MASSACHUSETTS
HEALTH POLICY COMMISSION

HPC Board Meeting

July 23, 2026

Agenda

UP NEXT: Call to Order

Approval of Minutes **(VOTE)**

Promoting Appropriate Transitions to Home (PATHways) Investment Program Awards **(VOTE)**

Recent Market Transactions

Select Findings: 2026 Health Care Cost Trends Report

Office of Health Resource Planning

Administration and Finance

Executive Director’s Report

Adjourn

Agenda

Call to Order

UP NEXT: Approval of Minutes (VOTE)

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VOTE

Approval of Minutes from the June 11, 2026, Board Meeting

MOTION

That the Commission hereby approves the minutes of the Commission meeting held on **June 11, 2026**, as presented.

Agenda

Call to Order

Approval of Minutes **(VOTE)**

UP NEXT: Promoting Appropriate Transitions to Home (PATHways) Investment Program Awards (VOTE)

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Why the HPC Invests in Innovative Health Care 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 Promising Interventions that Support Access to Health Care

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

Facilitate Community Partnership with Health Care and Hospital Systems

The HPC intentionally incorporates community engagement in its programs to ensure they best meet the needs of the people they're designed to serve.

Investing in Health Care Transformation and Innovation

masshpc.gov/cdt/investment-programs

ACTIVE

Promoting Appropriate Transitions to Home (PATHways)
Launched: 2026

Hypertensive disorders Equitably Addressed with Remote Technology for Birthing People (HEART-BP)
Launched: 2025

IN EVALUATION

Moving Massachusetts Upstream (MassUP)
Launched: 2020

Cost-Effective, Coordinated Care for Caregivers and Substance Exposed Newborns (C4SEN)
Launched: 2021

Birth Equity and Support through the Inclusion of Doula Expertise (BESIDE)
Launched: 2021

COMPLETED

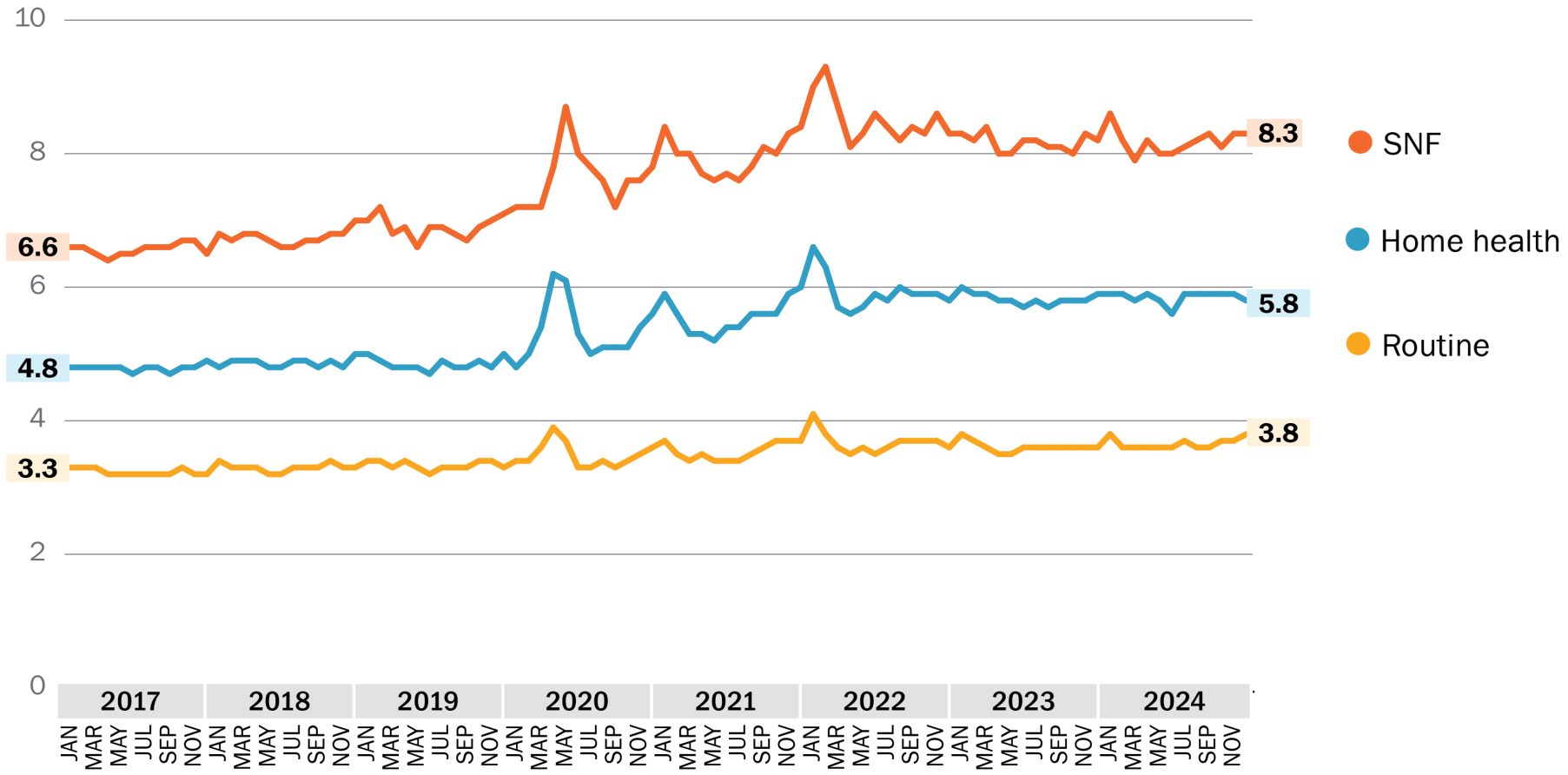
Community Hospital Acceleration, Revitalization, & Transformation (CHART)
Launched: 2014

Health Care Innovation Investment (HCII)
Launched: 2016

SHIFT-Care Challenge
Launched: 2018

Hospital length of stay increased during the COVID pandemic and remains elevated. The increase was concentrated among patients ultimately discharged to post-acute care.

Average length of stay (days) for inpatient admissions from the ED by discharge destination, 2017 to 2024

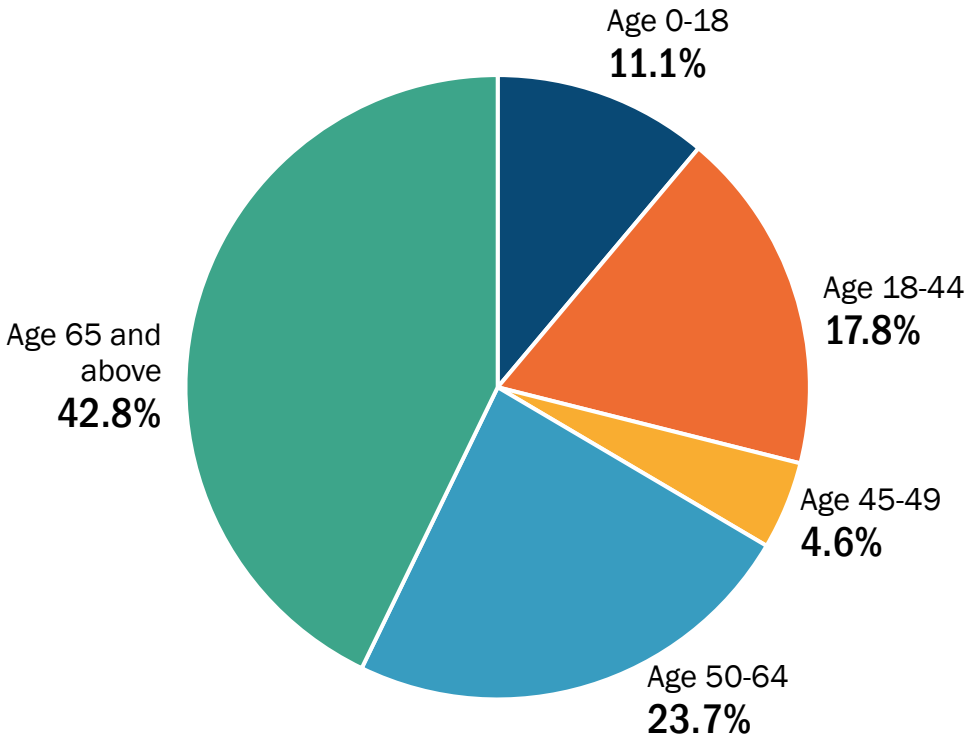


- In 2017, 3.8% of hospital bed days were used by patients with hospital stays lasting longer than a month.
- This percentage rose to 8.3% by 2024.

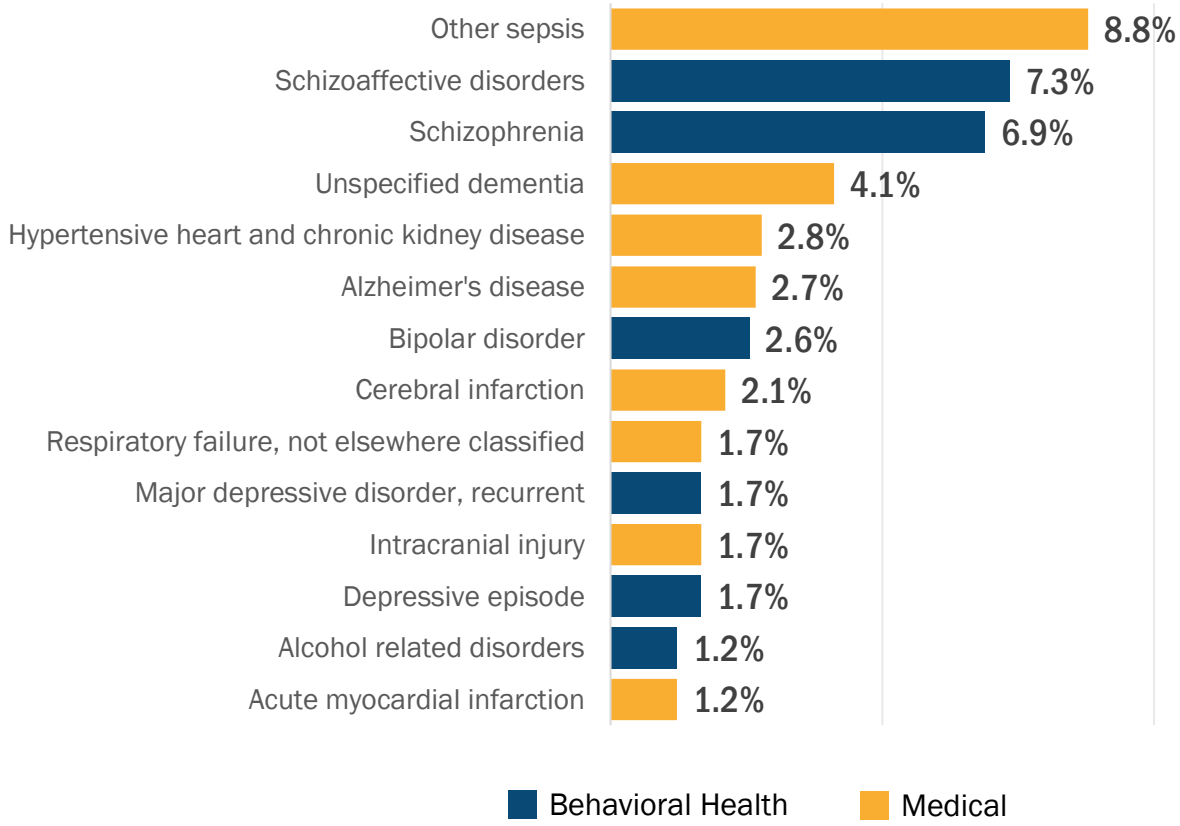
Notes: Based on patient discharge date and includes only admissions from the emergency department and scheduled admissions. Includes COVID-related discharges. Excludes pediatric, maternity, BH, and rehabilitation admissions and admissions with length of stay greater than 180 days. Two hospitals with at irregular length of stay data (MelroseWakefield - Lawrence and Shriner's Hospital for Children- Boston) were excluded for the entire study period.
Sources: HPC analysis of the Center for Health Information and Analysis (CHIA) Hospital Inpatient Discharge Database, FY2017 to FY2024, preliminary FY2025

Patients with behavioral health conditions and those over 50 comprised a large share of 30+ day hospital stays in 2024.

Age distribution of long inpatient stays (30+ days) on a given day, 2024



Top primary diagnosis codes of long inpatient stays (30+ days) on a given day, 2024



Notes: Data represents inpatient stays discharged on March 1st, 2024 with a length of stay greater than or equal to 30 days (N=899).
Source: HPC analysis of CHIA Hospital Inpatient Discharge Database, CY2016-2024

Promoting Appropriate Transitions to Home (PATHways) Investment Program Overview

- The **PATHways Investment Program** will support acute care hospitals in advancing hospital-to-home programs, streamlining patient discharges to home and community settings rather than skilled nursing facilities or other institutional settings.
- PATHways was designed to build on the Executive Office of Aging & Independence (AGE)-funded Hospital to Home Partnership Program (HHPP), which supported partnerships between hospitals and ASAPs and ended in 2025.

- **Partnership between Hospital and Aging Services Access Points (ASAPs)**
  - ASAPs are regional organizations that provide programs and services designed specifically to support adults aged 60 and older.

- **Embedded ASAP Liaison**
  - ASAP staff co-located with hospital discharge planners or social workers, who will connect patients with services, optimizing their discharge planning.

PATHways Investment Program Overview

$1.38 Million

The HPC will invest $1.38 million in hospitals with the PATHways Investment Program.

Performance Period: 27-30 Months

The program's Period of Performance will be 27-30 months, comprising a mandatory Planning Period of three to six months, and a 24-month Implementation Period.

7 Awards

The HPC will award up to $210,000 each to six hospitals eligible for funding through the Distressed Hospital Trust Fund (DHTF) and one additional acute care hospital through the Payment Reform Trust Fund (PRTF).

Evaluation Period: 6 Months

Following the Period of Performance, there will be a six-month Evaluation Period during which Awardees will participate in final reporting and evaluation-related activities.

PATHways Investment Program Aims

1. **Build and/or sustain partnerships between ASAPs and hospitals** to strengthen communication and promote effective coordination with home and community-based service providers.

2. **Support institutional (e.g., skilled nursing facility) diversion** and hospital discharge directly to home and community-based settings with home and community-based services.

3. Collect qualitative and quantitative data to **evaluate the effectiveness and feasibility of sustaining partnerships** between ASAPs and hospitals.

Request for Proposals (RFP) Review Process

Technical Review

Review and Selection Committee

- Reviewed and scored each proposal in accordance with RFP criteria
- Followed up with applicants for clarification as needed

Subject Matter Expert

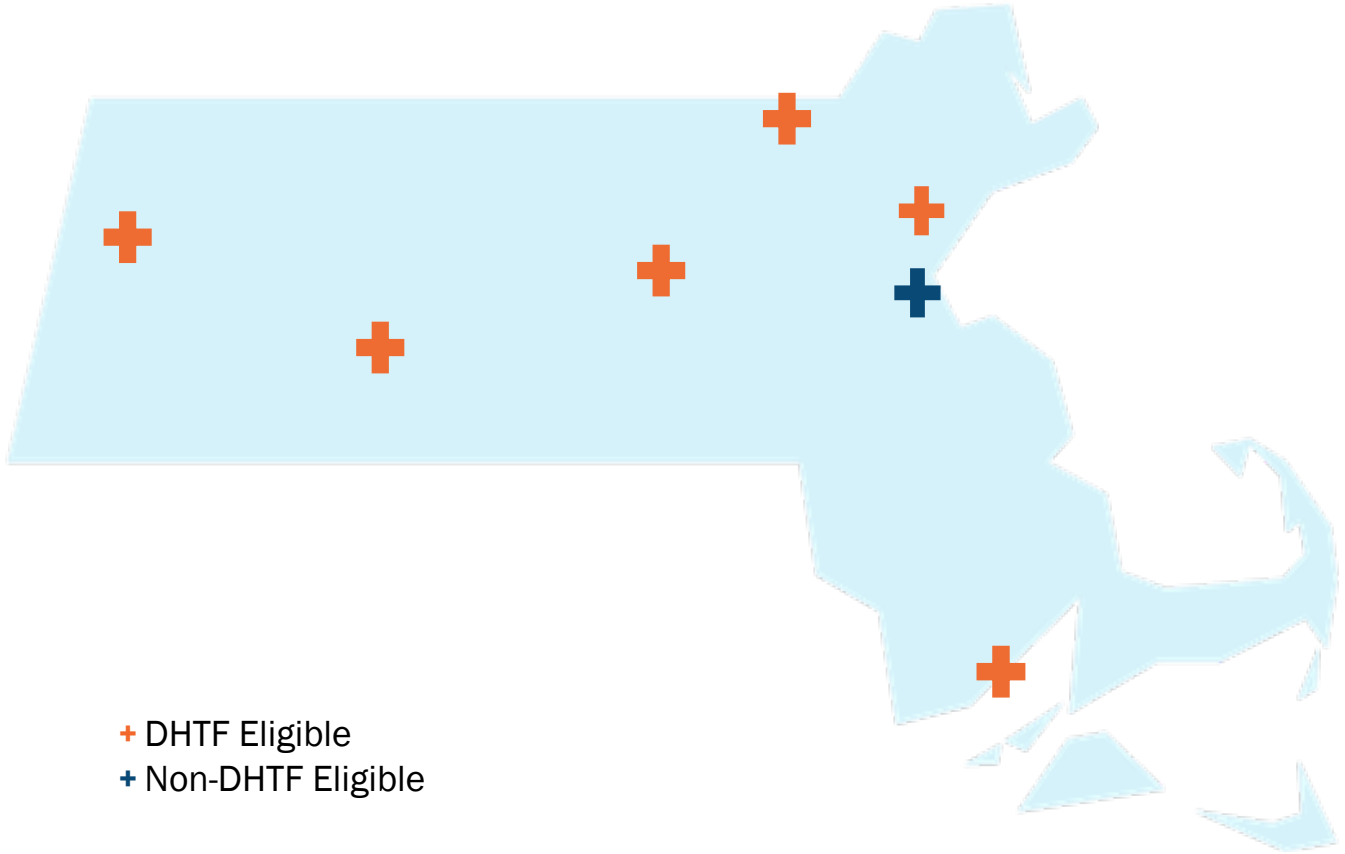
- The Executive Office of Aging and Independence (AGE) reviewed each application and provided input based on their past experience.

Financial Health Review

- Health Management Associates reviewed hospitals eligible for funding through the Distressed Hospital Trust Fund (DHTF).

Review and Selection Committee Award Recommendations

Applicant	Award Amount
Berkshire Medical Center	$210,000
Boston Medical Center	$210,000
Holyoke Medical Center	$210,000
Lowell General Hospital	$210,000
MelroseWakefield Hospital	$124,700
Southcoast Hospital	$201,424
UMass Memorial HealthAlliance – Clinton Hospital	$210,000



Berkshire Medical Center

Requested HPC Funding:
$210,000

ASAP Partner:
Elder Services of Berkshire County, Inc.

New or Existing Program:
Existing

Program Overview:

Berkshire Medical Center (Berkshire) proposes to continue their Berkshire-Elder Services of Berkshire County, Inc. (ESBCI) hospital-to-home partnership. An ESBCI staff person will serve as the liaison dedicated to assisting with discharge planning for home and community discharges. Berkshire operated a program under the Hospital to Home Partnership Program and is using PATHways to strengthen its operational infrastructure and build the case for sustaining the partnership.

Unique Program Highlights:

Berkshire will develop a resource page on its website where patients can access discharge forms, support materials, and community partner information.

Boston Medical Center

Requested HPC Funding:
$210,000

ASAP Partner:
Boston Senior Home Care, Central Boston Elder Services, and Ethos

New or Existing Program:
New

Program Overview:

Boston Medical Center (BMC) proposes a new program in partnership with the Elder Care Alliance (a non-profit collaboration of three designated ASAPs). The Home and Community-Based Services (HCBS) Hospital Liaison from ECA would be embedded within BMC's Inpatient/Emergency Services. This program will also include a pharmacy liaison and patient financial counseling, who will work in collaboration with the HCBS Liaison.

Unique Program Highlights:

Suburban Home Health Care will serve as the program's home health partner and utilize a dual-service model that allows for deployment of skilled and non-skilled staff within 24 hours of discharge from the same organization and eliminates fragmented transitions to home.

Holyoke Medical Center

Requested HPC Funding:
$210,000

ASAP Partner:
Access Care Partners

New or Existing Program:
Existing

Program Overview:

Holyoke Medical Center (HMC) proposes continuing their partnership with Access Care Partners (ACP) to embed bilingual hospital liaisons in the discharge department. This partnership originated with the HHPP funding and has been sustained in part but does not meet current demand. Through PATHways, HMC and ACP will broaden the role of hospital liaison to support other departments to provide efficient service delivery, connection to community services and prevent readmissions.

Unique Program Highlights:

Once the liaison returns to full time at the hospital, they will support additional departments including the Behavioral Health Geriatric Psychiatric unit and the outpatient Oncology department, with support from case management to develop more enhanced discharge plans while patients are hospitalized.

Lowell General Hospital

Requested HPC Funding:
$210,000

ASAP Partner:
AgeSpan

New or Existing Program:
Existing

Program Overview:

Lowell General Hospital (LGH) proposes resuming their partnership with AgeSpan and embedding the role of AgeSpan HCBS hospital liaison in the Department of Continuity of Care. The hospital liaison will work alongside a multidisciplinary team, including discharge coordinators and social workers. Once the patient transitions back into the community, the liaison will provide an initial face-to-face visit with the high-risk readmission population.

Unique Program Highlights:

LGH proposes the hospital liaison will spend half their time inside the hospital and the other half in the field, providing intensive case management post-discharge.

MelroseWakefield Hospital

Requested HPC Funding:
$124,700

ASAP Partner:
Mystic Valley Elder Services (MVES)

New or Existing Program:
Existing

Program Overview:

MelroseWakefield proposes to restore and expand their HHPP that has been integrated into their care transition processes. MelroseWakefield will continue their HHPP partnership with Mystic Valley Elder Services, Inc. (MVES) to have a hospital liaison embedded with the care management team to deliver efficient, high-quality care by improving discharge planning and strengthening care coordination.

Unique Program Highlights:

MVES will provide targeted ongoing training to hospital care management staff on ASAP services and eligibility pathways, available HCBS supports, and referral workflows.

Southcoast Hospital

Requested HPC Funding:
$201,424

ASAP Partner:
Coastline Elderly Services, Inc.

New or Existing Program:
New

Program Overview:

Southcoast Hospitals Group proposes embedding a HCBS hospital liaison staffed from Coastline Elderly Services, Inc. at St. Luke's Hospital. While the partnership between Southcoast and Coastline is well established, the role of the hospital liaison will enhance and streamline the discharge for patients to home and community settings. The hospital liaison will serve patients who are inpatient or presenting to the emergency department.

Unique Program Highlights:

The program team will develop a partnership tracking system to capture all assessment outcomes, arranged HCBS services, discharge destination, post-discharge follow-up results.

UMass Memorial HealthAlliance – Clinton Hospital

Requested HPC Funding:
$210,000

ASAP Partner:
Aging Services of North Central Massachusetts (ASNCM)

New or Existing Program:
New

Program Overview:

HealthAlliance-Clinton Hospital proposes a new partnership with Aging Services of North Central Massachusetts, where the ASAP HCBS liaison will function as an integrated member of the hospital care team. To promote safe transitions and reduce avoidable readmissions the liaison will complete 15- and 30-day post discharge follow-up calls to assess safety, confirm services are in place, and identify any emerging needs.

Unique Program Highlights:

Eligible patients include adults aged 60+ and younger adults with disabilities who may be eligible for ASNCM's Adult Foster Care program and other community-based supports.

VOTE

Promoting Appropriate Transitions to Home (PATHways) Investment Program Awards

MOTION

That the Commission hereby accepts and approves the Executive Director's recommendations that the Applicants for the Promoting Appropriate Transitions to Home (PATHways) investment program receive award funding pursuant to section 7 of chapter 6D and section 2GGGG of chapter 29 of the Massachusetts General Laws, and 958 CMR 5.07, as applicable, up to the amounts presented and subject to successful completion of awardee contracting, and authorizes the Executive Director in his discretion to determine the final terms and amount of each award.

Anticipated PATHways Program Timeline

JULY 2026

- Board vote, PATHways Investment Program Awardee Selection: **July 23**

SEPTEMBER 2026

- Contracting concludes: **September 30**

OCTOBER 2026

- Planning period begins (3-6 months)

JANUARY 2027

- Implementation Period begins (24 months)

JANUARY 2029

- Evaluation Period begins

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Approval of Minutes **(VOTE)**

Promoting Appropriate Transitions to Home (PATHways) Investment Program Awards **(VOTE)**

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Material Change Notices

4	MCNs currently open
20	MCNs received since 1/1/26
35	MCNs received since 4/8/2025 *Effective date of Chapter 343 of the Acts of 2024*
1	MCN involving a significant expansion of provider capacity

Material Changes Involving a Significant Equity Investor

- Several material change triggers involve proposed affiliations between two providers or provider organizations. One of the primary focuses of these reviews is the potential for consolidation to increase the parties' bargaining leverage with payers, leading to increased spending.
- Chapter 343's expansion of the definition of material changes reflected new research on how certain ownership and financing models impact spending, quality, and equitable access to care by changing provider incentives and operations. This includes, but is not limited to, private equity acquisitions.
- Material changes now include any transaction in which a **significant equity investor (SEI)** gains partial or complete ownership or control of a provider, provider organization, or contracting medical services organization (MSO).
- To be reportable, at least one involved provider or provider organization must meet the MCN filing threshold for net patient service revenue.

Significant Equity Investor Transaction Key Questions

- What other health care provider or management companies does the SEI own? How have other portfolio health care companies performed? Have any of the SEI's companies recently downsized or gone bankrupt?
- Would the acquisition be accomplished using debt that would be allocated to the Massachusetts provider entity?
- Would the SEI expect to use the newly acquired provider as a platform for other acquisitions in Massachusetts or other states?
- What role would the SEI or its other portfolio companies have in the management and operations of the provider?
- What changes would be expected in the provider's contracting with payers, including MassHealth?
- Would there be changes in the provider's clinical staffing or care delivery model?

Significant Equity Investor Transactions To-Date

- Out of the **15 SEI transactions**, 10 have involved private equity (PE) investors or PE-backed provider entities
- Of the **10 PE-involved transactions**:
  - 6 involved new PE investment in for-profit companies that were previously publicly traded or privately held
  - 2 involved a sale from one PE firm to another
  - 2 involved transfers from one set of funds to another set of funds managed by the same PE firm
- Provider types involved in PE transactions include:
  - Home Health and/or Hospice (4)
  - Durable Medical Equipment and Pharmacy (3)
  - Adult Day Health (1)
  - Outpatient Behavioral Health (1)
  - Home Infusion (1)
- Non-PE SEIs have been predominantly medical or dental services organizations.

Significant Equity Investor Transaction Monitoring

The HPC is **authorized to require reporting for 5 years after transactions close**. Upon completing preliminary MCN reviews, the HPC has required specific future reporting for certain SEI transactions. Topics for such reporting have included:

- Notification if the SEI sells its interest in the Provider/Provider Organization (if an MCN filing is not otherwise required)
- Notification if the Provider/Provider Organization files for bankruptcy
- Notification of reduction in service lines or closure of MA locations
- Notification in the event of aggregate rate increases over certain levels
- Information on quality improvement plans and patient-to-provider ratios

The Massachusetts Registration of Provider Organizations program (MA-RPO) is **authorized to require Provider Organizations with private equity investment to report certain information** and may require the disclosure of relevant information from any SEI associated with a Provider Organization.

- Under this authority, the MA-RPO program now collects information on provider organizations' relationships with SEIs, MSOs, and REITs.
- This past year, the program collected identifying information about these relationships, including names, Tax ID numbers, and affiliation start dates, and expects to phase additional reporting in over time.

Transactions HPC Elected Not to Proceed

- Guardian Dentistry Practice Management – Select Dental Management
- Carepoint Healthcare – New Heritage Capital
- Lahey Hospital and Medical Center Expansion
- Strive Medical – Cardinal Health
- Advantage Behavioral Health and Wellness – QCF
- Talkspace – Universal Health Services

Open Transactions Currently Under Review

- Falcon Hospice – CenterWell Health Services – BlackRock – Clayton, Dublier & Rice
- Baystate Health – Mercy Medical Center
- Northeast Health Services – Shore Capital Partners
- Tufts Medical Center – Sturdy Memorial Hospital

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Select Findings: 2026 Health Care Cost Trends Report

UP NEXT: HPC 2025 Policy Recommendations

Outline of 2026 Health Care Cost Trends Report

Premium Trends

Low Value Care

Avoidable Utilization

Provider Prices

HPC 2025 Policy Recommendations

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 (Abridged)

1 Administrative Complexity

The Commonwealth should take action to dramatically reduce costs by adopting policies that reduce, standardize, centralize, and/or automate common administrative tasks, prioritizing those that impede care for patients and burden primary care clinicians and support staff (e.g., prior authorization).

2 Health Care Prices

Many states are implementing policy solutions that seek to limit excessive prices for services above a fair, reasonable threshold or to moderate price growth to a sustainable rate. The Commonwealth should consider these approaches and others to address excessive prices for which competitive forces have failed to meaningfully constrain.

3 Pharmaceutical Spending

Recent legislative action established new tools for enhancing the transparency and oversight of pharmaceutical manufacturers and pharmacy benefit managers (PBMs), including through the HPC's new Office of Pharmaceutical Policy and Analysis (OPPA) and the Division of Insurance (DOI). In addition to considering policies implemented by other states, the Commonwealth should consider recommendations developed in the coming year by OPPA and DOI.

4 Low Value Care and Avoidable Utilization

The Commonwealth should encourage providers and payers 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. The Commonwealth should take immediate action on the recommendations of the Primary Care Task Force.

HPC 2025 Policy Recommendations in 2026 HPC Work

1 Administrative Complexity

- DataPoints Issue #33: Evidence of Administrative Complexity: Health Insurance Claim Denials in Massachusetts
- Development of the 2026 Aligned Measure Set by the Statewide Quality Advisory Committee

2 Health Care Prices

- Select findings from the 2026 Health Care Cost Trends Report presented today
- Special Report: Examination of Payments for Behavioral Health Care Services

3 Pharmaceutical Spending

- Select findings from the 2026 Health Care Cost Trends Report presented at the Benchmark Hearing on April 1, 2026
- Upcoming inaugural Annual Report from the HPC's new Office of Pharmaceutical Policy and Analysis

4 Low Value Care and Avoidable Utilization

- Select findings from the 2026 Health Care Cost Trends Report presented today
- Emergency Department Boarding in the Commonwealth of Massachusetts

Select Findings: 2026 Health Care Cost Trends Report

HPC 2025 Policy Recommendations

UP NEXT: Outline of 2026 Health Care Cost Trends Report

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Introduction to the HPC's Annual Health Care Cost Trends Report

What is the Health Care Cost Trends Report?

- State law directs the HPC to issue an **annual report on health care spending trends**, along with any **policy recommendations.**
- In its annual report for 2026, the HPC will include **new research** on the performance of the Commonwealth's health care system and evaluate progress in meeting the state's **affordability, access**, and **health equity** goals.
- The material will be presented in a **narrative report** and an accompanying **graphic chartpack**.
- The report is informed by sources including the data and research of the **Center for Health Information and Analysis (CHIA) and federal sources.**

2026 Health Care Cost Trends Report Outline

Massachusetts Spending Performance and Affordability of Care

Findings presented at the HPC Benchmark Hearing on April 1, 2026

Trends in Spending by Health Condition

Chartpacks *Select findings presented at the HPC Board meeting on July 23, 2026*

- Primary Care and Behavioral Health
- Price Trends and Variation
- Hospital Utilization and Post-Acute Care
- Provider Organization Performance Variation and Low Value Care

Policy Recommendations

Select Findings: 2026 Health Care Cost Trends Report

HPC 2025 Policy Recommendations

Outline of 2026 Health Care Cost Trends Report

UP NEXT: Premium Trends

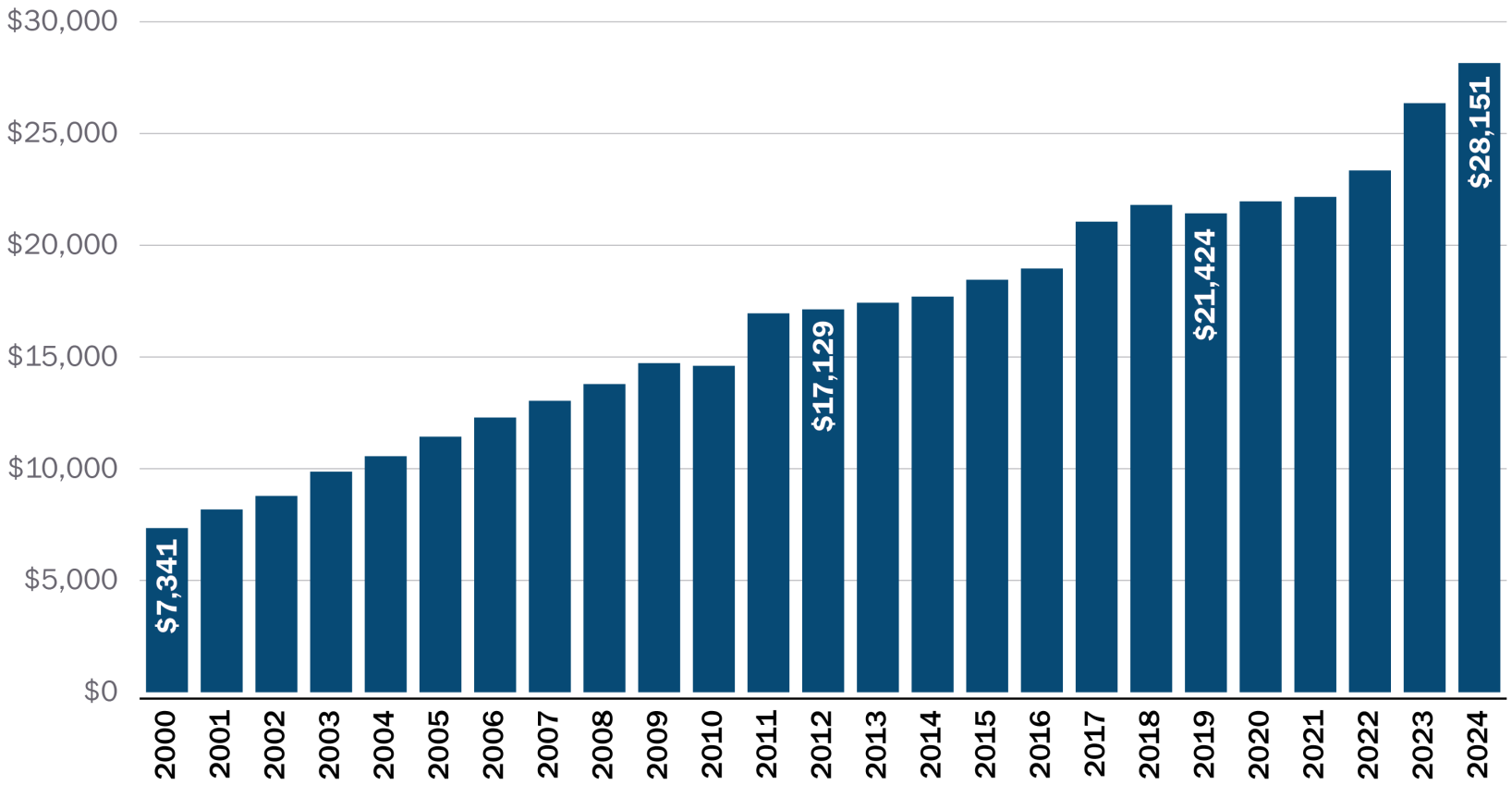
Low Value Care

Avoidable Utilization

Provider Prices

Since 2000, family health insurance premiums in Massachusetts have grown from $7,000 to over $28,000 per year, the highest in the U.S. in 2024, straining affordability.

Average family health insurance premium in Massachusetts for employer-based coverage including employer and employee contribution

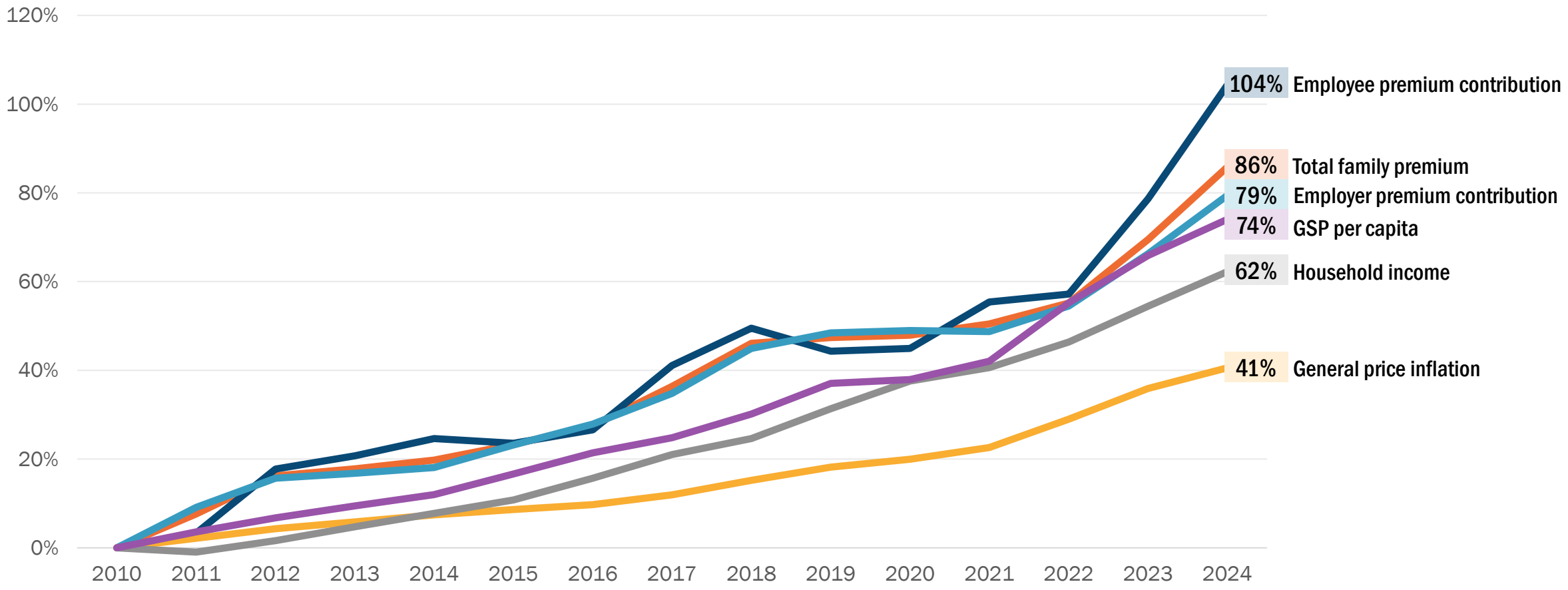


- Premiums grew 31% from 2019 to 2024 (vs 20% in the rest of the U.S.) and would reach **$50,000** by 2031 at recent rates of growth.[1]
- 2024 premiums **exceeded $37,000** for 10% of families.

Notes: Premium projection assumes 8.5% annual growth which is the rate of commercial spending growth per member from 2023 to 2024 in CHIA's 2026 Annual Report.
Sources: Commercial spending and premiums data are based on HPC's analysis of Center for Health Information and Analysis Annual Reports. Labor costs are sourced from the Bureau of Labor Statistics, Economic Cost Index. CPI is from the Bureau of Labor Statistics data for the Boston area MSA. Income distributions are from the American Community Survey and the Current Population Survey, Annual Social and Economic Supplement.

Growth in health insurance premiums in Massachusetts exceeded growth in household income, state economic growth, and inflation from 2010 to 2024.

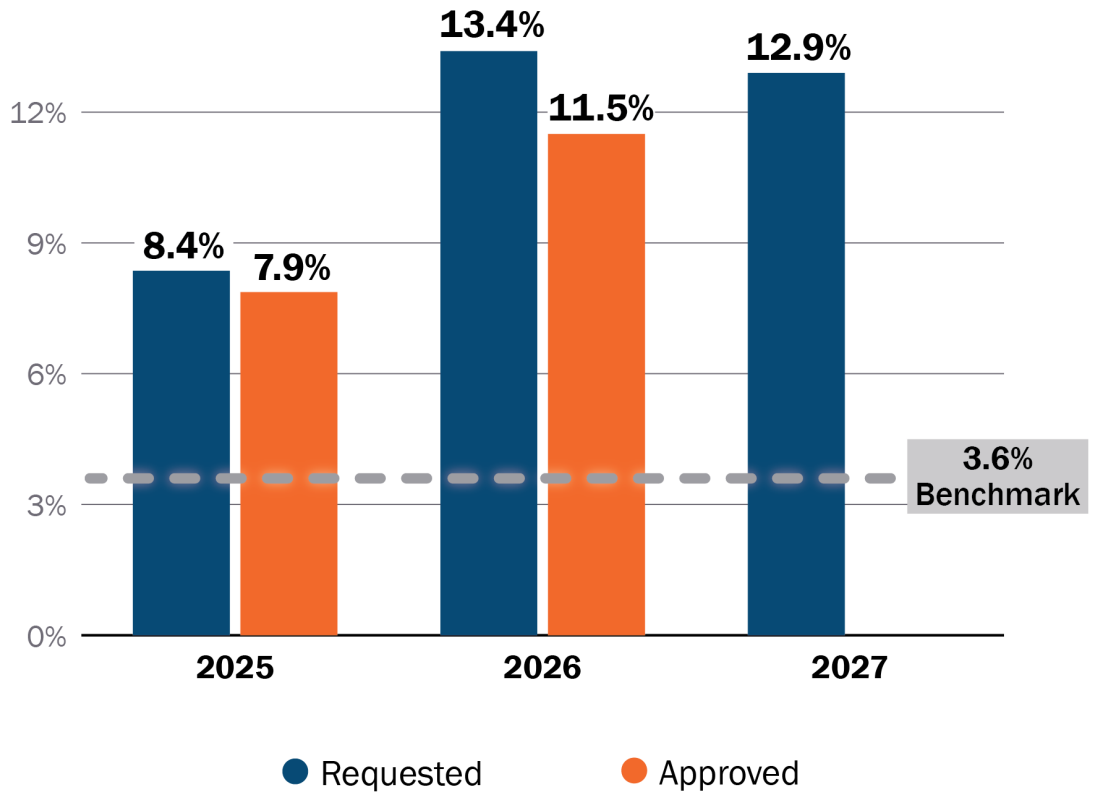
Cumulative growth since 2010 of various health care and economic indicators in Massachusetts



Sources: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, American Community Survey, and Bureau of Labor Statistics (CPI-U for the Boston/Newton/Cambridge metro area). Data points represent the average of the year shown and the previous year to smooth out trends.

Rapid health care spending growth is expected to continue into 2026 and 2027.

Massachusetts merged market average rate increases, 2025-2027



- A recent national industry report[1] projects 9% commercial spending growth in 2027, the highest in 19 years, driven by:
  - *AI-enhanced coding and revenue maximization by health care providers*
  - *Rising provider prices*
  - *Rising pharmacy spending*
  - *Behavioral health utilization*
  - *Higher spending due to the No Surprises Act arbitration process*

Sources: Data received upon special request to the Massachusetts Division of Insurance
1. PwC Health Research Institute (2026). Available at: https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html

Select Findings: 2026 Health Care Cost Trends Report

HPC 2025 Policy Recommendations

Outline of 2026 Health Care Cost Trends Report

Premium Trends

UP NEXT: Low Value Care

Avoidable Utilization

Provider Prices

Low Value Care

- Low value care (LVC) refers to medical services **recognized by clinicians as not based on evidence** and typically **unnecessary for any patient.**
- Researchers estimate 10% to 20% of health care spending in the U.S. is considered low value care.[1]
- Provision of these services to patients often involves additional unnecessary follow-up care ("**cost cascades**"),[2] **financial cost** to both the patient and health care system, **medical risk** (in some cases), **time, and physical or emotional distress** with no clinical benefit.
- The measures included in the HPC's analysis represent a subset of those compiled in the Choosing Wisely® recommendations by the American Board of Internal Medicine. The HPC included measures that both 1) can be adequately captured using insurance claims data and 2) have been identified and studied in the academic literature.
- By reducing overuse, overtreatment, and overdiagnosis, the Commonwealth would not only reduce financial waste in the health care system but **promote a system that provides patients with the right care they need.**

1) Mafi, John N., et al. "Trends in low-value health service use and spending in the US Medicare fee-for-service program, 2014-2018." *JAMA Network Open* 4.2 (2021): e2037328. 2 Ganguli, I., Lupo, C., Mainor, A. J., et al (2019). 2) Prevalence and cost of care cascades after low-value preoperative electrocardiogram for cataract surgery in fee-for-service Medicare beneficiaries. JAMA internal medicine, 179(9), 1211-1219.

In 2024, almost a quarter of Massachusetts residents were provided at least one of 17 low-value services tracked by the HPC.

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

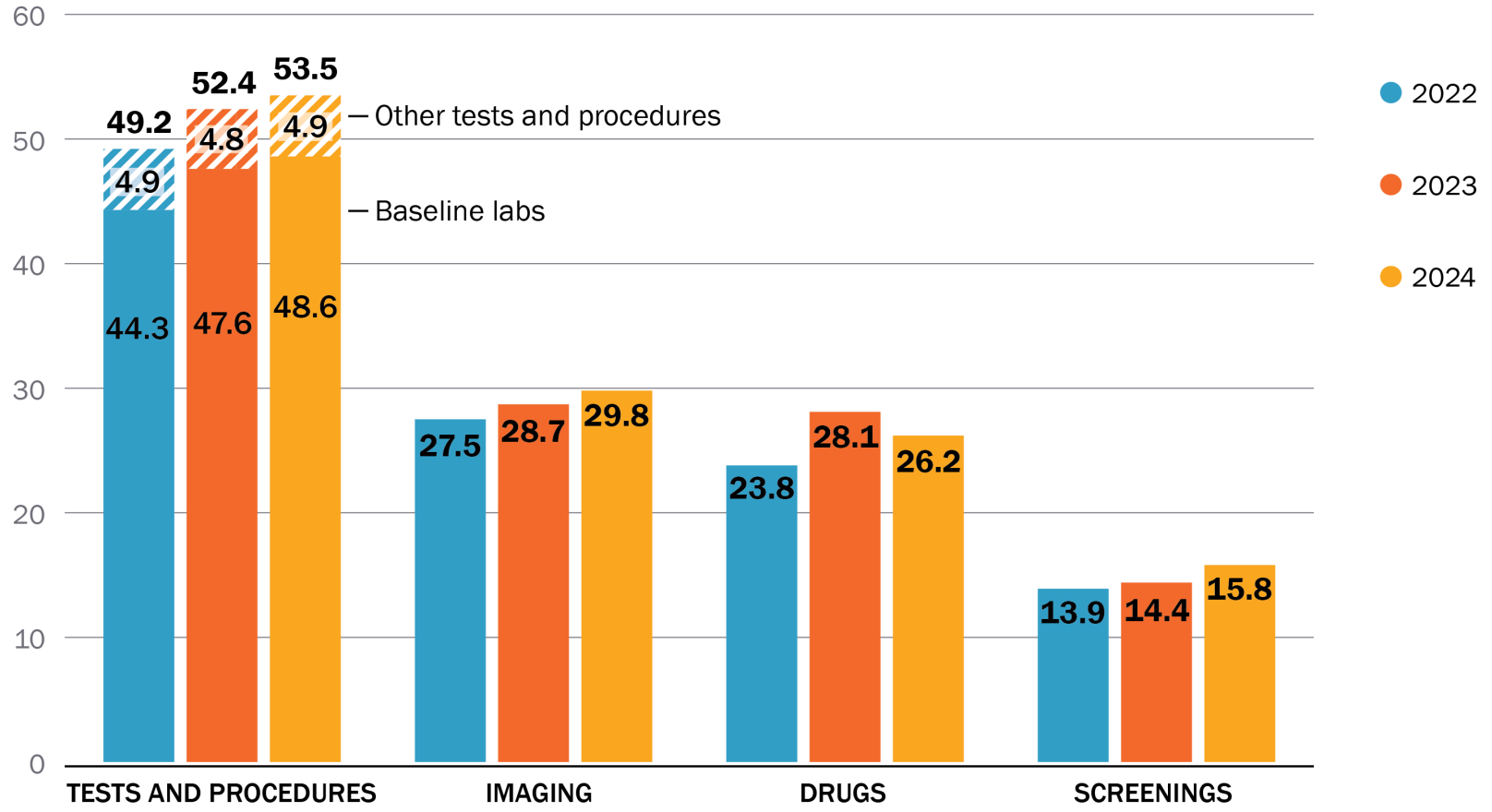
- Antibiotics for acute upper respiratory and ear infections
- Concurrent use of two or more antipsychotic drugs
- Chronic use of benzodiazepines for more than 180 days
- Gabapentinoids for non-neuropathic pain
- Concurrent use of two or more anticholinergic drugs

Percent and number of patients with at least 1 LVC service	**24% (337,300)**
Total number of LVC services provided as tracked by HPC	**752,500**
Total spending for LVC services tracked by HPC	**$61,579,400**
Spending variation across provider organizations	**~1.8:1**

Notes: The seven commercial payers processed by the HPC in the APCD represent approximately 39% of the commercial market (including ConnectorCare and subsidized plans). Results were extrapolated to represent the full commercial market by multiplying findings by a scaling factor of 2.58.

Provision of low-value services grew from 2022 to 2024.

Low value services per 1,000 individuals, 2022 - 2024

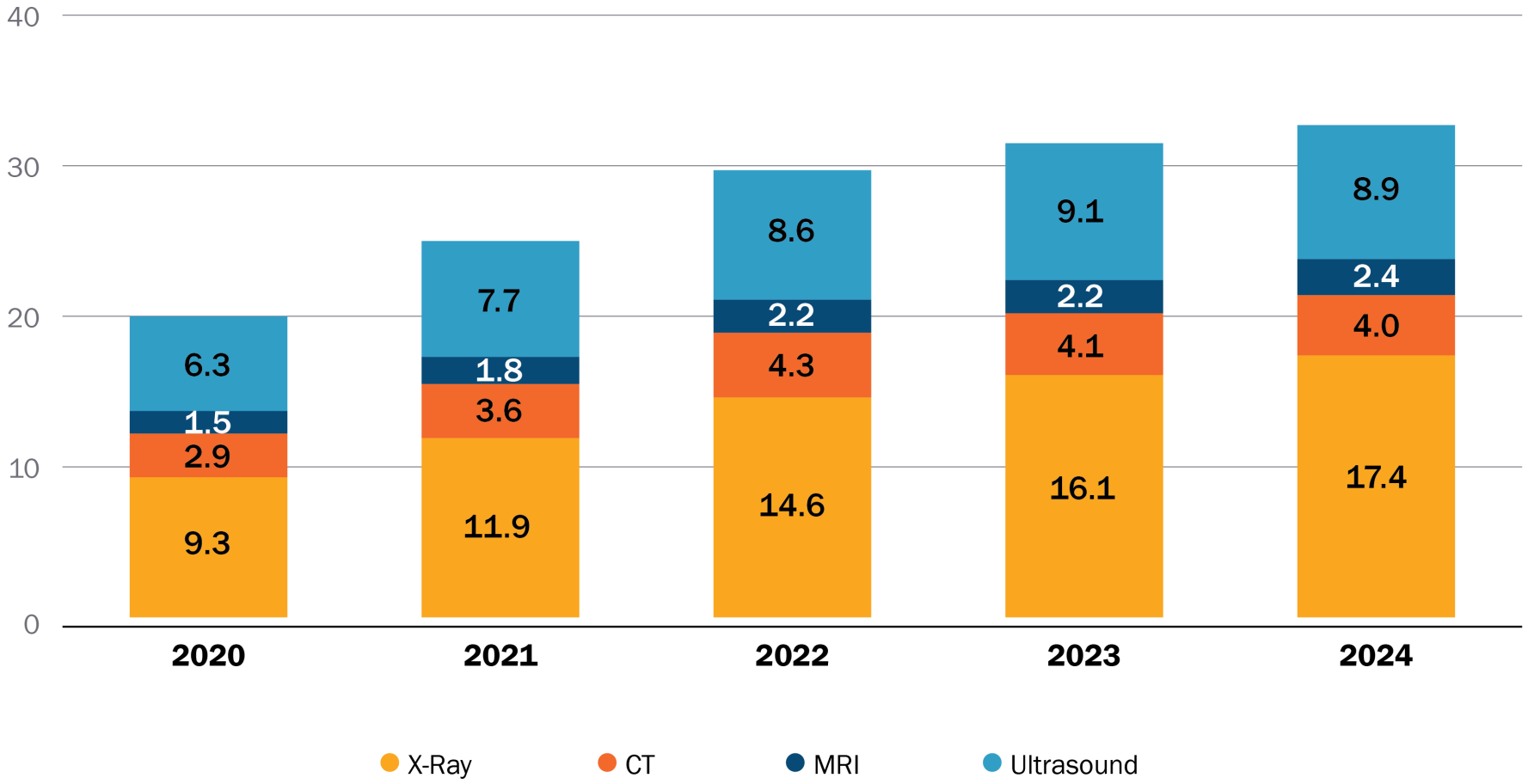


Notes: Tests and procedures includes baseline labs in patients without significant systemic disease undergoing low-risk surgery, pre-operative EKG, chest X-ray, and pulmonary function testing, and spinal injections for lower back pain. Imaging includes low value DEXA bone density scans; brain imaging for simple syncope; imaging for low back pain, heel pain, and headaches; and abdomen imaging. Prescription drugs includes 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, and concurrent use of two or more anticholinergic drugs. Screenings includes T3 (thyroid) screening for patients with hypothyroidism, cardiac stress testing for patients with an established diagnosis of ischemic heart disease or angina, and vitamin D screening for patients without chronic conditions.
Sources: HPC analysis of Center for Health Information and Analysis (CHIA) All-Payer Claims Database V2024, 2022-2024

- Service use increased across all four categories of low value care from 2022 to 2024.

The number of low-value imaging services provided to children has risen each year since 2020.

Low value imaging per 1,000 children, by imaging type, 2020 - 2024

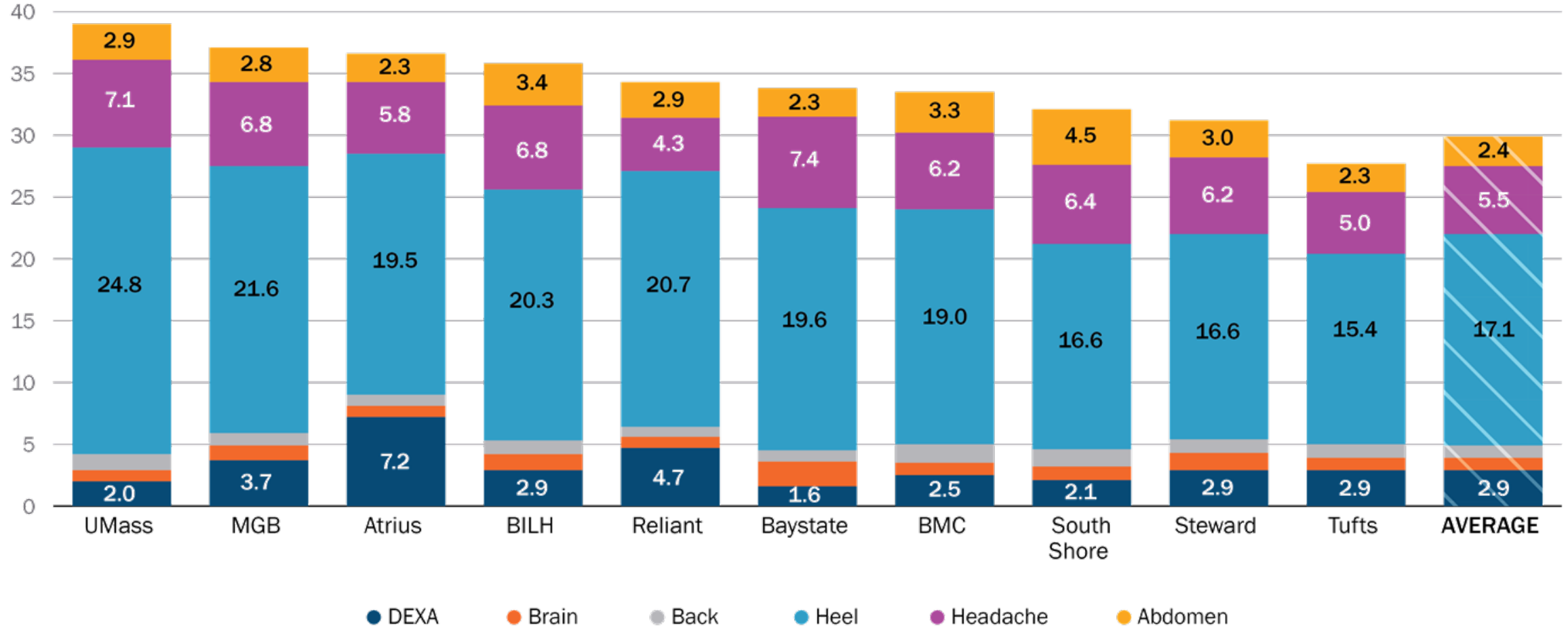


Notes: Data include commercial members less than 18 years of age. See HPC 2026 Annual Cost Trends Report for measure details.
Sources: HPC analysis of Center for Health Information and Analysis (CHIA) All-Payer Claims Database V2024, 2020-2024

- Pediatric low-value imaging services include:
  - Chest x-ray for bronchiolitis
  - Chest x-ray for asthma
  - Head/brain CT scan for minor head injury
  - MRI or CT scan for acute atraumatic primary headache
  - CT, ultrasound, or x-ray imaging for abdominal pain

Provision of low-value imaging varied across provider organizations.

Rates of provision of low-value imaging services per 1,000 attributed members



Notes: DEXA scans = low value DEXA scans (bone density scan). Brain imaging for simple syncope = low value MRI and CT scans for simple syncope. Heel pain = imaging services for heel pain. Back pain = imaging for back pain. Headache = imaging for simple headache. Abdomen = contrast imaging for abdomen. Average reflects rate for all commercial patients, including patients not attributed to a listed provider organization, total services divided by total eligible members. Clinicians attributed to Steward or Revere Medical Group were labeled as "Steward" as Steward Health Care transitioned its facilities in October 2024. See technical appendix in the HPC 2025 Annual Cost Trends Report for details.
Sources: HPC analysis of Center for Health Information and Analysis (CHIA) All-Payer Claims Database V2024, 2023-2024

Select Findings: 2026 Health Care Cost Trends Report

HPC 2025 Policy Recommendations

Outline of 2026 Health Care Cost Trends Report

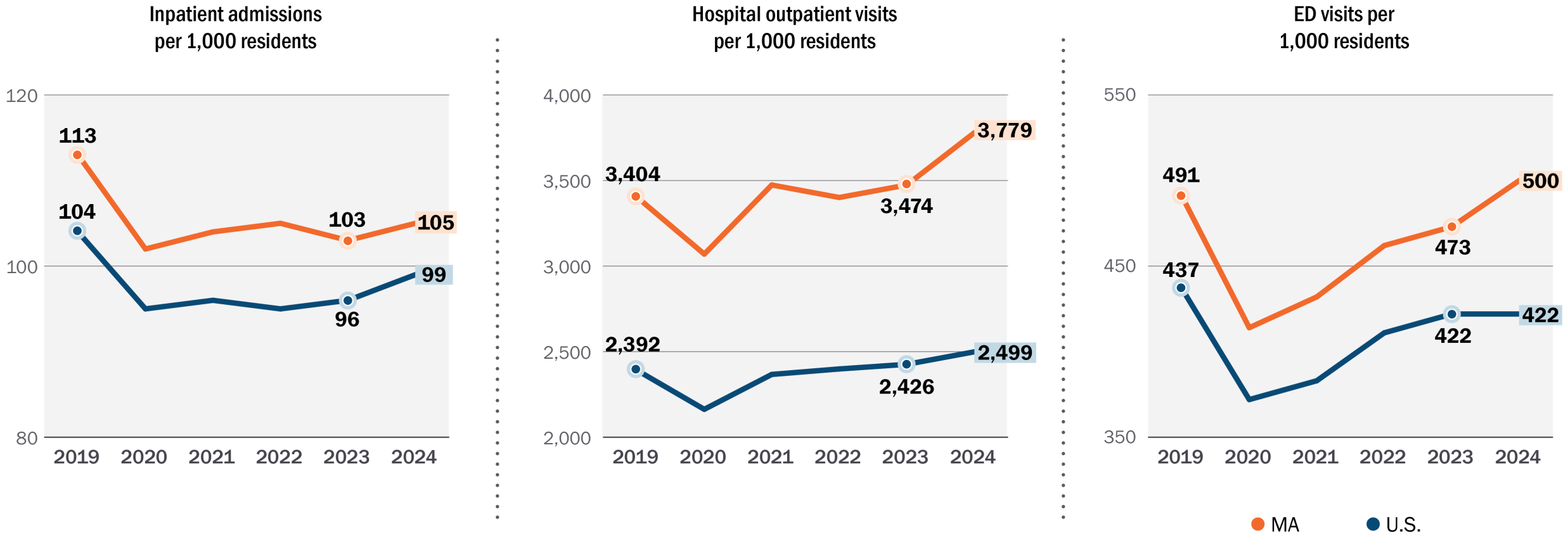
Premium Trends

Low Value Care

UP NEXT: Avoidable Utilization

Provider Prices

As of 2024, Massachusetts residents had 50% more visits to hospital outpatient departments and 18% more emergency department visits than the national average. 40% of ED visits in 2024 were potentially avoidable.

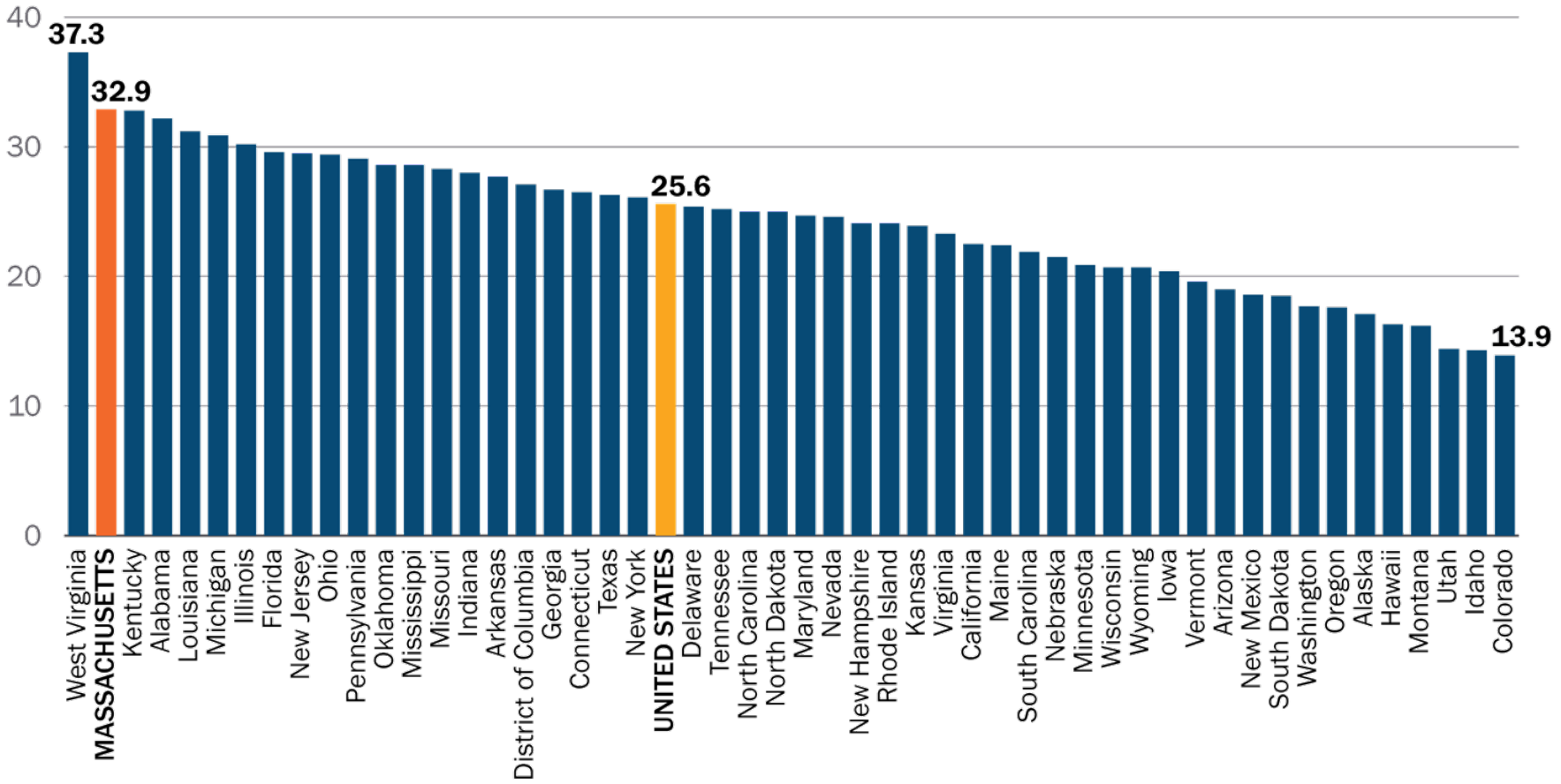


Notes: Data are for community hospitals as defined by Kaiser Family Foundation, which represent 85% of all hospitals. Federal hospitals, long term care hospitals, psychiatric hospitals, institutions for the intellectually disabled, and alcoholism and other chemical dependency hospitals are not included. The United States category includes Massachusetts.

Sources: Kaiser Family Foundation State Health Facts (2024). "Hospital Admissions per 1,000 Population by Ownership Type" (2019 - 2024); "Hospital Emergency Room Visits per 1,000 Population by Ownership Type" (2019-2024); "Hospital Outpatient Visits per 1,000 Population by Ownership Type" (2019-2024). http://www.kff.org/state-category/providers-service-use/hospital-utilization/

Massachusetts Medicare beneficiaries had the second highest rate of preventable hospitalizations after West Virginia in 2024.

Number of preventable hospital stays per 1,000 Medicare (FFS) beneficiaries, 2024

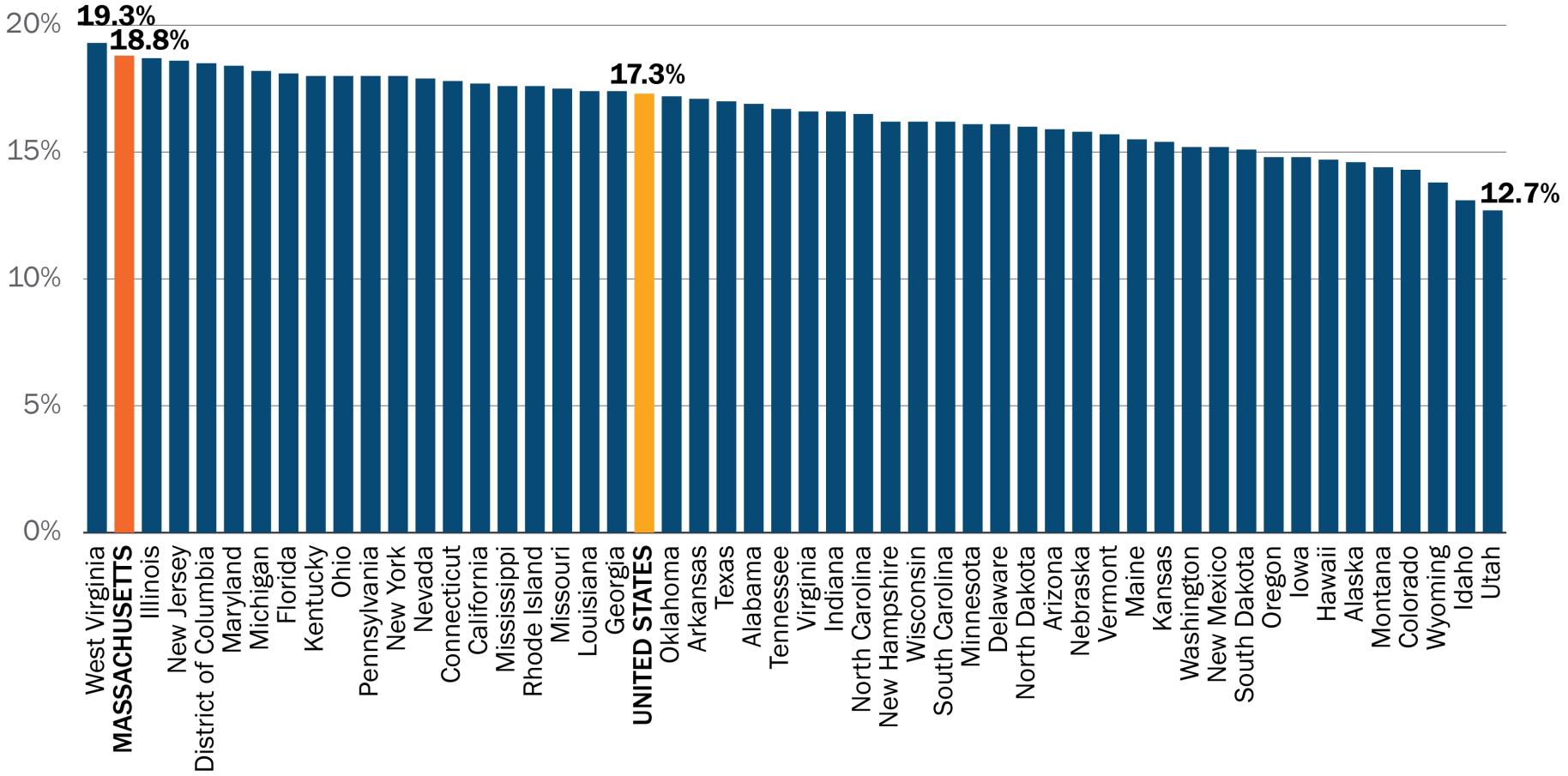


- Preventable hospitalizations are those that could potentially have been treated in ambulatory care settings if they had been seen earlier (e.g., earlier primary care visit for UTI symptoms). They are considered an indicator of both quality of care and health care access.

Notes: Data includes only beneficiaries enrolled in Original Medicare (fee-for-service) aged 65 and older and combines admissions for the following ambulatory care-sensitive conditions: diabetes, COPD, asthma, hypertension, CHF, bacterial pneumonia, UTI and lower extremity amputation.
Sources: HPC analysis of the Center for Medicare and Medicaid Services Geographic Variation Public Use file, 2024

Massachusetts Medicare beneficiaries also had the second highest readmission rate after West Virginia in 2024, up from the 4th highest in 2023.

Hospital readmission rate among Medicare beneficiaries by state, 2024

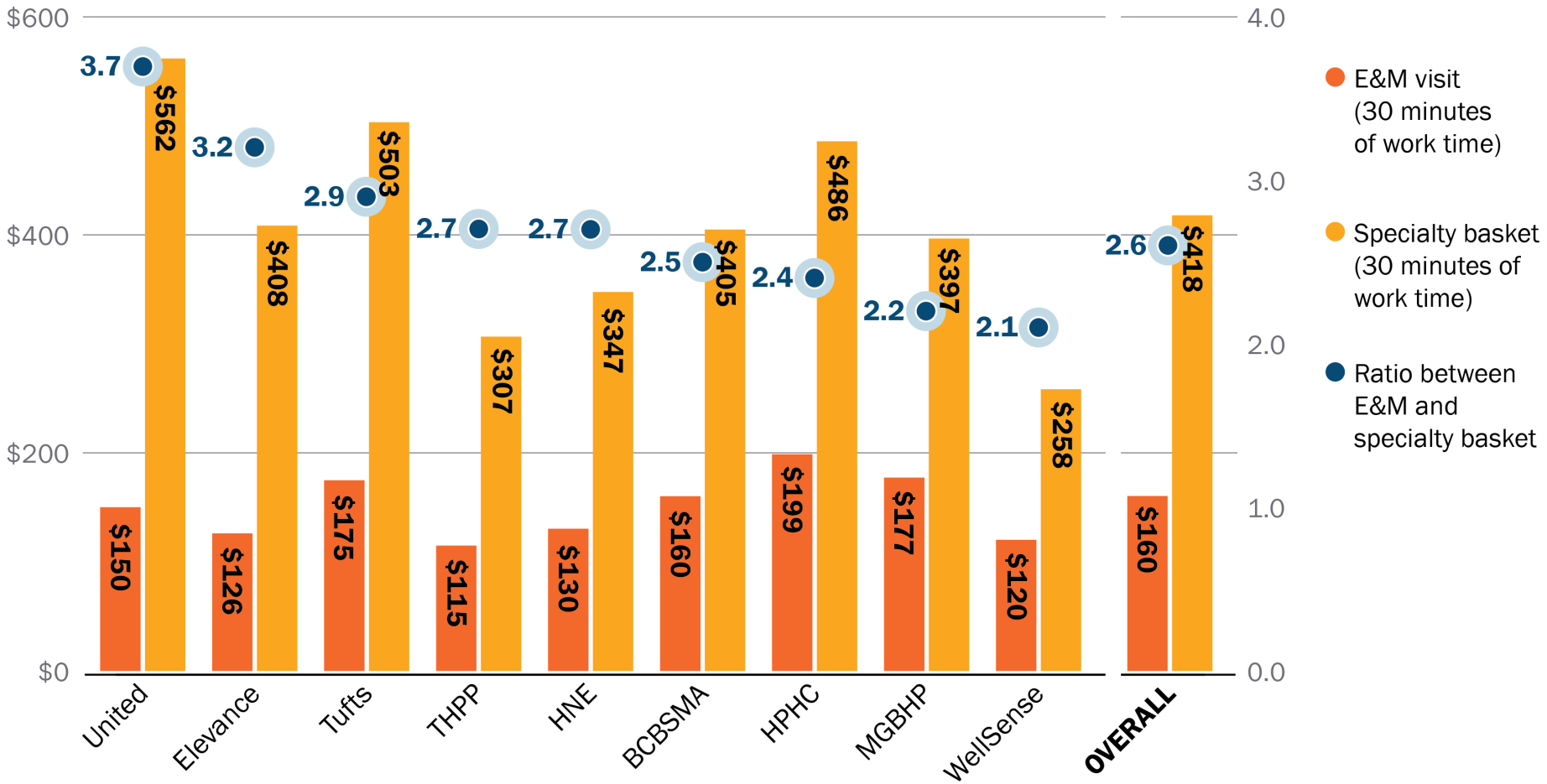


- Massachusetts climbed to the 2nd highest readmission rate (18.8%) in 2024, up from 4th highest in 2023 (18.5%).

Notes: Inpatient discharge data is based on 100% of Original Medicare (fee-for-service) claims for beneficiaries aged 65 and older.
Sources: HPC analysis of the Center for Medicare and Medicaid Services Geographic Variation Public Use file, 2024

Commercial insurers paid more for minor specialist procedures than for primary care visits of equivalent duration, ranging from 2.1 to 3.7 times more.

Price ratio for 30 minutes of work time for select specialty services to prices for primary care visits, 2024



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, 2024

- The average payment for a composite of specialty services was 2.6 times the average payment for an E&M visit representing the same amount of work time (30 minutes).
- Wellsense and THPP have a large portion of their total enrollment in the Massachusetts Connector.

Select Findings: 2026 Health Care Cost Trends Report

HPC 2025 Policy Recommendations

Outline of 2026 Health Care Cost Trends Report

Premium Trends

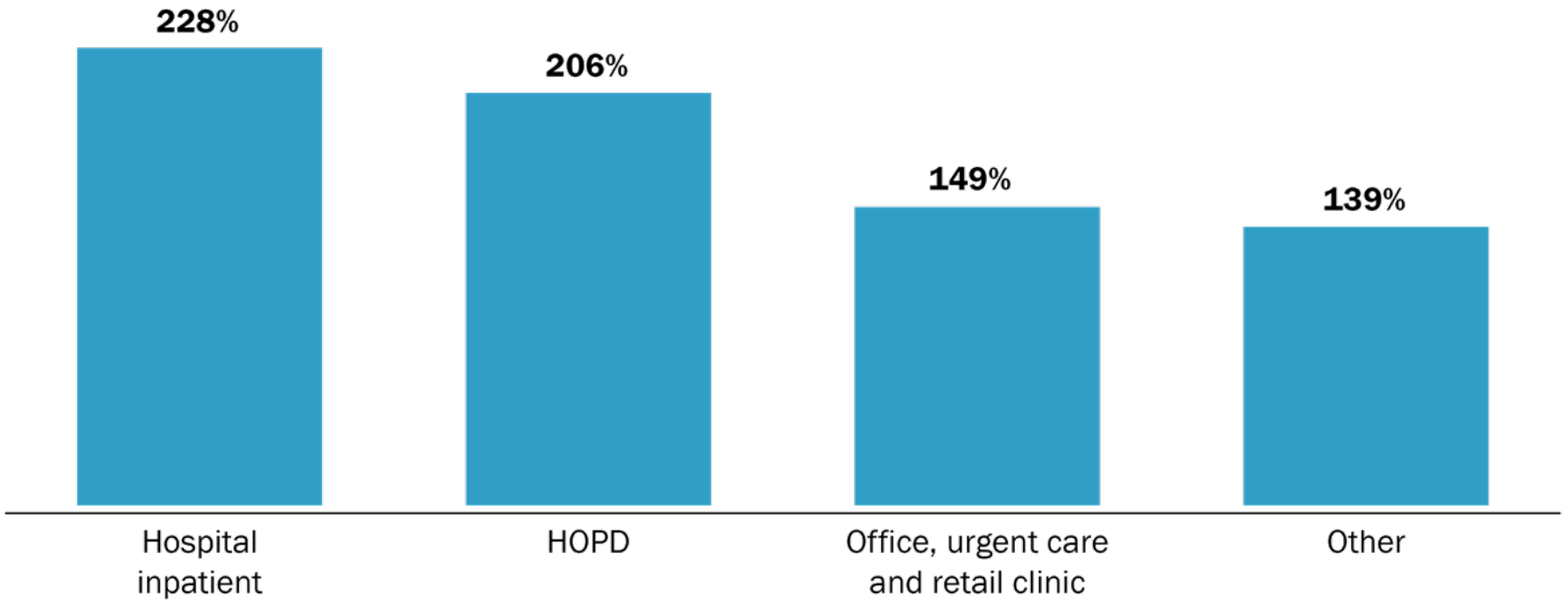
Low Value Care

Avoidable Utilization

UP NEXT: Provider Prices

Compared to Medicare prices as a reference, Massachusetts average commercial prices are higher for all care settings.

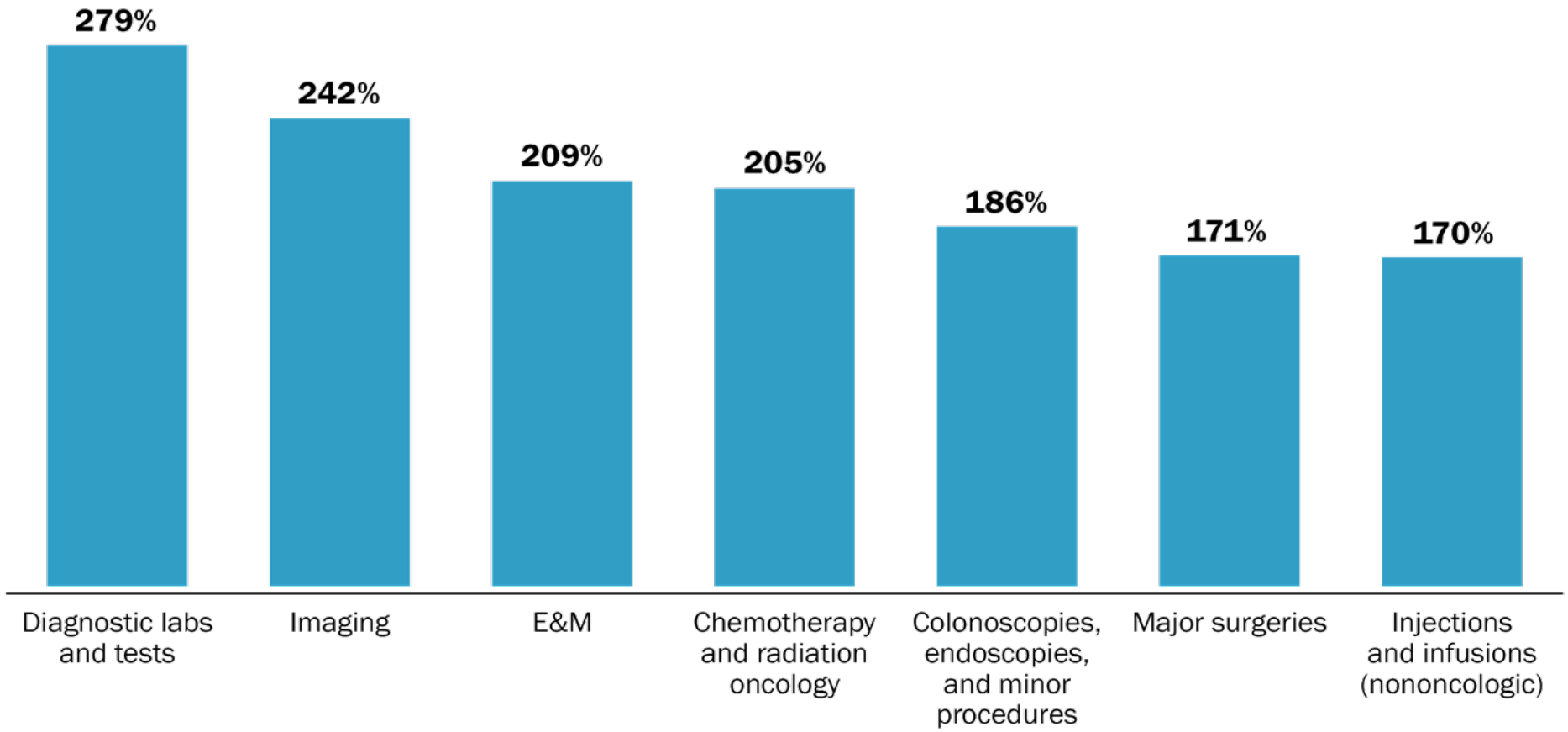
Average commercial prices as a percentage of Medicare by site of care, 2024. 100% = equivalent prices.



Notes: HOPD = hospital outpatient department. Data reflects medical spending for members ages 18-64 and excludes out-of-state providers and behavioral health inpatient spending. Spending amounts in all hospital categories include both professional and facility spending. Medicare allowed amounts are assigned at the claim line level and are evaluated relative to commercial spending at an aggregate level. Medicare allowed amounts for the inpatient category represent the base amount and do not include additional payments for teaching, outliers, or disproportionate share hospitals. "Other" includes emergency department spending, ambulatory surgical center spending, and spending in all other sites of care such as independent labs, telehealth, and home health. 100% is equivalent to Medicare. Excludes Tufts Health Public Plans and WellSense.
Sources: HPC analysis of Center for Health Information and Analysis (CHIA) All-Payer Claims Database v2024, 2024; Milliman MedInsight Global RVUs and Medicare Repricer software v2025.2.

Among hospital outpatient services, average commercial prices are much higher than Medicare for labs, tests, and imaging services, as compared to Medicare.

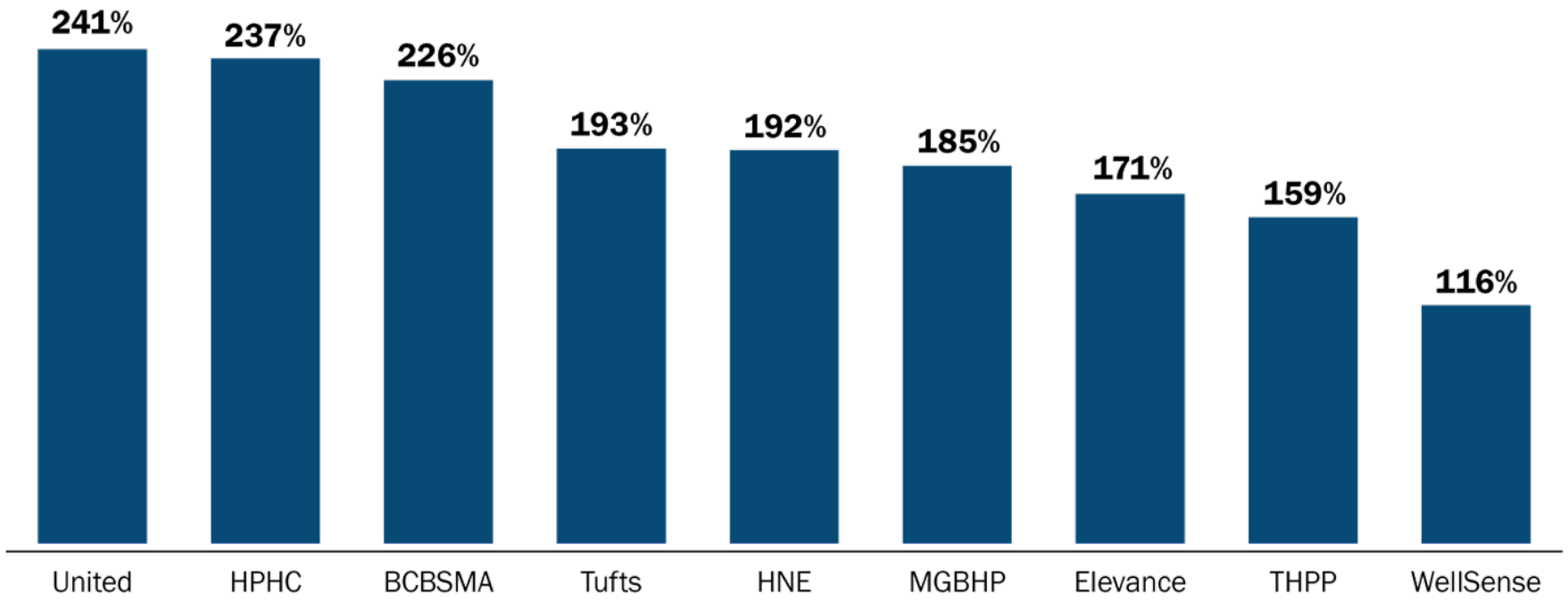
Average commercial prices as a percentage of Medicare by category of hospital outpatient department service, 2024. 100% = equivalent prices.



Notes: Data reflects medical spending for members ages 18-64 and includes spending from Massachusetts acute hospitals only (facility and professional). Medicare allowed amounts are assigned at the claim line level then aggregated to the claim level. Claims are assigned a service category based on the claim line with the highest spending. Medicare spending is evaluated relative to commercial spending at an aggregate level. Service categories adapted from Restructured BETOS Classification System 2023 and Agency for Health Care Research and Quality Surgery Flags Software. Categories with small spending amounts are omitted (e.g., durable medical equipment). Excludes spending on COVID tests and vaccines, emergency department care, and ASC spending. 100% is equivalent to Medicare. Excludes Tufts Health Public Plans and WellSense.
Sources: HPC analysis of Center for Health Information and Analysis (CHIA) All-Payer Claims Database v2024, 2024; Milliman MedInsight Global RVUs and Medicare Repricer software v2025.2.

The average prices commercial insurers pay also vary, ranging from 116% to 241% of Medicare for inpatient care.

Average commercial inpatient facility prices as a percentage of Medicare by payer, 2024. 100% = equivalent prices

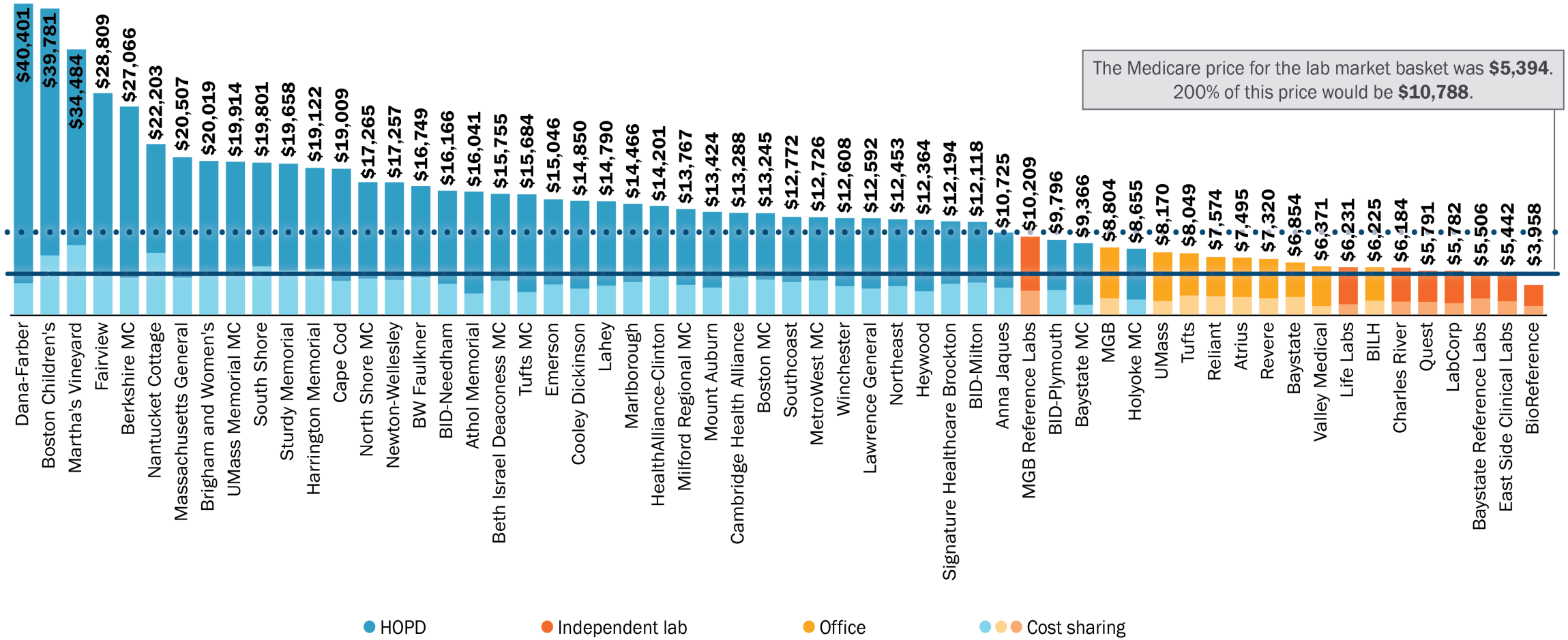


- THPP and WellSense have large numbers of enrollees in the Massachusetts Connector.

Notes: Exhibit includes only adult non-maternity and non-psychiatric inpatient stays in 2024. Stays that are outliers in payment and length of stay within their APR-DRG as well as transfers are excluded. Percent of Medicare was calculated using the sum of paid facility amounts over the sum of allowed Medicare base payment (e.g. only including the wage index and not additional payments for teaching or disproportionate share hospital funding). 100% is equivalent to Medicare.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, V2024, 2024; Medicare IPPS Final rule and correcting amendment documentation for FY 2024 and FY 2025

Prices for a basket of common lab tests varied by a factor of 7 across providers and were as high as 750% of Medicare.

Price of a fixed set of 50 common lab tests by provider organization along with Medicare price paid for the same basket, 2024



Notes: HOPD = Hospital outpatient department. The lab market basket reflects the quantity and type of lab tests ordered per 100 members in 2024. For each provider, the same 50 highest-aggregate-spending procedure codes are evaluated using a fixed statewide volume (computed using 2024 data) and provider-specific mean service prices in 2024 for each procedure code. Providers with fewer than 20 service encounters for any individual procedure code have imputed values for that procedure code and are not included if more than 24 procedure codes would have to be imputed. See technical appendix for details. About a quarter of the labs in the basket fall under the ACA preventative care coverage requirement and should not be subject to patient cost sharing if the lab service falls under the appropriate guidelines. Excludes Tufts Health Public Plans and WellSense.

Sources: HPC analysis of Center for Health Information and Analysis (CHIA) All-Payer Claims Database v2024, 2024

2026 Health Care Cost Trends Report Outline

Massachusetts Spending Performance and Affordability of Care

Findings presented at the HPC Benchmark Hearing on April 1, 2026

Trends in Spending by Health Condition

Chartpacks *Select findings presented at the HPC Board meeting on July 23, 2026*

- Primary Care and Behavioral Health
- Price Trends and Variation
- Hospital Utilization and Post-Acute Care
- Provider Organization Performance Variation and Low Value Care

Policy Recommendations

Agenda

Call to Order

Approval of Minutes **(VOTE)**

Promoting Appropriate Transitions to Home (PATHways) Investment Program Awards **(VOTE)**

Recent Market Transactions

Select Findings: 2026 Health Care Cost Trends Report

UP NEXT: Office of Health Resource Planning

Administration and Finance

Executive Director's Report

Adjourn

Context for Passage of Chapter 343 of the Acts of 2024

- Massachusetts has experienced **several recent, significant changes in its health care resources**:
  - The bankruptcy of Steward Health Care and the closures of Carney Hospital and Nashoba Valley Medical Center
  - Unexpected closures of North Adams Regional Hospital, Quincy Medical Center, Norwood Hospital, Signature Brockton Hospital, and Compass Medical
  - Expansion of inpatient services at several hospitals, the proliferation of outpatient surgery sites, and the impending construction of a new oncology hospital
  - A severely strained primary care landscape and a series of inpatient pediatric, behavioral health, and maternity closures
- **The Commonwealth has tools to track and, in some cases, address changes,** e.g., through facility licensure, Determination of Need (DoN), Material Change Notices (MCNs), and essential service closure authorities. However, these authorities are narrow and often focused on a specific change.
- Massachusetts leaders need more information on how the overall supply and distribution of services is changing and whether MA residents have **equitable access to affordable, high-quality health care**.

New Office of Health Resource Planning

Chapter 343 of the Acts of 2024 establishes a new **Office of Health Resource Planning (OHRP)** within the HPC.

OHRP's key responsibilities and authorities include:

- Developing a **State Health Resource Plan.**
- Conducting **focused assessments of supply, distribution, and capacity** in relation to projected need of a specific health care service and making recommendations to address the drivers of disparities and misalignment of need.
- Conducting at least one **annual public hearing** seeking input on the development of the plan and any focused assessment under development.
- Providing direction to DPH to establish and maintain an inventory of all health care resources.

OHRP also manages the **Massachusetts Registration of Provider Organizations (MA-RPO) Program**, a data collection and transparency effort that collects data on the largest provider organizations in the Commonwealth.

Office of Health Resource Planning: Vision and Approach

VISION

OHRP is a **trusted source of data, analysis, and recommendations** to ensure that the supply and distribution of health care resources in the Commonwealth are aligned with current and projected needs

APPROACH

- OHRP will produce **short-term, medium-term, and long-term** work products:
  - Ad hoc assessments at the request of the HPC Board or sister agencies
  - Focused assessments of a single service line, geography, or policy question
  - State Health Resource Plan, providing a broad overview of supply, access, and utilization across service lines
- OHRP incorporates **qualitative and quantitative data** into its work and prioritizes:
  - Leveraging existing data and methodology to achieve analytic depth quickly
  - Direct engagement with market participants, patient representatives, policymakers, and the community
- OHRP interfaces with policymakers and market participants to **effectuate its findings**

Office of Health Resource Planning: Focus Areas to Date

Strategic Planning

- Defined goals and workplans
- Hiring and contracting
- Spoke with other states engaged in health planning activities (e.g., CT, RI)
- **Next focus area:** Engagement with HPC Board, Advisory Council, and key stakeholder organizations to introduce OHRP and discuss priorities

Health Planning

- Provided analytics for Massachusetts' Maternal Health Access Task Force (MHTF)
- Initial scoping of first State Health Resource Plan (SHRP)
- SHRP analytics underway
- **Next focus area:** Finalize and execute on scope of first SHRP

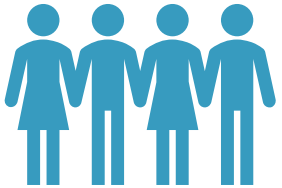
Data Planning

- Assessing and acquiring key data sources for the SHRP
- Preparation for 2025 and 2026 MA-RPO data collection
- **Next focus area:** Identifying, tracking, prioritizing, and strategizing approaches to filling key data gaps identified during SHRP development

State Health Resource Plan (SHRP) Overview

The goal of the **State Health Resource Plan (SHRP)** is to promote the **appropriate and equitable distribution of health care resources** across geographic regions of the Commonwealth.

The plan must identify:



The anticipated needs for health care services, providers, programs, and facilities

The existing health care resources, providers, programs, and facilities available to meet those needs

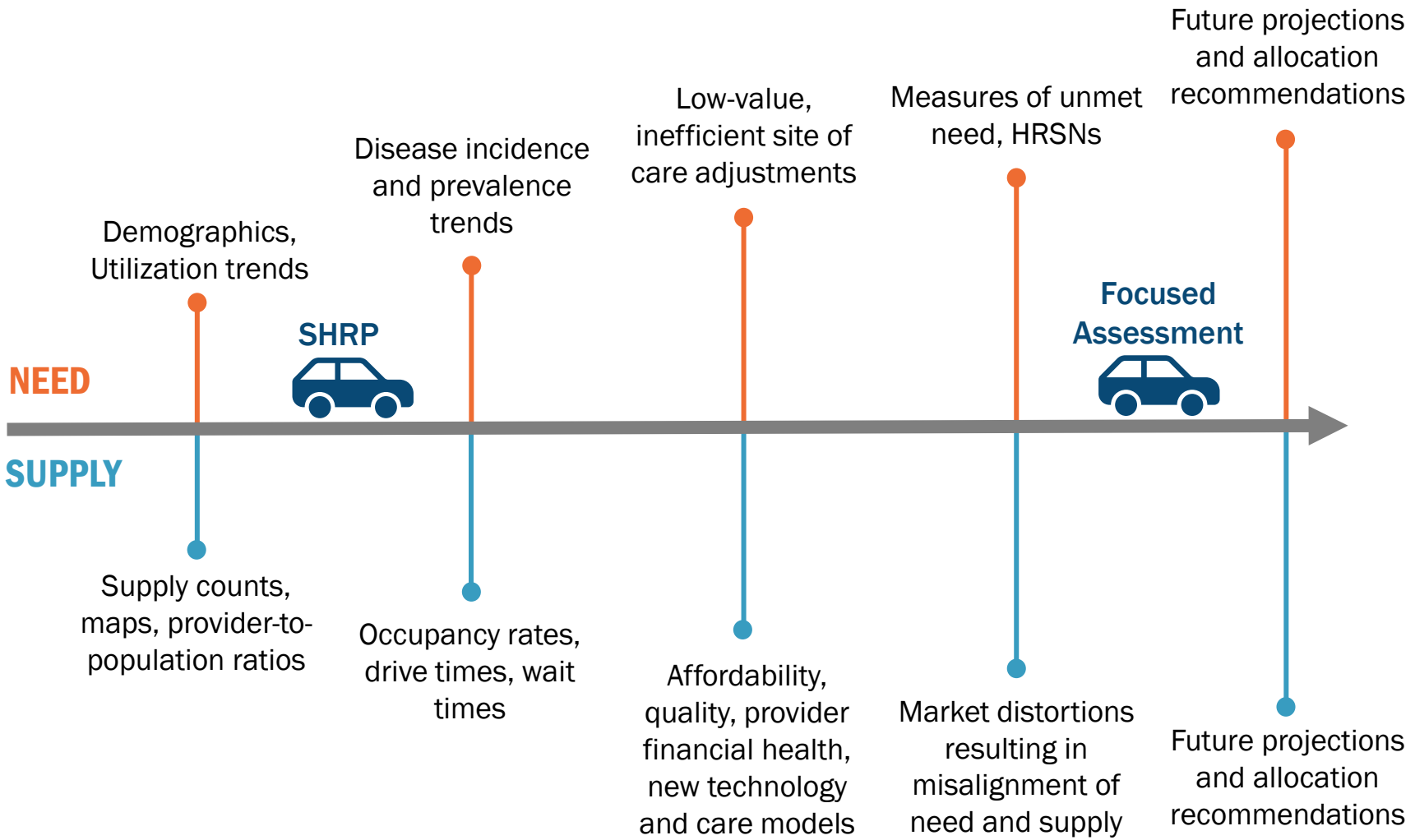
The projected resources necessary to meet those anticipated needs

Recommendations for the appropriate supply and distribution of resources, on a statewide and regional basis

Recommendations for any further legislative or regulatory state action

Scope of the SHRP vs. a Focused Assessment

- Chapter 343 of the Acts of 2024 outlines more than 24 unique services and an ambitious set of analytics for inclusion in the State Health Resource Plan.
- OHRP must define a feasible scope of work for the SHRP based on the timeline laid out in the law.
- Focused assessments are an opportunity to provide a more comprehensive, analytically rigorous assessment of resource sufficiency.



First SHRP: Scope

Key Questions

Supply

- How much supply does MA have statewide and regionally?
- How do supply levels compare to national?
- How have supply levels changed over time?
- How much of existing supply is currently being utilized?

Access

- Are patients reasonably geographically proximate to care?
- Are patients able to access timely care (where data allow)?

Utilization

- How do utilization rates look statewide, regionally, and compared to national?
- Are there notable differences in utilization by demographic group, insurance category, or other segmentation?
- How has utilization trended over time?

Interpretation

- Do the collective answers to these questions provide initial indications of over-supply or under-supply of the service, whether statewide or regionally?

First SHRP: Scope

- Acute care hospitals
- Behavioral health, including mental health and SUD services
- Emergency care
- Imaging
- Maternal health services*
- Outpatient surgery (ASCs, office-based surgery, and HOPDs)
- Pediatric care services
- Physician specialty care
- Primary care*
- Post acute and long-term care, including SNFs, rehabilitation hospitals, LTACHs, and home health
- Urgent care centers

* These chapters are anticipated to include more advanced analytics, building on recent HPC work on these topics.

SHRP Key Inputs

Literature Scan

- **Overview of the Service Line:** Service and facility types, where it falls in the continuum of care, potentially substitutable services, populations served, payment and coverage
- **Supply, Access, and Utilization:** National analysis of changing supply, access, and utilization levels
- **Key Policy Issues:** May include payment, pricing, ownership structures, staffing, quality, financial sustainability, regulatory oversight, etc.

Data and Analysis

- Limited set of measures designed to inventory **supply**, describe **access** and **utilization** trends, and identify excess or limited **capacity**
- **Key measures** include:
  - Raw and per capita supply counts
  - Drive time maps
  - Occupancy rates (inpatient)
  - Appointment wait times (primary care)
  - Utilization rates
- Focus on **time trends**, **geographic variation**, **demographic variation**.

Market Interviews

- Identify and interview 6-9 **national and local experts and market participants** per service line for qualitative insights:
  - Researchers
  - Trade and/or professional associations
  - Providers
  - Payers
  - Consumer advocates
  - State agency staff
- Use information as **background** for interpreting quantitative analyses and potential **themes for further study** in a Focused Assessment

Agenda

Call to Order

Approval of Minutes **(VOTE)**

Promoting Appropriate Transitions to Home (PATHways) Investment Program Awards **(VOTE)**

Recent Market Transactions

Select Findings: 2026 Health Care Cost Trends Report

Office of Health Resource Planning

UP NEXT: Administration and Finance

- FY 2027 Operating Budget **(VOTE)**

Executive Director's Report

Adjourn

Agenda

Call to Order

Approval of Minutes **(VOTE)**

Promoting Appropriate Transitions to Home (PATHways) Investment Program Awards **(VOTE)**

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Select Findings: 2026 Health Care Cost Trends Report

Office of Health Resource Planning

Administration and Finance

- **UP NEXT: FY 2027 Operating Budget (VOTE)**

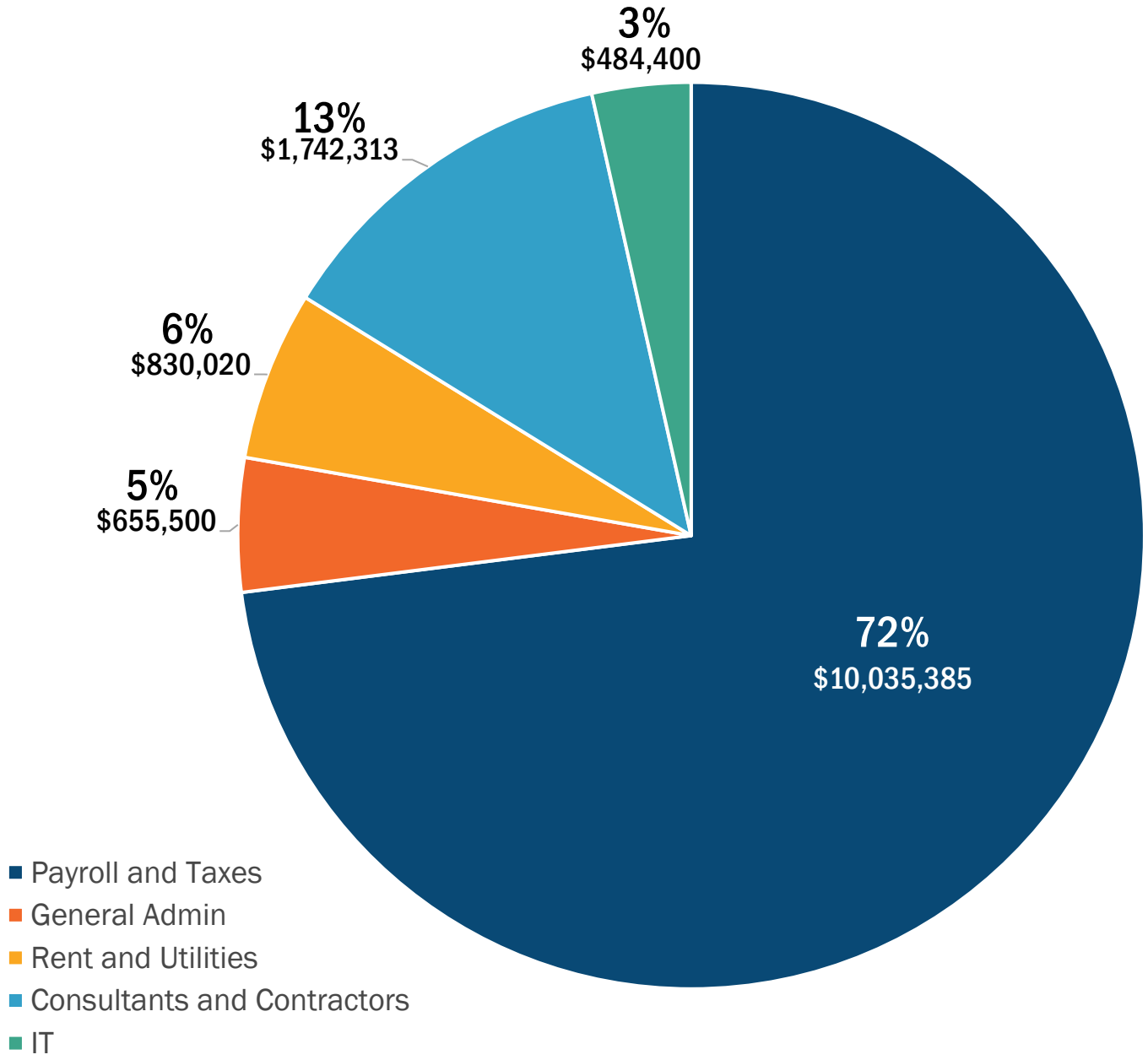
Executive Director's Report

Adjourn

Fiscal Year 2027 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. The assessment calculation was revised in recent health care legislation.
- For FY26, the HPC's initial appropriation 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 approved an additional $750,000 in a FY25 supplemental budget that was authorized to be spent into FY26. Therefore, the HPC's total funding for FY26 was **$13,234,844.**
- The FY27 budget includes the necessary funding for agency operations. It includes an appropriation of **$13,935,376** for the HPC and was signed by Governor Healey on July 9, 2026.

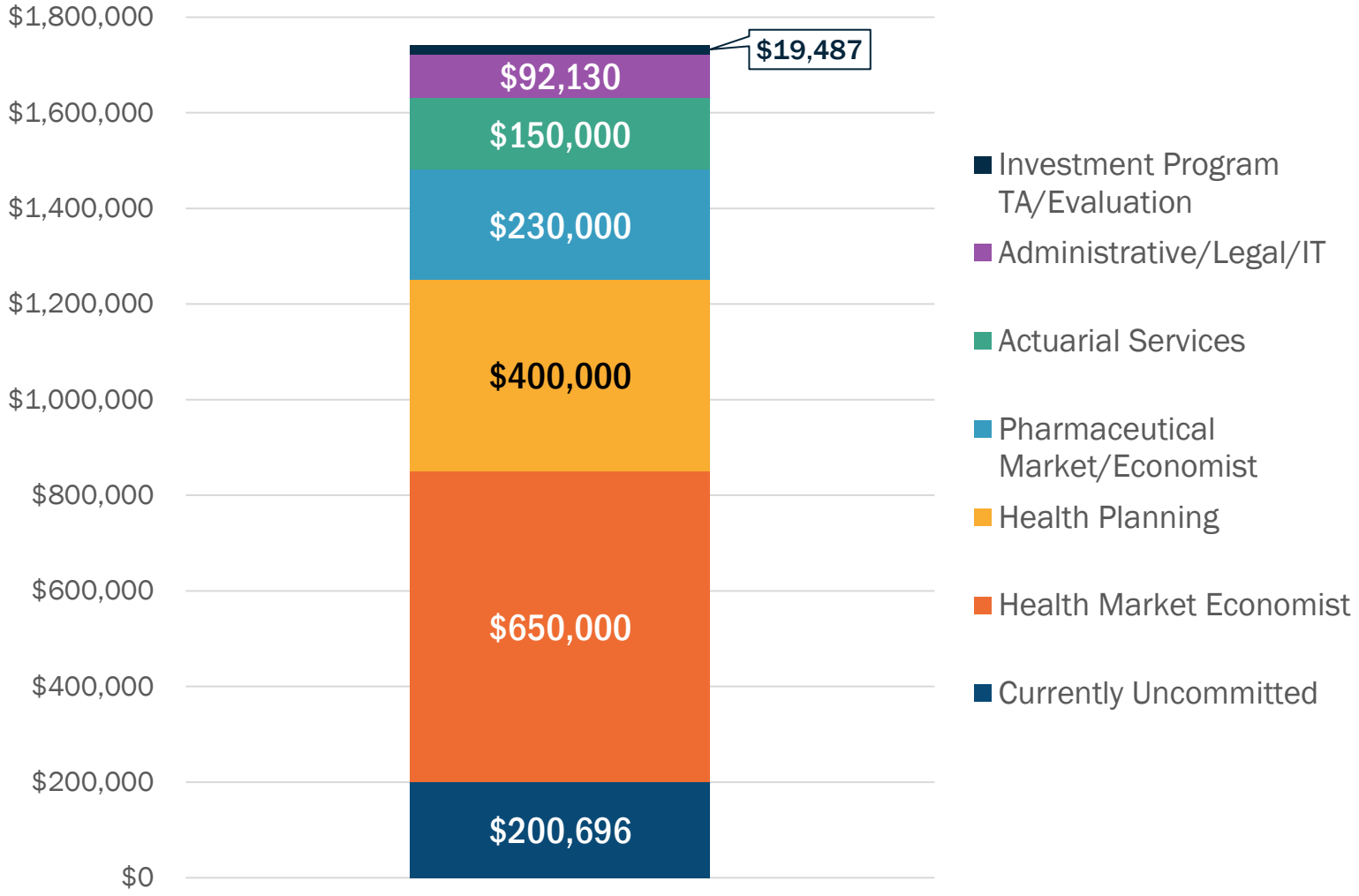
FY 2027 Budget by Category



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

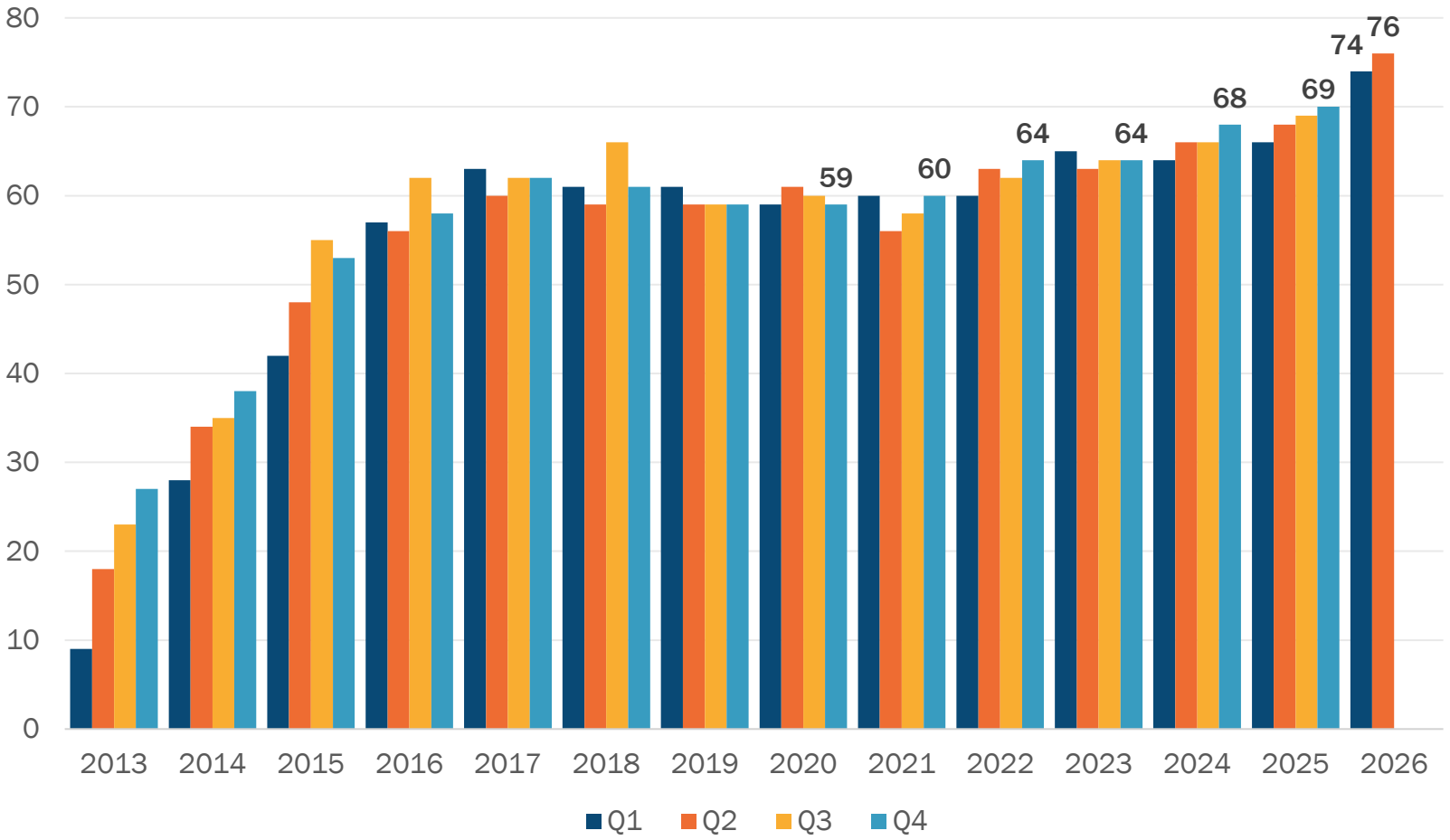
FY 2027 Consultant and Contractor Spending

A Closer Examination of the HPC's Estimated Spending on Consultants and Contractors in FY 2027



Legislation passed in early 2025 expanded the HPC's oversight authority and established new offices within the agency.

HPC Employee Count: 2013-2026*



Employees by Department July 1, 2026

Executive/Office of the Chief of Staff (Operations and External Affairs)	17
Office of the General Counsel/Office of Patient Protection	7
Health Care Transformation and Innovation	12
Market Oversight and Transparency	13
Research and Cost Trends	10
Behavioral Health Workforce Center	6
Office of Health Resource Planning	5
Office of Pharmaceutical Policy and Analysis	6
Total Employees	**76**

*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).

FY 2027 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 FY27.

Support for Ongoing and Expanded Market Oversight.

The new health care law expanded the type of transactions that must be noticed to the HPC, which has significantly increased the number and complexity of transactions for review, including transactions involving private equity. This funding also reflects the staff and professional services necessary to complete the HPC's first retrospective cost and market impact review (CMIR) of a major merger.

Support for Newly Established Offices and Responsibilities.

This budget funds the two new offices established within the HPC: the Office of Pharmaceutical Policy and Analysis (OPPA) and the Office of Health Resource Planning, including support for the newly hired staff, the acquisition of external data sources, and the contracts for expert professional services. With these resources, OHRP is prioritizing the development and release of the first Statewide Health Resource Plan in 2027, while OPPA is prioritizing the development and release of the first Annual Pharmaceutical Cost Trends Report.

FY 2027 Budget: Key Assumptions

Support for the Health Care Affordability Working Group.

The budget anticipates the continued need for HPC staff and professional services to support the ongoing work of the Health Care Affordability Working Group convened by the Healey-Driscoll Administration.

Stipends for HPC Board Members.

This year's budget appropriation includes funding for stipends for the nine appointed HPC Board members, as authorized by the new health care law. Appointed members receive a stipend of not more than 10% of the Secretary of Administration and Finance's salary, and the HPC Board Chair receives 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), and potential legislative action impacting the agency (e.g. primary care reform) 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.

VOTE

FY 2027 Operating Budget

MOTION

That the Commission hereby approves the Commission's total operating budget for fiscal year 2027, as presented and attached hereto, and authorizes the Executive Director to expend these budgeted funds.

Agenda

Call to Order

Approval of Minutes **(VOTE)**

Promoting Appropriate Transitions to Home (PATHways) Investment Program Awards **(VOTE)**

Recent Market Transactions

Select Findings: 2026 Health Care Cost Trends Report

Office of Health Resource Planning

Administration and Finance

UP NEXT: Executive Director's Report

Adjourn

Primary Care Access, Delivery, and Payment Task Force

- In January 2025, Governor Maura Healey signed **Chapter 343 of the Acts of 2024**, *An Act enhancing the market review process*.
- Section 80 established a **25-member task force** charged with studying and making recommendations to improve primary care **access**, **delivery**, and **payment** in the Commonwealth.
- Specifically, the task force was responsible for **developing and issuing recommendations** to:
  - **Stabilize and strengthen the primary care system** and the increase of recruitment and retention in the primary care workforce
  - **Increase the financial investment in and patient access** to primary care across the Commonwealth
- Members last convened on **June 17, 2026,** for the final formal meeting of the task force.
- All seven final statutory deliverables are available on the HPC's website.

Primary Care Task Force Statutory Deliverables

		DELIVERABLE	STATUTORY DEADLINE
✓	1	Define primary care services, codes, and providers	September 15, 2025
✓	2	Develop a standardized set of data and reporting requirements for private and public payers, providers and provider organizations	September 15, 2025
✓	3	Establish a primary care spending target for private and public health care payers that reflects the cost to deliver evidence-based, equitable and culturally competent primary care	December 15, 2025
✓	4	Propose payment models to increase public and private reimbursement for primary care services	March 15, 2026
✓	5	Assess the impact of health plan design on health equity and patient access to primary care services	March 15, 2026
✓	6	Monitor and track the needs of and service delivery to residents of the Commonwealth	May 15, 2026
✓	7	Create short-term and long-term workforce development plans to increase the supply and distribution of and improving working conditions of primary care clinicians and other primary care workers	May 15, 2026

masshpc.gov/pctf-deliverables

Maternal Health Access and Birthing Patient Safety Task Force

- The Maternal Health Access and Birthing Patient Safety Task Force was established by **Chapter 186 of the Acts of 2024.**
- The task force was charged with studying:
  - The current availability of and access to maternal health services and maternal health care across regions of the Commonwealth and among birthing patient populations,
  - Demographic information on Massachusetts birthing people,
  - The adequacy of the maternal health care workforce,
  - The essential service closure process and past essential service closures of maternity services, and
  - Patient quality and safety considerations.
- The task force's report must include recommendations to improve equitable access to maternity care in Massachusetts.

Maternal Health Task Force Final Report

Report Outline

- Overview of Massachusetts Births and Birthing People
- Massachusetts Maternity Care Supply and Capacity
- Hospital Maternity Unit Closures: 2014 through 2023
- Massachusetts Birth Centers: Challenges and Opportunities

Policy Recommendation Focus Areas

- Maternal Health Access and Outcomes
- Maternity Care Sustainability
- Hospital Maternity Units
- Maternity Unit Closures
- Maternal Health Workforce
- Freestanding Birth Centers
- Patient Awareness and Choice

Massachusetts 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

2026 ANNUAL HEALTH CARE COST TRENDS HEARING

SAVE THE DATE

Tuesday
November 10, 2026

Suffolk University
Law School

MASSACHUSETTS
HEALTH POLICY COMMISSION

Schedule of Upcoming 2026 Meetings

HPC BOARD

September 17 – VIRTUAL

December 10 – IN PERSON

ADVISORY COUNCIL

September 24

December 3

SPECIAL EVENTS

November 10

2026 Health Care Cost Trends Hearing

masshpc.gov/meetings

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Agenda

Call to Order

Approval of Minutes **(VOTE)**

Promoting Appropriate Transitions to Home (PATHways) Investment Program Awards **(VOTE)**

Recent Market Transactions

Select Findings: 2026 Health Care Cost Trends Report

Office of Health Resource Planning

Administration and Finance

Executive Director’s Report

UP NEXT: Adjourn