VOTE 1: MEETING MINUTES

Date of Meeting: February 5, 2026
Start Time: 12:00 PM
End Time: 2:30 PM

	Present?	Vote 1: Approval of Minutes	Vote 2: 958 CMR 7.00 Notices of Material Change and Cost and Market Impact Reviews	Vote 3: 958 CMR 6.00 Registration of Provider Organizations	Vote 4: 958 CMR 9.00 Assessment of Certain Heath Care Providers and Pharmacy Benefit Managers
Deborah Devaux*	X	X	X	2nd	X
Martin Cohen	X	X	2nd	X	X
Sandra Cotterell	X	X	X	X	X
Keith M Ericson	X	M	X	X	M
Umesh Kurpad	X	X	X	X	X
Christopher Leibman	X	2nd	X	X	X
Alecia McGregor	X	X	X	M	X
Steve Walsh	X	X	X	X	X
James Willmuth	X	X	X	X	2nd
Secretary Kiame Mahaniah or Designee	X	*not present for vote*	X	M	X
Commissioner Michael Caljouw or Designee	X	ab	M	X	X
Summary	**11 Members Attended**	**Approved with 9 votes in the affirmative**	**Approved with 11 votes in the affirmative**	**Approved with 11 votes in the affirmative**	**Approved with 11 votes in the affirmative**

Presented below is a summary of the meeting, including timekeeping, attendance, and votes.

*Chairperson; **Designee Present

(M): Made motion; (2nd): Seconded motion; (ab): Abstained from Vote; (A): Absent from Meeting

Proceedings

A meeting of the Health Policy Commission (HPC) was held on February 5, 2026, beginning at 12:00 PM. The meeting was held virtually via Zoom. A recording of the meeting and the meeting materials are available on the HPC's website.

Participating commissioners who were in attendance were Ms. Deborah Devaux (Chair); Mr. Martin Cohen (Vice Chair); Ms. Sandra Cotterell; Dr. Keith Marzilli Ericson; Mr. Umesh Kurpad; Mr. Christopher Leibman; Dr. Alecia McGregor, Mr. Steve Walsh; Mr. James Willmuth; Mr. Michael Caljouw, Commissioner of Division of Insurance (DOI); and Secretary Mahaniah, Executive Office of Health and Human Services (EHS).

ITEM 1: Approval of Minutes (VOTE)

Ms. Coleen Elstermeyer, Deputy Executive Director, asked for a motion to approve the minutes from the December 12, 2025, Board Meeting, Dr. Ericson made the motion, and Mr. Leibman seconded it. Commissioner Caljouw abstained from the vote and Secretary Mahaniah was not present at the time of the vote. The motion was approved by roll call vote.

ITEM 2: Healey-Driscoll Administration's Health Care Affordability Working Group and Prior Authorization Reform Announcement

Mr. David Seltz shared an update on the establishment and structure of the Healey-Driscoll Administration's Health Care Affordability Working Group (HCAWG). For more information, see slides 6-9.

Mr. Walsh agreed that the formation of HCAWG at this time is critically important and commended the Governor for establishing the working group. He said that one of the challenges of any working group is that it has beginning, middle, and end, and thinks that the work within HCAWG will only make the ongoing work of the HPC more important, noting that the HPC can bring value by working to evolve the current health system in areas that HCAWG identifies areas for improvement,

Ms. Devaux agreed with Mr. Walsh's comments and asked about timing of the working group's initial thinking and perspectives. Mr. Seltz responded that timing is still being worked out but the Governor emphasized urgency when she announced the HCAWG and asked for some initial recommendations to her as early at the beginning of the summer.

Mr. Willmuth added that the first meeting of the group would be in the coming week would be in person but not a public meeting.

Mr. Kurpad said that he would encourage Mr. Seltz to utilize his role in the working group to encourage the members to not to be constrained by structural issues and consider the benefits of considerable reform strategies. While acknowledging political and stakeholder constraints, he said that Mr. Seltz could use his role within the working group to use data to convey the urgency for reform. Mr. Seltz responded that he has been considering the assets, data, and evidence base that can be leveraged by the HPC data and brought to HCAWG members.

Dr. McGregor emphasized the importance for HCAWG to consider households in communities that have the lowest incomes and are the most financially vulnerable, noting that the Governor's press release mentioned that black and Hispanic households face the highest health care costs relative to their household income, she stated the importance of having the most economically vulnerable communities and individuals from areas where health care resources are limited around the table for HCAWG as well. She emphasized the need to consider the cost impact of catastrophic illnesses like cancer can be crippling for these households as well as immigrant households.

Mr. Seltz turned to Commissioner Caljouw to share a brief presentation on behalf of DOI focused on the agency's role in issuing updated regulations to streamline prior authorization practices in the state. For more information, see slides 10-13.

ITEM 3: DataPoints Issue #33: Evidence of Administrative Complexity: Health Insurance Claim Denials in Massachusetts

Ms. Nancy Ryan, Director, Office of Patient Protection, presented findings from the latest issue in the HPC's DataPoints series, Issue #33: Evidence of Administrative Complexity: Health Insurance Claim Denials in Massachusetts. For more information, see slides 15-24. DataPoints Issue #33 can be found on the HPC's website.

Ms. Devaux noted the timeliness of the report given the ongoing work of the Division of Insurance, and for the HCAWG.

Dr. Ericson thanked Ms. Ryan for the presentation and said that it was surprising to see the number of administrative denials. He questioned why existing tools, such as electronic health records (EHRs), or automation cannot attempt to address this issue, and what barriers interfere with solutions to reduce administrative costs for both providers and patients.

Mr. Kurpad said that one way to look at the claim denial problem is getting stakeholders to submit information the right way so that claims are adjudicated correctly and another way is to question whether claims could be eliminated altogether. He noted that, in a fully integrated system such as Kaiser Permanente, claims are not generated, and while encounter data exists, the system is structured so there are neither claims nor prior authorization. He said that systems like MGB or BMC have a unique opportunity in the marketplace to go beyond conventional approaches. He also acknowledged that much of the issue with claim denials is rooted in having multiple fee schedules and the complexity of a network-based health system and encouraged HCAWG to consider different ways to approach this problem beyond conventional methods.

Mr. Leibman said that the presentation was eye-opening, and particularly highlighted the overall 20% denial rate He also asked whether there is more information on what happens with denied claims, including whether they are later approved, noting that understanding whether denied claims are ultimately paid would help determine whether the process is adding value. He asked whether the services associated with the 20% of denied claims are ultimately covered or paid. Ms. Ryan said that the HPC is not able to make a connection between a denied claim and a subsequent paid claim for the same service.

Chair Devaux added that it would be helpful to get more feedback from plans and providers to understand how many claims are ultimately paid. Mr. Seltz added that this data does present an opportunity to get more information from health plans on these denials.

Ms. Cotterell agreed and noted that there are appeal processes to address these denials and emphasized the importance of obtaining insight into that information. She said that every plan likely has data on their appeal processes, including how many decisions are overturned which is key to understanding the full picture of these claims denials. Mr. Leibman responded to Ms. Cotterell's point and the importance of understanding what happens to the 20% of denied claims.

Ms. Lois Johnson, HPC General Counsel, commented that with respect to the denials that have an impact on patients, such as medical necessity claims, HPC does have that information and keeps track of grievances that were filed and overturned as well as any requests that come to OPP for external review. She added that, ultimately, the issues raised by this report are the volume of claims denials, how long it takes to get them paid, and the challenging interfaces that providers face with multiple payers and multiple rules overtime.

Mr. Cohen said the denial rate was eye-opening to him and asked about automated denials versus those that are done by an actual person. He also asked if there is an opportunity to meet with payers, and particularly those that have higher administrative denials and better understand what's different. Mr. Cohen said that he hopes that this data can be used to affect change within the industry over time, for health plans and providers, since both of those sectors of the health care industry are working to avoid these denials.

Mr. Caljouw noted some observations from the report, specifically the areas of claims processing and the administration of claims since stakeholders would benefit from taking further action to address these processes, especially because this is not an area where insurers compete with one another. He emphasized the importance of continuing to focus on areas, such as the administrative functions of health plans and provider systems, since there is not a competitive advantage or disadvantage of tackling this type of issue; improving these processes would benefit patients, clinicians, and insurers alike. He said that based on the comments from commissioners, a solution could be getting stakeholders to operate from a similar platform so that the information flowing in is already correct, before it even gets submitted. Mr. Caljouw also commented on the process of eliminating paper claims and moving toward a completely automated system. He said that there are going to be a variety of approaches to make this work correctly and if Massachusetts wants to create a seamless claim submission process, there must be an open dialogue about the trade-offs in that process. He said that groups such as the Administrative Simplification Task Force—the workgroup that Massachusetts Health and Hospital Association (MHA), the Mass Medical Society (MMS), Massachusetts Association of Health Plans (MAHP), and Blue Cross Blue Shield of MA, have worked on over the years has made progress on related issues and also that the HCAWG sessions provide an opportunity to put a real fine point on mandating a path to automated clinical data exchange.

Mr. Walsh agreed with Mr. Caljouw's comments and said that the current system is too complex but administrative denials are a solvable problem. He said that the focus should be bringing stakeholders together to address this problem and review annually to measure progress made. He also agreed that utilizing HCAWG could help make the administrative simplification process possible. He said that there is value in addressing these challenges across payers and providers and utilizing technology and AI to combat the problem and noted that stakeholders should not be against administrative simplification since it will allow for them to effectively serve patients. He offered another recommendation for the HPC to incentivize a pilot program, bringing multiple stakeholders together to test whether addressing these challenges is scalable and evaluate how it works in practice.

Chair Devaux noted that she heard optimism from commissioners that this issue can be solvable and that interests across the health care industry, between providers, health plans, and patients, are aligned in eliminating this problem. She echoed the points made by commissioners of the benefits of stakeholder collaboration on this issue.

Dr. McGregor noted the importance of thoughtfully approaching a solution to the high proportion of administrative claim denials. She said that while AI is clearly a very useful technology and it is rapidly improving, the health care industry should proceed with caution when using AI for administrative simplification. She added that UnitedHealth has been the subject of class action lawsuits related to its use of an AI-powered system that allegedly wrongly denied claims and referenced how UnitedHealth also had by far the highest percentage of administrative claim denials, according to the presentation. She emphasized the importance of being careful to ensure that errors are especially limited, otherwise it will create another major administrative burden for the healthcare system. Dr. McGregor also asked about the extent to which these claim denials are driven by insurer systems versus provider-side issues and whether the root cause is the insurer's processing system or providers not being able to submit claims properly. Referring to the data on Fallon Health as an example of denials due to incomplete claims or coding errors, she said if claim denials are partly an issue of training or administrative capacity on the provider side, then that needs to be incorporated into any solution.

ITEM 4: Market Transactions Reviews

Mr. Seltz introduced Mr. Sasha-Hayes Rusnov, Director, Market Oversight and Monitoring, to share the standard update on the HPC's ongoing Cost and Market Impact Reviews (CMIR) for the proposed transaction between Mass General Brigham and CVS and the retrospective analysis of the Beth Israel Lahey Health merger as well as the notices of material change currently under review by the Market Oversight and Transparency department. For more information, see slides 26-34.

Dr. McGregor asked about the proposed clinical affiliation of Atrius Health and Signature Healthcare Brockton Hospital and the agreed upon discounted payment rate for Atrius patients at Brockton Hospital, asking if the discounted rate applied to both outpatient and inpatient services and the what the discounted rate entailed. Mr. Hayes-Rusnov said that while the full details of the transaction are confidential, generally discount arrangements apply to services hospital-wide. He added that these discounts are demonstrative of an effort by Atrius to contain total cost of care for their patients by partnering with hospitals that it identifies as being high-value providers and ensures that those hospitals receive referrals while Atrius benefits under its alternative payment model (APM) contracts. Dr. McGregor added that she was concerned about whether the discounted rates would be low enough to threaten revenue or the financial health of Brockton Hospital. Mr. Hayes-Rusnov affirmed that this question is one that the HPC considers during the review process.

ITEM 5: Regulatory Updates: Chapters 342 and 343 of the Acts of 2024 (VOTE)

Ms. Lois Johnson shared an overview of the legislative background and purpose of the regulatory updates, and the regulatory promulgation process, before turning to Mr. Hayes-Rusnov to present an overview of the first regulatory update.

958 CMR 7.00 Notices of Material Change and Cost and Market Impact Reviews (VOTE)

Mr. Hayes-Rusnov shared an overview of the proposed changes to the regulation 958 CMR 7.00 Notices of Material Change and Cost and Market Impact Reviews. For more information, see slides 39-43.

958 CMR 6.00 Registration of Provider Organizations (VOTE)

Ms. Liz Reidy, Associate Director, Office of Health Resource Planning, shared an overview of the proposed changes to the regulation 958 CMR 6.00 Registration of Provider Organizations. For more information, see slides 45-49.

Mr. Cohen said that with the change to the registration threshold to include providers who collectively received $25 million in net patient service revenue to be inclusive of all payers, he anticipates that it will have an impact on behavioral health outpatient providers. He recommended that once the regulations are promulgated, the HPC should conduct some outreach to those respective trade associations and possibly consider offering training to their members to help these providers meet the intent of the regulations.

Mr. Kurpad asked with respect to the financial information collected by the RPO program and payer mix data, if it would be valuable to also collect the percentage of revenues that is fee-for-service versus value-based payment. Ms. Reidy responded that at this time the HPC has some information about the types of contracts that providers are entering, more specifically if the contracting entity is negotiating global payment contracts, bundled payment contracts, or fee for service contracts. She said that the entities will share that information by commercial payers and by some payer category types which then tells the HPC who is participating in those contracts, but currently the RPO program does not collect the associated revenue information with that. Ms. Reidy added that this data collection would be something to potentially consider for future updates to the RPO.

Dr. McGregor asked about the individuals and entities included in the RPO program, particularly hospital systems and physicians, and added that it is important to get a sense of other health care workers and clinicians affiliated with health care systems especially in terms of resource planning and workforce. She asked whether other clinical and frontline workers and nursing homes are included. Ms. Reidy responded that nursing homes are not currently included in RPO, but could be in the future given the updated registration threshold. Ms. Reidy said the current provider roster includes only M.D.s and D.Os. and will now include APPs and behavioral health clinicians, but other types could be explored.

Dr. Ericson asked about how the information reported to RPO is used, since that could help evaluate the cost-benefit analysis of the burden put on providers. Ms. Reidy said that the information is helpful input for variety of workstreams at the HPC including market transaction reviews, the HPC's annual cost trends report, other research publications, and health planning work. She added that it's also used by other state and federal government agencies and the market participants such as provider organizations and payers. She said that RPO team knows that a number of organizations and academic researchers are also using the data, and others can access on the HPC's website.

Mr. Willmuth echoed the comments of Dr. McGregor to include more entities or members of the workforce in the RPO reporting. He also asked about the change in the regulation regarding the Registering Level, specifically the language on a provider organization's "uppermost corporate parent with a primary business purpose of healthcare delivery, management, ownership or investment." Ms. Reidy said that in general, the change is to simplify the language in the regulation so RPO will get one filing from a corporate system. She used Mass General Brigham (MGB) and Revere Medical Group as examples, stating that the team will get one filing from MGB, as opposed to separate filings from Mass General Hospital, Brigham and Women's Hospital, etc.; RPO would get a filing from the health care entity, Revere Medical Group, but not necessarily include information for Kinderhook, as the private equity entity supporting the group.

958 CMR 9.00 Assessment of Certain Heath Care Providers and Pharmacy Benefit Managers (VOTE)

Ms. Johnson shared an overview of the proposed changes to the regulation 958 CMR 9.00 Assessment on Certain Health Care Providers and Pharmacy Benefit Managers. For more information, see slides 51-55.

Mr. Caljouw offered a suggestion on the public hearing process for the first two regulation changes. He said that it may be valuable to the HPC to incorporate a process of listening sessions instead of formal comment periods when regulation changes include more market-facing changes to allow for a number of interested parties, stakeholders, and members of the public interested in those matters to provide feedback on an informational basis. He commended the HPC's past hearing processes and noted the possible benefits of occasionally having a listening session process, prior to drafting.

Ms. Johnson thanked Mr. Caljouw for his suggestion and added that the HPC has occasionally hosted listening sessions with respect to the HPC's data submission manuals and other aspects of the RPO program for example.

Ms. Elstermeyer handled the roll call votes for each of the proposed regulations presented. Commissioners voted and approved each regulation separately.

958 CMR 7.00 Notices of Material Change and Cost and Market Impact Reviews (VOTE)

Mr. Caljouw made the motion to authorize the issuance of the proposed amendments to 958 CMR 7.00 Notices of Material Change and Cost and Market Impact Reviews, and Mr. Cohen seconded it. The motion was approved.

958 CMR 6.00 Registration of Provider Organizations (VOTE)

Secretary Mahaniah made the motion to authorize the issuance of the proposed amendments to 958 CMR 6.00 Registration of Provider Organizations, and Ms. Devaux seconded it. The motion was approved.

958 CMR 9.00 Assessment of Certain Heath Care Providers and Pharmacy Benefit Managers (VOTE)

Dr. Ericson made the motion to authorize the issuance of the proposed amendments to 958 CMR 9.00 Assessment of Certain Heath Care Providers and Pharmacy Benefit Managers, and Mr. Willmuth seconded it. The motion was approved.

ITEM 6: Executive Director's Report

Mr. Seltz began the Executive Director's report with an overview of a recent federal funding update and the health policy provisions included in the funding package. Mr. Seltz then shared an update on the HPC's Accountable Care Organization (ACO) Certification program for the 2026-27 cycle followed by an update on the HPC's latest investment opportunity, the PATHways Investment Program. For more information, see slides 60-65.

Mr. Kurpad noted his interest in the ACO program and the updated Certification Application Cycle and asked if the HPC would be able to report on the certified entities' performance during the 2028-209 ACO Certification Cycle. Mr. Seltz responded that the HPC does have the ability to map the organizations into other data sets that are collected at the agency, and assess an entity's performance on spending and quality, and outcomes. He added that this is something the HPC has considered in the past years and that there has been contemplation about having a "model ACO", where the HPC could stratify performance. Mr. Seltz added that could be revisited in the context of the next certification cycle. Mr. Seltz also acknowledged a previous comment from Mr. Kurpad during the RPO regulation presentation, regarding measuring value-based payment models versus fee for service models and said that data may be available through CHIA or through ACO and would update Mr. Kurpad accordingly. Mr. Kurpad said that he was excited about this area of the HPC's work and the ACO program's potential to be useful in evolving the health system and encouraged utilizing the ACO program to measure an entity's performance within the health care system.

Mr. Seltz turned to Ms. Coleen Elstermeyer, Deputy Executive Director, to share an update on recent and upcoming publications including the upcoming legislatively mandated report focused on the Assessment of Behavioral Health Commercial Rates. For more information, see slides 66-70.

ITEM 7: Adjourn

The public meeting adjourned at 2:30 PM