MASSACHUSETTS
HEALTH POLICY COMMISSION

HPC Board Meeting

February 5, 2026

Agenda

UP NEXT: Call to Order

Approval of Minutes **(VOTE)**

Healey-Driscoll Administration's Health Care Affordability Working Group and Prior Authorization Reform Announcement

DataPoints Issue #33: Evidence of Administrative Complexity: Health Insurance Claim Denials in Massachusetts

Market Transaction Reviews

Regulatory Updates: Chapters 342 and 343 of the Acts of 2024 **(VOTE)**

Executive Director's Report

Adjourn

Agenda

Call to Order

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VOTE

Approval of Minutes from December 11, 2025, Board Meeting

MOTION

That the Commission hereby approves the minutes of the Commission meeting held on December 11, 2025, as presented.

Agenda

Call to Order

Approval of Minutes **(VOTE)**

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In its 2025 Cost Trends Report, the HPC recommended a call to action on health care affordability.

In 2026, policymakers and health care leaders should **recommit to the health care cost growth benchmark** and **convene to develop a consensus on a comprehensive set of reforms**, consistent with the long-standing Massachusetts values of shared responsibility and shared sacrifice, for a greater public good. **Massachusetts should once again be the national leader in reimagining our health care system from the status quo to one capable of delivering affordable, accessible, and equitable care for all residents.**

HPC 2025 Policy Recommendations

ADMINISTRATIVE COMPLEXITY

The Commonwealth should take action to reduce these costs by adopting policies that reduce and standardize common administrative tasks, prioritizing those that impede care for patients and burden primary care clinicians and support staff.

HEALTH CARE PRICES

Prices continue to be a primary driver of health care spending growth in Massachusetts and there is persistent, significant variation in prices between providers for the same sets of services without commensurate differences in quality. The Commonwealth should implement policy solutions that seek to limit excessive prices for services above a fair, reasonable threshold or to moderate price growth to a sustainable rate.

PHARMACEUTICAL SPENDING

Net of rebates, pharmacy spending per enrollee grew an average of **8.6% per year from 2019 to 2023**, contributing significantly to the state's overall health care cost growth rate. In addition to considering policies implemented by other states, the Commonwealth should consider recommendations developed in the coming year by OPPA and DOI.

LOW VALUE CARE AND AVOIDABLE UTILIZATION

Providers and payers in the Commonwealth should be encouraged to adopt strategies to reduce low value care and avoidable emergency department (ED) use, ED boarding, and readmissions, and shift lower acuity care to the most appropriate setting. Fundamental to the success of these efforts is to expand access to primary care and behavioral health care.

Healey-Driscoll Administration's Health Care Affordability Working Group

On January 14, 2026, Governor Maura Healey announced a new working group charged with advancing proposals to reduce health care costs across the system, ultimately reducing costs for people and businesses across the state.

> *Health care is too difficult and too expensive for far too many people. We are taking the most comprehensive action in the country to make it faster, cheaper and easier to get the care you need. This is a moment of urgency, and today we are bringing together leaders from across health care, business and labor to find every possible step we can take to lower costs and improve health care in Massachusetts."*
>
> — Governor Maura Healey

Health Care Affordability Working Group

Kate Walsh (Chair), Former Secretary of Health and Human Services

Lisa Murray (Chair), Massachusetts State President, Citizens

Senator Cindy Friedman, Chair, Joint Committee on Health Care Financing

Representative John Lawn, Chair, Joint Committee on Health Care Financing

Matthew Gorzkowicz, Secretary of Administration and Finance, Massachusetts Executive Office of Administration and Finance (ANF)

Michael Caljouw, Commissioner, Massachusetts Division of Insurance (DOI)

Amy Rosenthal, Undersecretary for Health, Massachusetts Executive Office of Health and Human Services (EOHHS)

Mike Levine, Undersecretary for MassHealth and State Medicaid Director, Massachusetts EOHHS

Robbie Goldstein, MD, Commissioner of the Department of Public Health, Massachusetts EOHHS

David Seltz, Executive Director, Massachusetts Health Policy Commission (HPC)

Andrew Jackmauh, Interim Executive Director, Center for Health Information and Analysis (CHIA)

Matt Veno, Executive Director, Group Insurance Commission (GIC)

Audrey Morse Gasteier, Executive Director, Massachusetts Health Connector

Steve Walsh, President & CEO, Massachusetts Health and Hospital Association

Lois Cornell, Executive Vice President, Massachusetts Medical Society

Michael Curry, President & CEO, Mass League of Community Health Centers

Tara Gregorio, President & CEO, Mass Senior Care Association

Kendalle Burlin O'Connell, President & CEO, MassBIO

Cari Medina, Executive Vice President, 1199SEIU

Joe-Ann Fergus, Executive Director, Massachusetts Nursing Association

Sarah Iselin, President & CEO, Blue Cross Blue Shield of Massachusetts

Lora Pellegrini, President & CEO, Massachusetts Association of Health Plans

Doug Howgate, President, Massachusetts Taxpayers Foundation

Jon Hurst, President & CEO, Retailers Association of Massachusetts

JD Chesloff, President & CEO, Massachusetts Business Roundtable

Ashley Blackburn, Interim Executive Director, Health Care for All

Danna Mauch, President & CEO, Massachusetts Association for Mental Health

Zirui Song, Associate Professor of Health Care Policy and Medicine, Harvard Medical School

Bela Gorman, health care actuary; Health Connector Board member

Chris Koller, health policy researcher; former RI DOI Commissioner

Reducing Administrative Waste:

Supporting Responsible, Transparent and Time-Sensitive Prior Authorization and Claims Submissions Practices

February 5, 2026

DOI Listening Sessions, Special Examination & Report

- **Public Information Sessions** on health care affordability in 2024 and 2025.

- **DOI Special Market Examination**
  - DOI launched a market-wide special examination in early 2025.
  - Focused on prior authorization practices in the fully insured market in 2023 and 2024.
  - Massachusetts DOI: first full study of extent and variation of practices in the market in a systematic manner.

- **Examination Report**
  - Aggregated, de-identified data from 14 carriers.
  - Substantial differences in how and when carriers require prior authorization.
  - Additional opportunities for reduction of administrative waste through regulatory streamlining and standardization.
  - Responsible use promotes high-quality, cost-effective care while restricting potential fraud, waste, or abuse.

Proposed Changes to 211 CMR 52.00

- **Insurance Division Hearing on February 19, 2026.**
- Requires insurers to post all services, supplies, and medications that require prior authorization.
- Eliminates the use of prior authorization for specified services:

  - Emergency and urgent care services
  - Inpatient acute care services
  - Post-acute care services on weekends or holidays
  - Primary Care Services
  - Chronic Disease Management services, devices and prescription drugs, pursuant to requirements established under Chapter 342 of the Acts of 2024 (the PACT Act)
  - Preventive Health Services and vaccinations
  - Abortion and abortion-related care
  - Maternity services
  - Physical therapy, occupational therapy, and speech therapy
  - Outpatient substance use disorder services

Proposed Changes to 211 CMR 52.00

- ❑ Automatic “continuity of care” authorizations for at least three months.
- ❑ Responses to requests within 24 hours when the patient’s life is imperiled.
- ❑ Updated websites and notices to providers 60 days prior to new or revised requirements.
- ❑ Annually review of prior authorization lists and survey of patient experience.
- ❑ Insurers can discourage duplicate, excessive, uncovered and incomplete claims submissions.
- ❑ “*Utilization Safety Valve*”: If insurers demonstrate to the DOI that for a consistent period, there is markedly increased utilization for certain services (net of overall trend), insurers may request temporary relief from specific service limits.

Agenda

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Healey-Driscoll Administration's Health Care Affordability Working Group and Prior Authorization Reform Announcement

UP NEXT: DataPoints Issue #33: Evidence of Administrative Complexity: Health Insurance Claim Denials in Massachusetts

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Background

- **Administrative costs are a driver of high health care spending, accounting for 15-30% of total health care spending.** Both insurers and providers incur administrative costs, and most of these non-clinical costs are billing- and insurance-related expenditures.
- Administrative costs can be difficult to identify and quantify as the costs are borne by multiple parties and comprise a wide range of tasks within the health care system. **Analyzing health care claims data, specifically claim denials, is one way to provide greater insight into administrative costs related to provider-insurer claims processing.**
- Each year, **insurers report data on claim denials to the Office of Patient Protection and the Division of Insurance** categorized by claim type, clinical category, and reasons for claim denials. Insurers report the **total number of claims (both paid and denied)** and the **reasons for the denied claims.**

Source: Health Affairs (2022). "The Role Of Administrative Waste In Excess US Health Spending." (October 6, 2022); Health Affairs Council on Health Care Spending and Value (2023). "A road map for action: recommendations of the Health Affairs Council on Health Care Spending and Value." (February 2023).

Key Considerations and Context

- **Data Source:** Calendar Year 2022 to 2024 reports to OPP.
- **Scope:** Data includes only fully-insured commercial health insurance plans in the Commonwealth.
- **Carriers:** Cigna data were excluded due to data quality concerns. Connecticare and Welfleet were excluded due to relatively small claim volume. Certain insurers under the same corporate umbrella were consolidated, resulting in a total of 9 carriers for purposes of these analyses.
- **Exclusion**: Inpatient institutional claims were excluded as they are reported at the header level (all other claims are reported at the claim line level).
- **Claim Status:** The data reflect fully adjudicated claims with a calendar year 2022-2024 service date. Multiple claims may pertain to the same service. As such, the reported data does not indicate how many of the reported denials resulted in a patient not receiving coverage for the services.

Denial Categories

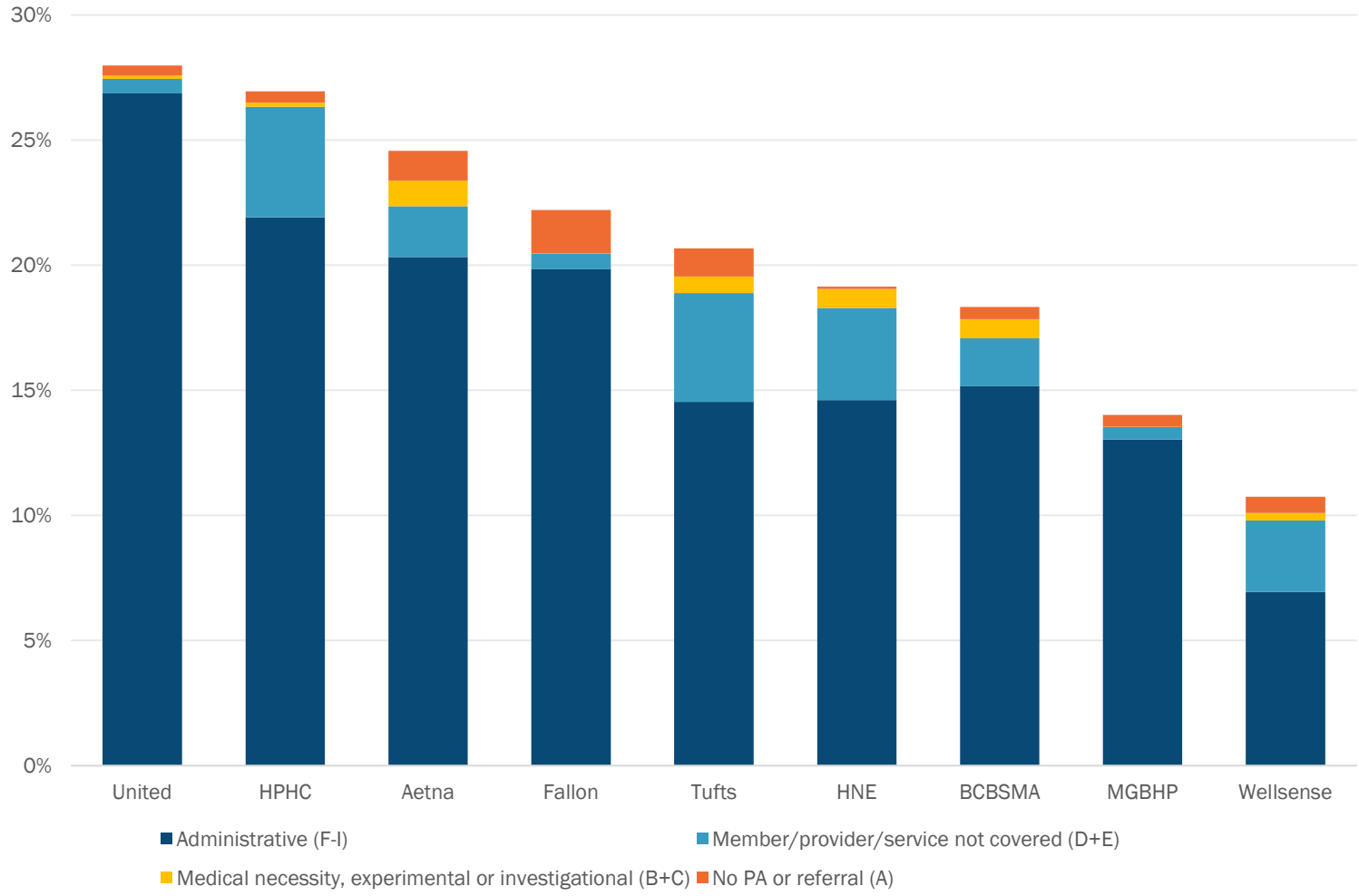
Reasons Reported	Consolidated Reasons
(A) No prior authorization or referral by insured	Denial Reason A
(B) Medical Necessity	Denial Reasons B + C
(C) Experimental or investigational	Denial Reasons B + C
(D) Member not covered or eligible at the time services were rendered	Denial Reasons D + E1 + E2 + E3
(E1) Service not covered–benefit limit	Denial Reasons D + E1 + E2 + E3
(E2) Service not covered–benefit exclusion	Denial Reasons D + E1 + E2 + E3
(E3) Provider not covered / out-of-network	Denial Reasons D + E1 + E2 + E3
(F) Duplicate claim or coverage	Denial Reason F
(G) Incomplete claim	Denial Reasons G + H
(H) Coding error	Denial Reasons G + H
(I) Other administrative denial	Denial Reason I

For purposes of the analyses present, the eleven (11) denial reasons were consolidated into six (6) broader categories, based on similarity in nature.

- The reporting guidelines identify 11 reasons for claim denials. For purposes of these analyses, similar reasons were consolidated to create 6 broader categories.
- For these analyses, categories F, G, H, and I are categorized broadly as “administrative denials” because there are no clinical decisions being made, and the denials are largely based on errors in submission.

The average overall denial rate was 20.4%, with some variability by insurer.

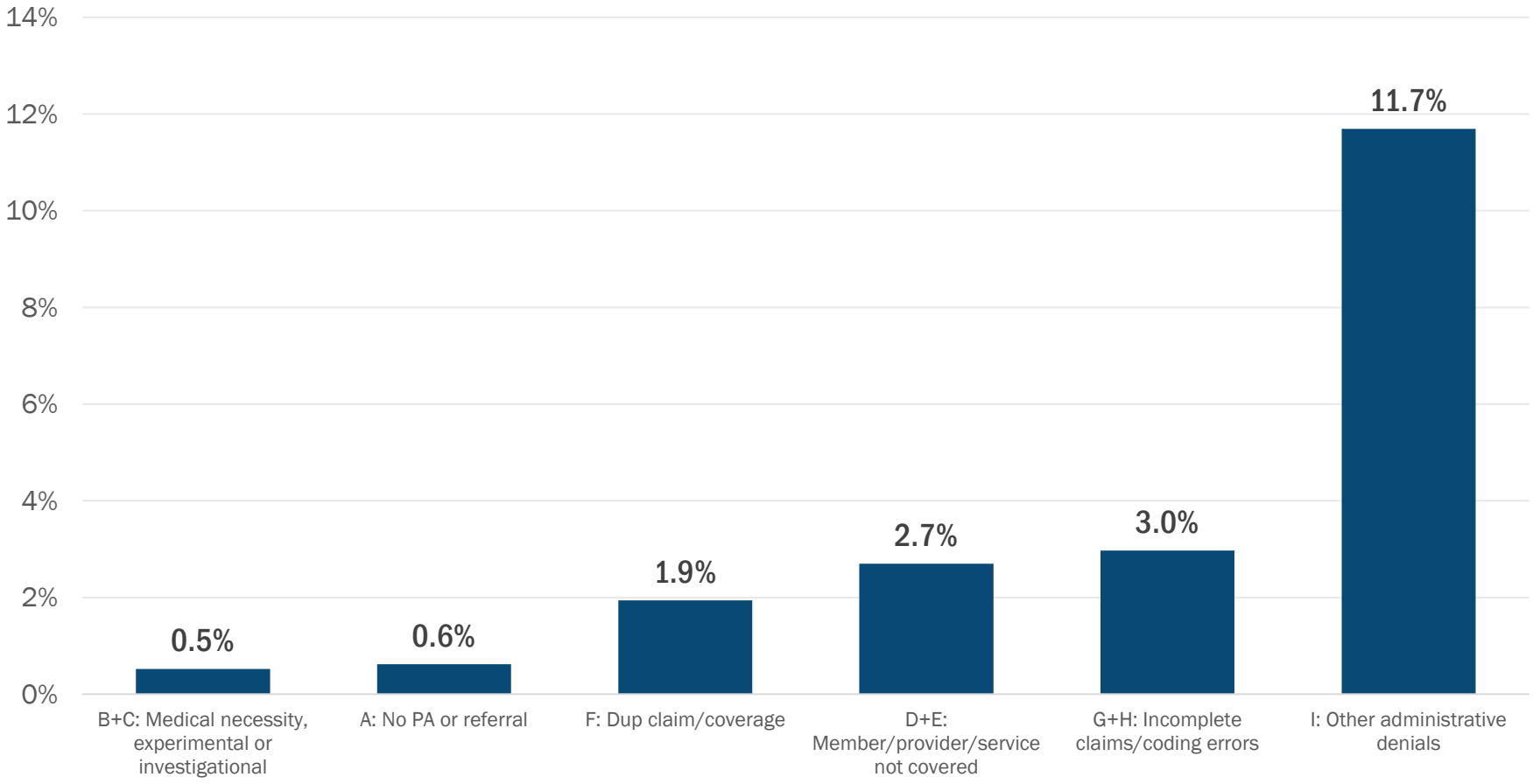
Percent of total claims denied by carrier, CY 2024



Notes: The denominator is total reported claim lines (both paid and denied). Total claims combines all categories of claims reported at the claim line level, including a few small claim categories: institutional (MH), institutional (SUD), labs (MH) and labs (SUD). Insurers reported approximately 45.9 million total claims. Cigna data were excluded due to data quality issues. Connecticare and Wellfleet data are not included in this analysis due to relatively small claim volume.
Source: OPP (Health Policy Commission) analysis of CY 2024 carrier reports, submitted pursuant to Chapter 52 of the Acts of 2016 and 958 CMR 3.000.

“Other administrative denials” were the most common reason for denial by a significant margin.

Percent of total claims denied by denial reason, CY 2024

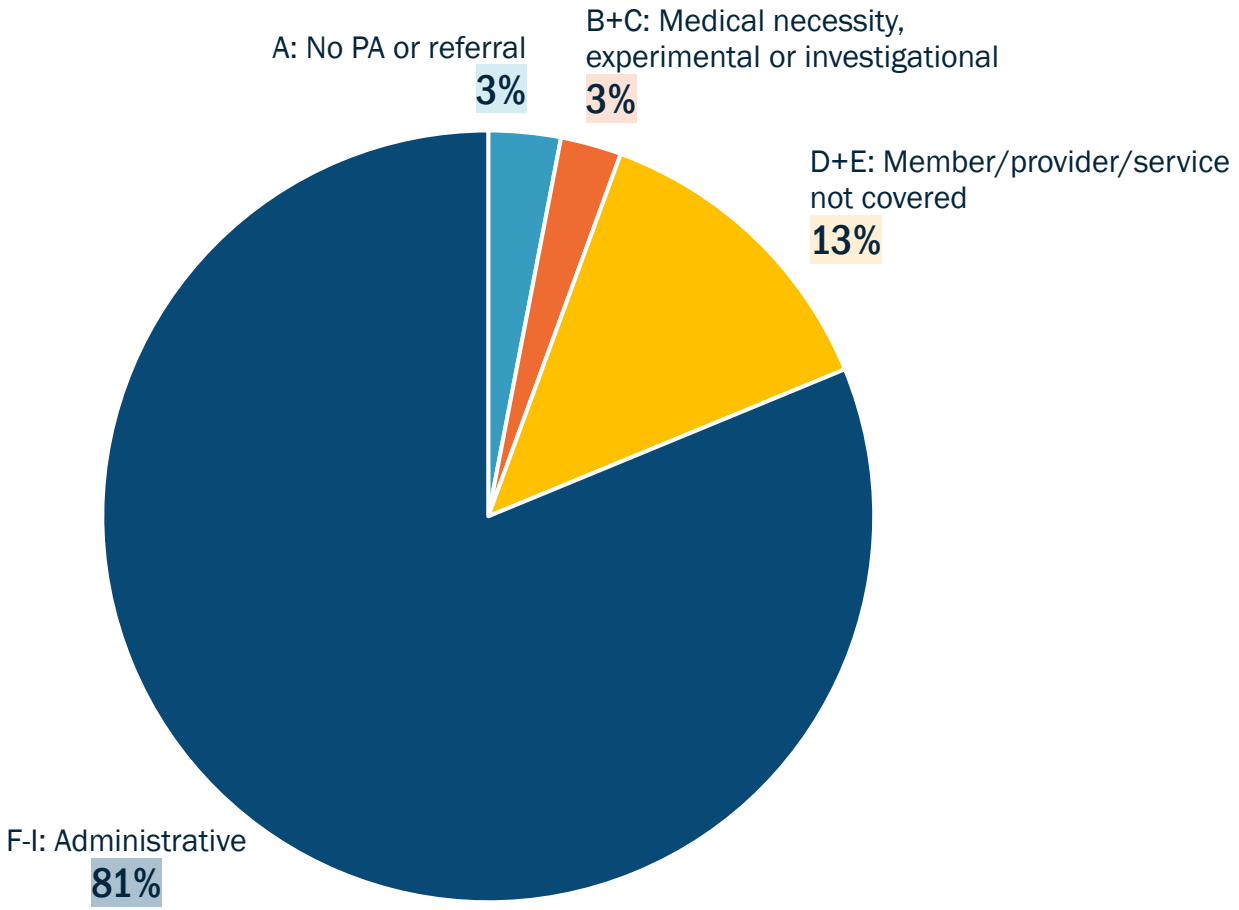


- Insurers reported approximately 45.9M total claims.
- Other administrative denials primarily include claims denied for not meeting the plans’ rules and procedures including timely filing, inclusion of correct documentation, and services that should be billed separately

Notes: The denominator is total reported claim lines (both paid and denied, approximately 45.9 million). Results include all categories of claims reported at the claim line level and all payers that reported data. Cigna data were excluded due to data quality issues. Connecticare and Wellfleet data are not included in this analysis due to relatively small claim volume.
Source: OPP (Health Policy Commission) analysis of CY 2024 carrier reports, submitted pursuant to Chapter 52 of the Acts of 2016 and 958 CMR 3.000.

Administrative denials were by far the most common reason for denial, accounting for over 80% of all denied claims.

Percent of denied claims by denial reason, CY 2024

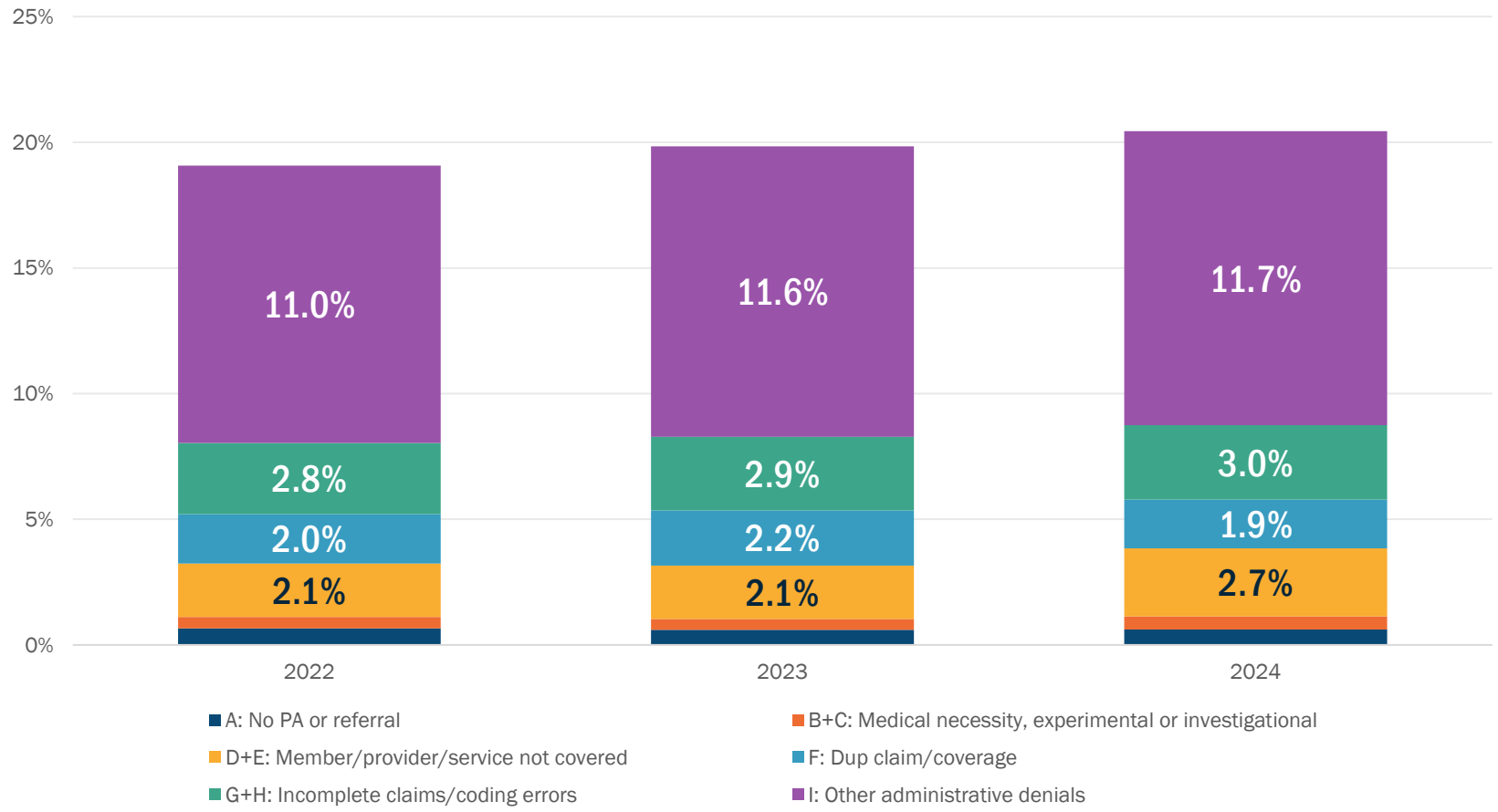


- Administrative reasons for denials include
  - F: Duplicative claim/coverage (9%)
  - G+H: Incomplete claims/coding errors (15%)
  - I: Other administrative denials (57%)

Notes: The denominator is all denied claim lines (approximately 9.4 million). Results include all categories of claims reported at the claim line level and all payers that reported data. Cigna data were excluded due to data quality issues. Connecticare and Wellfleet data are not included in this analysis due to relatively small claim volume.
Source: OPP (Health Policy Commission) analysis of CY 2024 carrier reports, submitted pursuant to Chapter 52 of the Acts of 2016 and 958 CMR 3.000.

The reasons for denial remained consistent from 2022-2024.

Percent of total claims denied by denial reason, CY 2022 - 2024

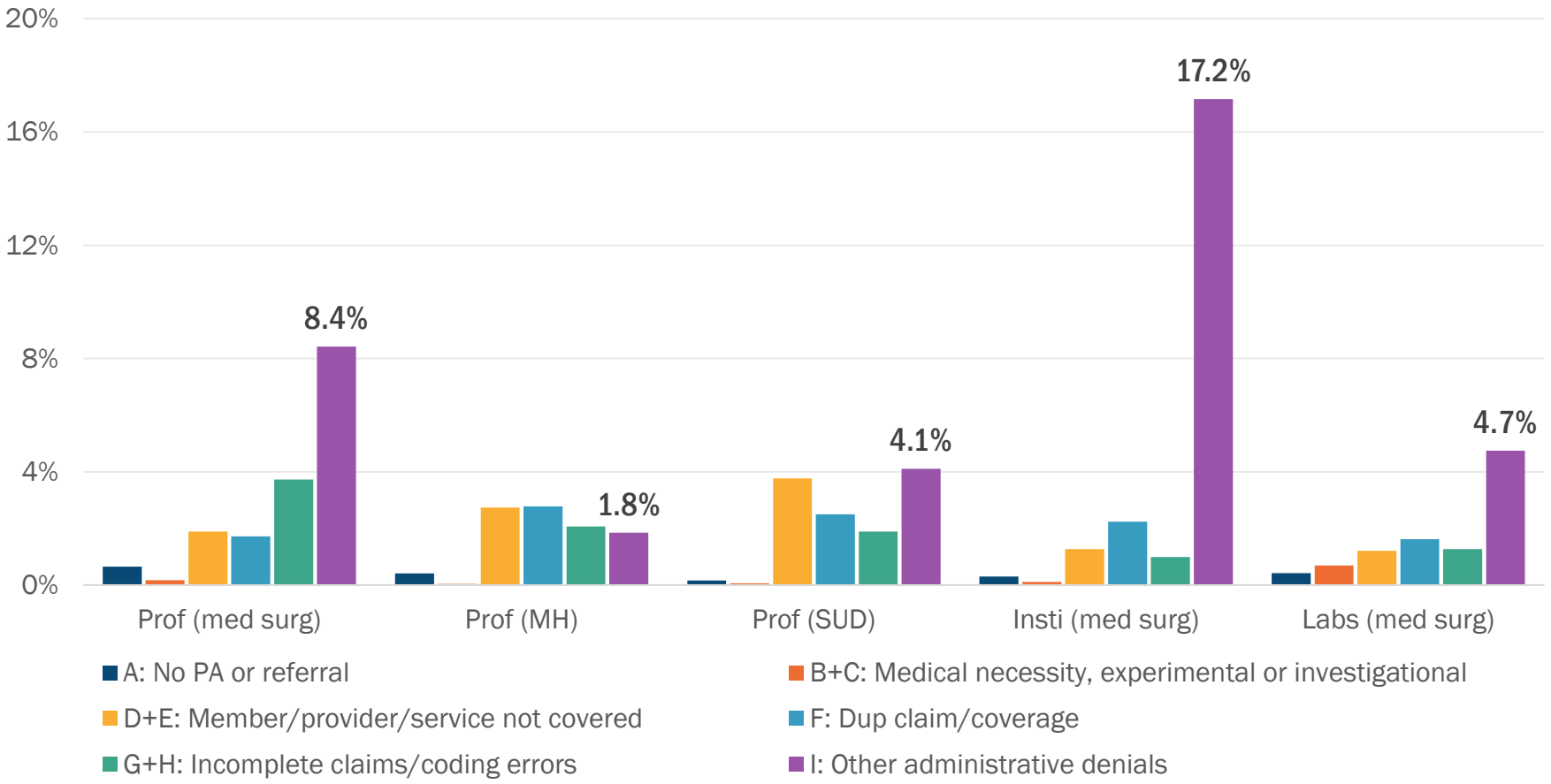


- Administrative denials, categories F, G, H, and I, made up 15.8% of claims in 2022, 16.7% in 2023, and 16.6% in 2024

Notes: The denominator is total reported claim lines (both paid and denied) in each calendar year. Results include all categories of claims reported at the claim line level and all payers that reported data. Cigna data were excluded due to data quality issues. Connecticare and Wellfleet data are not included in this analysis due to relatively small claim volume.
Source: OPP (Health Policy Commission) analysis of CY 2022- CY2024 carrier reports, submitted pursuant to Chapter 52 of the Acts of 2016 and 958 CMR 3.000.

For all claim categories except professional mental health, “other administrative denials” were the most common denial reason.

Median denial rate among insurers by denial reason and claim category, CY 2024

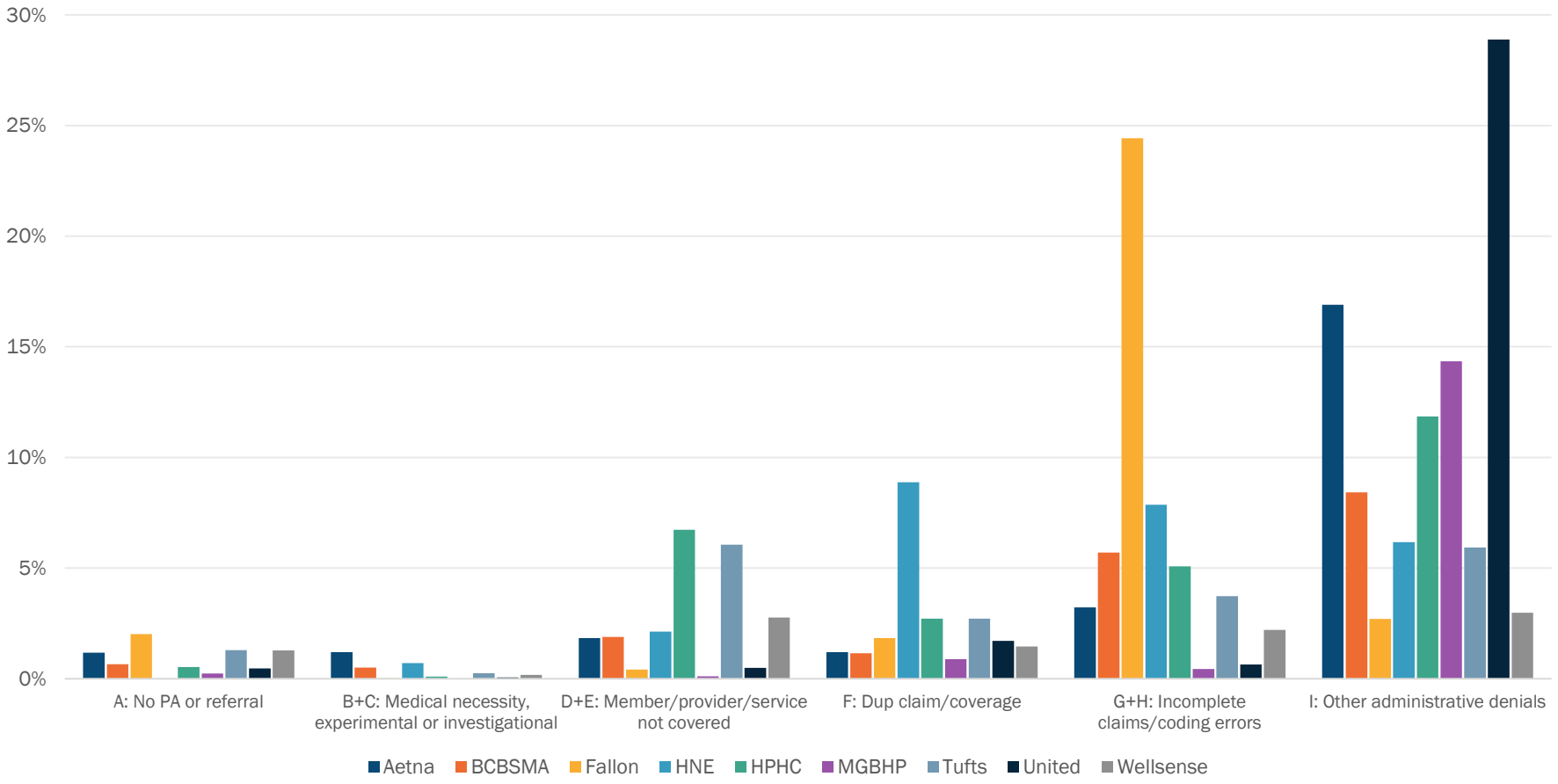


Notes: Denominator is total reported claim lines (both paid and denied). Results for several smaller claim categories are not shown: institutional (MH), institutional (SUD), labs (MH) and labs (SUD). Cigna data were excluded due to data quality issues. Connecticare and Wellfleet data are not included in this analysis due to relatively small claim volume.
Source: OPP (Health Policy Commission) analysis of CY 2024 carrier reports, submitted pursuant to Chapter 52 of the Acts of 2016 and 958 CMR 3.000.

- Volume for each claim category:
  - Prof (med surg): 24.3M
  - Prof (MH): 3.8M
  - Prof (SUD): 446K
  - Insti (med surg): 12.9M
  - Labs (med surg): 4.1M

“Other administrative denials” accounted for the largest share of denied claims for professional medical/surgical claims for 6 out of the 9 insurers shown.

Percent of total claims denied by denial reason and insurer for professional medical/surgical claims, CY 2024



Notes: Denominator is total reported professional medical/surgical claim lines (both paid and denied), thus the bars attributed to an individual insurer will sum to the percent of reported claims that were denied for that insurer. Cigna data were excluded due to data quality issues. Connecticare and Wellfleet data are not included in this analysis due to relatively small claim volume.
Source: OPP (Health Policy Commission) analysis of CY 2024 carrier reports, submitted pursuant to Chapter 52 of the Acts of 2016 and 958 CMR 3.000.

- The denominator is total professional med/surg claims.
- Insurers reported approximately 5.3M professional med surg denials.

Conclusions

- In 2024, fully-insured health insurers reported 45.9 million total claims, over 9 million of which were denied, an **average overall denial rate by insurers of 20.4%.**
- **7.6 million claims were denied for administrative reasons in 2024** These findings are consistent from 2022-2024.
- Six out of nine insurers reported “other administrative denials” as the largest claim denial reason for professional medical surgical claims. Across all insurers, **80% of denied professional medical/surgical claims were denied for administrative reasons: incomplete claims, coding error, duplicate claim or coverage, or other administrative denials.**
- Results from this analysis highlight claims processing as an area of **opportunity to address administrative inefficiencies** in the health care system, including by
  - **Standardizing, streamlining, automating, and providing incentives** to providers to reduce duplicates and other inappropriate claims

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Call to Order

Approval of Minutes **(VOTE)**

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UP NEXT: Market Transaction Reviews

Regulatory Updates: Chapters 342 and 343 of the Acts of 2024 **(VOTE)**

Executive Director's Report

Adjourn

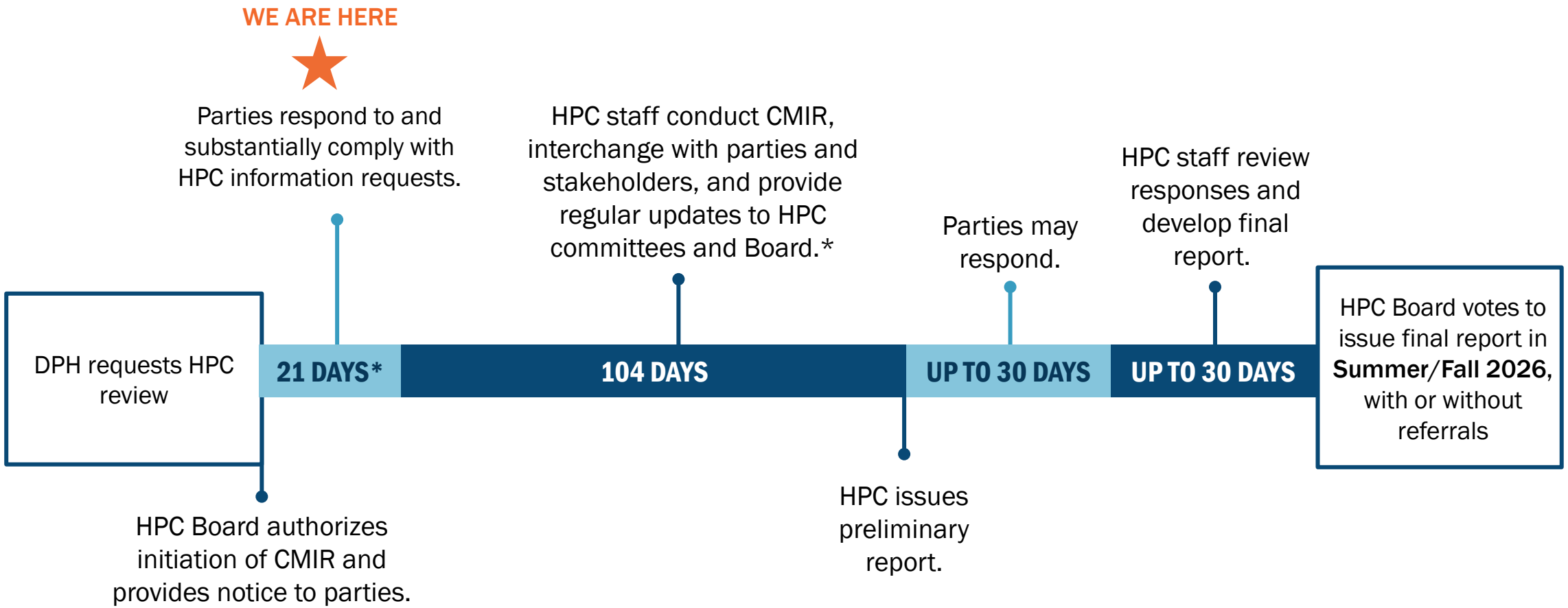
Since 2013, the HPC has reviewed 204 market changes.

Type of Transaction	Number	Frequency
Physician group merger, acquisition, or network affiliation	45	22%
Formation of a contracting entity	42	21%
Clinical affiliation	39	19%
Merger, acquisition, or network affiliation of other provider type (e.g., post-acute)	35	17%
Acute hospital merger, acquisition, or network affiliation	31	15%
Change in ownership or merger of corporately affiliated entities	6	3%
Ownership/control change involving significant equity investor	5	2%
Affiliation between a provider and a carrier	**1**	**1%**

Cost and Market Impact Reviews in Progress

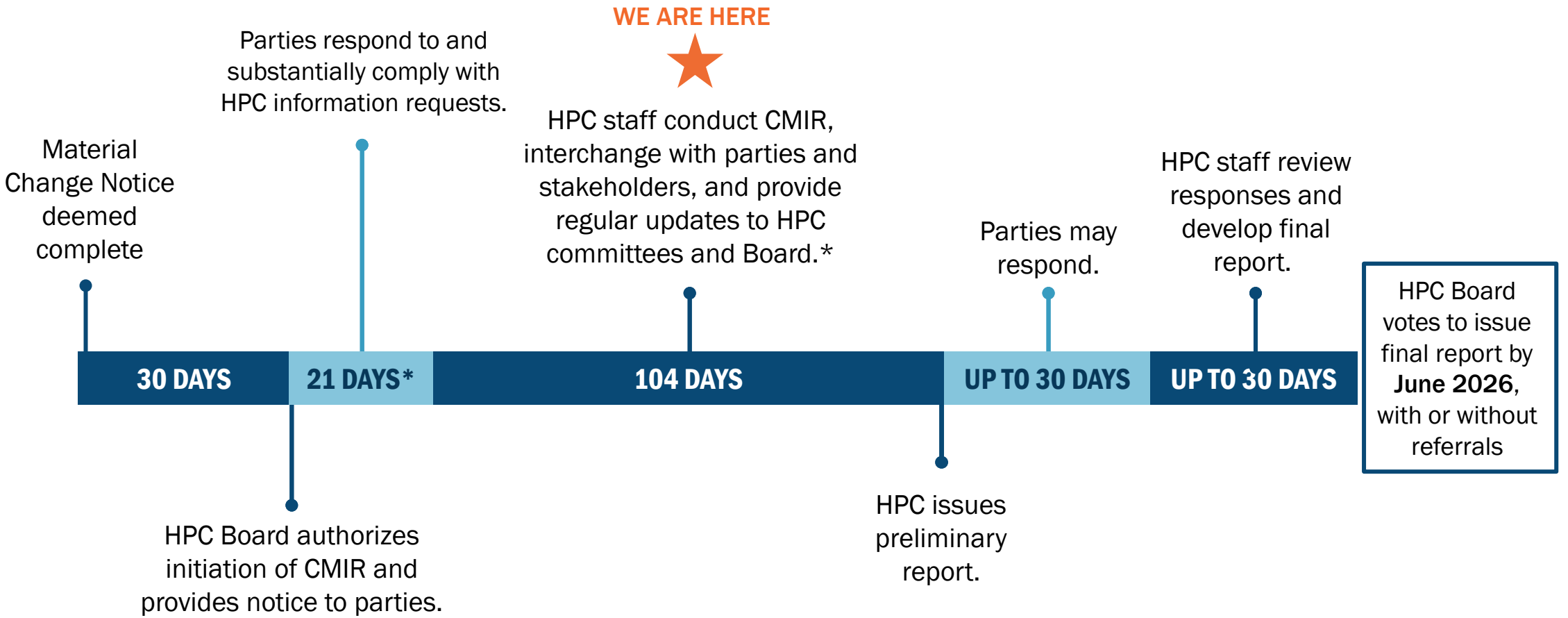
- Retrospective review of the impacts of the creation of **Beth Israel Lahey Health**.
- The proposed contracting affiliation between **MinuteClinic Primary Care**, a physician-owned entity managed by CVS Management Support, a subsidiary of CVS Pharmacy, and **Mass General Brigham**.

Timeline for BILH Retrospective CMIR Review



* The parties may request extensions to this timeline which may likewise affect the timing of the report

Timeline for MGB-CVS CMIR Review



* The parties may request extensions to this timeline which may likewise affect the timing of the report

Transactions HPC Elected Not to Proceed

- The proposed acquisition of **Quality Life Lawrence, LLC**, a licensed adult day health facility located in Lawrence, MA, by **Active Day**, an adult day service and home care provider backed by the private equity firm Audax Group with 100 centers across 10 states, including seven in Massachusetts.

- A proposed transaction involving a significant equity investor in which **Suncrest Health Services, LLC**, an owner of hospice, home health, and palliative care companies in 25 states including Brighton Hospice Massachusetts, would be acquired by **Sun Comfort Parent, LP**, a Delaware limited partnership. The significant equity investor involved in this transaction is Court Square Capital Partners.

Other Transactions Currently Under Review: Received Since 12/11/25

- A proposed clinical affiliation between **University Orthopedics, Inc.**, a physician-owned orthopedic specialty practice based in Rhode Island, with Massachusetts locations in Mansfield, Plymouth, Raynham, and North Easton, and **Boston Medical Center-South Corporation (BMC-South)**, formerly Steward Good Samaritan Hospital, a 224-bed hospital located in Brockton, MA, owned by BMC Health System. Under this affiliation, University Orthopedics would manage the BMC-South hospital outpatient department ambulatory surgery center.

- A proposed clinical affiliation between **Atrius Health (Atrius)**, 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, and **Signature Healthcare Brockton Hospital (Brockton Hospital)**, a 217-bed not-for-profit, acute care, community-based, teaching hospital in Brockton. Under this affiliation, Brockton Hospital would be designated by Atrius as a preferred hospital provider for Atrius patients and the parties have agreed on a discounted payment rate for services provided by Brockton Hospital for which Atrius is at risk for financial and quality results.

Other Transactions Currently Under Review: Received Since 12/11/25

- The proposed acquisition by **Fulgent Genetics, Inc.** of certain equity and assets of **BPA Holding Corp**. Fulgent Genetics is a technology-based company with laboratory services and therapeutic development businesses, including affiliate Cohen Dermatopathology, PC, which operates licensed clinical laboratories in Massachusetts. BPA Holding Corp. operates a dermatopathology platform through its subsidiary Dermatopathology Experts, LLC, under the brand StrataDx, which is headquartered in Lexington, Massachusetts, and an anatomic/clinical pathology platform under the brand BakoDx.

- The proposed acquisition of **Exact Sciences**, a provider of cancer screening and diagnostic tests, by **Abbott Laboratories**, an international company that manufactures and sells diagnostics, medical devices, nutritional products, and branded generic pharmaceuticals, and that provides services to Massachusetts residents through its specialized durable medical equipment service line Acelis Connected Health.

Other Transactions Currently Under Review: Received Since 12/11/25

- The proposed acquisition of the corporate parent of **Care Alternatives Hospice Services, LLC (dba Ascend Hospice), a part of Ascend Health**, by a newly formed **employee stock ownership plan**. Ascend Health provides end-of-life, hospice, and palliative care in six states, including Massachusetts, and Puerto Rico. Under the proposed acquisition, the organization's employees would gain an ownership stake in the company and current ownership would exit.

- The proposed acquisition of **Quipt Home Medical Corp. (Quipt)**, which owns health care entities that provide medical equipment such as mobility aids, ventilator therapy, oxygen and related equipment, and general medical supplies, by a significant equity investor, **REM Aggregator**. One of the entities owned by Quipt is Good Night Medical of Ohio, LLC, which has one location in Massachusetts that provides respiratory care services, including portable oxygen and ventilator services.

Other Transactions Currently Under Review

- 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.

- A proposed clinical affiliation between **Dana-Farber Cancer Institute (DFCI)**, an acute care cancer hospital and research institute, and **Sturdy Memorial Hospital (Sturdy)**, a 153-bed independent community hospital in Attleboro, under which DFCI would operate a satellite ambulatory cancer clinic on Sturdy's campus.

- A proposed joint venture between **Sturdy Memorial Hospital**, a 153-bed independent community hospital in Attleboro, and **University Orthopedics**, a physician-owned orthopedic specialty practice based in Rhode Island, with Massachusetts locations in Mansfield, Plymouth, Raynham, and North Easton. The joint venture would establish a freestanding ambulatory surgery center in Mansfield, Massachusetts.

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UP NEXT: Regulatory Updates: Chapters 342 and 343 of the Acts of 2024 (VOTE)

- 958 CMR 7.00: Notice of Material Change and Cost and Market Impact Reviews
- 958 CMR 6.00:Registration of Provider Organizations
- 958 CMR 9.00: Assessment on Certain Health Care Providers and Pharmacy Benefit Managers

Executive Director's Report

Adjourn

Chapter 343 of the Acts of 2024 was signed into law on January 8, 2025.

An Act enhancing the market review process: Key HPC Provisions

- Changes the HPC's Board membership, board stipends, and annual budgetary assessment
- Expands the scope of annual Cost Trends Hearing
- Requires statewide health planning with increased data collection and agency coordination
- Expands pharmaceutical and PBM oversight (see also Chapter 342 of the Acts of 2024)
- Enhances market oversight, including by requiring additional types of transactions (e.g., transactions involving a significant equity investor) be filed as "Material Change Notices" with the HPC and by allowing the HPC to assess post-transaction impacts for 5 years
- Expands the entities that may be required to report to the Registration of Provider Organization program and the scope of information that may be collected, including regarding significant equity investors, REITs, and MSOs

Regulatory Promulgation Process

- The HPC is required to promulgate its regulations pursuant to M.G,L, chapter 30A, which provides for notice and an opportunity for public comment.
- **Issuance of Proposed Regulation**. Board approval of a proposed regulation is the first step in the process.
- **Hearing and Written Comments**. The HPC will hold a public hearing and provide an opportunity for interested parties to submit written testimony.
- **Adoption of Final Regulation**. After consideration of comments and incorporation of appropriate changes, the Board votes to approve a final regulation.
- **Effective Date**. The final regulation will be filed with the Secretary of State and become effective upon publication in the Massachusetts Register.
- **Adoption of Emergency Regulation**. Where immediate adoption is necessary, the Board may vote to adopt a regulation on an emergency basis. That regulation will be effective for 3 months and can be made permanently effective after a hearing and comment period and Board vote.

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- 958 CMR 6.00, Registration of Provider Organizations
- 958 CMR 9.00, Assessment on Certain Health Care Providers and Pharmacy Benefit Managers

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Current Regulation Governing Material Change Notices and Cost and Market Impact Reviews, 958 CMR 6.00

- The HPC adopted the regulation governing the process for Notices of Material Change (MCNs) and Cost and Market Impact Reviews (CMIRs) in January 2015.
- The regulation define the transaction types that require a Provider or Provider Organization to file an MCN, and set forth the process for conducting reviews, including requests for and treatment of confidential information, the factors to be considered in a CMIR, and timing of Preliminary and Final CMIR reports.
- The HPC has also issued a Technical Bulletin and several sub-regulatory guidance documents to provide additional detail and address stakeholder questions about the MCN and CMIR processes.

Expansions of HPC Market Oversight Authority in Ch. 343

- Expanded the triggers for material change notice (MCN) reviews to include:
  - **Significant expansion** in a provider's capacity;
  - Transactions involving a **significant equity investor** that result in a change of ownership or control of a provider or provider organization;
  - Significant acquisitions, sales, or **transfers of assets**, including real estate lease-backs; and
  - Conversions of a provider from a non-profit entity to **for-profit**
- **Expanded HPC authority to collect information from significant equity investors and other parties to a transaction**, including by allowing the HPC to require financial statements and materials on an investor's capital structure be filed with the notice
- Authorized the HPC to require **additional reporting** for a period of five years after the completion of an MCN to assess post-transaction impacts
- Added to the factors the HPC examines in a cost and market impact review (CMIR) any related health planning data as well as the size and market share of any significant equity investors
- New authorities were implemented in guidance issued March 17, 2025

Proposed Regulatory Updates to 958 CMR 7.00: Implementation and Alignment

MCN Triggers Added by Chapter 343:

- Transactions involving a significant equity investor that result in a change of ownership or control of a provider or provider organization
- Significant acquisitions, sales, or transfers of assets, including real estate lease-backs
- Conversions of a provider from a non-profit entity to for-profit
- Significant expansion of a provider's capacity
  - Capacity increases requiring an Application for Substantial Capital Expenditure to be submitted to the Determination of Need program
  - Capacity increases that would result in an increase in annual NPSR by at least the Revenue Increase Threshold ($10 million in year 1)

Regulatory Updates in 958 CMR 7.00: Implementation and Alignment

Filing Thresholds and Indexing:

- In line with existing thresholds, the initial MCN Filing Threshold is $25 million and initial Revenue Increase Threshold is $10 million.
- Thresholds must be adjusted annually. This will be based on the Personal Health Care – Overall index established by the US Department of Health and Human Services. The HPC will publish annual Technical Bulletin with the adjusted thresholds.

Information Requests and Post-Transaction Review:

- Process for requiring information from Significant Equity Investors in addition to Providers and Provider Organizations
- Implementation of authority to require reporting by parties for a period of up to five years after the transaction. The HPC will publish additional details regarding timing in a future Technical Bulletin.

Regulatory Updates in 958 CMR 7.00: Implementation and Alignment

Clarifications and Regulatory Alignment:

- Clarification that MCN filings cannot be considered complete if any party to the transaction is out of compliance with RPO filing requirements
- Inclusion of additional statutory language from MGL ch. 6D § 13
- Inclusion of details formerly provided in guidance regarding clinical affiliations, contracting affiliations, other corporate affiliations, and transactions involving out-of-state entities

Agenda

Call to Order

Approval of Minutes **(VOTE)**

Healey-Driscoll Administration's Health Care Affordability Working Group and Prior Authorization Reform Announcement

DataPoints Issue #33: Evidence of Administrative Complexity: Health Insurance Claim Denials in Massachusetts

Market Transaction Reviews

Regulatory Updates: Chapters 342 and 343 of the Acts of 2024 **(VOTE)**

- 958 CMR 7.00, Notice of Material Change and Cost and Market Impact Reviews
- **UP NEXT: 958 CMR 6.00, Registration of Provider Organizations**
- 958 CMR 9.00, Assessment on Certain Health Care Providers and Pharmacy Benefit Managers

Executive Director's Report

Adjourn

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.
- Provider organizations are required to register with the MA-RPO Program if they meet the **net patient service revenue (NPSR)-based threshold** or if they receive a **risk certificate from the Division of Insurance**.
  - Approximately 50-60 provider organizations register each year. The exact number of registrants fluctuates annually due to changing market dynamics (e.g., mergers, acquisitions, changes in provider annual volume/revenue).
  - 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 COLLECTION AREAS

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
10. SEIs, MSOs, REITs **NEW in 2025**
11. APP Roster **NEW in 2025**

Background: MA-RPO Program Timeline

November 2012

The HPC's Registration of Provider Organizations Program and related annual reporting to CHIA were established under Chapter 224 of the Acts of 2012

July 2014

First governing regulation, 958 CMR 6.00, *Registration of provider organizations,* was finalized

Fall 2014 – Fall 2015

Provider Organizations submitted initial filings in 2 parts

Fall 2016

The HPC and CHIA created a single program, the MA-RPO program, that incorporated the required elements of both statutes

2017 - 2024

Annual filings of the MA-RPO program are submitted, with new requirements phased in over time

Early 2025

Chapter 343 of the Acts of 2024 passed; released Guidance governing the 2025 reporting cycle

Chapter 343 Changes to the MA-RPO Program and Corresponding Regulation Updates

NPSR-Based Registration Threshold:

- Previously, Provider Organizations were required to register if they represented providers who collectively received $25 million or more in annual NPSR from **Carriers** (commercial, Medicare Advantage, and MMCO plans).
- Chapter 343 amends the threshold to include Provider Organizations that represented providers who collectively received $25 million or more in annual NPSR from all **Payers**.

New and Clarified Reporting Requirements:

- A Provider Organization's relationships with **Significant Equity Investors (SEI)**, **Managed Services Organizations (MSO)**, and **Real Estate Investment Trusts (REIT)**
- The **name, address and capacity** of all other locations (beyond licensed facilities) where the provider organization, or any of its affiliates, delivers health care services
- Comprehensive **financial information**, including on out-of-state operations, SEIs, MSOs and REITs, and other assets and liabilities that could impact the provider organization's financial condition

New and Clarified Authorities:

- Require provider organizations with private equity investment to report information quarterly
- Require the disclosure of relevant information from any SEI associated with a provider organization.

Regulation Updates: CHIA Alignment

- The regulation has been updated to reflect the alignment between the HPC and CHIA in administering the program.
- **Formalizing the MA-RPO Program**: Added a defined term for the Commonwealth program, jointly administered by the HPC and CHIA.
- **Annual Filing**: Updated language to reflect that the joint program collects data on an annual basis.
- **Required Information**: Updated the list of data elements that Provider Organizations must report to include information from both program's statutes.
- **Non-Compliance**: Formalized procedure for Provider Organizations that are out of compliance with the MA-RPO Program and incorporated penalty provisions from CHIA's statute.

Regulation Updates: Technical and Operational Updates

- The regulation has been updated to better reflect how the program has been operationalized over the last decade.
- **Updated Definitions:** Some definitions have been updated to reflect details formerly provided in sub regulatory guidance, such as the Data Submission Manual or Frequently Asked Questions documents.
- **Registering Level**: Added language to clarify that a Provider Organization's Uppermost Corporate Parent with a primary business purpose of healthcare delivery, management, ownership, or investment is the entity that is expected to register on behalf of the Provider Organization.
- **Timeline Clarification**: Clarified registration timing to reflect Annual Filings, rather than the initial registration period.

Agenda

Call to Order

Approval of Minutes **(VOTE)**

Healey-Driscoll Administration's Health Care Affordability Working Group and Prior Authorization Reform Announcement

DataPoints Issue #33: Evidence of Administrative Complexity: Health Insurance Claim Denials in Massachusetts

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Executive Director's Report

Adjourn

Regulatory Update: 958 CMR 9.00: HPC Annual Assessment

- **Recent statutory changes** require the HPC to update its current regulation implementing the annual industry assessment that funds the Commission's expenses.
- Under the previous law and regulation, 958 CMR 9.00, HPC was authorized to assess **hospitals and ambulatory service centers (ASCs)** (which contributed 50% of the total expenses) and **payers** (carriers and third-party administrators) (which contributed 50% of the total expenses).
- Statutory Changes:
  - **New Entities Assessed.** Chapter 343 of the Acts of 2024 made reduced the proportion of the assessment paid by hospitals and ASCs (between 30-40%) and added three new categories of entities to be assessed:
    - **Pharmacy benefit managers (PBMs)** (between 5-10%)
    - **Pharmaceutical manufacturers** (5-10%)
    - **Certain non-hospital providers** (physician organizations with over $500 million in revenue; and imaging facilities and urgent care centers with revenue over $25M) (between 3-8% of the hospital/ASC amount)
  - **Payer Assessment**. The HPC's payer assessment was consolidated with other payer assessments in a statute now administered by EOHHS. That law provides that the payer assessment amount must be equal to the hospital/ASC assessment amount.

Key Points: Assessment Amounts

- The key decision point in the regulation is determining the proportion of the assessment per entity category, within the ranges laid out in the statute. The updated regulation establishes the proportions of the assessment as follows:
  - **Hospitals and ASCs: 40%**
    - *By operation of the new payer assessment law, the payer proportion will also be 40%*
  - **PBMs: 10%**
- The regulation tracks the statutory language regarding how the assessment percentage for each entity is calculated.
- The HPC will rely on the data reported to CHIA and the Division of Insurance (DOI) to calculate each entity's assessment amount.

Key Points: Non-hospital Providers and Pharmaceutical Manufacturers

- Consistent with CHIA's recently adopted regulation, the HPC regulation **does not include the non-hospital provider and pharmaceutical manufacturer categories**.
- In consultation with CHIA and the Executive Office of Health and Human Services, the HPC has determined that the assessment for these categories cannot be implemented at this time based on compliance concerns regarding changing federal law and CMS guidance on provider taxes.
- Because the statute provides that the assessment on these entities should be implemented "to the maximum extent permissible under federal law," the HPC does not include these providers in the proposed regulation.

Key Points: Emergency Adoption

- The HPC is proposing to adopt revisions to its regulation on the annual assessment on an **emergency basis**.
- To allow for collection to fund its operations this fiscal year, the HPC is proposing that the Board adopt the revised regulation on an emergency basis so that the regulation can go into effect immediately.
- CHIA adopted a mirror emergency earlier this month.
- The emergency regulation will be effective for three months and will be permanently adopted following a hearing, an opportunity for comment, and subsequent Board vote.

Regulatory Process Timeline

1 Proposed Regulations Released

Text of the regulations will be available on the HPC's website following this meeting.

2 Public Hearing and Comment Period

The HPC will hold a virtual public hearing on the proposed regulations on **Thursday, March 12**. Public comments will be accepted through **Friday, March 20** and should be submitted to HPC-Testimony@mass.gov.

- Comments on **958 CMR 6.00** can also be submitted to HPC-RPO@mass.gov.
- Comments on **958 CMR 7.00** can also be submitted to HPC-Notice@mass.gov.

3 Final Regulations

Following consideration of feedback received during the public comment period, the Board is anticipated to consider adoption of final regulations at the April 16 Board meeting.

VOTE

Approval of Proposed Regulation

MOTION

That the Commission hereby authorizes the issuance of the PROPOSED regulation on Notices of Material Change and Cost and Market Impact Reviews, 958 CMR 7.00, pursuant to M.G.L. c. 6D, § 13, and a public hearing and comment period on the regulation pursuant to M.G.L. c. 30A.

VOTE

Approval of Proposed Regulation

MOTION

That the Commission hereby authorizes the issuance of the PROPOSED regulation on Registration of Provider Organizations, 958 CMR 6.00, pursuant to M.G.L. c. 6D, §§ 11 and 12, and a public hearing and comment period on the regulation pursuant to M.G.L. c. 30A.

VOTE

Approval of Proposed Regulation

MOTION

That the Commission hereby adopts the regulation on Assessment on Certain Health Care Providers and Pharmacy Benefit Managers 958 CMR 9.00, pursuant to M.G.L. c. 6D, § 6, on an emergency basis and authorizes a public hearing and comment period on the regulation pursuant to M.G.L. c. 30A.

Agenda

Call to Order

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UP NEXT: Executive Director's Report

Adjourn

Federal Funding Package: Health Policy Provisions

Pharmacy Benefit Manager Reforms

- The federal funding package prohibits PBMs from linking payments to Medicare Part D list prices, reducing incentives for high-cost drugs, and strengthens PBM reporting requirements.
- PBMs are now required to pass through all manufacturer rebates in full to Medicare Part D plan sponsors and must allow any qualified pharmacy willing to meet plan terms to participate in Part D networks.

Medicare Acute Hospital at Home Waiver Extension

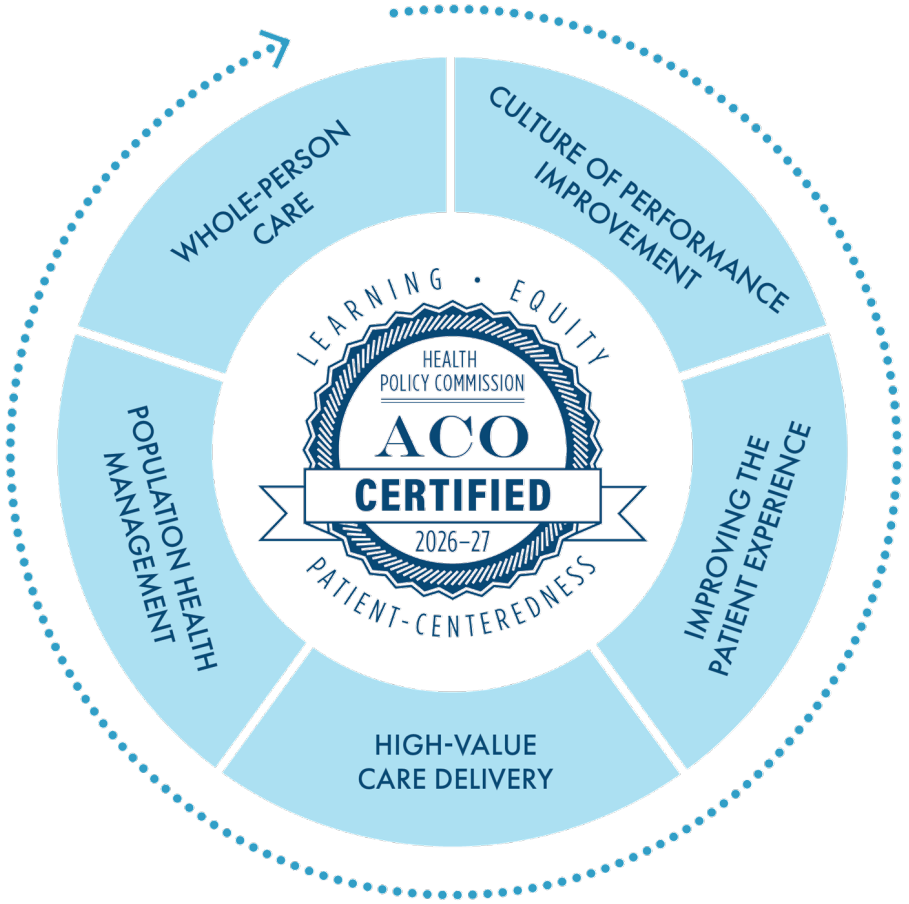
- Medicare funding for acute hospital at home services has been extended through September 30, 2030.

Medicare Telehealth Flexibilities

- Medicare coverage of telehealth services regardless of patient location has been extended through December 31, 2027, with an extension through December 31, 2028, for mental health services.
- Medicare will also continue to cover telehealth services provided by Federally Qualified Health Centers and Rural Health Clinics through December 31, 2027.

HPC's Accountable Care Organization (ACO) Certification program sets all-payer standards and delivers transparency for the public.

The 2026-2027 "Learning, Equity, and Patient-Centeredness (LEAP)" certification standards encourage evidence-based and data-driven strategies to improve care delivery.



ACO CERTIFICATION OBJECTIVES

1. Promote continued transformation in care delivery across markets
2. Complement existing local and national care transformation and payment reform efforts
3. Encourage value-based care delivery
4. Promote investments by all payers in high-quality and cost-effective care across the continuum

ACO LEAP 2026-2027 Certifications

- **Baycare Health Partners**, inclusive of Pioneer Valley Accountable Care and Baystate Health Care Alliance
- **Beth Israel Lahey Health Performance Network**, inclusive of BILH Performance Network Medicare ACO-1 and ACO-2
- **BMC Health System**, inclusive of Boston ACO and BMC Integrated Care Services
- **Cambridge Public Health Commission** D/B/A Cambridge Health Alliance
- **Children's Medical Center**, inclusive of Children's Hospital Corporation and Boston Children's Health ACO
- **Collaborative Care Holdings**, inclusive of Atrius Health and Reliant Medical Group
- **Community Care Cooperative**, inclusive of C3 REACH, C3 MSSP, and C3 MSSP Enhanced
- **Mass General Brigham**, inclusive of Mass General Brigham ACO
- **Signature Healthcare Corporation** D/B/A Signature Healthcare
- **Southcoast Health System**, inclusive of Southcoast ACO and Southcoast Health Network
- **RHG Network**, inclusive of RHG Medicaid Network and Pursuit Accountable Care Network
- **Trinity Health of New England**, inclusive of Mercy Health ACO and Trinity Health Of New England CIN
- **Tufts Medicine**, inclusive of Tufts Medicine Integrated Network, Tufts Medicine Partnership ACO, and Wellforce ACO

Looking Ahead: Preparing for ACO Certification at 10 Years (2028-2029 ACO Certification Application Cycle)

WINTER/SPRING 2026

PROGRAM REVIEW

- **Complete review** of the program's experience and findings through its first 10 years, and of the current state of value-based care

SUMMER/FALL 2026

PROPOSAL FINALIZATION

- Engage with stakeholders
- Identify recommended updates to the program as it moves into its second decade
- **Review a proposal** for program updates with Commissioners

WINTER/SPRING 2027

OPERATIONAL UPDATES AND ROLLOUT

- **Finalize updates** to standards, program policy documents, and web-based application platform

SUMMER/FALL 2027

ACO APPLICATIONS AND REVIEW

- Review of ACO submissions
- **Determinations for 2028-2029 Certifications** issued by 12/31/2027

All dates are approximate

PATHways Investment Program Opportunity

Program Aims

- Support and/or sustain partnerships between hospitals and Aging Service Access Points (ASAPs)
- Support institutional (e.g., SNF) diversion and hospital discharge directly to home and community-based settings
- Collect qualitative and quantitative evidence to advance the case for sustaining partnerships between hospitals and ASAPs

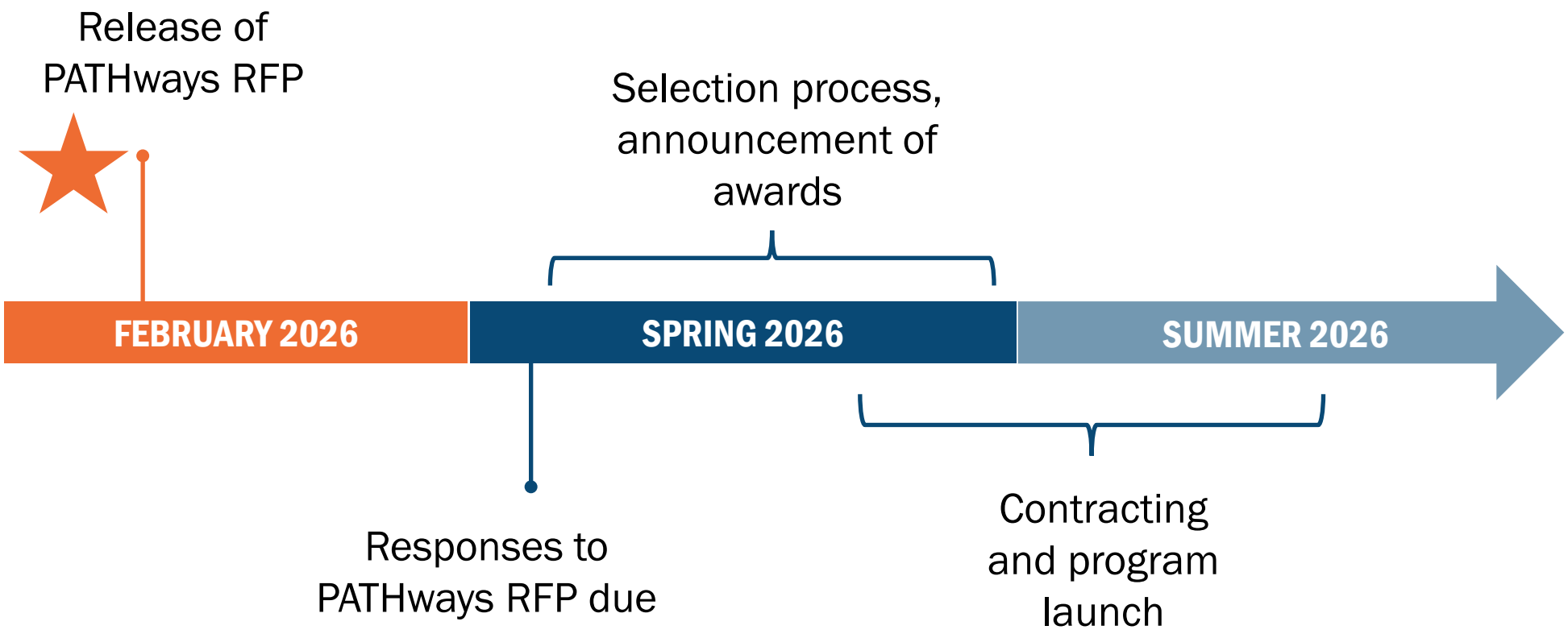
Applicants: Massachusetts acute care hospitals, in partnership with ASAPs

Funding: Up to 7 awards of $210,000 each over 3 performance years

- Additional $90,000 to be contributed in-kind from each hospital for a total program budget of $300,000 per Awardee

State Partnership: The HPC is funding and implementing PATHways in partnership with the Executive Office of Aging & Independence (AGE)

Upcoming: Release of the PATHways Request for Proposals



Other Recent and Upcoming Publications

RECENTLY RELEASED

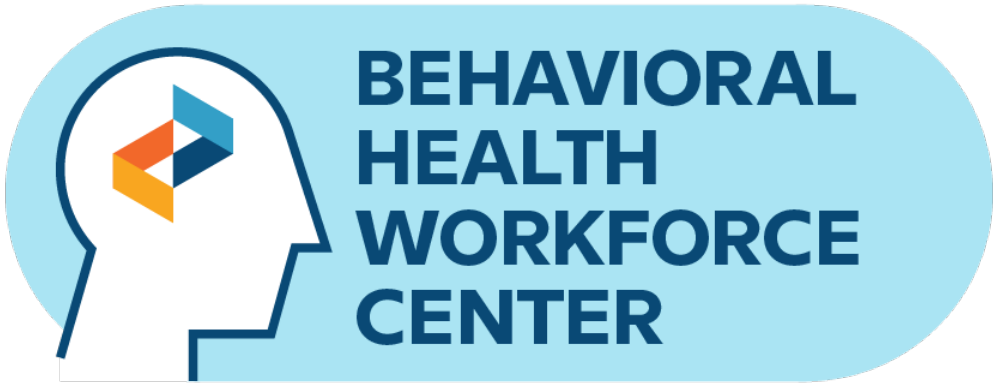
- **DataPoints**: Issue #33, Office of Patient Protection Claims Denials (February 2026)
- **2025 Health Care Cost Trends Report**: Annual Report, Chartpack, and Policy Recommendations (December 2025)
- **DataPoints:** Issue #32, Examining the True Cost of Care: Patient Cost Sharing in Massachusetts (December 2025)
- **DataPoints:** Issue #31, When the Closest Pharmacy is Too Far: Mapping Pharmacy Deserts in Massachusetts (October 2025)

UPCOMING

- **Legislative Report**: Assessment of Behavioral Health Commercial Rates
- **Legislative Report**: Trends in Behavioral Health Emergency Department Boarding
- **Evaluation Report**: Moving Massachusetts Upstream (MassUP) Investment Program
- **Final Report**: Maternal Health Access and Birthing Patient Safety Task Force

About the HPC Behavioral Health Workforce Center

- The **HPC Behavioral Health Workforce Center (BHWC)** was established in partnership with the Massachusetts Executive Office of Health and Human Services (EOHHS) to strengthen the state's capacity to identify and respond to current and ongoing behavioral health workforce needs.
- The BHWC will **drive state-wide efforts** and **leverage cross-sector partnerships** to achieve a unified vision for the Commonwealth's behavioral health workforce.
- Through development of **actionable, evidence-based strategies**, the BHWC will prepare state leaders to:
  - Build equitable education and training pipelines,
  - Improve workforce diversity and cultural competency,
  - Enhance professional pathways, and
  - Retain behavioral health providers within settings and communities that are accessible to all residents.



Legislative Report: Assessment of Behavioral Health Commercial Rates

- A component of the original charge for the HPC's Behavioral Health Workforce Center is *"conducting or contracting for a comprehensive study and analysis of rates paid for behavioral health services by both private and public payers and the adequacy of said rates to support the provision of equitable, quality behavioral health services in the Commonwealth."*
- Using data from commercial payers, MassHealth, and Medicare, the BHWC examined the 2023 prices for common behavioral health services in the Commonwealth.
- The analysis focused on prevention, treatment, and maintenance services and interventions delivered in inpatient, outpatient, home, or telehealth settings.
- Following engagement and coordination with inter-agency partners, the HPC plans to issue this report in the first quarter of 2026.

HPC Advisory Council 2026-2027 Term

The HPC Advisory Council supports the agency's work by:

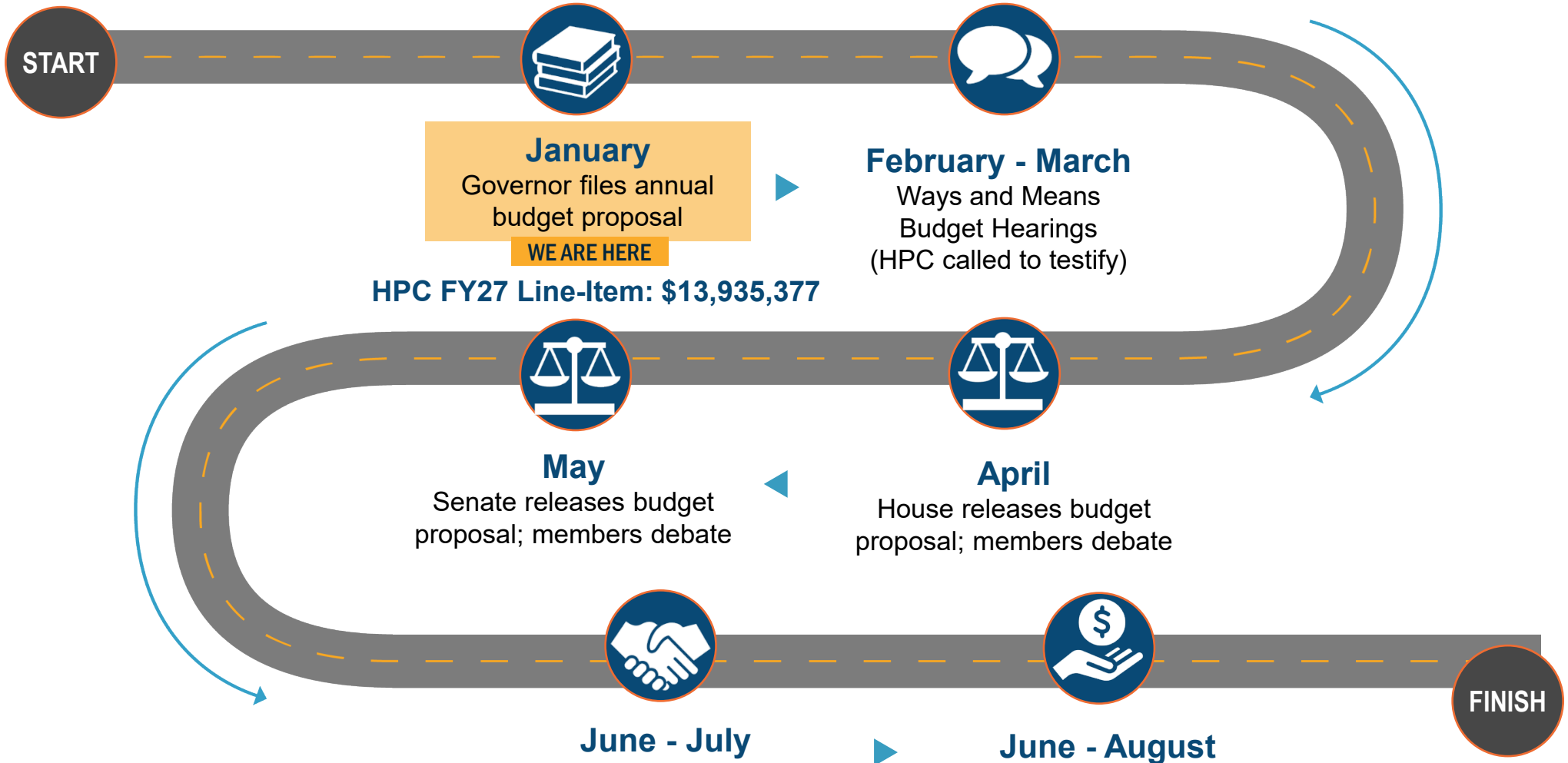
- Providing input on the HPC's research and policy initiatives;
- Contributing feedback on proposed investment priorities;
- Facilitating connections between HPC staff, HPC commissioners, and health care industry participants and stakeholders; and
- Serving as a network for communicating the HPC's work to the larger community.

2026-2027 Advisory Council Term:

- The deadline for applications was January 20, 2026.
- The HPC received over 70 applications to join the Advisory Council.

Announcements will be made in the coming weeks about membership for the 2026 – 2027 HPC Advisory Council term and the schedule for meetings.

Annual State Budget Process



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UP NEXT: Adjourn