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March 20, 2026

Susan M. Flanagan-Cahill
Deputy General Counsel
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Re: Proposed Changes to the Health Policy Commission Material Change Notice and Cost and Market Impact Review Regulations

Dear Ms. Flanagan-Cahill and Members of the Health Policy Commission:

The Massachusetts Health & Hospital Association (MHA) and Conference of Boston Teaching Hospitals (COBTH), on behalf of its member hospitals, health systems, physician organizations, and allied healthcare providers, appreciate the opportunity to submit these comments regarding the proposed amendments to *958 CMR 7.00, Notice of Material Change and Cost and Market Impact Reviews* necessitated by the changes enacted pursuant to Chapter 342 and 343 of the Acts of 2024.

MHA and COBTH and their respective memberships share the commonwealth's commitment to cost containment, transparency, and the preservation of and access to high-quality healthcare across Massachusetts and are appreciative of our ongoing collaboration in these important areas. We are fully aligned with the commonwealth's resolve to prevent bad actors from again destabilizing access to care for Massachusetts residents, as seen several years ago. While we are generally supportive of the proposed amendments and how they aim to address these goals, we would like to raise a few concerns from hospitals and offer suggestions that are intended to provide greater clarity for organizations navigating the requirements of these regulations. We believe that these changes will help strike an important balance between fulfilling the intent of the regulations while being responsive to the on-the-ground needs of patients and providers in today's healthcare environment – particularly around protecting access to timely patient care and avoiding duplicative oversight requirements and unnecessary administrative burdens that could stand in the way of that care.

Overarching Concern: Duplication of Existing Oversight, Timing

While we appreciate the statutory requirements for both the HPC's Notice of Material Change (MCN) and Cost and Market Impact Review (CMIR) processes and the Department of Public Health's (DPH's) Determination of Need (DON) requirements, in practice many of these programs' requirements are duplicative of each other. We ask that HPC and DPH work together to ensure their shared authority over these matters does not result in increased, unnecessary

regulatory burden and expense for healthcare entities participating in these processes. In particular, we note that information and data required of applicants for HPC and DPH review, approval, and post-review processes can be duplicative. In practice, the requirements are incredibly similar, but just distinct enough so that providers must undertake two workstreams to produce almost the same information to both agencies. In subregulatory implementation, we respectfully request that the HPC and DPH align these information and data requests and reporting requirements to reduce administrative burden. We also encourage the agencies to ensure that the intertwined processes do not unnecessarily extend the approval process so that essential projects that support patient access and system sustainability are not delayed. For hospitals and health systems facing urgent facility needs, workforce shortages, or evolving patient demand, prolonged regulatory timelines threaten both access for patients and financial sustainability for providers. Of note, while these proposed regulations would require applicants to submit MCNs and DONs at the same time, the review periods for these applications can be quite different, sometimes by months.

Overly Broad Definition of "Significant" Changes in Capacity

Of particular concern to the hospital community is the language related to the implementation of the statute's requirement that a material change include "significant expansions in a provider or provider organization's capacity." The proposed amendments to the regulation reference that a significant change in capacity requiring an MCN includes any proposal that requires an Application for Significant Capital Expenditures through DPH's DON process. The inclusion of open-ended language such as "including but not limited to" would create uncertainty for hospitals attempting to comply in good faith.

Additionally, the explicit inclusion of "Emergency," "Significant Amendments," and "Significant Change in Services" of DON applicant types being subject to an MCN would sweep in routine service adjustments and DON-reviewed projects that are not intended to materially affect market structure or costs. This would result in successive MCN processes for a single project, even when there is no change in intent or outcome. We are particularly concerned with the inclusion of emergency DON applications listed as an example in 958 CMR 7.03:(1)(f). Emergency DONs should not be subject to MCN review as delays could directly compromise patient safety and access to care. We also question whether the intent of the statute was to require material change notices for equipment. Regulatory frameworks should distinguish between market-altering transactions and ordinary-course operational decisions.

Clinical Affiliations

The proposed expansive definition of clinical affiliations in 958 CMR 7.03(1)(d) raises concern that common, non-integrative arrangements could trigger MCN filings. Hospitals rely on a myriad of clinical affiliations to maintain access to specialty services, recruit clinicians, and preserve care locally and across state lines. Often these arrangements do not generate revenue. The proposed regulations would inhibit much-needed collaboration for hospitals that have clinical affiliations within the state, as well as those that have clinical trials and affiliations across state lines. Unintended consequences include limited clinical partnerships and decreasing patient access to high-quality care in underserved regions of the state and beyond. An overly broad

approach risks discouraging collaborations that enhance, rather than limit, patient access, particularly in underserved regions.

Consistency in Requirements Between Hospital and Non-Hospital Transactions

The draft regulations would benefit from clearer distinctions between acquisitions *of* hospitals or hospital systems by other providers and acquisitions *by* hospitals of non-hospital providers or provider organizations. In particular, there is inconsistency in the regulations, as under 958 CMR 7.03(1)(b) a merger or acquisition by a hospital/hospital system of another provider/provider organization does not have a materiality threshold (Net Patient Service Revenue or dominant market share), while under 958 CMR 7.03(1)(c) there is such a threshold for acquisitions, mergers, corporate affiliations, or contracting affiliations by other, non-hospital providers/provider organizations.

As drafted, filing thresholds are not appropriately aligned with transactions that are more likely to affect costs and market impact concerns. Applying MCN requirements without such thresholds to hospital acquisitions of small, non-hospital providers risks capturing transactions that are unlikely to affect market dynamics but are essential for care integration and continuity.

Additionally, 978 CMR 7.03's detailed requirements to file a notice of material change do not include provider-to-provider transactions. If other transaction types that meet the determined thresholds require MCNs, the regulation should require the same for provider-to-provider transactions. In the past few years there have been numerous instances of large for-profit provider organizations acquiring local Massachusetts provider practices. To ensure there is oversight for all types of transactions with the potential to alter the healthcare market, MHA and COBTH urge uniform oversight of these types of transactions, regardless of provider type.

As a somewhat separate matter, we are also concerned about HPC's inclusion in 958 CMR 7.01(1)(c) of entities representing providers of healthcare services that are qualified under the laws of a state other than Massachusetts in contracting with payers for healthcare services. While we understand that patients and providers operate in Massachusetts and our surrounding states, we question how this relates to HPC's authority (or lack thereof) outside of the commonwealth. While we understand that healthcare is not always provided neatly within state lines, and numerous Massachusetts-based providers have affiliations with providers across the region, it does not appear appropriate for HPC's material change notice review to apply to out-of-state actors.

Significant Equity Investors & Management Services Organizations

The language in 958 CMR 7.03(1)(g) includes change of ownership or control of Management Services Organizations (MSOs), despite the fact that MSOs themselves are not required to file MCNs. Only providers and provider organizations are required to file. This raises practical and legal concerns. For example, if a significant equity investor acquires an interest in an MSO that has no direct relationship with a provider or provider organization, it is unclear who would be responsible for filing. Hospitals may not even be aware of such transactions, making compliance impossible. We urge the HPC to update the regulation clarifying that MCNs should only be

required when a Significant Equity Investor (SEI) acquires the ownership or control interest, as opposed to when the SEI sells its interest in a provider or provider organization.

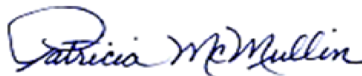
Real Property

Proposed language in 958 CMR 7.03(1)(h) speaks to the "significant" acquisition, sale, or transfer of a provider or provider organization's assets. The regulation would benefit from clarity as to what constitutes "significant." Measuring "significant" in relation to the size of the provider or provider organization would lead to unnecessary notices. For example, if a small physician group sells all of its assets to move to employment under a larger provider, that sale would be "significant" in relation to the group itself but likely would not be a transaction that should trigger a material change notice because of the sale. Acquisition of assets should not be a concern unless it is part of a "significant expansion of capacity" or an acquisition of provider assets already covered under other material change events.

Thank you for the opportunity to provide comments on these proposed amendments as we continue our shared mission of transparency, cost containment, and preserving access to healthcare for all Massachusetts residents. The proposed amendments must be carefully calibrated to ensure clarity and consistency, and avoid unnecessary duplication, overly broad applicability, and unintended consequences for patient access and hospital sustainability. We respectfully urge the HPC to narrow the scope of review to transactions that truly implicate market impact and cost growth, clarify ambiguous and inconsistent definitions, and align the regulations more closely with statutory intent and existing DPH oversight. MHA and COBTH welcome the opportunity to meet and discuss the recommended changes.

Respectfully,

Leigh E. Simons
Vice President, Policy & Regulatory Affairs
Massachusetts Health & Hospital Association



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