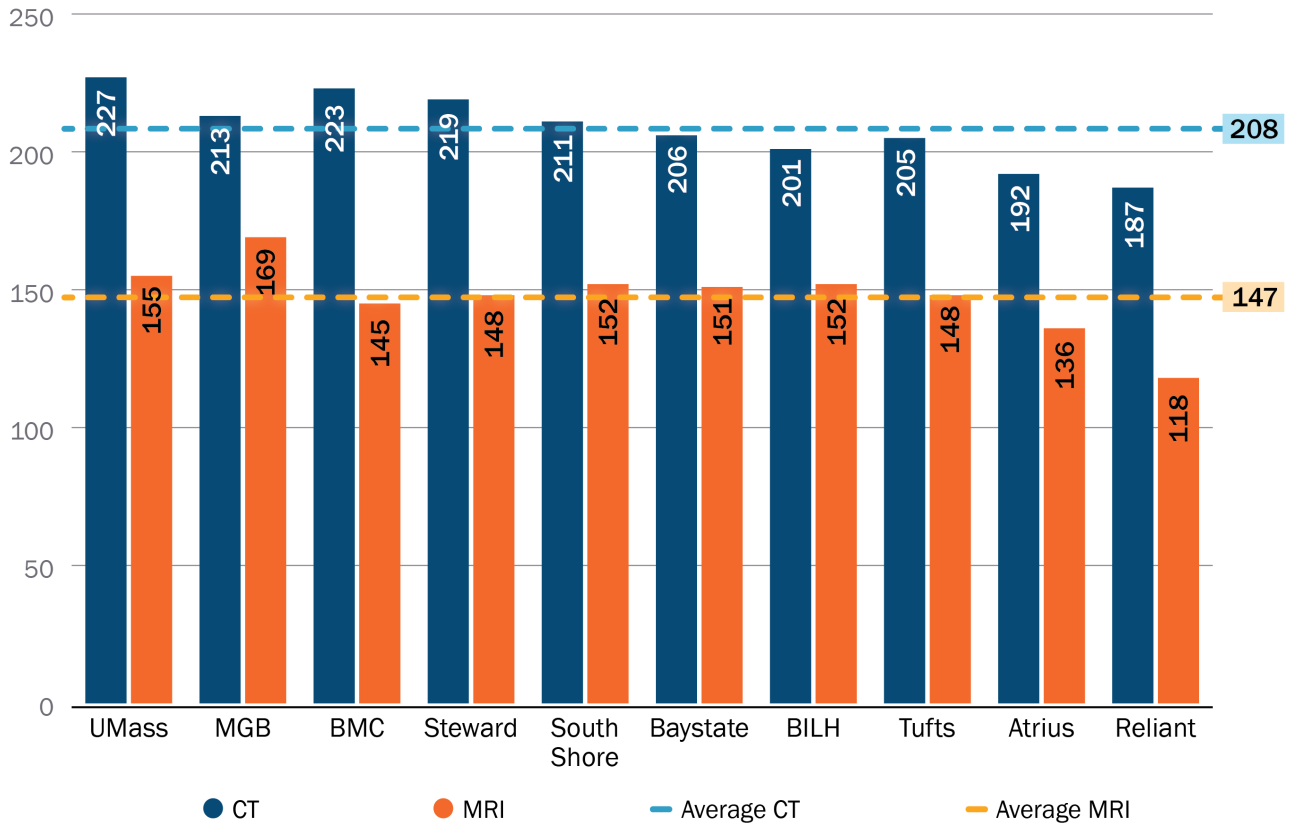
Unadjusted and Adjusted Total Annual Spending per Attributed Patient by Provider Organization



Notes: Prescription drug spending and non-claims-based spending excluded. Data include commercially-insured adults who could be attributed to larger provider organizations via their primary care provider using claims-based analysis of primary care visits. Included adults had 12 months of continual medical insurance coverage (N= 702,925). Prescription drug spending is excluded from this analysis because a significant portion of members' plans have prescription drug benefits "carved out" to third parties for which the HPC does not have access to the claims data. HPC methods for health status adjustment and attributing patients to provider group differ from payer methods used in CHIA TME data; HPC health status adjustment methods include adjustments based on factors noted in sidebar and a risk score as estimated by the HHS-HCC Risk Adjustment Model Software: HHS-HCC Risk Adjustment Model "Do It Yourself (DIY)" Software. Version 0723. Centers for Medicare and Medicaid Services (CMS). January 2024. See technical appendix for details.
Sources: HPC analysis of Center for Health Information and Analysis (CHIA) All-Payer Claims Database V2023, 2023.

Health status adjusted CT and MRI utilization varies by provider organization.

Annual CT And MRI Utilization by Provider Organization per 1,000 Attributed Patients



Notes: Provider organizations sorted by total imaging rates as a sum of the relative rates of CT and MRI. Results reflect commercial attributed adults, at least 18 years of age with 12 months of continual medical insurance coverage (N= 702,925). Session are defined as same day, same person, and same category of service (CT or MRI). A patient can have multiple encounters on one day, defined as same person, same procedure code, and same day, but the patient will only be recorded as having one session per day if all procedures are either CTs or MRIs. If a patient had an MRI and a CT service both on the same day, those would be considered as two sessions. Results are adjusted for differences in age, sex, health status, and community-level variables related to education and socioeconomic status. Averages are calculated across the provider organizations included in this graph. HPC health status adjustment methods include adjustments based on factors noted in sidebar and a risk score as estimated by the HHS-HCC Risk Adjustment Model Software: HHS-HCC Risk Adjustment Model "Do It Yourself (DIY)" Software. Version 0723. Centers for Medicare and Medicaid Services (CMS). January 2024.

1 Health Care Cost Institute, Health Care Vitals Data Dashboard. 2023.

Sources: HPC analysis of Center for Health Information and Analysis (CHIA) All-Payer Claims Database v2023, 2023

2023 Adult Low Value Care Summary (Among 1,618,021 Commercially-insured Patients)

NON-PRESCRIPTION DRUG LOW VALUE CARE MEASURES

Screening

- T3 (Thyroid) screening for patients with hypothyroidism
- Cardiac stress testing for patients with an established diagnosis of ischemic heart disease or angina
- Vitamin D screening for patients without chronic conditions

Testing

- Baseline labs in patients without significant systemic disease undergoing low risk surgery
- Pre-operative EKG, chest X-ray, and pulmonary function Testing

Procedures

- Spinal injections for lower back pain

Imaging

- Low value DEXA bone density scans
- Brain imaging for simple syncope
- Imaging for low back pain
- Imaging for heel pain
- Imaging for headaches
- Abdomen imaging

LOW VALUE CARE PRESCRIPTION DRUG MEASURES

- Antibiotics for acute upper respiratory and ear infections
- Concurrent use of two or more antipsychotic drugs
- Chronic use of benzodiazepines for more than 180 days
- Gabapentinoids for non-neuropathic pain
- Concurrent use of two or more anticholinergic drugs

Percent and number of patients with at least 1 LVC service	9% (118,973)
Total number of LVC services provided	173,988
Total spending for LVC services	$20,629,151
Spending variation across provider organizations	~1.7:1

While recent legislation implemented many of HPC's recent policy recommendations as included in past HPC Cost Trends Reports, there continues to be areas in need of potential policy action to promote affordability, accessibility and equity in the Massachusetts health care system.

Agenda

Call to Order

Approval of Minutes **(VOTE)**

2025 Health Care Cost Trends Hearing

Health Care Transformation and Innovation: Investment Programs

HPC DataPoints Issue #31, "*When the Closest Pharmacy is Too Far: Mapping Pharmacy Deserts in Massachusetts*"

Select Findings from the 2025 Health Care Cost Trends Report Chartpack

UP NEXT: Administration and Finance

- HPC FY 2026 Operating Budget **(VOTE)**

Executive Director's Report

Adjourn

Agenda

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- **UP NEXT: HPC FY 2026 Operating Budget (VOTE)**

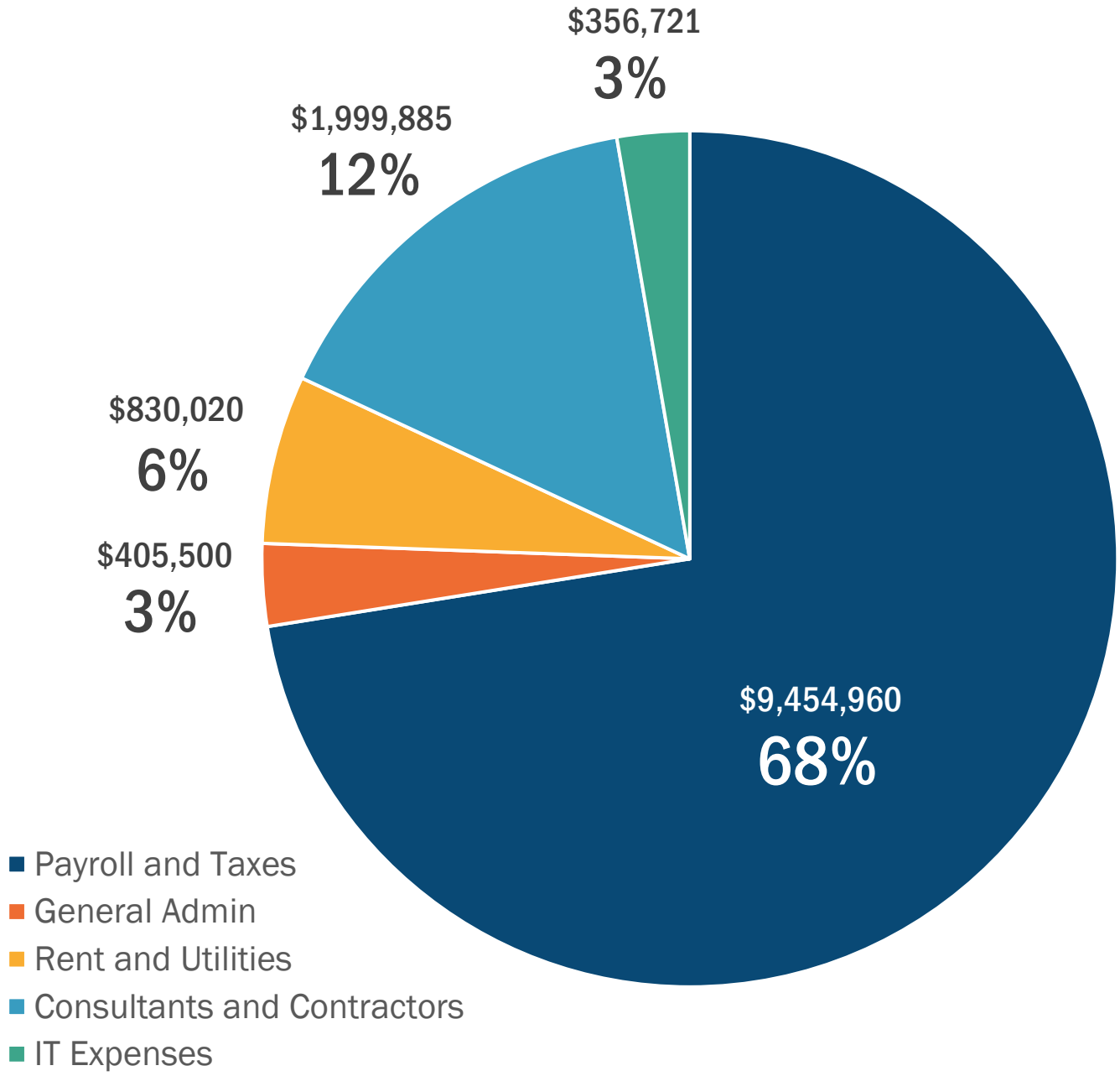
Executive Director's Report

Adjourn

Fiscal Year 2026 Budget

- The operating budget for the HPC is established in the annual state budget through an appropriation in line-item 1450-1200.
- The HPC subsequently assesses certain industry participants to collect revenue to offset the state's appropriation. This assessment calculation was revised in recent health care legislation and the HPC's regulation governing this process will need to be updated this fiscal year to reflect these changes.
- For FY25, the HPC's appropriation was **$12,028,078**.
- For FY26, the HPC's initial appropriation in the FY26 state budget was **$12,484,844**.
- Recognizing the significant **expanded HPC responsibilities mandated by the new health care legislation** and the need for additional staff and expert consulting services, the Legislature is approving an additional $750,000 in a FY25 supplemental budget that is authorized to be spent into FY26. Therefore, the total available funds for FY26 is **$13,234,844.**

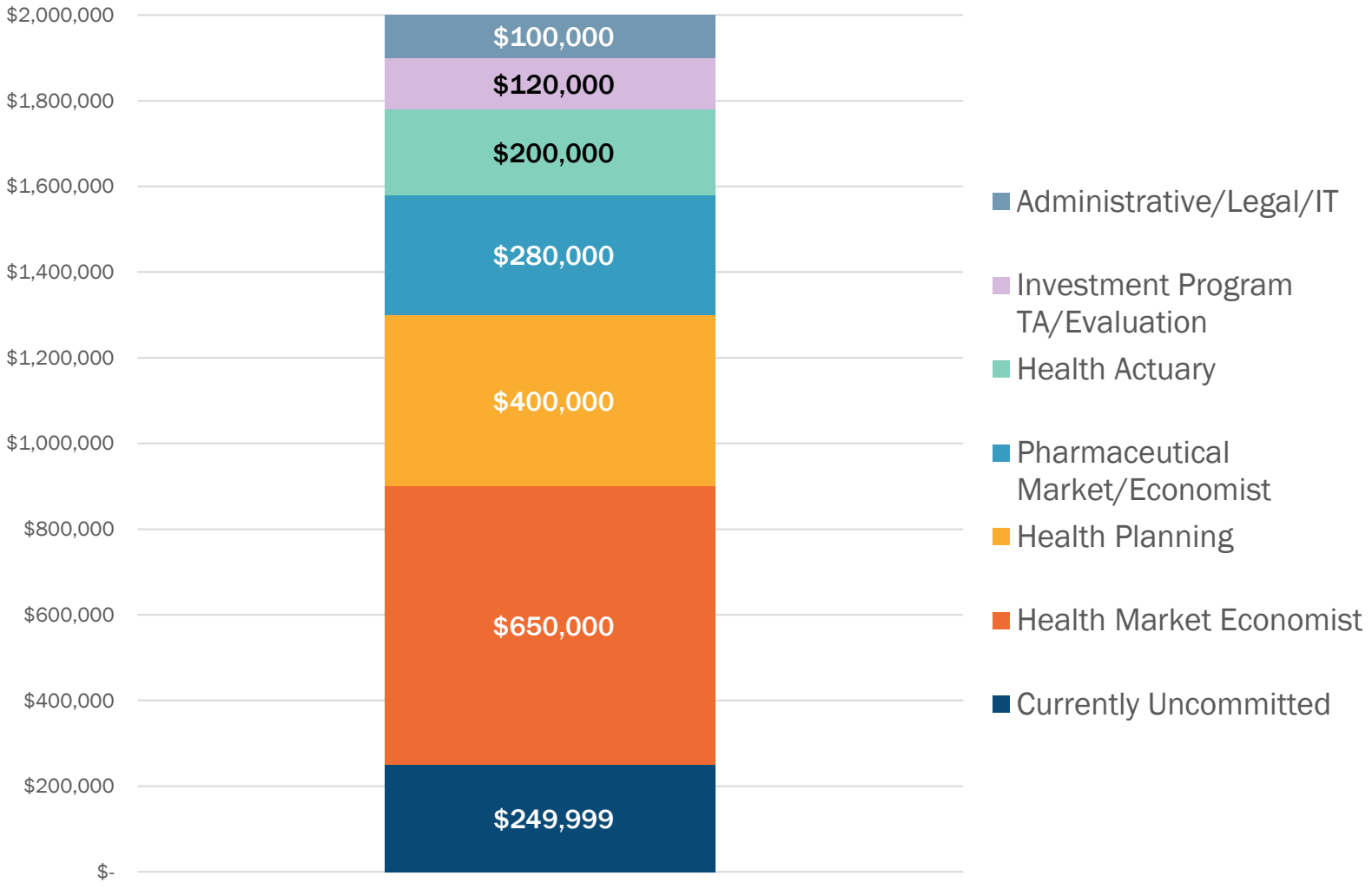
FY 2026 Budget by Category



Note: $187,758 was built into budget assumptions for the ongoing operation of the HPC's investment programs.

FY 2026 Consultant and Contractor Spending

A Closer Examination of the HPC's Estimated Spending on Consultants and Contractors in FY 2026



FY 2026 Budget: Key Assumptions

Maintenance of Core HPC Programs and Activities.

The budget assumes annualized funding for existing staff and professional services to support the HPC's ongoing, unchanged statutory obligations for FY26.

Support for Ongoing and Expanded Market Oversight.

The budget reflects the staff and professional services necessary to conduct the HPC's first retrospective cost and market impact review (CMIR) of the Beth Israel Lahey Health (BILH) merger, and the CMIR of the clinical affiliation between Mass General Brigham and CVS Health. The new health care legislation expanded the type of transactions that must be noticed to the HPC, which is expected to increase the number and complexity of transactions for review, including transactions involving private equity.

Phased Expansion of New Offices Focused on Pharmaceutical Policy and Health Planning.

The appropriated budget increase will allow for the first year of a multi-year build-out of the new Office of Pharmaceutical Policy and Analysis (OPPA) and Office of Health Resource Planning (OHRP), established in the new health care legislation. In this first year, the budget will support the hiring of 2 to 3 new staff for each office and an initial allocation of funding for qualitative and quantitative professional services support and data acquisition.

FY 2026 Budget: Key Assumptions

Collaboration with EOHHS and DPH on Task Forces Focused on Primary Care and Maternal Health.

The budget assumes ongoing operational and analytic support for the *Primary Care Access, Delivery, and Payment Task Force* and the *Maternal Health Access and Birthing Patient Safety Task Force*, both co-chaired by the HPC. The HPC Office of Health Resource Planning (OHRP) is conducting extensive qualitative and quantitative research on behalf of the Maternal Health Task Force as an initial exercise in resource distribution planning and assessment.

New Stipends for HPC Board Members.

The budget includes funding for stipends for the nine appointed HPC Board members, as authorized by the new health care legislation. Appointed members shall receive a stipend of not more than 10% of the Secretary of Administration and Finance's salary, and the HPC Board Chair shall receive a stipend of not more than 12% of the Secretary's salary.

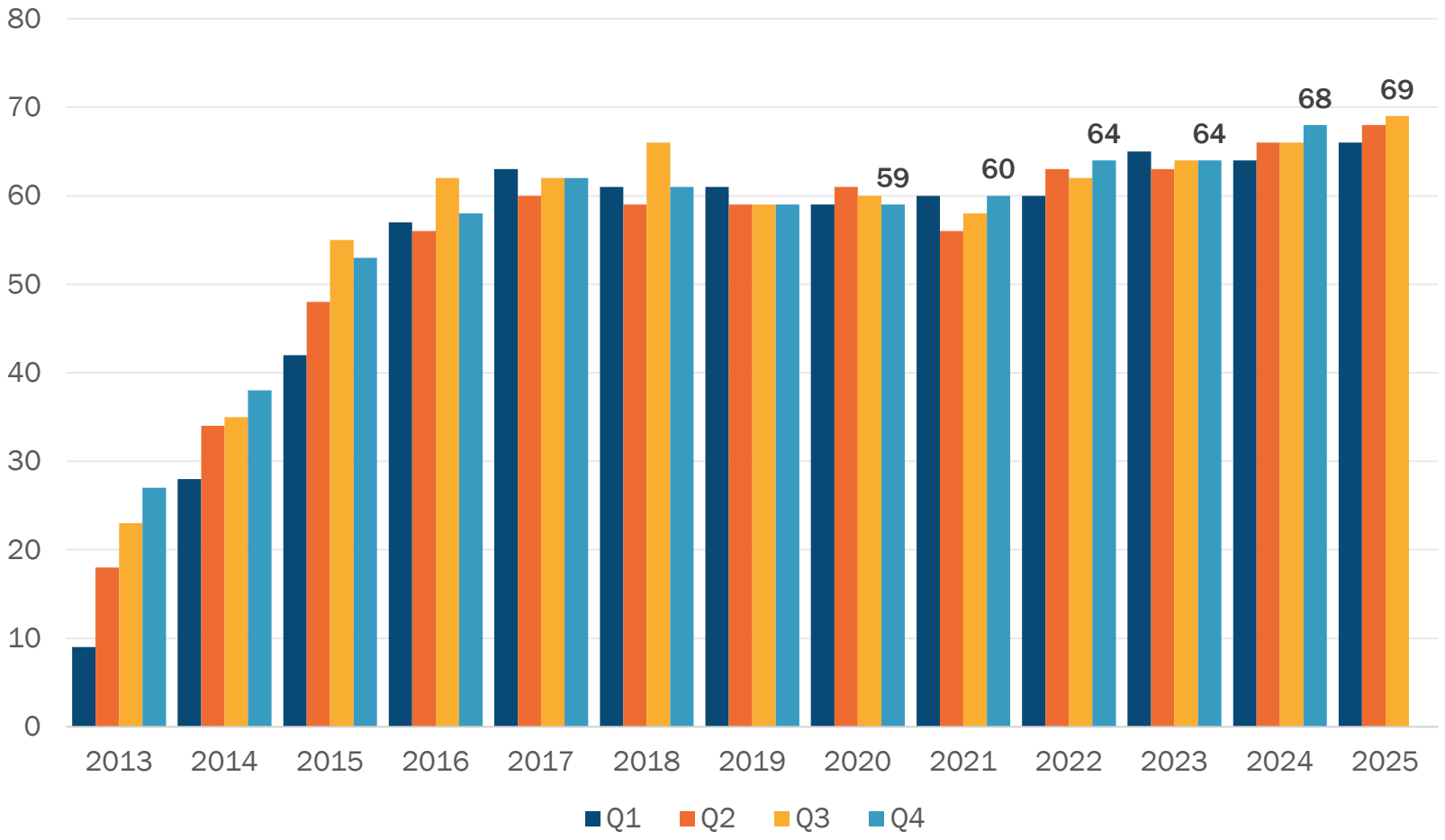
Conservative Fiscal Management.

As there are significant unknowns in any given fiscal year due to market conditions (e.g., the number and timing of transactions, drugs that may be referred to the HPC by MassHealth for review, potential new PIPs), the HPC manages the annually budget closely. If, in any year, there is unspent funds, assessed entities are credited in the following year's assessment.

The agency head count consistently held between 60-65 for the last five years; legislation passed in early 2025 expanded the HPC's oversight authority and established new offices.

HPC

HPC Employee Count: 2013-2025*



Employees by Department October 1, 2025

Executive/Office of the Chief of Staff (Operations and External Affairs)	16
Office of the General Counsel/Office of Patient Protection	7
Health Care Transformation and Innovation	12
Market Oversight and Transparency	15
Research and Cost Trends	10
Behavioral Health Workforce Center	4
Office of Health Resource Planning	3
Office of Pharmaceutical Policy and Analysis	2
Total Employees	**69**

*This graph includes a count of both full time and part time paid employees, including temporary contract employees but excluding seasonal fellows. The table is an adjusted count based on 37.5-hour work week (FTE).

VOTE

FY 2026 Operating Budget

MOTION

That the Commission hereby approves the Commission's total operating budget for fiscal year 2026, as presented and attached hereto and authorizes the Executive Director to expend these budgeted funds.

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UP NEXT: Executive Director's Report

Adjourn

The HPC employs four core strategies to realize its vision of better care, better health, and lower costs for all people of the Commonwealth.

MARKET OVERSIGHT

Monitor and intervene when necessary to assure market performance

CONVENE

Bring together stakeholder community to influence their actions on a topic or problem

RESEARCH AND REPORT

Investigate, analyze, and report trends and insights

PARTNER

Engage with individuals, groups, and organizations to achieve mutual goals

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Since 2013, the HPC has reviewed 193 market changes.

Type of Transaction	Number	Frequency
Physician group merger, acquisition, or network affiliation	44	23%
Formation of a contracting entity	41	21%
Clinical affiliation	36	19%
Merger, acquisition, or network affiliation of other provider type (e.g., post-acute)	33	17%
Acute hospital merger, acquisition, or network affiliation	31	16%
Change in ownership or merger of corporately affiliated entities	6	3%
Affiliation between a provider and a carrier	1	1%
Ownership/control change involving significant equity investor	1	1%

Cost and Market Impact Reviews in Progress

- Retrospective review of the impacts of the creation of **Beth Israel Lahey Health**.
- The proposed contracting affiliation between **MinuteClinic Primary Care**, a physician-owned entity managed by CVS Management Support, a subsidiary of CVS Pharmacy, and **Mass General Brigham**.

Other Transactions Currently Under Review

- A proposed joint venture between **UMass Memorial Health – Milford Regional Medical Center**, and **Shields Health Care Group, Inc.**, which would own and operate MRI and PET/CT services at Milford.
- The proposed acquisition of Ambulatory Topco, LLC, the parent entity of **AMSURG**, a private-equity-backed owner of over 245 ambulatory surgery centers nationwide including nine in Massachusetts, by **Ascension Health Alliance**, a national non-profit Catholic health system.
- The proposed acquisition of **KabaFusion, Inc.**, a national specialty home infusion services company with locations in Massachusetts, by a newly formed subsidiary of **Nautic Partners**, a private equity firm.

RECEIVED SINCE 9/18/2025

- The proposed acquisition of **Acton Medical Associates**, a primary care practice with locations northwest of Boston, by **Atrius Health**, a 700-physician multi-specialty group practice that receives administrative and non-clinical support from Atrius MSO, which is owned by OptumCare, a subsidiary of UnitedHealth.

Background on the Massachusetts Registration of Provider Organizations Program (MA-RPO)

- The MA-RPO Program, a joint effort of the Health Policy Commission (HPC) and the Center for Health Information and Analysis (CHIA), is a **first-in-the-nation** initiative for collecting **public, standardized information on health care provider organizations throughout Massachusetts**.

- Approximately 50 provider organizations that that met the program's **net patient service revenue (NPSR)-based threshold** or that received a **risk certificate from the Division of Insurance** were required to register in the 2024 filing.
  - The data include **all general acute hospital systems and over 24,000 physicians.**

- The data contribute to a foundation of information needed to support health care system transparency and improvement.
  - This regularly reported information on the health care delivery system supports many functions including care delivery innovation, evaluation of market changes, health resource planning, and tracking and analyzing system-wide and provider-specific trends.

DATA COLLECTED TO-DATE

1. Background Information
2. Corporate Affiliations
3. Contracting Affiliations
4. Contracting Entity
5. Facilities
6. Clinical Affiliations
7. Physician Roster
8. Financial Statements
9. Payer Mix

Statutory Updates to the MA-RPO Program

Chapter 343 of the Acts of 2024 made several key updates to the MA-RPO Program statutes.

Updated Registration Threshold: The program's revenue threshold was changed from $25 million in commercial, Medicare Advantage, and MMCO NPSR (excluding revenue from traditional Medicare, MassHealth fee-for-service and PCC plans, and other government payers) to $25 million in NPSR from all payers.

Additional Areas for Data Collection: The law directs the MA-RPO Program to collect several new types of information, including:

- Provider Organizations' relationships with significant equity investors (SEIs), health care real estate investment trusts (REITs) and managed services organizations (MSOs), including financial information.
- The name, address, and capacity of all locations (including unlicensed sites) where the Provider Organization delivers health care services.

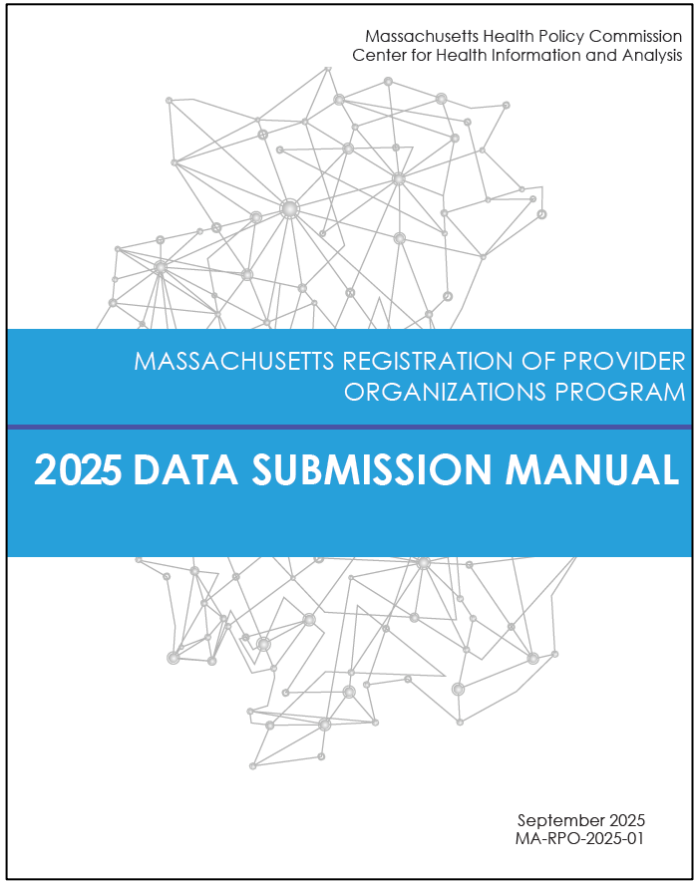
Private Equity Oversight: The MA-RPO Program may require Provider Organizations with private equity investment to report certain information quarterly and may require the disclosure of relevant information from any SEI associated with a Provider Organization.

MA-RPO Program: 2025 Filing Updates

- In June, the **MA-RPO Program released Guidance** regarding changes to the registration threshold (see previous slide) and the expansion of the provider types required to register.
  - New provider types required to register include specialty non-acute and chronic care hospitals, urgent care centers, ambulatory surgery centers, freestanding imaging facilities, and clinical laboratories.
- The MA-RPO Program also released proposed updates to the 2025 reporting requirements. After considering public comments, the MA-RPO Program will collect two new files in 2025:
  - Information on provider organizations' relationships with **SEIs, MSOs, and REITs.**
  - A roster of **Advanced Practice Providers and Behavioral Health Clinicians**
- Additional requirements are expected to be phased in during future registration cycles.

2025 Data Submission Manual and Online Submission Platform Update

- The MA-RPO Program released the final **2025 Data Submission Manual** and filing templates last month.
  - Filing materials are available on the program website: https://masshpc.gov/moat/rpo
- The deadline for submitting all required information is **Monday, December 1, 2025 at 5:00 PM.**
- Program staff will host training sessions for new and experienced reporters next week.
  - **Refresher Training**: Monday, October 27 at 2pm
  - **New Reporter Training**: Wednesday October 29 at 2pm
- Please email HPC-RPO@mass.gov if you would like to participate in one of the training sessions.



Other Recent and Upcoming Publications

RECENTLY RELEASED

- **DataPoints:** Issue #31, When the Closest Pharmacy is Too Far: Mapping Pharmacy Deserts in Massachusetts (October 2025)
- **Policy Brief and Video:** Hospital at Home in Massachusetts: Trends in an Emerging Clinical Model (September 2025)
- **DataPoints:** Issue #30, The Primary Care Spending Gap: Paying Less for What Matters Most (July 2025)
- **DataPoints:** Issue #29, Polypharmacy Trends in Massachusetts: Examining the Prevalence of Multiple, Concurrent Prescriptions (June 2025)

UPCOMING

- **2025 Health Care Cost Trends Report**: Annual Report, Chartpack, and Policy Recommendations
- **Evaluation Report**: Moving Massachusetts Upstream (MassUP) Investment Program
- **Policy Brief**: Assessment of Pharmacy Deserts in Massachusetts and Policy Considerations
- **Legislative Report**: Assessment of Behavioral Health Commercial Rates
- **Legislative Report**: Trends in Behavioral Health Emergency Department Boarding

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UP NEXT: Adjourn

Schedule of Upcoming 2025 Meetings

BOARD

December 11

TASK FORCES

PRIMARY CARE

October 29

December 3

MATERIAL HEALTH

Additional meetings TBA

SPECIAL EVENTS

November 12
2025 Health Care Cost Trends Hearing

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2026 HPC public meeting calendar coming soon