State Health Planning to Improve Access to Care in Massachusetts:

Needs and Current Tools

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MASSACHUSETTS FOUNDATION

Robert W. Seifert
Consultant

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ABOUT THE AUTHOR

Robert Seifert is a public policy professional with experience in public sector, not-for-profit, and university settings. His primary focus is health care policies and programs that seek to improve access to care and correct inequities in health care delivery and outcomes. An independent consultant since 2022, he has worked on projects related to health care spending, Medicaid, telemedicine, medical debt, and private equity ownership of health care providers.

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GLOSSARY OF ACRONYMS

AGO	Office of the Attorney General
BHWC	Behavioral Health Workforce Center
CCMC	Committee on the Costs of Medical Care
CHA	Community Health Assessment
CHHA	Community Health and Healthy Aging
CHI	Community-Based Health Initiative
CHIA	Center for Health Information and Analysis
CHIP	Community Health Improvement Plan
CHNA	Community Health Needs Assessment
CLAS	Culturally and Linguistically Appropriate Services
CMIR	Cost and Market Impact Review
CON	Certificate of Need
DoN	Determination of Need
DPH	Department of Public Health
EOHHS	Executive Office of Health and Human Services
FQHC	Federally Qualified Health Center
HCWC	Massachusetts Health Care Workforce Center
HMO	Health Maintenance Organization
HPC	Health Policy Commission
HRiA	Health Resources in Action
HRSN	Health-Related Social Needs
HSA	Health Systems Agencies
HSP	Health Systems Plan
MHIS	Massachusetts Health Insurance Survey
NHPRDA	National Health Planning and Resources Development Act
OHRP	Office of Health Resource Planning
PBM	Pharmacy Benefit Manager
PIP	Performance Improvement Plan
SHA	State Health Assessment
THCE	Total Health Care Expenditures

I. INTRODUCTION

The Massachusetts health care system is stressed. Insurance coverage remains high in the Commonwealth, and Massachusetts is a national leader in broad measures of prevention strategies, premature deaths, reproductive health, and many others.[1] However, state-level data reveals numerous access and equity challenges. Many people are unable to get an appointment with a doctor's office or clinic when they need it – about one-quarter of respondents to the 2023 Massachusetts Health Insurance Survey (MHIS) reported that they could not get an appointment when they needed one.[2] About one person in 10 reported having an unmet need for behavioral health care (comprising treatment for mental health and substance use disorder conditions) in the same survey.[3] Nine percent of Massachusetts residents, and 13 percent of adults, did not have a primary care physician in 2023, the latest data point in what has been a steady decline in primary care access over the last several years.[4] Wait times for a new physician appointment for a physical were the second longest (40 days) in Boston out of 15 metropolitan areas in a 2022 study.[5] There is a shortage of nurses as well. The registered nurse vacancy rate in acute care hospitals was 13.6 percent in 2022, more than double the rate in 2019, mainly owing to high turnover rates.[6]

Emergency departments are also overwhelmed across Massachusetts. From October 2023 to June 2024, more than one out of five emergency department visits lasted longer than six hours. For behavioral health the situation is more dire: 45 percent of behavioral-health-related emergency department visits were longer than 12 hours between October 2023 and June 2024, and 20 percent of patients with behavioral health needs were boarded in the emergency department for more than 24 hours.[7] Likely contributing to these bottlenecks are insufficient numbers of primary care providers and post-acute beds, staff shortages, and the financial incentive for hospitals to fill beds with privately insured, elective cases.[8]

Gaps in access to care are worse for certain racial and ethnic groups. For example, Black individuals were twice as likely as White respondents to report not having a primary care provider in the 2023 MHIS (13.5% versus 6.7%). Hispanic respondents were almost three times more likely (18.7%) not to have a primary care provider. Hispanic people also reported a higher level of unmet need for behavioral health care than others. Additionally, respondents who were Black or Hispanic were 50 percent more likely than White respondents to have visited an emergency department in the past 12 months.[9]

While access is constrained, health care costs continue to rise. From 2022 to 2023, health care spending per capita in Massachusetts grew 8.6 percent, the second highest one-year growth trend since measurement began in 2013, and exceeding the benchmark set by the Health Policy Commission (HPC) by five percentage points.[10] The average annual cost of a family health insurance premium plus deductible exceeded $29,000 in 2023, and many Massachusetts residents report putting off needed medical care because of cost.[11]

Against this backdrop, the financial collapse of Steward Health Care in 2024 exacerbated the Commonwealth's access challenges. The closure of two Steward hospitals – Carney Hospital in Dorchester and Nashoba Valley Medical Center in Ayer – was a blow to the communities that received care there and to the people who worked there. The loss of those hospitals' services puts additional pressure on an already strained system. The ripple effects will be felt for years, and the ultimate impacts on the system and on the health of the people of the Commonwealth are yet to play out.

These chronic access and equity challenges and the focusing event of the Steward crisis have given rise to discussions about reviving the idea of statewide health services planning in Massachusetts.[12] The HPC included among its annual policy recommendations a call to "revitalize health planning to ensure that the supply of health services aligns with community health needs and to protect the interests of historically underserved communities."[13] In January 2025, Governor Healey signed into law Chapter 343 of the Acts of 2024, which, among other important measures, includes the creation of an Office of Health Resource Planning within the HPC and the mandate to develop a five-year plan.[14]

Informed by a literature review and landscape scan, this issue brief offers background on health services planning, describing the concept and outlining its history, including the rise and fall of planning in the United States and in Massachusetts. The bulk of the brief is a catalog of the regulatory and policy tools that Massachusetts uses today that incorporate some aspect of health services planning, and how these tools do and do not interact. The brief concludes with a discussion of the gaps Massachusetts needs to fill to realize a complete, comprehensive health services planning initiative.

II. BACKGROUND

WHAT IS HEALTH SERVICES PLANNING?

Planning is a process that seeks to coordinate the components of a system to achieve stated goals. Ideally, the system would achieve its goals through a planning process by allocating resources – such as facilities, workforce, and technology – as efficiently as possible. Building on this concept, health services planning (or health planning)* is "a process that appraises the overall health needs of a geographic area or population and determines how these needs can be met in the most effective manner through the allocation of existing and anticipated future resources."[15]

HEALTH PLANNING PROCESS

Using this definition, we can infer the elements of a health planning process. First, the process should set formal goals that are known to all stakeholders and can guide decisions about health care resource allocation. A high level goal might be "promoting the appropriate and equitable distribution of health care resources across geographic regions," as a new Massachusetts law requires.[16] A health planning agency in New York sets more granular goals, including preventing chronic disease; promoting healthy women, infants, and children; and preventing communicable diseases.[17] In the case of statewide health planning, goals should support shared public objectives related to access, equity, affordability, or quality of care, and the goal setting task should be led by a public agency, with input from a wide set of stakeholders. There should be active monitoring of whether the goals are achieved, informed by relevant, reliable, timely, and objective data. The process should identify health care needs related to the established goals, across the state, by region, and by population groups, again supported by data. Planners should assess current resources available to meet the needs and project what resources may be required to meet future health care needs. Finally, the planners should use these results to prioritize needs that reflect the goals and develop public policy that can support the desired allocation of resources by incentivizing, prohibiting, or regulating service expansions and contractions.[18]

Effective health planning is ongoing, not static. The process is iterative and important to making clear what the state's health services needs are and what resources are available to meet them, now and into the future. An inclusive process will also engender buy-in among stakeholders and build and strengthen relationships and trust.

HEALTH PLANNING BENEFITS

There are several potential benefits of organized statewide health services planning. Because health care resources are always limited, planning can help distribute them most equitably and effectively. It enables the state and communities to take responsibility for this distribution, rather than leaving it to independent parties, for which the public interest might not be paramount. Planning allows setting priorities at the state or community level, and a state-led process can focus on collectively agreed upon statewide priorities, such as access for underserved populations, which may not be easily attained through market mechanisms.

Planning offers a venue for getting "out on the table" issues that might not otherwise be discussed, and it promotes thoughtful consideration of these issues. The venue, and the interaction among stakeholders, provides a framework for decision making. Rather than individual stakeholders making decisions in a vacuum, the plan provides a common context for those decisions. Planning might also promote cost containment, through greater emphasis on coordination across systems, efficiency, and accountability in a statewide health plan.[19]

HEALTH PLANNING CHALLENGES

Though it offers benefits, health planning can also be a challenge. Health services planning happens as the system continues to operate and evolve, services are being delivered, facilities are being built or updated, and business transactions are occurring. The nature of the health care system can also hinder planning. There are many autonomous parties, and a wide variety of customers with different objectives. Providers often do not have an incentive to coordinate, and, in the United

* This issue brief uses the terms "health services planning" and "health planning," as well as the term "planning," interchangeably.

States, they are not usually constrained by centralized control. Health care consumers do not make many of the decisions about the services they receive and often do not directly pay for those services when delivered, and so are not motivated by typical market incentives. Because planning involves compromise among many stakeholders, the process is at least partly political and not completely objective, leaving it open to criticism among participants who do not like the results. Finally, because planning is an ongoing process, the state or other public sponsor must commit resources (in the form of staff, financing, etc.) to sustain the process into the future, and those resources might not always be available.[20] Therefore, a true commitment to the value of state health planning is required.

A BRIEF HISTORY OF HEALTH PLANNING IN THE UNITED STATES AND MASSACHUSETTS

EARLY PLANNING EFFORTS

Health services planning in the United States goes back to the early 20th century, when medicine was coming into its own as a profession. An early national planning effort was the Committee on the Costs of Medical Care (CCMC), formed in 1926 around concerns about the costs and distribution of medical care. The committee was privately funded and initially consisted of 15 members – economists, physicians, and public health specialists. It later grew to about 50 members, incorporating members of other interest groups. In a statement that has echoed through the ensuing century, the committee's staff director said that medical care needed "better organization," and that medicine was characterized as "not a system but lack of a system."[21]

The CCMC published 27 research reports over five years, covering topics including access, equity, and how the "medical dollar" was distributed. It estimated the need for medical care based on the prevalence of disease, without regard to other determinants of health, and concluded that there were insufficient levels of care, regardless of one's income. In its final report in 1932, the committee called for an increase in the proportion of national resources going to medicine, initiating the focus of planning efforts oriented toward expansion of health care resources.[22]

The next significant national planning effort followed this pattern. The Hospital Survey and Construction Act of 1946, more commonly known as the Hill-Burton Act, supported hospital construction and expansion, with a particular emphasis on rural communities. The law was modified in 1954 to allow grants to long-term care and ambulatory care facilities; however, as of 1971, three-quarters of Hill-Burton funds had been distributed to hospitals. Hill-Burton authorized grants for facility construction according to states' needs, estimated using state-conducted surveys. Hill-Burton's original objectives included improved coordination of hospital development, with planning and construction grants based on state estimates of regional hospital needs. But the law did not require states to coordinate hospitals' expansions after they received their grants.[23]

THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT

Health services planning continued to focus on hospitals through the 1960s and into the early 1970s, even as a sense was developing that emphasis should be shifting to ambulatory care.[24] During these decades, the cost of health care was increasingly a concern. In 1974, Congress passed the National Health Planning and Resources Development Act (NHPRDA). NHPRDA focused on containing costs, with its main mechanism being the management of capital expenditures through a Certificate of Need (CON) process. NHPRDA required states to adopt a CON law to be administered by a designated state health planning agency.[25]

The law created statewide planning entities, called State Health Coordinating Councils, and about 200 local health systems agencies (HSA), run by boards with consumer majorities. HSAs were responsible for creating a local health systems plan (HSP) for its health service area, geographic areas distributed across the country with populations between 500,000 and 3 million people.[26] The State Health Coordinating Councils were then tasked with creating a state health plan, made up of the local HSPs. Most federal support under the law went to the HSAs, not to states,[27] though the law did not give HSAs much decision-making power.[28]

Certificate of Need (CON) laws are state protocols for approving major capital expenditures and projects for health care facilities. CON programs primarily aim to control health care costs by restricting duplicative services and determining whether new capital expenditures meet a community need.

SOURCE: National Conference of State Legislatures, "Certificate of Need State Laws." https://www.ncsl.org/health/certificate-of-need-state-laws.

The legislation did not include a clear statement of national goals. The hope was to rein in costs, but it was left to the HSAs and local interests to determine how. Local planning bodies responded to the lack of strong compliance measures and articulated goals by "taking a scattershot approach rather than focusing on cost containment."[29] This era of health planning differed from the previous health planning initiatives in that it focused on containment rather than expansion. Because the forces for expansion were still strong, the HSAs' lack of authority to achieve cost containment was a significant hindrance. As one observer noted, "Some things people will not do without coercion."[30]

Support for the NHPRDA declined over time. There was little evidence that limiting capital investment through CON effectively controlled costs, and thinking developed that CON was the wrong tool. Planners promised cost control but lacked the tools to deliver it and broader planning goals, where they existed, were difficult to measure.[31]

The planning practices of the 1970s were ultimately insufficient to help communities determine their needs for health facilities and services, and how they should be geographically distributed. The need for consultation and bargaining among stakeholders moved planning away from its scientific and data-driven basis and opened the door to promoting a variety of interests and to political activity. At the same time, the idea of government as a disinterested party in advancing the public interest was losing support, while hospitals' community ties were weakening and – because of the increasing importance of third-party payers, Medicare, private investors, and access to capital – they were developing a more businesslike approach to financial management.[32]

The NHPRDA was repealed in 1986, and market-imposed discipline supplanted local and state-based public planning. Payers imposed accountability on providers through contracting arrangements, and decisions about resource allocations came to be driven by the market, not by the public interest.[33] Medical historian Evan Melhado, describing the American health care system in the wake of planning's demise, wrote "The new health care economy … privileges economic over extra-market values and exposes care to the hazards, both economic and moral, that mark the culture of business."[34]

HEALTH PLANNING IN MASSACHUSETTS

Massachusetts's health planning experience mostly parallels the national experience, moving away almost four decades ago from a state-guided process toward a health care system that is regulated by market forces. Massachusetts adopted a CON law (called Determination of Need, or DoN, in Massachusetts) in the 1970s, as well as hospital rate setting policies to contain costs. Rate setting was abolished in 1991, as managed care and capitation emerged as alternate strategies for controlling health spending.[35] DoN remains, however, and there have been a number of other state-level planning efforts in the past few decades:

- The Department of Public Health (DPH) created **Community Health Network Areas** in 1992. The 27 Community Health Network Areas, made up of all 351 cities and towns in Massachusetts, undertook efforts to assess the health of their communities, identify needs, and support initiatives to improve community health. The Community Health Network Area model is no longer functioning, according to the DPH website;[36] some continue as community-based organizations in their original form or as part of a larger coalition.[37]
- The Attorney General's Office established **community benefits guidelines** in 1994 and updated them most recently in 2018. Community benefits are investments that nonprofit hospitals and health maintenance organizations (HMOs) are expected to make as part of their charitable mission. Investments include charity care (for hospitals) and other programs that address documented community needs, which are identified through a periodic community health needs assessment. There is further discussion of these needs assessments as a planning tool in the next section.
- **Chapter 224 of the Acts of 2012** created the Health Policy Commission (HPC) and the Center for Health Information and Analysis (CHIA) as centerpieces of legislation intended to address the rising costs of health care in Massachusetts. Chapter 224 authorized the HPC to set an annual health care cost growth benchmark and gave it other significant market oversight responsibilities, which are described in the next section. CHIA performs information functions that are essential to rigorous planning – data collection and analysis, monitoring, and reporting.
- Massachusetts **revised its DoN regulations** in 2017 to require hospitals seeking a DoN to invest five percent of the value of its capital project in a community health initiative, a portion of which flows to a statewide Community

Health and Healthy Aging fund (see "Community Health Improvement Plans" in Section III, below) for distribution across the state to historically marginalized communities, addressing the problem of inequities in community health resources.[38]

These examples demonstrate that public and private organizations in Massachusetts still have an impulse toward health planning in the public interest, even as market forces dominate how resource decisions are made. But Massachusetts does not have a systematic, comprehensive health services planning process that sets systemwide goals, coordinates and aggregates the identification of health service needs across communities, and sets priorities for the allocation of resources statewide. The Steward crisis, persistent spending increases, workforce shortages, and other challenges have led some to call for a health planning revival, and recent legislation has moved the Commonwealth in that direction. The next section identifies some of the building blocks that might support it.

III. EXISTING TOOLS FOR HEALTH PLANNING

Along with most other states, Massachusetts moved away from health planning to a health care system that is largely regulated by market forces. Some remnants of the old planning paradigm remain, however, and the Commonwealth has created other tools that offer insight into population health needs and ways to affect the allocation of resources to meet the needs. Most recently, the Office of Health Resource Planning (OHRP) was created within the Health Policy Commission (HPC) and charged with creating a five-year state health plan, including assessments of health care resource supply and capacity in relation to projected health care needs. OHRP launched in April 2025.

TOOLS THAT ADDRESS ALLOCATION OF HEALTH CARE RESOURCES

DETERMINATION OF NEED – DEPARTMENT OF PUBLIC HEALTH

Purpose of Determination of Need

"To encourage competition with a public health focus; to promote population health; to support the development of innovative health delivery methods and population health strategies within the health care delivery system; and to ensure that resources will be made reasonably and equitably available to every person within the Commonwealth at the lowest reasonable aggregate cost."

SOURCE: Massachusetts Department of Public Health, Determination of Need. https://www.mass.gov/determination-of-need-don.

The Determination of Need (DoN) process is a link to the era of formal statewide health planning in the 1960s and 1970s. Massachusetts enacted its DoN law in the 1970s, following the 1974 passage of the National Health Planning and Resources Development Act. The Department of Public Health (DPH) significantly amended the DoN regulations in 2017. DoN applies to health care facilities – hospitals and clinics including federally qualified health centers, or FQHCs, long-term care facilities such as nursing homes and rest homes, clinical laboratories, and public medical institutions. Facilities must apply for a DoN when they are planning a substantial capital expenditure or substantial change in services, or when they are pursuing original licensure, a transfer of ownership, or a change in site. (FQHCs do not require a DoN for substantial capital expenditures or changes in service.[39]) "Substantial" is defined in regulation; for example, the minimum level of capital expenditure by non-hospital health care facilities requiring DoN in state fiscal year 2025 is $2.8 million, and the minimum level for hospitals is $26.6 million.[40]

Changes in 2017 broadened the purpose of DoN beyond the approval of substantial capital expenditures by leveraging the process to address community health needs. Specifically, applications must show that they align with state health priorities related to social determinants of health – built environment, social environment, housing, violence, education, and employment – and that the applicant has solicited meaningful community input. Further, the DoN process now requires the applicant to set aside funds to support public health and prevention initiatives within the applicant's community and in historically marginalized communities across the state (see "Community Health Improvement Plans," below).[41]

Process

A DoN applicant must demonstrate that its proposed project meets six DoN factors (see box).[42] Applicants for DoN publish a notice of intent at least 14 days prior to submitting their application. "Parties of record" (including the attorney general, the Center for Health Information and Analysis [CHIA], HPC, all government agencies with relevant oversight or licensure authority over the proposed project, and registered "Ten Taxpayer Groups"[43]) must have a reasonable opportunity to comment and may seek to affect DPH's action by requesting a public hearing, filing a written reaction to the application or the staff report, or making an oral presentation to the Department. Members of the general public may also provide comments at a public hearing or in writing. Any party of record may request a public hearing, or the commissioner may order one. Public hearings on DoN applications appear to be infrequent: there were two public hearings in 2024 and 29 DoN applications either completed in 2024 or pending as of January 17, 2025.[44] The public hearing is held in the primary service area of the proposed project, if feasible. A written staff report is provided to parties of record and made available to the public at least 30 days prior to action.

Determination of Need Factors:

1. The application must show sufficient need for the expenditure or change among the applicant's patient panel, and that it will add measurable public health value and quality of life to the patient panel, along with reasonable assurances of health equity. The application must include evidence of sound community engagement to establish this DoN factor.
2. The application must demonstrate that the project will contribute to the Commonwealth's goals for cost containment, improved public health outcomes, and delivery system transformation, and that the project serves one or more of the state's health priorities (built environment, social environment, housing, violence, education, employment).
3. The proposed project must comply with federal, state, and local laws and regulations.
4. There must be sufficient funds for capital and operating costs to support the project without negative impacts on the patient panel.
5. The application must demonstrate that the proposed project is superior to alternative methods for meeting the patient panel needs.
6. Unless the application demonstrates that the proposed project, in its entirety, addresses one or more of the state's health priorities (see factor number 2),* the applicant must fund a community-based health initiative (CHI) at an amount equal to five percent of the total capital expenditure of the proposed project. A CHI is a locally planned and implemented project that addresses one or more of the social determinants of health that represent the health priorities. DPH must approve the CHI plan before the DoN application can be approved.

* There has not been a case in which an applicant has been exempted from the CHI factor in recent years. (Source: Author's communication with the Determination of Need Program, Department of Public Health. January 2025.)

SOURCE: 105 CMR 100.210.

Identifying Access Challenges

Local access challenges may emerge in the course of the DoN process, as applicants are required to engage their communities and align their proposals with identified community health needs. In regard to addressing access challenges, a DoN applicant, if eligible, must attest to participation or the intent to participate in MassHealth. The applicant must also provide a plan for the development and improvement of language access and assistive services for their patients. They must provide professional, trained medical interpreters to the patient panel and must require and arrange for Culturally and Linguistically Appropriate Services (CLAS) training for administrative, clinical, and support staff.[45]

DoN is intended as a planning tool, and it functions as such. It is narrowly focused, however, in that the process is prompted by a health care provider's application to make a substantial capital expenditure, and most of the DoN factors focus on the applicant's patient panel, not the broader community. While the revised DoN rules make it more responsive to broader community health considerations, it is not designed to be forward-looking and comprehensive in its scope.

OFFICE OF HEALTH RESOURCE PLANNING – HEALTH POLICY COMMISSION

The Massachusetts Legislature revived a health planning function for state government in 2025 with the creation of OHRP within the HPC. OHRP is mandated to create a five-year state health resource plan, the goal of which is "to promote the appropriate and equitable distribution of health care resources across geographic regions of the Commonwealth based on the needs of the population on a statewide basis and the needs of particular geographic and demographic groups." In addition to the statewide plan, the Office may also conduct focused assessments of health care resource supply, distribution, and capacity

in relation to a projected need. The legislation further authorizes OHRP to direct DPH in establishing and maintaining a current, publicly accessible statewide inventory of health care resources.[46]

The state health resource plan will anticipate needs for health care services, providers, programs, and facilities; identify existing resources to meet those needs; and project the additional resources needed. The plan will make recommendations and set priorities regarding the appropriate supply and distribution of resources, workforce, programs, capacities, technologies, and services on a statewide and regional basis.

The state health resource plan should support statewide goals in the areas of:

- Ensuring quality and access
- Ensuring a stable workforce
- Meeting the health care cost growth benchmark
- Supporting delivery and payment innovation
- Avoiding duplication
- Advancing health equity
- Integrating behavioral health and oral health with medical care
- Aligning housing and health care
- Promoting the best standards of care
- Ensuring equitable access to health care resources across geographic regions

Recommendations may also include further legislative or regulatory action that might be needed.

SOURCE: M.G.L. c. 6D, §22(a).

Process

The process for completing the health resource plan is not spelled out in the legislation and will presumably be developed by HPC in the coming months, to enable OHRP to deliver its first five-year plan by January 1, 2027.[47] At a minimum, the Office is required to seek input from interested parties by conducting at least one public hearing per year and maintaining a website to facilitate public comments. The Office is also instructed to consult with a list of state agencies in conducting its focused assessments; these agencies would also be available for consultation on the full plan. The office will also use available state and national data, academic research, and the community health needs assessments and other community statements of need, some of which are described below.[48] While it is not spelled out in the legislation, a meaningful process that includes a broad range of stakeholders, including community members, will be critical for engendering the support needed to achieve the plan's goals.

The Office must report annually to the legislature on its activities – progress on developing the state plan and focused assessments, and recommendations for further legislative action.[49] It is also authorized to publish analyses and reports to promote public awareness about the distribution of health care resources, but it has no authority to direct or influence supply levels beyond these reports.

It is not clear from the legislation whether the state health resource plan is to be refreshed after five years as part of an ongoing planning process. As of the publication of this issue brief, the legislature has not appropriated additional funds for HPC to support the Office's work.

Identifying Access Challenges

A central purpose of the state health resource plan and focused assessments is to identify and address access challenges, both current and into the future. Access and equity are embedded in the statutory goals of the plan.

TOOLS THAT ADDRESS POPULATION HEALTH

STATE HEALTH ASSESSMENT – DEPARTMENT OF PUBLIC HEALTH

DPH compiles publicly available state-level data – on demographics, health outcomes, health behaviors, and community resources – and publishes a data tool on its website. The purpose of the data is to "help to identify the most important public health issues that are being addressed in order to achieve optimal health and well-being for all people in Massachusetts."[50]

DPH compiles the data periodically from a wide variety of state and federal sources.[51] The current iteration exists online as a data tool, which users can access to analyze for health planning or other needs.

Users may create custom reports and maps for the entire state or for individual communities by choosing some or all of the available data sets. The resulting reports may be viewed online, printed, or downloaded.

The data are extensive, and the tool is designed to be user-friendly. Data about health care providers and workforce is lacking, however. The data are drawn from public sources, and many have a one- or two-year lag. In this sense, the tool is not forward-looking, though planners could use the data in the tool as a basis for projections to the future. The reports that the current version of the tool creates do not include interpretation, policy context, or recommendations. The State Health Assessment (SHA) is therefore not itself a planning document, but it can be a resource to planning initiatives. For health services planning, the SHA tool would need to be supplemented by information about hospitals and other health care facilities, specialty providers, and health care workforce data.

State Health Assessment data are organized into health care–related topics, such as:

- Access to care (e.g., insurance coverage, FQHCs, primary care, mental health care)
- Prevalence of behavioral health conditions, chronic disease, infectious disease, and maternal and child health
- Population demographics
- Public health risk factors (e.g., tobacco use, air quality, access to open space)
- Other social factors affecting population health (e.g., poverty, employment, housing measures, access to healthy food, "social vulnerability index")

SOURCE: Commonwealth of Massachusetts, Massachusetts Health Data Tool. https://healthdatatool.mass.gov/state-assessment/?REPORT=%7B%22name%22%3A%22Massachusetts%20State%20Health%20Assessment%22%2C%22style%22%3A%22MADPH_SHA%22%7D.

COMMUNITY HEALTH NEEDS ASSESSMENT – OFFICE OF THE ATTORNEY GENERAL

Under the Office of the Attorney General's (AGO) guidelines, nonprofit hospitals and health maintenance organizations (HMO) must complete a community health needs assessment (CHNA) at least every three years. A CHNA is a comprehensive review of unmet health needs for a defined community, including the negative health impacts of social and environmental conditions. The CHNA informs the hospitals' and HMOs' charitable activities – also called community benefits – that the attorney general's guidelines encourage. The AGO encourages hospitals and HMOs to collaborate on the CHNA, to the extent that their communities overlap.

Beyond the Massachusetts guidelines, nonprofit hospitals are also required by Section 501(r) of the federal Internal Revenue Code to conduct a CHNA as a condition of their charitable tax status.

Process[52]

The guidelines instruct hospitals and HMOs to define the community they are assessing, using their geographic service area as a starting point. The guidelines note that the "community" may differ from the hospital's patient care population. The hospital/HMO should use a variety of primary and secondary data, both qualitative and quantitative, to identify unmet health needs. The assessment should consider the needs of target populations such as children or older adults and whether there are populations within the defined community with particular unmet needs. Whenever possible, the data should be stratified to allow identification and monitoring of inequities among particular groups.

In prioritizing community health needs, the hospital/HMO should consider these criteria:

1. The income levels and race/ethnicity (or other characteristics linked to discrimination or exclusion) of the affected populations
2. The presence of other significant barriers that hinder access to appropriate health care programs or contribute to poor health outcomes, such as immigrant status, housing conditions, access to healthy foods, safe recreational opportunities, and others

A community health needs assessment includes:

1. A definition of the community
2. A description of the hospital's or HMO's process and methods
3. A description of how the hospital or HMO solicited and used input from persons and organizations in the community
4. A prioritized description of the significant health needs of the community
5. A description of the resources potentially available to address the significant health needs
6. An evaluation of the impact of any actions the hospital or HMO took to address significant health needs since its last CHNA
7. A review of relevant programs and reports of other filers in the region to avoid duplication, improve coordination, and assess whether to continue with existing programs

SOURCE: Commonwealth of Massachusetts, Office of the Attorney General, The Attorney General's Community Benefits Guidelines for Non-Profit Hospitals. February 2018.

3. The absence of relevant and accessible resources and programs

4. Specific primary, acute, or chronic health care needs

5. Assessment of the hospital's capability of responding to the identified needs

6. Availability of other service providers, public and private

While its primary focus should be the distinct needs of their community, as determined from community input, the CHNA should also take note of statewide priorities. These include four issues that the Executive Office of Health and Human Services (EOHHS) has identified as drivers of mortality, morbidity, and health care costs. In addition, DPH adopted six health priorities that emphasize the importance of health-related social needs (HRSN), and which hospitals and HMOs are encouraged to consider in their community benefits planning (see box).

The AGO incorporates these statewide priorities into its guidelines in recognition of its commitment to coordinate with other initiatives across state government to build capacity, improve outcomes, and reduce inequities. The AGO may single out programs that address the priorities for public recognition or dissemination as best practices.[53] The primary focus of the CHNA, however, remains the needs of the local community.

Health Issues Driving Mortality, Morbidity, and Costs (EOHHS):

1. Chronic disease, with a focus on cancer, heart disease, and diabetes
2. Housing instability/ homelessness
3. Mental illness and mental health
4. Substance use disorders

HRSN-Related Health Priorities (DPH):

1. Built environment
2. Social environment
3. Housing
4. Violence
5. Education
6. Employment

Use of the Community Health Needs Assessment

Hospitals and HMOs use the CHNA to determine the issues and populations that they choose to make the focus of their community benefits strategies. In this sense, the final report, which is adopted by an authorized body of the hospital or HMO and made widely accessible, is a forward-looking document in that it informs the hospital's or HMO's community activities for the next several years. The AGO also collects feedback from community representatives as part of the CHNA and community benefits process.

CHNAs are regularly updated and are designed to reflect the input of the communities in which the hospitals and HMOs operate. They are locally focused – the AGO maintains a searchable list of community benefits reports, which link to the relevant CHNAs, on its website[54] – but the CHNAs can also be woven together for a broader regional or statewide perspective.[55] While the AGO issues guidelines and collects the reports, the CHNAs themselves are done by private organizations, not by the state.

COMMUNITY HEALTH IMPROVEMENT PLAN – DEPARTMENT OF PUBLIC HEALTH

A community health improvement plan (CHIP) is a long-term effort to improve the health of a defined community. CHIPs are funded by grants from the Massachusetts Community Health and Healthy Aging (CHHA) Funds. CHHA funds flow from the DoN process (see above): a portion of the DoN-required Community-Based Health Initiative (CHI) funds – 10 or 25 percent of the value of the CHI project, depending on its size – go to the CHHA Funds, to be redistributed to communities across the state. CHIPs involve multiple sectors and stakeholders – health care systems and hospitals, health departments, local government, community-based organizations, businesses, and residents. The grantmaking for funding CHIPs focuses on equity, with explicit prioritization of people of color and older adults.[56]

Process

A CHIP is based on the results of a community health assessment (CHA) of the community's health-related needs and strengths or assets. The long-term process is:

1. Reflect and strategize

2. Identify and engage stakeholders

3. Define the community
4. Collect and analyze data
5. Prioritize community health issues
6. Document and communicate results
7. Plan implementation strategies
8. Implement
9. Evaluate progress[57]

Massachusetts-based 501(c)(3) organizations, groups with a 501(c)(3) fiscal sponsor, and municipalities may apply for a grant to fund a CHIP. Health Resources in Action (HRiA), under a contract with DPH, facilitates the application review process. A review committee of subject matter and lived experience experts reviews the applications based on criteria of equity, impact, collaboration, and feasibility. HRiA makes funding recommendations to DPH, which makes the final funding decisions.[58] The CHHA Fund began making CHIP grants in 2020, and there have been subsequent funding cohorts in 2022 and 2024. There were nine grantees in the first cohort and four in each of the next two.[59] CHIP grants average $375,000 for a period of three to five years.[60]

Recipients of CHIP Grants

- Town of Ware, Quaboag Hills region
- Town of Randolph
- Pioneer Valley Planning Commission – Hampden County CHIP
- Franklin County/North Quabbin CHIP Network
- Community Health Network of North Central Mass (CHNA 9)
- Coalition for a Healthy Greater Worcester
- City of New Bedford
- Cambridge Public Health Department
- Berkshire Regional Planning Commission
- African Cultural Services, Inc. (Ugandan immigrants in Waltham)
- Breaktime United, Inc.
- City of Lawrence, Mayor's Health Task Force
- Family Nurturing Center
- Multicultural BRIDGE (Berkshire Resources for Integration of Diverse Groups and Education)
- Outer Cape Community Solutions
- North Shore Community Health Center (planning grant)

SOURCE: Massachusetts Health Funds, What We Fund. https://mahealthfunds.org/what-we-fund/.

Funding favors awardees that focus their initiatives on the root causes of health and on social determinants of health, with a particular focus on racial inequities. CHIPs provide a strong focus on community health, informed by local stakeholders. The process and the plan are very locally specific. While CHIPs can be woven together to provide a larger picture of health needs, similar to hospitals' CHNAs, the CHIP grantees do not cover all of Massachusetts. Further, because of the focus on root causes and environmental factors driving community health, the health care delivery system is just one of many factors that a CHIP might identify as an area for improvement. An example of this is the Franklin County/North Quabbin CHIP Network, which has been funded in each of the CHHA Fund's cohorts. The Franklin County/North Quabbin CHIP Network's 2024-2028 plan includes 13 priority goals and objectives, with health care access and workforce shortages among them. The other priorities, which include age-friendly communities, connectedness, driving access, and housing, are clearly connected to community health but are not directly related to health services resources.[61]

TOOLS THAT ADDRESS THE HEALTH CARE WORKFORCE

HEALTH CARE WORKFORCE CENTER – DEPARTMENT OF PUBLIC HEALTH

The Massachusetts Health Care Workforce Center (HCWC) was originally authorized by Chapter 305 of the Acts of 2008, and its purpose was amended and expanded by Chapter 224 of the Acts of 2012. The HCWC is authorized to collect and provide data on the health care workforce, make policy recommendations to strengthen the workforce, and administer programs that address workforce shortages and support health care providers.[62] According to its enabling statute, the HCWC:

1. Coordinates workforce activities with other state agencies and public and private entities involved in training, recruitment, and retention
2. Monitors trends in access to primary care providers, behavioral health providers, and other physician and nursing providers

3. Establishes criteria to identify underserved areas for administering a loan repayment program and determining statewide target areas for provider placement

4. Addresses workforce shortages through various policy and programmatic activities[63]

It is not clear how active the HCWC is with respect to all of the aforementioned responsibilities. The function of the HCWC that appears to be currently active is its administration of the Massachusetts Loan Repayment Program for Health Professionals (see below).[64] The statute also requires the HCWC to file an annual report that includes data on patient access and regional disparities, and projections of workforce supply and demand. The most recent publicly available annual report is from 2017.[65] Its Health Professions Data Series – which includes workforce supply data on dentists, dental hygienists, pharmacists, physicians, physician assistants, registered nurses, and licensed practical nurses – is also not current, with the exception of data on dentists from 2022.[66†]

Newly Available Health Care Workforce Data

Another state agency, CHIA, launched the Massachusetts Health Care Workforce Survey in 2023.[67] The survey collects information on staffing capacity in a variety of health and human service sectors. CHIA plans to conduct the survey biannually, so that the data may be used to monitor workforce trends. The survey includes select occupations in each sector. For example, the acute care hospital sector survey includes data on physicians, physician assistants, registered nurses, licensed practical nurses, medical technologists, radiologic technologists, and social workers.[68] Data are publicly available on a web-based dashboard and include information on:

- Employee composition by occupation
- Employee race and ethnicity by occupation
- Vacancy and turnover rates by occupation
- Challenges to recruitment and retention
- Organizational strategies to facilitate recruitment and retention
- Impacts on access due to workforce shortages[69]

BEHAVIORAL HEALTH WORKFORCE CENTER – HEALTH POLICY COMMISSION

HPC, in partnership with EOHHS, launched a new Behavioral Health Workforce Center (BHWC) in September 2024. Acknowledging the special challenges of capacity, turnover, and burnout in the behavioral health workforce and the impacts of those challenges on access and outcomes, the BHWC will identify gaps and challenges across communities and provider types; monitor trends in workforce representation and demand for services; convene stakeholders with diverse perspectives; and conduct research and make policy and programmatic recommendations. The recommendations will touch on education and training, diversity and cultural competency, opportunities for professional growth, and reducing turnover. The BHWC will explore policy solutions such as streamlining licensure processes, expanding the role of skilled, non-licensed professionals, and fostering partnerships with academic institutions to address challenges.[70]

The BHWC will tap stakeholder expertise through the creation of an advisory group. The Center's initial research agenda includes:

- A study of rates paid for behavioral health services
- A study to establish baseline behavioral health workforce needs
- A study of the licensure and certification process for the behavioral health workforce[71]

† According to correspondence with the Department of Public Health, the Massachusetts Health Care Workforce Center is in the process of modernizing and updating its data collection and dashboards so that reporting can resume.

The BHWC named its 31-member advisory group and met for the first time in February 2025.[72] The goal is for the BHWC to be the data and research hub for all stakeholders with an interest in strengthening the behavioral health workforce in Massachusetts.

Student Loan Repayment

Responding to workforce capacity concerns, the Commonwealth created two programs that offer assistance with student loan repayment in exchange for service commitments. The Massachusetts Loan Repayment Program offers up to $50,000 in exchange for a commitment to serve in a Health Professional Shortage Area. The "MA Repay" program focuses on strengthening the primary care and behavioral health workforce by providing incentives for recruiting and retaining providers in underserved, community-based settings. Both are public programs, funded by state and federal dollars, and are administered by the Massachusetts League of Community Health Centers. While not planning tools themselves, these programs represent programmatic responses to statewide challenges to meeting identified health care service needs.

SOURCE: Massachusetts League of Community Health Centers, Student Loan Repayment Programs. https://www.massleague.org/programs-initiatives/workforce-development/repayment-programs/.

TOOLS THAT ADDRESS HEALTH CARE COSTS

HEALTH CARE COST GROWTH BENCHMARK AND PERFORMANCE IMPROVEMENT PLANS – HEALTH POLICY COMMISSION AND CENTER FOR HEALTH INFORMATION AND ANALYSIS

The cost growth benchmark is an annual target for the rate of growth of total health care expenditures (THCE), to monitor health care spending for the purpose of bringing it into line with the growth of the overall economy in Massachusetts. The HPC sets and monitors the benchmark; CHIA collects and analyzes data to support the benchmark process. Chapter 224 of the Acts of 2012, the law that created the HPC and CHIA, is also the statutory authorization for the cost growth benchmark.

Total Health Care Expenditures Subject to the Benchmark:

1. All medical expenses paid to providers by private and public payers, including Medicare and MassHealth
2. All patient cost-sharing amounts (for example, deductibles and co-payments)
3. The net cost of private insurance (for example, administrative expenses and operating margins for commercial payers)

Though prescription drugs are a significant and growing share of health care spending, Chapter 224 did not include pharmaceutical manufacturers and pharmacy benefit managers (PBM) within the scope of HPC's and CHIA's oversight of health care cost growth. That was changed recently, with the enactment of "An Act Enhancing the Market Review Process" in January 2025.[73] HPC's scope of examination now includes data submitted to CHIA by PBMs, and representatives of pharmaceutical manufacturers and PBMs will be called to testify at the HPC's annual cost trends hearing.[74] In addition, the HPC is now authorized to collect ownership, governance, and organizational information from "significant equity investors, health care real estate investment trusts, and management services organizations."[75]

A related activity for the HPC and CHIA is the analysis of health care costs and utilization trends for total medical expenses and for primary care and behavioral health spending. The purpose of tracking trends is to examine their underlying drivers and inform evidence-based policy recommendations to achieve the goals of controlling cost growth, improving health care access and quality, and promoting public health.[76]

Process

The HPC and CHIA work in coordination to establish the benchmark and to monitor and report on cost growth compared to the benchmark. The process starts with the HPC prospectively setting the benchmark for the coming calendar year. In March, the HPC holds a public hearing in collaboration with the legislature to consider data, public testimony, and other information to inform its setting of the benchmark. A key source of data is CHIA's *Annual Report on the Performance of the Massachusetts Health Care System*, which includes THCE information for the most recent year for which data are complete. For example, CHIA's March 2024 report includes THCE information for calendar year 2022.[77] HPC commissioners then vote by April 15 to set the benchmark for the next year.

After the close of the year, CHIA uses its health care expenditure data for a retrospective analysis of providers' and insurers' performance against the benchmark. CHIA may confidentially refer to the HPC health plans or provider groups whose spending growth has exceeded the benchmark for evaluation and potential implementation of a performance improvement plan (PIP). (To date, Mass General Brigham is the only entity to have had a PIP.) Every fall, the HPC issues its annual cost trends report, which includes an analysis of trends in CHIA's THCE data, data from other sources, and policy recommendations.[78] Shortly after releasing this report, HPC holds its annual cost trends hearing, an opportunity to hear testimony from stakeholders and engage in discussions about the trends; their effects on health care access, quality, and outcomes; and recommendations for policy changes.

In 2022, CHIA also began analyzing data and publishing reports on spending for primary care and behavioral health services. Sufficient spending on and access to these services are important to a well-performing health system that meets communities' needs. CHIA's initial report included baseline data for calendar years 2018, 2019, and 2020. The latest report includes data on primary care and behavioral health care spending for calendar years 2021 and 2022.[79] The HPC also used CHIA's data on primary care spending in a recent policy report, combining it with workforce, access, and other data to analyze what is driving the "declining health" of primary care in Massachusetts.[80]

Identifying Access Challenges

The cost growth benchmark process typically identifies access challenges through its data collection and analysis of trends in insurance premiums and cost sharing. These expenses drive coverage rates and medical debt, which are both significant factors in health care access. HPC's cost trends report also includes data about affordability from CHIA's Massachusetts Health Insurance Survey – for example, the percentage of Massachusetts residents who report spending a high share of their income on out-of-pocket health care expenses, or who reported forgoing health care because of the cost. Such access and affordability data are retrospective, relying on surveys from a period nearly two years in the past.

CHIA's primary care and behavioral health report describes variations in spending and utilization by certain demographic characteristics, such as age, diagnosis, and zip code, which can provide clues to access challenges. This information could potentially be married to data about provider supply – particularly if it included characteristics such as race, ethnicity, and languages spoken – to give a fuller picture of access challenges.

Access challenges can also surface in the HPC's annual benchmark and cost trends hearings. The witness panels offer opportunities for stakeholders to use the published retrospective data to make forward-looking policy recommendations. For example, the final panel of the November 2024 Cost Trends Hearing, featuring the leaders of the Massachusetts League of Community Health Centers, the Massachusetts Association of Health Plans, Blue Cross Blue Shield of Massachusetts, Health Care For All, and the Massachusetts Health and Hospital Association, explored policy solutions for access, affordability, and equity and discussions on topics such as language access and improving access to primary care and behavioral health services.[81]

The cost growth benchmark process focuses on an important aspect and perennial challenge of the Massachusetts health care system. HPC and CHIA provide strong data analysis and broadly disseminate their findings. It could be a central feature of a comprehensive planning process, though time lags in key data sources could limit it in that regard.

TOOLS THAT ADDRESS BUSINESS TRANSACTIONS

MATERIAL CHANGE NOTICES – HEALTH POLICY COMMISSION

The HPC also tracks and conducts analyses of any "material changes" in the health care delivery system to determine their likely impact on health care costs, market functioning, quality, access, and equity. Material changes include capacity expansions and mergers, affiliations, and partnerships involving health care providers and insurers (see box below).

Process

Any providers and provider organizations with more than $25 million in net patient service revenue must file a notice of material change. The parties must file the notice at least 60 days before the closing or effective date of the transaction.

Identifying Access Challenges

The HPC conducts an initial review of the material change notice within 30 days of receiving the complete notice. If the HPC determines that a particular change is likely to have a significant impact on health care costs or market function, it will recommend that the HPC board authorize a more in-depth Cost and Market Impact Review (CMIR; see below). The parties may not close the transaction until the HPC completes its initial review or 30 days after HPC issues its final CMIR report, if it does one. For the initial review, the HPC assesses the parties' stated goals for the material change and confidential information that the parties provide to the HPC in support of the notice, including information provided in response to information requests. The HPC may also consult other information, such as CHIA's price, expense, claims, and discharge data, to project forward and assess the possible impact on costs, quality, access, equity, and the functioning of the market.[82]

Triggers for a Material Change Notice

- Significant expansions in a provider's capacity
- A merger or affiliation with, or acquisition of or by, an insurance carrier
- A merger with or acquisition of or by a hospital or hospital system
- Acquisition of insolvent provider organizations
- Transactions involving a significant equity investor, resulting in a change of ownership or control of a provider organization
- Significant acquisitions, sales or transfers of assets, including real estate lease-back arrangements
- Conversion of a provider organization from nonprofit to for-profit
- Mergers or acquisitions of provider organizations that would result in the provider or provider organization having a dominant market share in a given service or region

SOURCE: Chapter 343, Acts of 2024.

The HPC board publicly reviews material change notices at its monthly meeting. Staff present descriptions of the transaction and a justification of the recommendation whether to proceed with a CMIR. Most material change notices do not trigger a CMIR (discussed in more detail below).[83]

COST AND MARKET IMPACT REVIEW – HEALTH POLICY COMMISSION

As part of its market oversight role, the HPC conducts CMIRs to evaluate the impact of significant health provider changes on the competitive market, and on the Commonwealth's ability to meet the health care cost growth benchmark (see above).[84] Effects of a transaction on health care access are not an explicit trigger for a CMIR, but the HPC considers access as part of the review.

CMIRs are tied to the HPC's responsibility to review material change notices. If, in the course of such a review, the HPC finds that a provider's proposed market transaction is likely to have a significant impact, it may undertake a CMIR. The HPC may also initiate a CMIR independent of a material change notice if a provider organization's increase in costs is considered excessive and threatens the state's ability to meet the cost growth benchmark. This reason for review is only authorized when the change in total health care expenditures from the previous calendar year exceeds the cost growth benchmark.[85]

Process

Following the HPC's preliminary review of a material change notice, the HPC board may authorize initiation of a CMIR and notify the relevant parties. The parties must respond to and comply with HPC information requests within 21 days, after which HPC conducts the CMIR, which takes approximately six months. Staff give regular updates to HPC committees and the board during this period. When its review is complete, the HPC makes a preliminary report on its findings, to which the parties may respond within 30 days. The HPC reviews these responses and drafts its final report. Finally, the HPC board votes to issue the final report.

The process is forward looking by design – the CMIR uses available information to project the impact of a material change on future access, costs, and quality. The HPC does not have the authority to block a transaction or impose conditions, but it may refer its report to the attorney general to consider such actions if it finds that a provider organization has a dominant market share, materially higher prices, or materially higher medical expenses.[86] Over its history, the HPC has referred four transactions to the attorney general, based on the CMIR findings. For instance, one referral resulted from findings that the proposed transaction would "increase health care spending, likely reduce market competition, and result in increased

premiums for employers and consumers."[87] The HPC may also refer findings to DPH or other agencies with regulatory or legal authority. The HPC board's vote to issue the final report on the CMIR may or may not include referrals to other agencies or offices.[88] The final CMIR report is public and available on the HPC's website.

Identifying Access Challenges

The HPC is concerned with providers' potential to dominate hospital and other provider markets, which can drive up prices and affect the Commonwealth's ability to meet the cost growth benchmark. Changes to market balance and prices can also affect access to and quality of care. The HPC therefore may consider several factors in its CMIR. They cover impacts on competition, costs, standing among consumers, and access – particularly for underserved groups and for services that tend not to be profitable (see box). The HPC has a clear mandate for market oversight, with clear criteria for review. The CMIR is a tool that could support a broader health planning vision. To date, the HPC has not made extensive use of the CMIR – there have been just seven reports covering 10 reviews since the process was first established.

Factors Considered in a Cost and Market Impact Review:

1. The provider's size and market share in its service areas
2. The provider's prices for services, including how they compare to other providers for the same services in the same market
3. The provider's total medical expense (adjusted for health status), compared to similar providers
4. The quality of the services it provides, including patient experience
5. Provider cost and cost trends in comparison to statewide total health care expenditures
6. The availability and accessibility of similar services to those provided, or proposed to be provided within the service areas
7. The provider's impact on competing options for the delivery of health care services within its service areas
8. The methods the provider uses to attract patient volume and to recruit or acquire health care professionals or facilities
9. The provider's role in serving at-risk, underserved, and government payer patient populations, including those with behavioral, substance use disorder, and mental health conditions
10. The provider's role in providing low margin or negative margin services
11. Consumer concerns, including complaints about unfair competition or deceptive practices
12. The size and market share of any corporate affiliates or significant equity investors
13. The inventory of health care resources maintained by DPH
14. Any related data or reports from the new Office of Health Resource Planning
15. Any other factors that the HPC determines to be in the public interest

SOURCE: M.G.L. c. 6D, §13(d).

ESSENTIAL SERVICE CLOSURES – DEPARTMENT OF PUBLIC HEALTH

The essential service closures process provides a mechanism for reviewing a hospital's proposed closure or service reduction before it happens, to evaluate the impact on the community and see that measures are put in place, if needed, to minimize the impact. The process is part of DPH's hospital licensure authority, and it applies to all private nonprofit or for-profit hospitals. State-operated and federally operated hospitals are not included.

Process

An "essential" service is almost any service a hospital is licensed to provide, such as ambulatory care services, birth services, medical/surgical services, intensive care, psychiatric services, outpatient dental, psychiatric, and reproductive health services, and others. Certain services are excluded from being considered essential hospital services: skilled nursing facility services, intermediate care facility services, cardiac catheterization, chronic care services, trauma service at a designated trauma center, and several others.[89] A hospital that plans to close or to discontinue a service must give DPH 120 days' notice of its intent and also must notify the hospital's patient and family council, hospital staff, labor organizations, and elected officials.[90] The formal notice of closure must be made at least 90 days in advance. DPH must then hold a public hearing at least 60 days prior to the closing, giving interested parties the opportunity to share comments and concerns. Within 15 days following the hearing, DPH will determine whether the service is "necessary" for preserving access and health status in the hospital's service area. In determining whether a service is necessary, it considers the evidence from the public hearing, the current utilization of the service, the capacity of alternative delivery sites to deliver the service, travel times to alternative sites, the clinical importance of local access to the service, and any other relevant information.

If DPH finds the service is necessary for preserving access and health status, it requires the hospital to submit a plan within 15 days that assures access following the hospital's closure of the service. The plan must include information on utilization of the service, the location and capacity of alternative sites, travel time and transportation needs, and protocols for obtaining the service and maintaining continuity of care. DPH reviews the plan within 10 days and either approves or sends written comments to the hospital. The hospital must respond to comments within 10 calendar days.

Importantly, DPH does not have the legal authority to require a hospital to keep a service open. DPH monitors implementation of the hospital's plan for preserving access to necessary services following the closure.[91]

Identifying Access Challenges

The process is explicitly intended to identify anticipated access challenges, using information from the public hearing and analysis of alternative capacity and transportation needs. DPH's role in the essential services closure process is primarily reactive, however: it does not include anticipating potential future closures and service reductions, and the regulations only allow DPH and the community to respond to essential service closures for a relatively limited time.

Documentation of individual essential service closure processes – hospital notices, DPH determinations, facility plans, and responses – are public and available on the DPH website.[92] Public hearing proceedings are not included in the public-facing documentation. The findings are facility specific, related to hospital licensure, and do not interact with a regional or statewide plan.

IV. PIECES OF A LARGER PICTURE

Amidst this catalog of tools are interactions among them that might provide the underpinnings of a complete state health planning process. For example:

- The Determination of Need (DoN) process generates community health initiatives locally and community health improvement plans (CHIP) across the state.
- Community needs are identified through the DoN process, community health needs assessments (CHNA), and CHIPs. As has been done in the past, these locally focused needs can be aggregated to provide a picture of regional or statewide health and health care needs.
- The State Health Assessment (SHA) tool offers a broad range of data, which can be a source for state and community planning. The SHA does not include workforce data, but the Center for Health Information and Analysis (CHIA) workforce survey does, and the Health Policy Commission's (HPC) Behavioral Health Workforce Center and the Department of Public Health's (DPH) Health Care Workforce Center may soon have data as well. CHIA's health care cost growth data is another valuable data resource, as are numerous other existing and planned state data sources (such as CHIA's cost reports, hospital profiles, and all-payer claims data, DPH's health care resource inventory and health care capacity dashboard).
- Workforce data can inform where recipients of student loan repayment programs fulfill their service commitments.
- DPH's essential service closures process and the HPC's Cost and Market Impact Reviews (CMIR) can raise red flags about pending changes in health care resource allocation. Cost growth data can be the basis for a CMIR.

More of these interactions likely exist and others are possible, but the tools were not designed as part of a coherent whole to serve a formal planning process, so there are gaps to fill. Use of the tools is not guided by overarching goals or by a state-led process for assessing needs and resources in the public interest. Community-driven needs assessments do not guarantee a total state perspective, nor do needs assessments associated with DoN applications. Hospital and health maintenance organization CHNAs, while covering most of the state in aggregate, are led by private entities.

Data is plentiful in Massachusetts, but it is not comprehensive and not currently used to monitor and report on progress on a statewide plan. Nor is there consensus on either the goals of a statewide plan or the process to monitor progress toward those goals. Further, most of the tools reviewed here are concerned mainly with current conditions, and (with some exceptions) they are not intended to look ahead several years to anticipate needs and inform responses.

V. WHAT IS NEEDED TO SUPPORT A SYSTEMATIC PLANNING EFFORT?

As we have seen, Massachusetts has several building blocks for statewide health planning, but it does not yet have statewide health planning. Some elements that are absent from the current environment include:

- Clearly articulated statewide and regional goals related to the distribution of health care resources. The goals should reflect public priorities around access, equity, quality, and outcomes and should be widely disseminated and reinforced.
- An orientation to meeting future needs, in addition to responding to current concerns.
- An overarching structure, led by a state agency, for stakeholder input and local community involvement.
- A mechanism for monitoring, reviewing, and updating priorities.
- A focus on the health care system beyond hospitals. While some of the tools are broader in scope, central state-level activities – DoN, CHNA, CMIR, for example – are largely about hospitals.

The new Office of Health Resource Planning at the Health Policy Commission appears to have been created with such planning principles in mind. Its process is still under development, but it holds promise as the state-led vehicle that can fill these gaps, learn from the history of health services planning, and help Massachusetts meet its current and future health system challenges with a public interest orientation.

VI. CONCLUSION

A well-functioning health care system should provide affordable and timely access to needed health care for all residents, without regard to their race, ethnicity, income, zip code, age, gender, or sexual orientation. The Massachusetts health care system, despite many exemplary qualities, does not do this. Recent challenges and crises have brought into relief the shortcomings of a system that is largely governed by market dynamics and the decisions of private actors. Though the Commonwealth moved away from most health planning practices years ago, there is new interest in exploring how health planning can improve the allocation of health care resources in service to access, quality, and affordability. Policymakers and administrators can learn from past and present experience to enhance the health care system in a way that benefits all people in Massachusetts.

ENDNOTES

1 The Commonwealth Fund, 2023 Scorecard of State Health System Performance. June 2023. *https://www.commonwealthfund.org/publications/scorecard/2023/jun/2023-scorecard-state-health-system-performance*.

2 MHIS, 2023.

3 Ibid.

4 Massachusetts Health Quality Partners, "Patient Experience Scores for Adults Improve Since Before the Pandemic, Except in One Key Area: Access." February 2024. *https://www.mhqp.org/2024/02/13/patient-experience-scores-for-adults-improve-since-before-the-pandemic-except-in-one-key-area-access/*.

5 AMN Healthcare and Merritt Hawkins. 2022 Survey of Physician Appointment Wait Times and Medicare and Medicaid Acceptance Rates. 2022, cited in Massachusetts Health Policy Commission, "A Dire Diagnosis: The Declining Health of Primary Care in Massachusetts and the Urgent Need for Action." January 2025. *https://masshpc.gov/publications/policyresearch-brief/dire-diagnosis-declining-health-primary-care-massachusetts-and*.

6 Massachusetts Health Policy Commission, Health Care Workforce Trends and Challenges in the Era of COVID-19. March 2023. *https://masshpc.gov/publications/policyresearch-brief/health-care-workforce-trends-and-challenges-era-covid-19*.

7 Center for Health Information and Analysis, Emergency Department Discharge Quarterly Databook. *https://www.chiamass.gov/emergency-department-database-edd-reporting#dashboard*.

8 Liz Kowalczyk, "Emergency Patients in Boston Are Waiting Longer Than Ever for Care." *Boston Globe*, February 5, 2024. *https://www.bostonglobe.com/2024/02/05/metro/massachusetts-er-patients-wait-for-care/*.

9 MHIS, 2023.

10 Center for Health Information and Analysis, Annual Report on the Performance of the Massachusetts Health Care System, March 2025. *https://www.chiamass.gov/assets/2025-annual-report/2025-Annual-Report.pdf*.

11 KFF State Health Facts, cited in Massachusetts Health Policy Commission, Annual Health Care Cost Trends Report and Policy Recommendations. October 2024.

12 For example, see Sarah Iselin, "Massachusetts Needs Comprehensive, Long-Term Health Care Planning Today." *Boston Globe*, April 6, 2024. *https://www.bostonglobe.com/2024/04/06/opinion/health-care-policy-affordability-access/*; John E. McDonough and Paul A. Hattis, "The State's Options With Steward on the Brink." *Commonwealth Beacon*, February 20, 2024. *https://commonwealthbeacon.org/opinion/the-states-options-with-steward-on-the-brink/*.

13 Massachusetts Health Policy Commission, Annual Health Care Cost Trends Report and Policy Recommendations. October 2024.

14 An Act Enhancing the Market Review Process. Chapter 343, Acts of 2024. Section 25.

15 R. K. Thomas, "Introduction to Health Services Planning." In *Health Services Planning*. Springer, 2021. *https://doi.org/10.1007/978-1-0716-1076-3_1*.

16 M.G.L. c. 6D, §22(a)(3).

17 Common Ground Health, "Comprehensive Regional Community Health Assessment." December 2022. *https://media.cmsmax.com/ravk3pgz5ktlujs1r08ci/134-45-cgh-communityhealthassessment-2022-r9.pdf*.

18 Massachusetts Health Policy Commission, Meeting of the Market Oversight and Transparency Committee. Slide presentation. May 9, 2024.

19 Thomas, "Introduction to Health Services Planning."

20 Ibid.

21 P. Starr, *The Social Transformation of American Medicine*. Basic Books, 1982.

22 Ibid.

23 Ibid.

24 Ibid.

25 P.L. 93-641, §1523(a)(4).

26 P.L. 93-641, §1511(a)(3).

27 Evan M. Melhado, "Health Planning in the United States and the Decline of Public-Interest Policymaking." *The Milbank Quarterly*, 84(2), 359–440. 2006. *http://www.jstor.org/stable/25098121*.

28 Starr, *The Social Transformation of American Medicine*.

29 Melhado, "Health Planning in the United States."

30 H. E. Klarman. Health Planning: Progress, Prospects, and Issues. Milbank Mem Fund Q Health Soc. 56(1): 78-112. 1978.

31 Melhado, "Health Planning in the United States."

32 Ibid.

33 Starr, *The Social Transformation of American Medicine*.

34 Melhado, "Health Planning in the United States."

35 John E. McDonough, "Tracking The Demise of State Hospital Rate Setting," Health Affairs 16(1) (January 1, 1997): 142–49, *https://doi.org/10.1377/hlthaff.16.1.142*.

36 Commonwealth of Massachusetts, Community Health Network Areas (CHNA) Configuration. *https://www.mass.gov/info-details/community-health-network-areas-chna-configuration*.

37 Community Health Training Institute, Coalitions. *https://hriainstitute.org/coalitions/*.

38 Ben Wood, John Auerbach, and Monica Bharel, "Leveraging Certificates of Need to Increase Public Health Spending: The Massachusetts Example." *Health Affairs Forefront*, December 17, 2024. *https://doi.org/10.1377/forefront.20241125.447737*.

39 105 CMR 100.726.

40 Memorandum from Dennis Renaud, Determination of Need Program, Massachusetts Department of Public Health, "Annual Adjustments to Determination of Need (DoN) Expenditure Minimums. November 8, 2024. *https://www.mass.gov/doc/expenditure-minimums-for-applying-for-a-don-2024-2025-pdf/download*.

41 Wood, Auerbach, and Bharel, "Leveraging Certificates of Need."

42 105 CMR 100.210.

43 105 CMR 100.100.

44 Commonwealth of Massachusetts, DON Completed Projects. *https://www.mass.gov/info-details/don-completed-projects#2024-*; Commonwealth of Massachusetts, DON pending projects and applications. *https://www.mass.gov/info-details/don-pending-projects-and-applications*.

45 105 CMR 100.310.

46 M.G.L. c. 6D, §22.

47 Chapter 343, Acts of 2024, Section 82.

48 M.G.L. c. 6D, §22(b)(1).

49 M.G.L. c. 6D, §22(f).

50 Massachusetts Department of Public Health, State Health Assessment (SHA). *https://www.mass.gov/info-details/state-health-assessment-sha*.

51 Commonwealth of Massachusetts, Community Health Data Tool: Data and Source List. *https://healthdatatool.mass.gov/data-list/*.

52 Commonwealth of Massachusetts, Office of the Attorney General, The Attorney General's Community Benefits Guidelines for Non-Profit Hospitals. February 2018; The Attorney General's Community Benefits Guidelines for Health Maintenance Organizations. February 2018.

53 Commonwealth of Massachusetts, Office of the Attorney General. The Attorney General's Community Benefits Guidelines for Non-Profit Hospitals. February 2018.

54 Commonwealth of Massachusetts, Office of the Attorney General, Hospital and HMO Community Benefits Reports. *https://massago.hylandcloud.com/231cbs/annualreport.aspx*.

55 For an example, see Massachusetts Department of Public Health, *Scan of Community Health & Health Needs Assessments From Across Massachusetts, 2012 – 2017*. July 2017.

56 MA Health Funds, What We Fund. *https://mahealthfunds.org/what-we-fund/*.

57 Ibid.

58 MA Health Funds, Frequently Asked Questions. *https://mahealthfunds.org/frequently-asked-questions/*.

59 MA Health Funds, Current Awardees. *https://mahealthfunds.org/current-awardees/*.

60 MA Health Funds, Frequently Asked Questions.

61 Franklin County/North Quabbin CHIP Network, *Goals and Objectives 2024-2028*. *https://frcog.org/wp-content/uploads/2024/09/CHIP-3.0-Plan-final-for-web.pdf*.

62 Massachusetts Department of Public Health, The Massachusetts Health Care Workforce Center. *https://www.mass.gov/the-massachusetts-health-care-workforce-center-hcwc*.

63 M.G.L. c. 111, §25L. *https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter111/Section25L*.

64 Commonwealth of Massachusetts, Apply for the Massachusetts Loan Repayment Program for Health Professionals. *https://www.mass.gov/how-to/apply-for-the-massachusetts-loan-repayment-program-for-health-professionals*.

65 Massachusetts Department of Public Health, Massachusetts Health Care Workforce Center Annual Report. July 2017. *https://www.mass.gov/doc/health-care-workforce-center-annual-report-2017-2/download*.

66 Commonwealth of Massachusetts, Health Professions Data Series. *https://www.mass.gov/lists/health-professions-data-series*.

67 Center for Health Information and Analysis, Massachusetts Health Care Workforce Survey. *https://www.chiamass.gov/massachusetts-healthcare-workforce-survey*.

68 Ibid.

69 Center for Health Information and Analysis, Massachusetts Health Care Workforce Survey. 2023. *https://www.chiamass.gov/assets/docs/r/pubs/2024/Massachusetts-Health-Care-Workforce-Survey-Executive-Summary.pdf*.

70 Massachusetts Health Policy Commission, "Health Policy Commission Announces New Behavioral Health Workforce Center." Press release, September 19, 2024. *https://masshpc.gov/news/press-release/health-policy-commission-announces-new-behavioral-health-workforce-center*.

71 Massachusetts Health Policy Commission, HPC Board Meeting Presentation, September 19, 2024. *https://masshpc.gov/sites/default/files/2024-09/20240919_Board_Presentation.pdf*.

72 Massachusetts Health Policy Commission, Behavioral Health Workforce Center Advisory Group. *https://masshpc.gov/bh-workforce/advisory-group*.

73 Commonwealth of Massachusetts, Bill H.5159: An Act Enhancing the Market Review Process. *https://malegislature.gov/Bills/193/H5159*.

74 M.G.L. c. 6D, §8.

75 M.G.L. c. 6D, §11.

76 Massachusetts Office of the State Auditor, Chapter 224 Overview. *https://www.mass.gov/info-details/chapter-224-overview*.

77 Center for Health Information and Analysis, Annual Report on the Performance of the Massachusetts Health Care System. March 2024. *https://www.chiamass.gov/annual-report*.

78 Health Policy Commission, Annual Health Care Cost Trends Report and Policy Recommendations. October 2024. *https://masshpc.gov/sites/default/files/2024_Cost_Trends_Report.pdf*.

79 Center for Health Information and Analysis, Primary Care and Behavioral Health Care (PCBH) Spending. *https://www.chiamass.gov/primary-care-and-behavioral-health-care-pcbh-expenditures*.

80 Massachusetts Health Policy Commission, "A Dire Diagnosis: The Declining Health of Primary Care in Massachusetts and the Urgent Need for Action." January 2025. *https://masshpc.gov/publications/policyresearch-brief/dire-diagnosis-declining-health-primary-care-massachusetts-and*.

81 Health Policy Commission Annual Cost Trends Hearing. November 14, 2024. *https://youtu.be/rrSosNPs2y8*.

82 Massachusetts Health Policy Commission, Material Change Notices and Cost and Market Impact Reviews. *https://masshpc.gov/moat/mcn-cmir*.

83 Massachusetts Health Policy Commission, Material Change Notices Transaction List. *https://masshpc.gov/moat/mcn-cmir/mcn-transactions*.

84 Massachusetts Health Policy Commission, Information About Material Change Notices (MCNs) and Cost and Market Impact Reviews (CMIRs). *https://masshpc.gov/sites/default/files/2024-04/Transaction-Review-Process.pdf*.

85 M.G.L. c. 6D, §13(a) and (b).

86 958 CMR 7.14.

87 Massachusetts Health Policy Commission, Review of Partners HealthCare System's Proposed Acquisition of South Shore Hospital and Harbor Medical Associates. February 19, 2014. *https://masshpc.gov/sites/default/files/2023-04/20140219-final-cmir-report-phs-ssh-hmc.pdf*.

88 Massachusetts Health Policy Commission, Material Change Notices and Cost and Market Impact Reviews.

89 105 CMR 130.020.

90 In the case of Steward Health Care's closures of Nashoba Valley Medical Center and Carney Hospital, these notice requirements were truncated or waived, by order of the bankruptcy court. (See *https://www.mass.gov/info-details/hospital-essential-service-closures*).

91 105 CMR 130.122.

92 Commonwealth of Massachusetts, Hospital Essential Service Closures. *https://www.mass.gov/info-details/hospital-essential-service-closures*.

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