MASSACHUSETTS
HEALTH POLICY COMMISSION

# HPC Board Meeting

April 11, 2024

# Agenda

## CALL TO ORDER

Board Operations

Executive Session **(VOTE)**

Market Oversight

Potential Policy Solutions Regarding Private Equity in Health Care

2025 Health Care Cost Growth Benchmark **(VOTE)**

Executive Director's Report

Adjourn

# Agenda

Call to Order

## BOARD OPERATIONS

- Approval of Minutes (**VOTE**)
- Vice Chair Appointment (**VOTE**)

Executive Session **(VOTE)**

Market Oversight

Potential Policy Solutions Regarding Private Equity in Health Care

2025 Health Care Cost Growth Benchmark **(VOTE)**

Executive Director's Report

Adjourn

# Agenda

Call to Order

Board Operations

**APPROVAL OF MINUTES (VOTE)**

- Vice Chair Appointment (**VOTE**)

Executive Session **(VOTE)**

Market Oversight

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Adjourn

# VOTE

## Approval of Minutes from the January 25, 2024 Board Meeting

### MOTION

That the Commission hereby approves the minutes of the Commission meeting held on **January 25, 2024**, as presented.

# Agenda

Call to Order

Board Operations

- Approval of Minutes **(VOTE)**

**VICE CHAIR APPOINTMENT (VOTE)**

Executive Session **(VOTE)**

Market Oversight

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# VOTE

## Vice Chair Election

### MOTION

That, pursuant to Section 2.3 of the By-Laws, the Commission hereby elects _____ to serve as Vice Chair of the Health Policy Commission.

# Agenda

Call to Order

Board Operations

**EXECUTIVE SESSION (VOTE)**

Market Oversight

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# VOTE

## Enter Executive Session

### MOTION

That, having first convened in open session at its April 11, 2024 Commission meeting and pursuant to M.G.L. c. 30A, § 21(a)(7), the Commission hereby approves going into executive session for the purpose of complying with M.G.L. c. 6D, § 10 and its associated regulation, 958 CMR 10.00, M.G.L. c. 6D, § 2A, and M.G.L. c. 12C, § 18, in discussions about whether to require performance improvement plans by entities confidentially identified to the Commission by the Center for Health Information and Analysis.

# The HPC Board is in Executive Session.

# The livestream will resume at approximately 1:00 PM.

# Agenda

Call to Order

Board Operations

Executive Session **(VOTE)**

## MARKET OVERSIGHT

- 2023 Performance Improvement Plan Process
- Mass General Brigham Performance Improvement Plan
- Notices of Material Change

Potential Policy Solutions Regarding Private Equity in Health Care

2025 Health Care Cost Growth Benchmark **(VOTE)**

Executive Director's Report

Adjourn

# Agenda

Call to Order

Board Operations

Executive Session **(VOTE)**

Market Oversight

## 2023 PERFORMANCE IMPROVEMENT PLAN PROCESS

- Mass General Brigham Performance Improvement Plan
- Notices of Material Change

Potential Policy Solutions Regarding Private Equity in Health Care

2025 Health Care Cost Growth Benchmark **(VOTE)**

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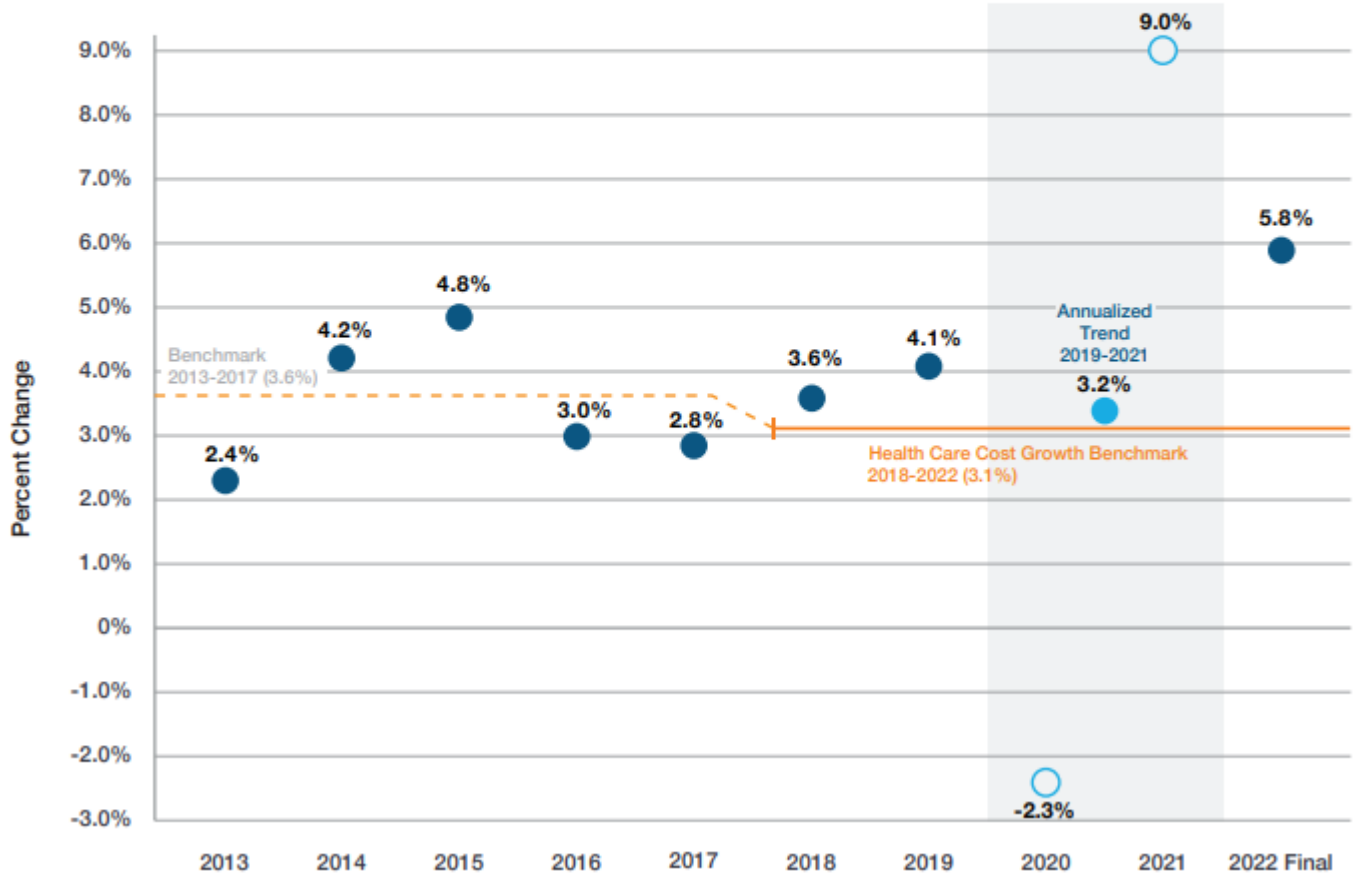
Adjourn

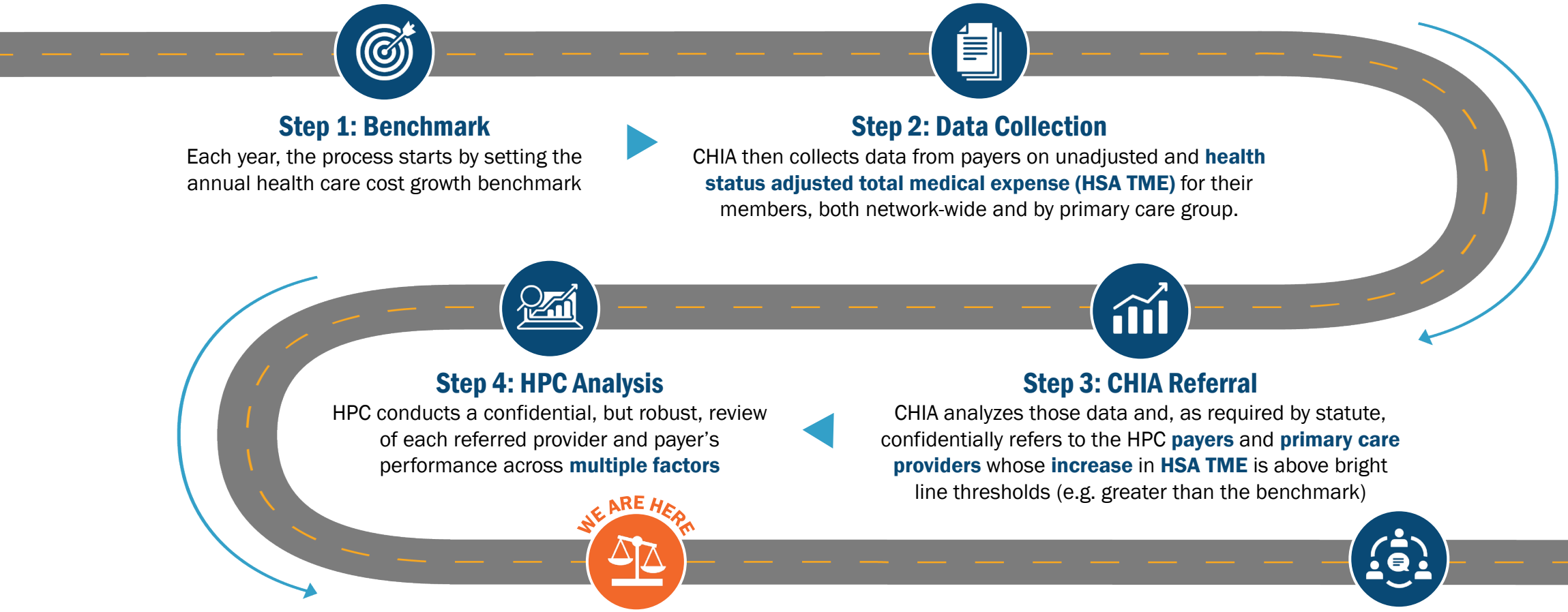
# Overview of Performance Improvement Plans: Purpose

## Per Capita Total Health Care Expenditure Trends, 2013-2022




- Over the last five years, Total Health Care Expenditures have grown at an annualized rate of 4.0%, **exceeding the benchmark**.
- Performance Improvement Plans are the **key mechanism to hold individual payers and providers accountable** for their spending performance relative to the benchmark.
- Through the PIPs process, the **HPC conducts a robust review of referred entities** to understand the drivers of the entity's spending growth.
- When the HPC determines that a PIP is warranted, it **works collaboratively with the entity** to develop a plan to address its spending drivers and to monitor outcomes.

# Accountability for the Health Care Cost Growth Benchmark: An Overview



## Step 1: Benchmark

Each year, the process starts by setting the annual health care cost growth benchmark

## Step 2: Data Collection

CHIA then collects data from payers on unadjusted and **health status adjusted total medical expense (HSA TME)** for their members, both network-wide and by primary care group.

## Step 3: CHIA Referral

CHIA analyzes those data and, as required by statute, confidentially refers to the HPC **payers** and **primary care providers** whose **increase** in **HSA TME** is above bright line thresholds (e.g. greater than the benchmark)

## Step 4: HPC Analysis

HPC conducts a confidential, but robust, review of each referred provider and payer's performance across **multiple factors**

WE ARE HERE

## Step 5: Decision to Require a PIP

After reviewing all available information, including confidential information from payers and providers under review, the **HPC Board may vote** to require a PIP if it identifies significant concerns and finds that a PIP could result in meaningful, cost-saving reforms. The entity's identity is public once a PIP is required.

## Step 6: PIP Implementation

The payer or provider must propose the PIP and is subject to **ongoing monitoring** by the HPC during the **18-month implementation**. A fine of up to $500,000 can be assessed as a last resort in certain circumstances.

# Overview of Performance Improvement Plans: Factors Review by the Commission

The HPC may require any entity referred to it by CHIA to complete a Performance Improvement Plan if, after a review of the factors below, it identifies significant concerns about the Entity's costs and determines that a Performance Improvement Plan could result in meaningful, cost-saving reforms.

| Regulatory Factors | |
|---|---|
| a | Baseline spending and spending trends over time, including by service category; |
| b | Pricing patterns and trends over time; |
| c | Utilization patterns and trends over time; |
| d | Population(s) served, payer mix, product lines, and services provided; |
| e | Size and market share; |
| f | Financial condition, including administrative spending and cost structure; |
| g | Ongoing strategies or investments to improve efficiency or reduce spending growth over time; |
| h | Factors leading to increased costs that are outside the CHIA-identified Entity's control; and |
| i | Any other factors the Commission considers relevant. |

Source: 958 CMR 10.00: Performance Improvement Plans

# 2021 Spending Growth

- After falling by 2.3% in 2020, per-capita statewide **THCE grew by 9.0% in 2021**.
- Recognizing the **significant disruptions in enrollment, utilization, spending** that occurred in 2020 and 2021, the HPC focused its evaluation on annualized, per member per month spending trends.
- **Annualized PMPM trends** represent the growth in per-enrollee spending that would have occurred from both 2019 to 2020 and 2020 to 2021 if growth had been constant over the two-year period.

| Spending Category | 2019-2021 Annualized |
|---|---|
| Statewide per Capita | 3.2% |
| Commercial PMPM | 6.6% |
| Medicare PMPM | 2.4% |
| MassHealth PMPM | -2.3% |

Sources: Center for Health Information and Analysis. 2023 Annual Report: https://www.chiamass.gov/assets/2023-annual-report/2023-Annual-Report.pdf

# 2021 Spending in Context

**The COVID Pandemic:**

- Healthcare spending was artificially low in 2020, as patients deferred elective and non-urgent care during the pandemic. In 2021, **utilization and spending rebounded**.
- The HPC estimates that spending on **COVID testing and vaccine administration** accounted for approximately 1 ppt of growth in 2019-2021 annualized trends.

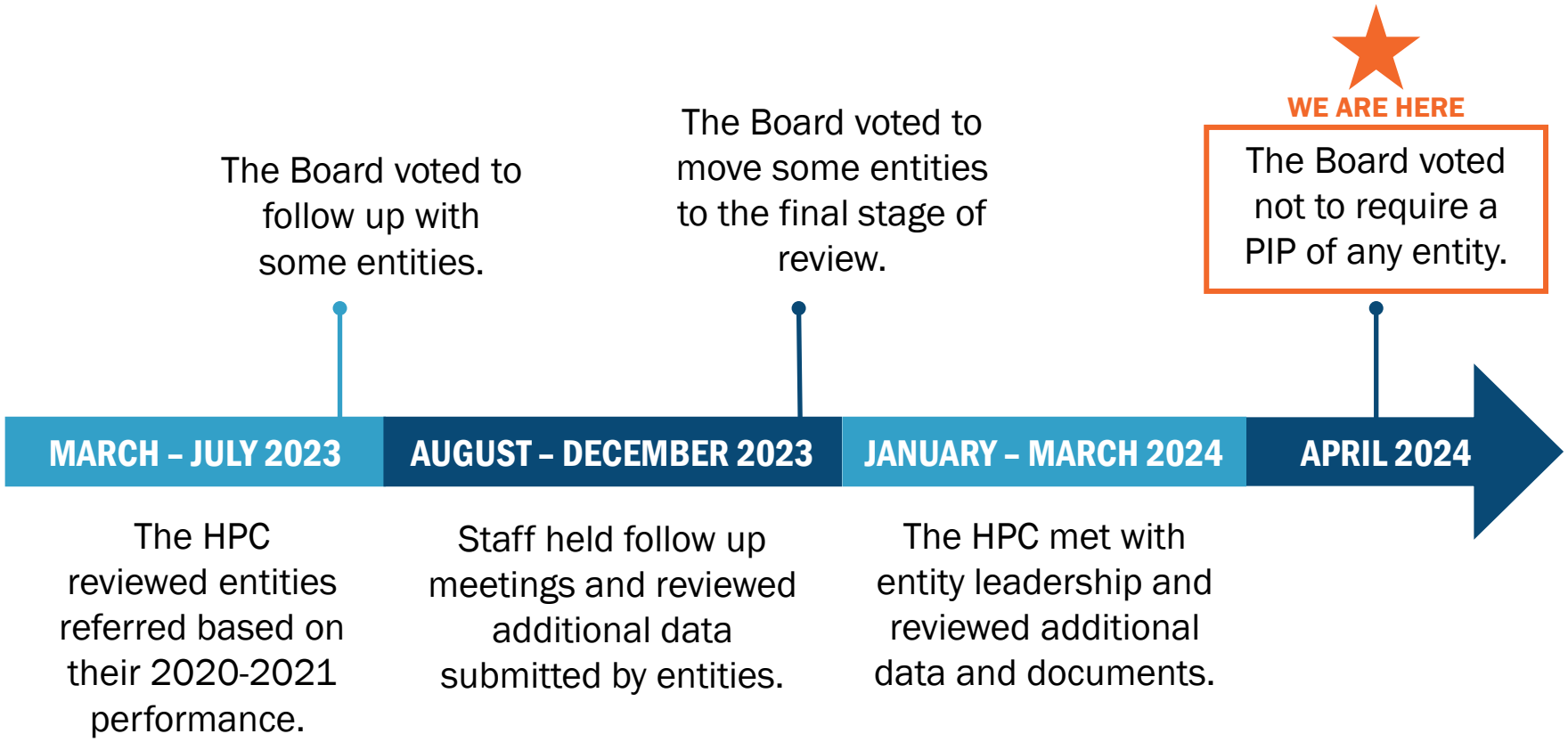
**Provider Cost Pressures:**

- Consistent with national trends, MA **experienced high inflation** in 2021 and 2022.
- COVID-19 also exacerbated existing **workforce shortages** across the continuum of care, leading to high rates of vacancy and turnover, increased use of contract labor, and a competitive labor market generally.

**Price Increases:**

- Prior HPC analysis of the APCD found that in 2021, Massachusetts providers had higher commercial **price growth** across office, HOPD, and inpatient settings than in the previous two years.

# Timeline of 2023 Review




- In the **2023 PIPs Cycle**, the HPC examined the spending performance of entities referred based on their 2020 to 2021 HSA TME growth.
- As a result of COVID-related statewide trends from, a **larger number of payers and providers were referred** in this cycle than in past cycles;
- The HPC carefully considered **contextualizing factors related to the pandemic and broader market disruptions** in its review of spending performance.

# Conclusion of the 2023 PIPs Review Cycle

- The HPC has **completed its review** of the 2023 PIPs Review Cycle and elected **not to require a PIP** from any referred payer or provider entity.
- Significant disruptions to utilization patterns, workforce availability, and provider financial pressures contributed to **market-wide spending growth** during this period.
- However, the HPC **continues to monitor and evaluate** entities' long-term spending performance and may consider 2020-2021 referrals and all available spending data when determining whether to require a PIP.
- The HPC expects to receive the **2024 PIPs list from CHIA,** based on 2021-2022 spending growth, imminently.

# Agenda

Call to Order

Board Operations

Executive Session **(VOTE)**

Market Oversight

- 2023 Performance Improvement Plan Process

**MASS GENERAL BRIGHAM PERFORMANCE IMPROVEMENT PLAN**

- Notices of Material Change

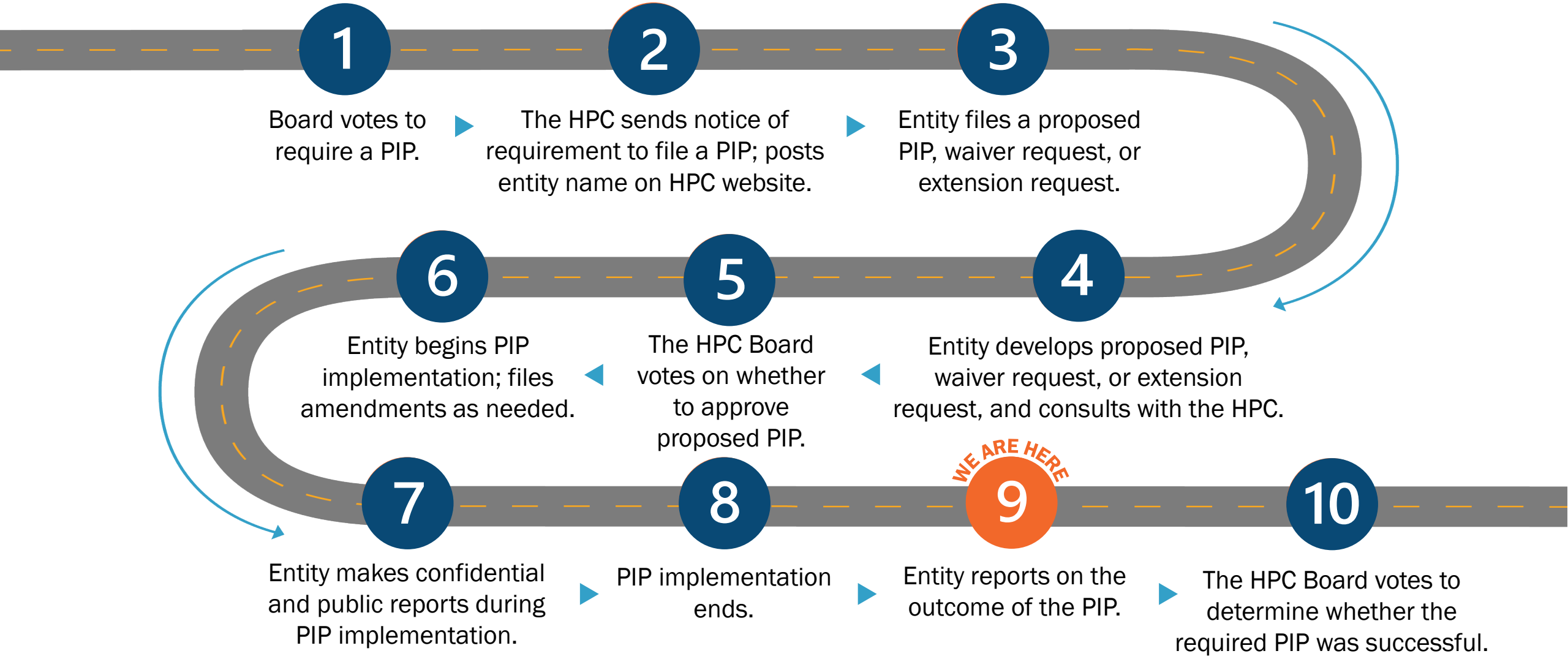
Potential Policy Solutions Regarding Private Equity in Health Care

2025 Health Care Cost Growth Benchmark **(VOTE)**

Executive Director's Report

Adjourn

# Performance Improvement Plan Process: An Overview



# Mass General Brigham Performance Improvement Plan

- **Conclusion of Implementation:** Mass General Brigham **completed the implementation period** of its Performance Improvement Plan on March 31, 2024.
  - The PIP ran for a total of 18 months, from October 2022 through March 2024.
  - MGB implemented 10 different cost control strategies with a goal of saving **$176M**.
- **Monitoring:** Every quarter of implementation, **MGB provided qualitative and quantitative progress reports**.
- **Evaluation:** Both **the HPC and MGB will now conduct their own evaluations** of the success of the PIP. After these evaluations are complete, **the HPC must vote as to whether MGB's PIP was successful**, based on a set of regulatory factors including:
  - Whether MGB **fully implemented** the PIP and has addressed the HPC's concerns about its costs;
  - The **sustainability** of the efficiencies and cost savings of the PIP;
  - The impact of any events **outside of MGB's control** and any other relevant factors.
- **Next Steps:** Staff expect to bring findings before the HPC Board **later this year**.

# Agenda

Call to Order

Board Operations

Executive Session **(VOTE)**

Market Oversight

- 2023 Performance Improvement Plan Process
- Mass General Brigham Performance Improvement Plan

## NOTICES OF MATERIAL CHANGE

Potential Policy Solutions Regarding Private Equity in Health Care

2025 Health Care Cost Growth Benchmark **(VOTE)**

Executive Director's Report

Adjourn

# Since 2013, the HPC has reviewed 168 market changes.

| TYPE OF TRANSACTION | NUMBER | FREQUENCY |
|---|---|---|
| Formation of a contracting entity | 39 | 23% |
| Clinical affiliation | 36 | 22% |
| Physician group merger, acquisition, or network affiliation | 35 | 21% |
| Acute hospital merger, acquisition, or network affiliation | 27 | 16% |
| Merger, acquisition, or network affiliation of other provider type (e.g., post-acute) | 25 | 15% |
| Change in ownership or merger of corporately affiliated entities | 5 | 3% |
| Affiliation between a provider and a carrier | 1 | 1% |

# Since 2013, over 50% of market changes reviewed by the HPC involved for-profit entities.

| TYPE OF TRANSACTION | ALL ENTITIES | FOR-PROFIT |
|---|---|---|
| Formation of a contracting entity | 39 | 28 |
| Clinical affiliation | 36 | 9 |
| Physician group merger, acquisition, or network affiliation | 35 | 24 |
| Acute hospital merger, acquisition, or network affiliation | 27 | 5 |
| Merger, acquisition, or network affiliation of other provider type (e.g., post-acute) | 25 | 17 |
| Change in ownership or merger of corporately affiliated entities | 5 | 3 |
| Affiliation between a provider and a carrier | 1 | 0 |
| **TOTAL** | **168** | **86** |

Note: Transaction counted in "For-Profit" if either party is a for-profit entity.

# Elected Not to Proceed

- The proposed acquisition of **Amedisys**, a publicly-held, for-profit home health and hospice care company based in Louisiana that owns nineteen home health, hospice, or palliative care locations across Massachusetts, by **UnitedHealth Group**, a national diversified healthcare company.
- The proposed acquisition of certain outreach laboratory assets of **Baystate Medical Center** and establishment of a clinical laboratory by the **Laboratory Corporation of America**.
- A proposed joint venture between **Atrius MSO,** the subsidiary of Optum Inc. that owns and provides management services to Atrius Health, and **Shields Imaging Services,** an affiliate of **Shields HealthCare Group (Shields)**, to own and operate a new mobile PET/CT clinic in the Dedham area.
- A proposed joint venture between **Shields** and **UMass Memorial Health – Harrington** that would integrate and manage MRI services at Harrington via a new management services organization owned by Shields and Harrington.

# Material Change Notices Currently Under Review

A proposed joint venture between **Greater Springfield Surgery Center,** which operates an ambulatory surgery center in Springfield, and **Mercy Medical Center**, a community hospital also located in Springfield, owned by Trinity Health of New England. Through the joint venture, Mercy would acquire a majority ownership stake in the existing surgery center.

A proposed clinical affiliation between **Dana-Farber Cancer Institute**, **Beth Israel Deaconess Medical Center**, and the **Harvard Medical Faculty Physicians**. The Board voted on January 25 to authorize the initiation of a CMIR once the notice was complete.

## RECEIVED SINCE 1/25

The proposed acquisition of **Milford Regional Medical Center** by **UMass Memorial Health Care**.

# Material Change Notices Currently Under Review (continued)

- A proposed contracting affiliation between **Pediatric Associates of Greater Salem**, which is currently part of Steward Health Care's contracting network, and **Affiliated Pediatrics Practices**, which establishes most of its payer contracts through Mass General Brigham.

- A proposed joint venture between **BMC Health System** and **Tellica Imaging** to establish and operate a licensed clinic offering MRI and CT services at three Massachusetts locations.

- The proposed acquisition of **New England Neurological Associates PC**, a multispecialty neuroscience group with physician and advance practice providers that serves patients in the greater Boston and Merrimack Valley area, by **LGH Medical Group LLC**, a multispecialty physician practice affiliated with Lowell General Hospital.

# Material Change Notices Currently Under Review (continued)

## Stewardship – OptumCare

The proposed sale of Steward subsidiary **Stewardship Health**, the parent of Stewardship Health Medical Group, which employs primary care and other clinicians across nine states, and Steward Health Care Network, a provider contracting network, to **OptumCare**, a subsidiary of UnitedHealth Group.

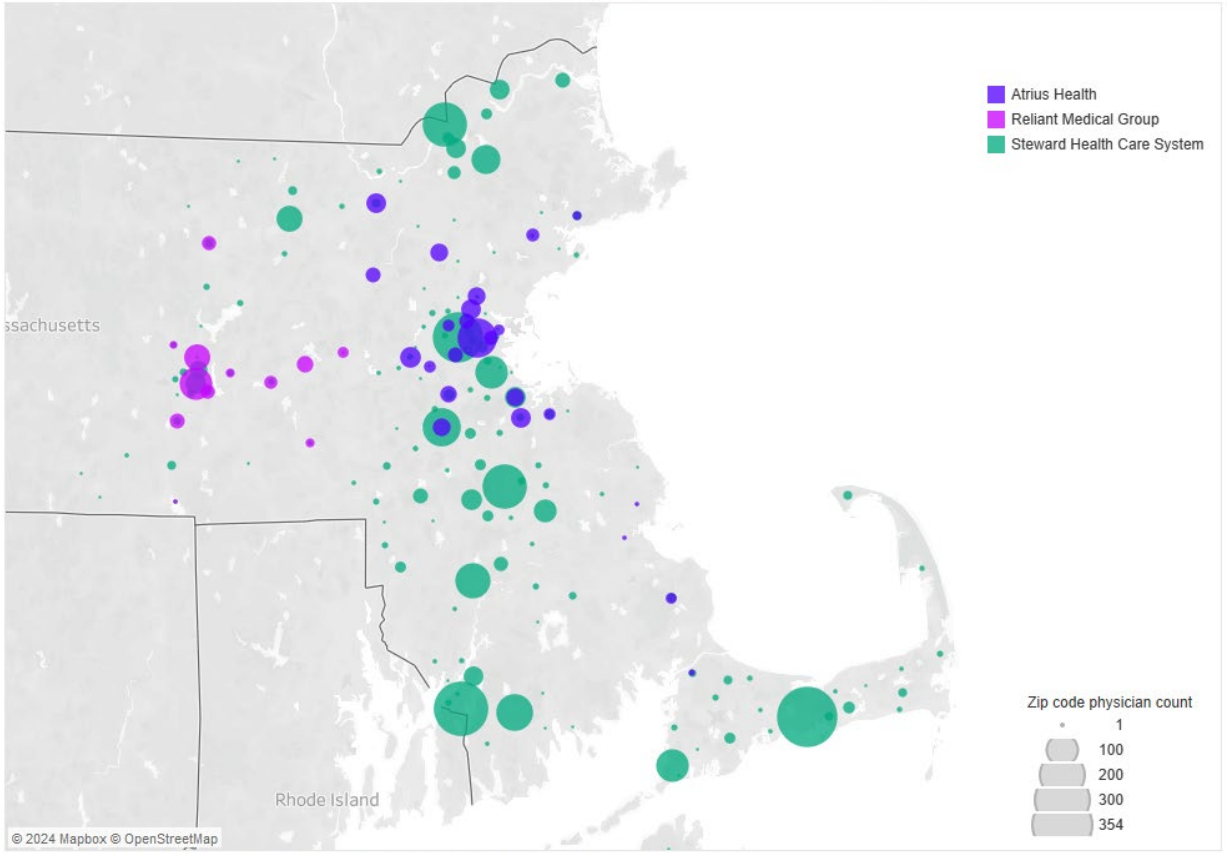
- The parties have submitted a Hart-Scott-Rodino filing with federal antitrust agencies.
- HPC staff have begun our initial review, but the notice is not yet complete, so the 30-day timeline for preliminary review has not yet begun.
- The HPC is working to understand which Steward physicians are involved in the transaction, and what the relationship will be between the physicians and Steward's hospitals.
- Steward is currently the third-largest physician contracting network in Massachusetts, behind Mass General Brigham and Beth Israel Lahey Health, with approximately 2,950 physicians (45% employed) reported into our Registration of Provider Organization (RPO) program.
- OptumCare's physician network includes Atrius, Reliant, and MedExpress, with approximately 975 physicians (86% employed) in Massachusetts combined in RPO.

# Material Change Notices Currently Under Review (continued)

## Stewardship – OptumCare

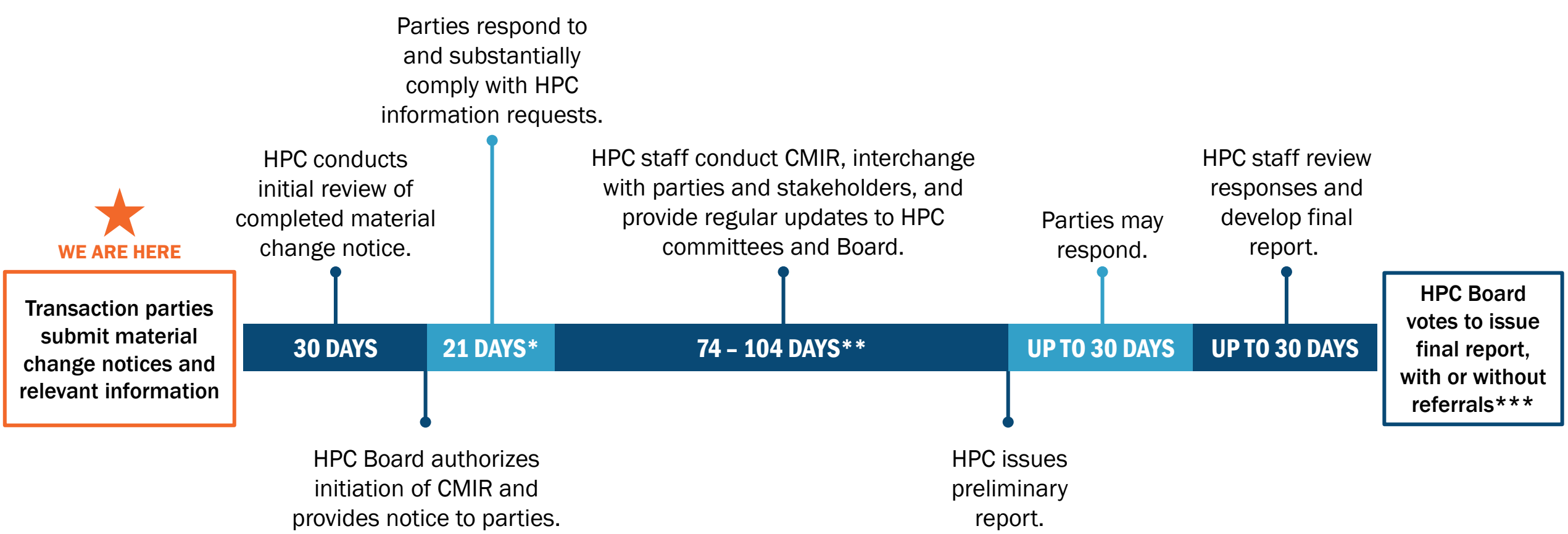
- Steward and Atrius physicians both operate in eastern Massachusetts, while Reliant physicians are primarily in central Massachusetts.

Steward, Atrius, and Reliant physician locations by zip code




Source: HPC analysis of 2022 Massachusetts Registration of Provider Organizations (MA-RPO) Physician Roster.
Locations indicate the zip code of each physician's primary site of practice
Physicians reported on more than one provider organization's roster are included in each organization's physician count in the above maps.
Includes physicians employed by and contracting through each provider network

# Timelines for MCN/CMIR Review




* The parties may request extensions to this timeline which may likewise affect the timing of the report
** Plus any time granted to parties for responses to information requests
*** The parties must wait 30 days following the issuance of the final report to close the transaction

# Overview of Cost and Market Impact Reviews (CMIRs)

**The HPC may conduct a Cost and Market Impact Review (CMIR) for transactions anticipated to have "a significant impact on the commonwealth's ability to meet the health care cost growth benchmark, or on the competitive market."**

## WHAT A CMIR IS

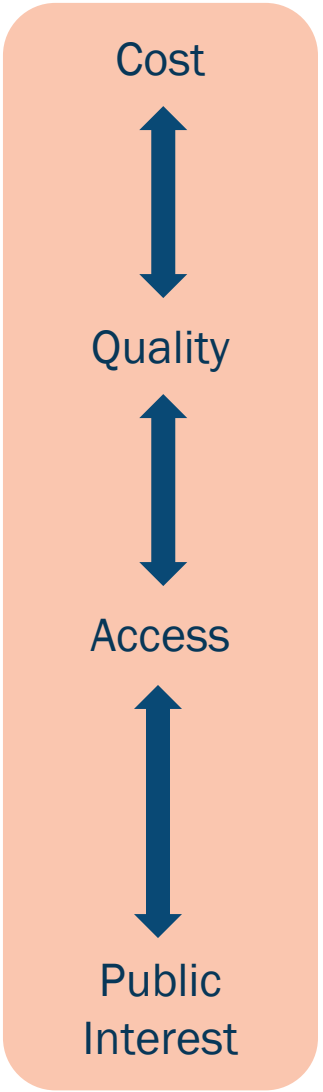
- Comprehensive, multi-factor review of the provider(s) and their proposed transaction
- A public transparency process, including a preliminary report, opportunity for the providers to respond, and a final public report
- An opportunity for accountability, encouraging market participants to address negative impacts and enhance positive outcomes of transactions
- An input to other oversight processes: Proposed changes cannot be completed until 30 days after the HPC issues its final report, which may be referred to the state Attorney General, Department of Public Health, or others for further investigation

## WHAT IT IS NOT

- CMIRs are a separate, but complementary, process from Determination of Need reviews by Department of Public Health
- CMIRs are distinct from antitrust or other law enforcement review by state or federal agencies

# Statutory Factors for Evaluating Cost and Market Impacts

MARKET FUNCTIONING




- Unit prices
- Health status adjusted total medical expenses
- Provider costs and cost trends
- Provider size and market share within primary service areas and dispersed service areas
- Quality of services provided, including patient experience
- Availability and accessibility of services within primary service areas and dispersed service areas
- Impact on competing options for health care delivery, including impact on existing providers
- Methods used to attract patient volume and to recruit or acquire health care professionals or facilities
- Role in serving at-risk, underserved, and government payer populations
- Role in providing low margin or negative margin services
- Consumer concerns, such as complaints that the provider has engaged in any unfair method of competition or any unfair or deceptive act
- Other factors in the public interest

# Other Recently Proposed Market Changes

**Mass. General Brigham (MGB)** has requested the Department of Public Health's Determination of Need (DoN) program allow the addition of 94 inpatient beds at Mass. General Hospital (MGH).

- This request was filed as an amendment to MGH's previously approved clinical tower DoN, which MGB states will add the equivalent of 64 beds. The additional 94 beds would be available after the tower is completed (approximately 2027).
- The HPC issued a comment on the original proposal, outlining potential impacts on spending, market functioning, and health equity, including increased annual commercial spending of $23.7M to $40.6M.

**Cape Cod Healthcare** has also filed a DoN amendment to add 32 inpatient beds at Cape Cod Hospital.

- These beds would replace 28 beds Cape Cod is currently permitted to staff under a temporary DPH waiver when the hospital's permanent beds are filled.

# Agenda

Call to Order

Board Operations

Executive Session **(VOTE)**

Market Oversight

**POTENTIAL POLICY SOLUTIONS REGARDING PRIVATE EQUITY IN HEALTH CARE**

2025 Health Care Cost Growth Benchmark **(VOTE)**

Executive Director's Report

Adjourn

# Joint Committee on Health Care Financing Public Hearing

## *Examination of the Effects of Private Equity Ownership and Investment in Health Care*

> We must better **understand the role of private equity in this ongoing crisis** and how health care delivery is affected when a company whose business model is short term investment for enormous financial return enters the health care market, where the model is and must be providing high-quality health care. **Where the patients and those providing the care come first.** Where profit is not the motivator and where everyone, regardless of who they are, or where they live, or what their economic status is, has access to that health care.
>
> – *Senator Cindy Friedman, Senate Chair, Joint Committee on Health Care Financing*

# National Trends in Private Equity Investment in Health Care

## PRIVATE EQUITY EXPANSION

Research indicates significant growth of private equity (PE) investment in the U.S. health care market. For example, one analysis found a six-fold increase in physician practices (various specialties) acquired by PE firms from 2012 (75) to 2021 (484).[1] Similar increases have been seen in other areas of health care.[2]

## CORPORATE STRUCTURES

Transactions with PE and other for-profit firms often use complex corporate structures, including using management services organizations (MSOs) to purchase providers' non-clinical assets and provide non-clinical services to health care practices. The use of MSOs avoids corporate practice of medicine prohibitions.

## ONGOING CONSOLIDATION

PE and other for-profit firms often acquire multiple providers (sometimes merging firms through "roll-ups"), leading to increased market consolidation and increased prices.[3] Nationally, the health care market continues to consolidate, including through cross-market mergers (mergers or acquisitions involving providers that do not directly compete in the same geographic markets).[4]

[1] Scheffler R et al., Monetizing Medicine: Private Equity and Competition in Physician Practice Markets.
[2] See, e.g., the Private Equity Stakeholder Project, Private Equity Hospital Tracker, available at https://pestakeholder.org/private-equity-hospital-tracker/. The Private Equity Stakeholder Project also tracks private equity activity in other healthcare areas such as home health and urgent care.
[3] La Forgia A et al., Association of Physician Management Companies and Private Equity Investment with Commercial Health Care Prices Paid to Anesthesia Practitioners, 182 JAMA Internal Medicine 4 (April 2022).
[4] UC Law San Francisco, The Source on Healthcare Price and Competition, Cross-Market Systems, available at https://sourceonhealthcare.org.

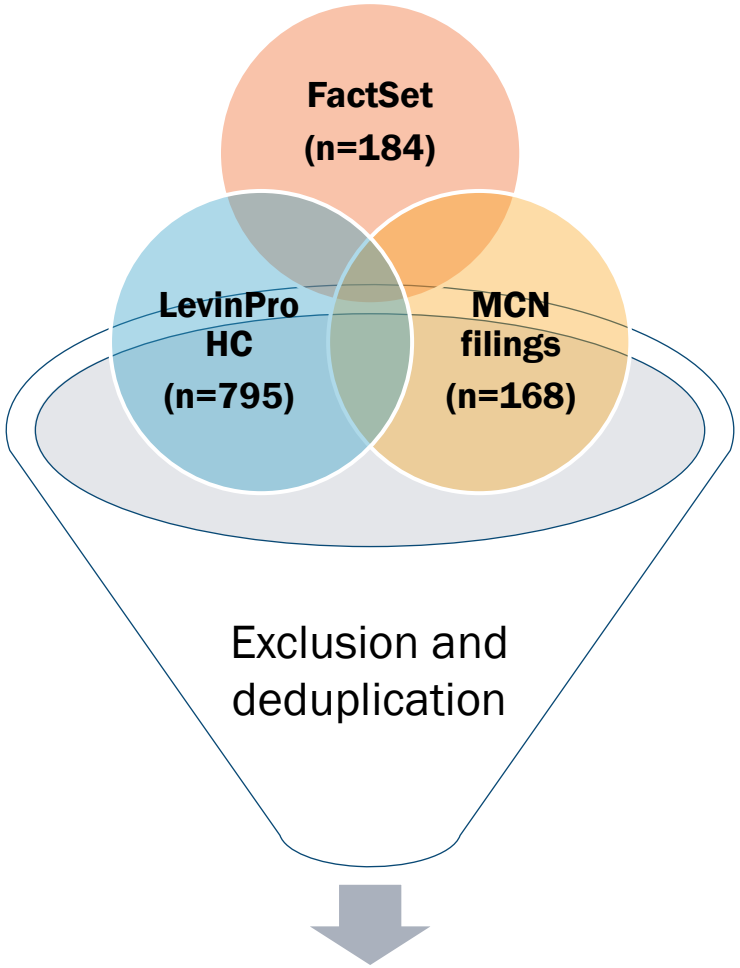
# The Role and Impact of Private Equity in Health Care

- Features that distinguish Private Equity (PE) deals from other for-profit investment in health care entities:
  - **Rapid and high expected return on investments**, which are difficult to achieve through efficiency gains alone
  - PE firms pursue a variety of unique strategies that are anticompetitive and destabilizing to the health care market: **leveraged buyouts, sale-leaseback of real estate, debt-funded dividends, and roll-ups**[1]
  - PE firms benefit from **certain tax privileges and operate under the regulatory radar**[2]
  - PE investors are "lay investors" who are not "subject to professional or institutional norms keyed to the higher ethical goals of medical care"[3]
- PE investments in health care have increased substantially in recent years: **annual deal values have been estimated to grow from $41.5 billion in 2010 to $119.9 in 2019, totaling roughly $750 billion in the last decade**.[4]
- A growing body of research suggests that **PE ownership can affect health care spending, quality, and access**. For example, PE investments in nursing homes have been linked to **higher spending**, **lower quality of care**, and **higher mortality rates**.[5] In hospitals and specialty care such as anesthesiology, dermatology, ophthalmology, and emergency care where PE has concentrated, most studies have found that PE acquisitions are associated with higher prices and increased utilization.[6-9]


1. Private Equity Stakeholder Project. PESP Private Equity Hospital Tracker. Available at: https://pestakeholder.org/private-equity-hospital-tracker/
2. Cai C, Song Z. A Policy Framework for the Growing Influence of Private Equity in Health Care Delivery. JAMA. 2023 May 9;329(18):1545-6.
3. Fuse Brown EC, Hall MA. Private Equity and the Corporatization of Health Care. Stanford Law Review. 2024 Feb 28;76.
4. Scheffler R, Alexander L, Godwin J. Soaring private equity investment in the healthcare sector. Nicholas C. Petis Center on Health Care Markets and Consumer Welfare at UC Berkley. May 18, 2021. Available at: https://publichealth.berkeley.edu/wp-content/uploads/2021/05/Private-Equity-I-Healthcare-Report-FINAL.pdf
5. Gupta A et al. Owner Incentives and Perf. in Healthcare: Private Equity Investment in Nursing Homes. NBER W.P. No. 28474. August 2023; see also Braun R et al. Assoc. of Private Equity Investment in US Nursing Homes with the Quality and Cost of Care for Long-Stay Residents. 2 JAMA Health Forum 11 (Oct. 2021).
6. Singh Y, Song Z, Polsky D, Bruch JD, Zhu JM. Association of private equity acquisition of physician practices with changes in health care spending and utilization. JAMA Health Forum 2022 Sep 2 (Vol. 3, No. 9, pp. e222886-e222886).
7. Braun RT, Bond AM, Qian Y, Zhang M, Casalino LP. Private Equity In Dermatology: Effect On Price, Utilization, And Spending: Study examines the prevalence of private equity acquisitions and their impact on dermatology prices, spending, use, and volume of patients. Health Affairs. 2021 May 1;40(5):727-35.
8. La Forgia A, Bond AM, Braun RT, Yao LZ, Kjaer K, Zhang M, Casalino LP. Association of physician management companies and private equity investment with commercial health care prices paid to anesthesia practitioners. JAMA internal medicine. 2022 Apr 1;182(4):396-404.
9. Liu, Tong. Bargaining with Private Equity: Implications for Hospital Prices and Patient Welfare. SSRN. November 1, 2022.

# HPC Study to Identify Massachusetts Private Equity Transactions in Health Care

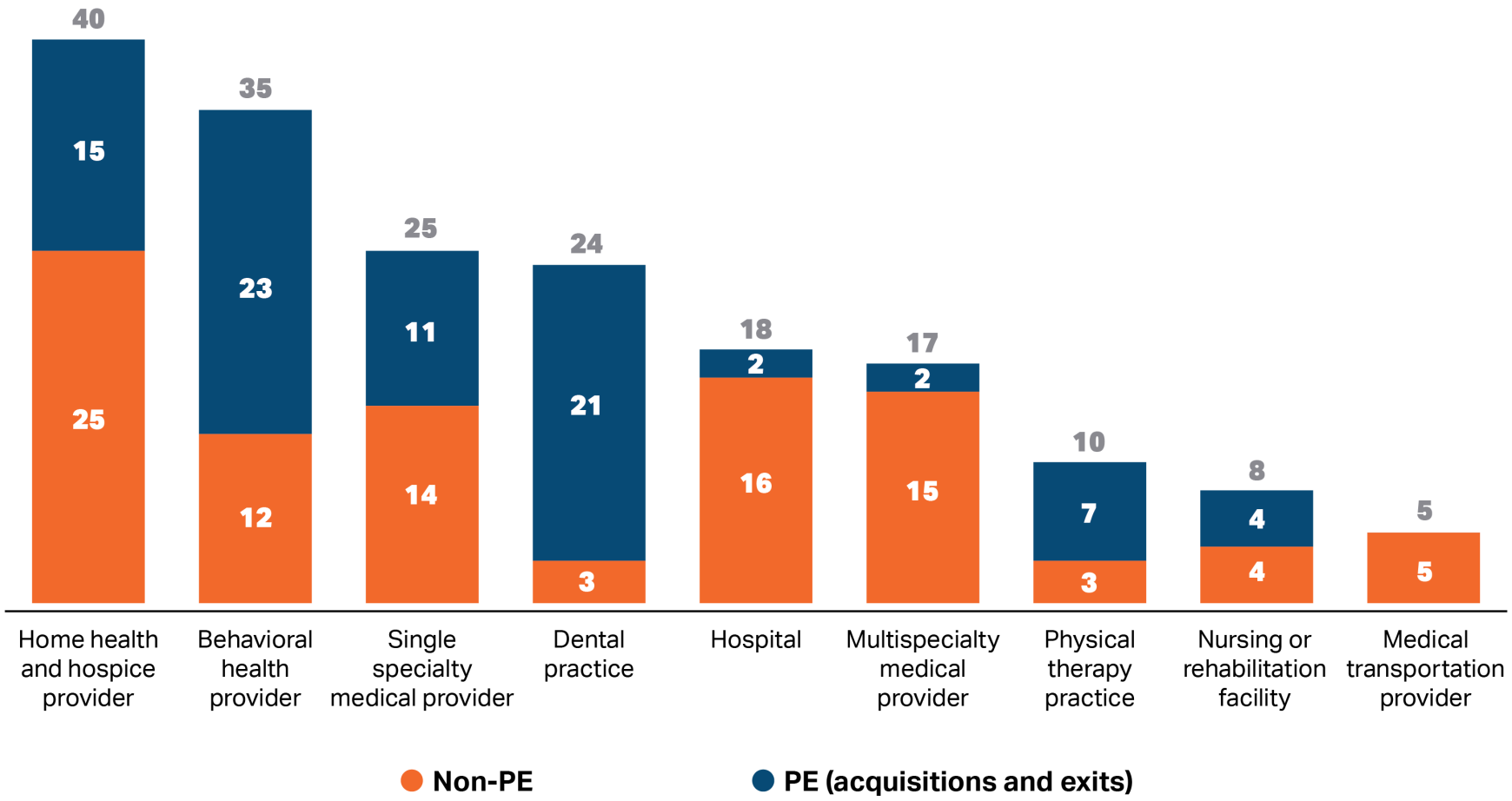
- **Inclusions**: Health care provider mergers and acquisitions from 2013-2023
- **Exclusions:**
  - Cancelled or pending transactions
  - Transactions of entities that are not patient-facing (e.g., labs, device manufacturers, biotech)
  - Transactions of entities that may be patient-facing but operate largely outside of insurance (e.g., e-health, cannabis dispensary)
  - Partnerships for joint contracting or changes in clinical or contracting affiliations
  - Transactions solely between payers
- Acquisitions of multiple entities announced together or which occurred on the same day were counted as one transaction




Unique transactions in the final sample: 182

# Private equity investments have been particularly active among behavioral health, dental, and home health providers, and certain specialty providers.

*Number of provider transactions by health care sector in Massachusetts, 2013-2023*

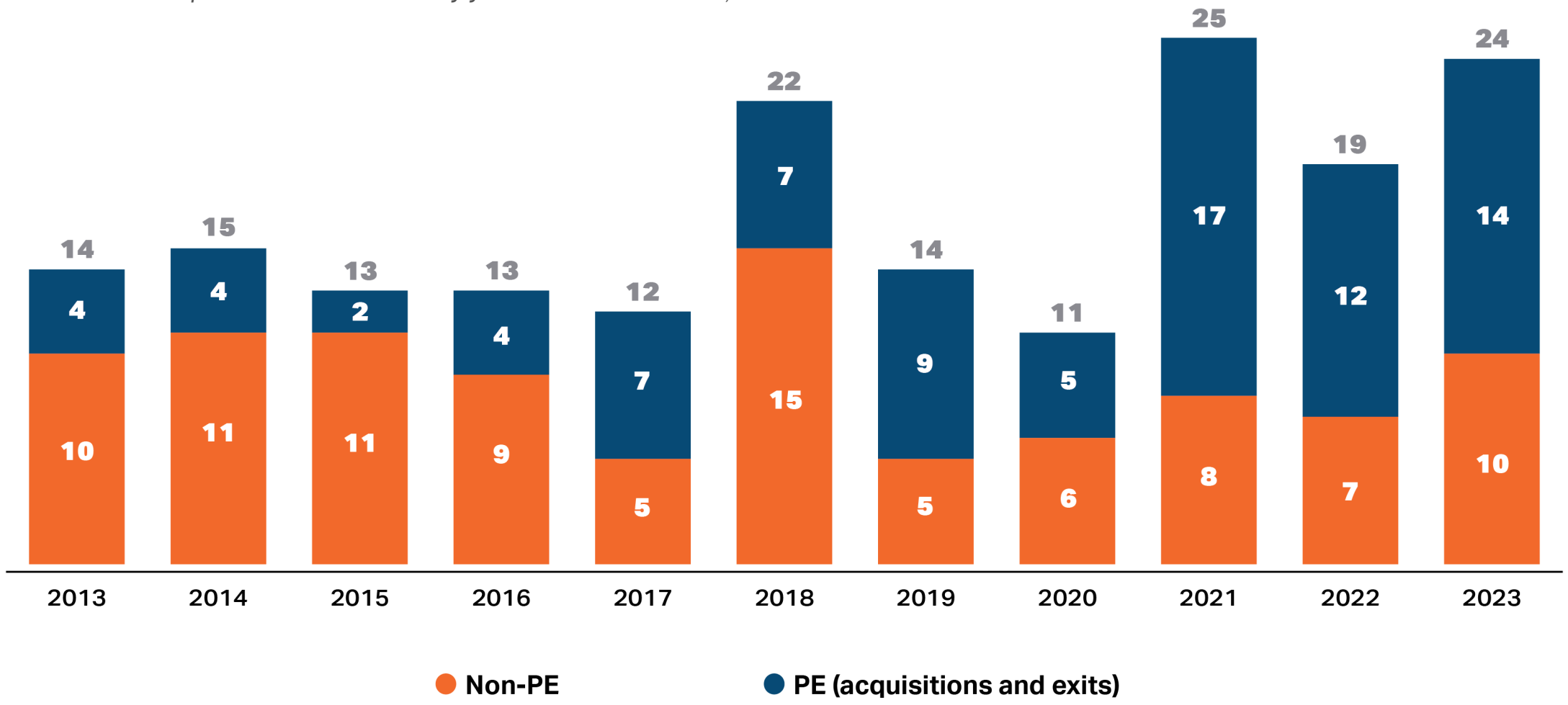



Notes: Of transactions that involved private equity, 74 were private equity acquisitions, 3 were private equity exits, and 8 were acquisitions and exits. One exit occurred in the behavioral health sector; 2 exits were rehabilitation facilities.
Sources: HPC analysis of FactSet financial data and analytics; HPC Material Change Notice filings; LevinPro HC, Levin Associates, January 2024, levinassociates.com; and other publicly available information.

- Of the 182 health care providers transactions in the HPC's analysis; **85 (47%)** involved PE firms.
- Of these, **74** were PE acquisitions, **3** were PE exits, and **8** were acquisitions *and* exits (i.e., PE firm selling to another PE firm)

# Private equity investments in health care have accelerated in Massachusetts in recent years.

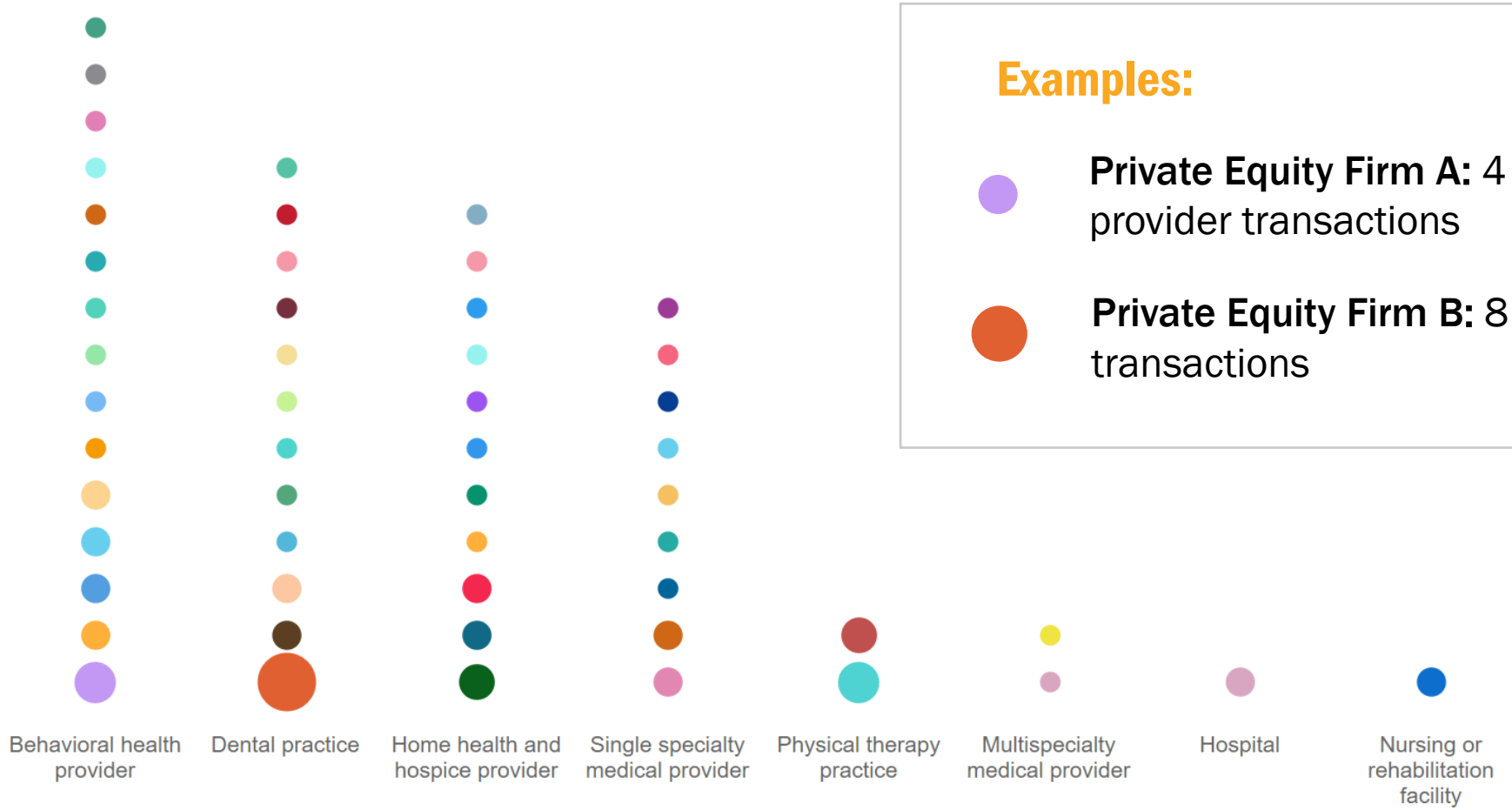
*Number of health care provider transactions by year in Massachusetts, 2013-2023*




Sources: HPC analysis of FactSet financial data and analytics; HPC Material Change Notice filings; LevinPro HC, Levin Associates, January 2024, levinassociates.com; and other publicly available information.

# Many private equity transactions in Massachusetts have been one-offs, although there are some instances of the individual PE firms acquiring multiple practices in the same sector.

*Private equity transactions by health care sector and acquiring private equity firm in Massachusetts, 2013-2023*




## Examples:

**Private Equity Firm A:** 4 BH provider transactions

**Private Equity Firm B:** 8 dental transactions

Notes: Each bubble represents a private equity firm that made acquisitions in a given sector. Bubble size is proportional to the number of acquisitions per private equity firm. Bubble color represents a distinct firm or distinct group of firms.
Sources: HPC analysis of FactSet financial data and analytics; HPC Material Change Notice filings; LevinPro HC, Levin Associates, January 2024, levinassociates.com; and other publicly available information.

# Additional Detail on Private Equity Transactions in Select Sectors

## BEHAVIORAL HEALTH PROVIDERS (23)

- **10** pediatric behavioral and developmental disorder provider transactions
- **8** substance use treatment and/or mental health provider transactions
- **2** transactions involving providers specializing in treating eating disorders
- **1** psychiatric hospital
- **1** transaction of provider that works with individuals with intellectual, developmental, physical or behavioral disabilities
- **1** transaction was a PE exit

## SINGLE SPECIALTY MEDICAL PROVIDER (11)

- **5** ophthalmology provider transactions
- **2** orthopedics transactions
- **1** gastroenterology transaction
- **1** urology transaction
- **1** plastic surgery transaction
- **1** fertility medicine transaction

## NURSING AND REHABILITATION FACILITY (4)

- **2** acquisitions of inpatient rehabilitation facilities
- **2** transactions were PE exits

Sources: HPC analysis of FactSet financial data and analytics; HPC Material Change Notice filings; LevinPro HC, Levin Associates, January 2024, levinassociates.com; and other publicly available information.

# Joint Committee on Health Care Financing Public Hearing

***Examination of the Effects of Private Equity Ownership and Investment in Health Care***

## Hearing Panel: Impact of Private Equity on Health Care Quality, Access, and Cost

> We need to obviously **strengthen enforcement, increase ownership transparency, and set federal certification criteria for ownership**. Then require greater financial transparency and accuracy. Then improve the financial accountability of these organizations, but keep in mind that no two of these deals are the same, and it's subject to firm to firm.
>
> – *Robert Tyler Braun, PhD, Assistant Professor of Population Health Sciences, Weill Cornell Medical College*

> **...Private equity is one financial actor.** There are multiple different financial actors, REITs, hedge funds, private investors, that are not only investing in, acquiring as minority, as full owners... then there are health care entities becoming investors in themselves. So, at multiple different levels, you're **seeing the ways in which finance influences healthcare delivery**.
>
> – *Joseph Dov Bruch, PhD: Assistant Professor of Public Health Sciences, University of Chicago*

# Hearing Panel: State Policy Levers and the Role of Real Estate Investment Trusts

## Private Equity Ownership and Investment in Health Care: State Policy Options

**Erin Fuse Brown, JD, MPH** Catherine C. Henson Professor of Law, Director of the Center for Law, Health & Society, Georgia State University College of Law

### 1 Strengthen State Oversight Authority over Health Care Transactions

**Example:** Establish ability to block or impose conditions; increase mechanisms for enforcement and ongoing monitoring

### 2 Strengthen Corporate Practice of Medicine (CPOM) Prohibition

**Example:** Clarify CPOM Prohibition in statute; close existing loopholes; regulate friendly PC/MSO structure

### 3 Ownership Transparency

**Example:** Require all health care entities to report information on ownership, controlling entities, and business structure; make information available to public

# Hearing Panel: State Policy Levers and the Role of Real Estate Investment Trusts

## Private Equity Ownership and Investment in Health Care: State Policy Options

**Erin Fuse Brown, JD, MPH** Catherine C. Henson Professor of Law, Director of the Center for Law, Health & Society, Georgia State University College of Law

> As you heard this morning from David Seltz and from all the researchers, **even the state officials and researchers with the greatest access to data often find themselves using manual Google searches** and expensive proprietary databases to try to get a sense of the degree of private equity penetration in the state. Moreover, if you are a patient and you want to look up whether your doctor or your hospice or your hospital is private equity owned **there is no searchable database** to find this information.

# Summary of HPC Research

- Consistent with national trends, **private equity investments have accelerated in Massachusetts since 2020**, in volume and as a share of all health care transactions.
- National literature indicates private equity acquisitions often result in **higher prices** and are also often associated with **higher utilization** and **worse quality of care**, although outcomes may vary by industry.
- There are opportunities to **increase transparency** of private equity investments and the **impact of their financial strategies** on the healthcare market.

# HPC Market Oversight Process and Private Equity in Health Care

The HPC has reviewed some transactions involving private equity firms already in the business of health care. Examples include:

- Acquisition of the non-clinical assets of **Greater Boston Urology**, a MA-based urology practice, by **U.S. Urology Partners**, a national management services organization that is a portfolio company of **NMS capital** (2023).
- Acquisition of the private equity-affiliated corporate parent **Monte Nido**, a national provider of eating disorder treatment programs that operates several facilities in MA, including Walden Behavioral Care, by affiliates of **Revelstoke Capital Partners** (2022).

The HPC does not receive notice of transactions between health care entities and PE firms that do not qualify as a "provider" or insurance "carrier" under MA law.

- For example, the HPC did not review the acquisition of **Steward's hospital real estate by Medical Properties Trust** (MPT) – which were then leased back to the hospitals - and MPT's concurrent acquisition of limited equity stake in Steward (2016).

HPC also does not receive notice of smaller transactions involving private equity firms that do not meet financial thresholds for filing (e.g., acquisition of a provider with less than $10 million in NPSR).

# HPC Authority to Enhance Public Transparency of Provider Structure and Financial Performance

Separately, HPC and CHIA jointly administer the Massachusetts Registration of Provider Organizations (RPO) Program. RPO annually collects and publishes standardized information from provider organizations on **corporate structure**, **governance**, **contracting and clinical affiliations**, and **financial performance**. HPC is required by law to make all information available to be public.

- RPO requires the submission of comprehensive financial statements, including **audited financial statements at the system-level**, consolidating schedules and standardized filings that shall include a balance sheet, a statement of operations, and a cash flow statement.
- **Steward Healthcare has refused** to produce its audited, parent-level financial statements to CHIA/HPC and has engaged in over six years of (ongoing) litigation to challenge the state's transparency requirements.

State law requires all provider organizations with **more than $25 million in commercial revenue** to register and submit all required information to the HPC.

- The unintended consequence of this threshold is that it excludes many significant provider organizations that primarily rely on public payers (e.g., behavioral health providers, skilled nursing facilities, home health).

# Potential Policy Solutions: HPC Recommendations

## ENHANCE HEALTH CARE MARKET TRANSPARENCY AND OVERSIGHT THROUGH THE HPC'S CURRENT AUTHORITIES

Enhance **public transparency** and **oversight** by amending the HPC's Material Change Notice process to capture a broader range of transactions, reflecting emerging market trends, including:

- Substantial **changes in capacity;**
- Significant **investment by private equity or for-profit** in an existing health care provider;
- Substantial **sale of assets for an ownership share** or for the purposes of a lease-back arrangement.

- Expand witnesses at the HPC's annual cost trends hearing to include owners and/or investors in health care providers and payers.

Amend the HPC's **Registration of Provider Organization** (RPO) program to:

- Include public payer revenue in the reporting threshold. This change will expand the type of entities that must file with the RPO program to include sectors frequently targeted by PE firms and provide more **public insight** into the **structure and financial health** of provider organizations.
- Strengthen **enforceable penalties** for non-compliance to ensure all required information is provided in a timely manner.

# Potential Policy Solutions: HPC Recommendations

## ALIGN STATE REGULATORY TOOLS AND ENHANCE MONITORING OF HEALTH CARE RESOURCES

Recent health care market activity, implicating both access and cost, have highlighted the opportunity to better align the range of state agency oversight processes and the need for a better understanding of the allocation of health care resources across the Commonwealth. The HPC recommends the Commonwealth should conduct **data-driven assessments of service supply and distribution based on identified needs.**

## CONSIDER ADDITIONAL STATE AUTHORITY TO APPROVE OR DENY TRANSACTIONS, OR IMPOSE CONDITIONS, TO MITIGATE POTENTIAL HARMS

Similar to other states such as Oregon, further empower state oversight authorities (e.g., HPC, DPH, AGO) to ensure all proposed transactions are consistent with state goals on cost, quality, access, and equity (not limited to PE transactions). Potential conditions of approval could include:

- efforts to maintain or enhance **access to needed services**,
- **quality standards** and improvements,
- **ongoing financial and compliance monitoring** including on **staffing**, and,
- conditions on **exit** or **sale**.

# Next Steps for the HPC on Private Equity in Health Care

- Incorporate commissioner feedback into an **upcoming white paper** on HPC's research, including a number of potential policy solutions. Anticipated for release Early Summer 2024.
- Conduct further research into private equity trends and health care related real estate transactions in Massachusetts, with a focus on **long-term care and senior living facilities**.
- Collaborate with the **Office of the Attorney General**, the **Executive Office of Health and Human Services**, and the **Department of Public Health**, to identify additional potential state options to implement in Massachusetts.
- Engage with Senators Markey and Warren and follow the work of the Federal Trade Commission (FTC), the Department of Justice (DOJ), and President Biden's recently announced task force focused on tackling **"unfair and illegal pricing"** in health care.

# Agenda

Call to Order

Board Operations

Executive Session (VOTE)

Market Oversight

Potential Policy Solutions Regarding Private Equity in Health Care

**2025 HEALTH CARE COST GROWTH BENCHMARK (VOTE)**

Executive Director's Report

Adjourn

MASSACHUSETTS
HEALTH POLICY COMMISSION

HEARING TO DETERMINE THE 2025

# HEALTH CARE COST GROWTH BENCHMARK

# Benchmark Modification Process: 2024 Timeline

**January 8, 2024**
3.6% PGSP established in consensus revenue process

**March 14, 2024**
Public hearing of HPC Board and Joint Committee on potential modification of benchmark

**April 11, 2024**
HPC Board votes to set the benchmark. If the Board votes to maintain the benchmark at the default rate of 3.6%, the annual process is complete. If the Board votes to modify, it submits notice of intent to modify to Joint Committee on Health Care Financing

**April 15, 2024**
Statutory deadline for HPC Board to set benchmark

**April/May 2024**
Joint Committee may hold a hearing within 30 days of notice

**May/June 2024**
Joint Committee may report findings and recommended legislation to General Court within 30 days of hearing; the HPC Board's vote to modify takes effect unless the General Court rejects the proposed modification and enacts legislation establishing the benchmark within 45 days of the hearing.

# The HPC's authority to modify the benchmark is prescribed by law and subject to potential legislative review.

**1-5 years**

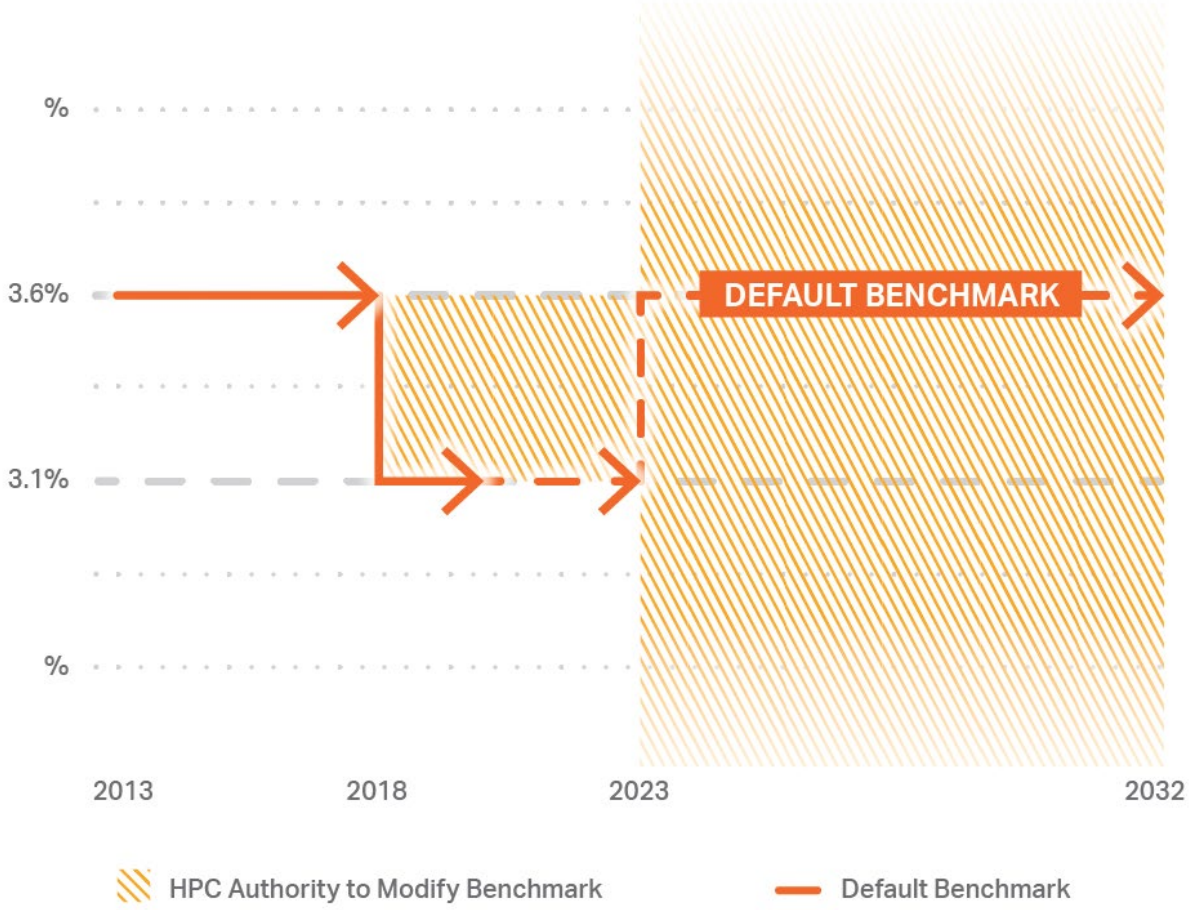
Benchmark established by law at PGSP (3.6%)

**6-10 years**

Benchmark established by law at the statutory rate of PGSP minus 0.5% (3.1%); HPC can modify the benchmark up to 3.6%, subject to legislative review.

**10-20 years**

Benchmark established by law at the statutory rate of PGSP; HPC can modify to any amount by a two-thirds vote of the Board, subject to legislative review.



# Key Findings from Center for Health Information and Analysis (CHIA) and HPC Data Presentations

## SPENDING TRENDS

- Total health care expenditure (THCE) increased **5.8%** from 2021 to 2022.
  - Totaling **$10,264 in average annual health care spending** per resident.
- **Pharmaceutical costs continue to be a major driver with 7.3% growth**, more than double the benchmark.
  - If prescription spending grew at benchmark rate of 3.1% from 2019 to 2022, rather than actual rate of 7.3%, commercial spending would have been **nearly a billion dollars lower (-$978 million)**.
- Despite a slightly slower growth rate, annual health care spending per person in MA exceeded the national average **by more than $2,000** in 2022.
- Commercial health care spending **grew nearly 5% per year** from 2019 to 2022, faster than the national average, and was driven primarily by **growth in prices**.

## AFFORDABILITY IMPLICATIONS

- Costs were passed on to residents, with a **26% increase in cost sharing** combined over 2021 and 2022, the largest shift in the decade this data has been tracked.
- **40%** of poll respondents reported **delaying care due to cost** in the last 12 months
  - Burdens were **greater for residents of color**, with 54.9% of Hispanic residents and 50.8% Black residents reporting affordability issues in 2021.
- Commercially-insured residents enrolled in high deductible plans increased from **16% to 42%** from 2013 to 2022.
  - Adults with high deductible plans were **twice as likely** to go without needed health care or prescription drugs because of cost.
  - 1 in 4 residents with family coverage faced an annual deductible greater than **$4,500** per year.
- Average **out of pocket spending for a 30-day supply of prescription drugs** for several common chronic conditions **doubled** from 2017 to 2022.
  - Average gross commercial spending per branded prescription fill **increased 10% per year** since 2017 (61% overall).

https://www.mass.gov/doc/chia-presentation-2024-benchmark-hearing/
https://www.mass.gov/doc/benchmark-data-presentation-2024-benchmark-hearing/

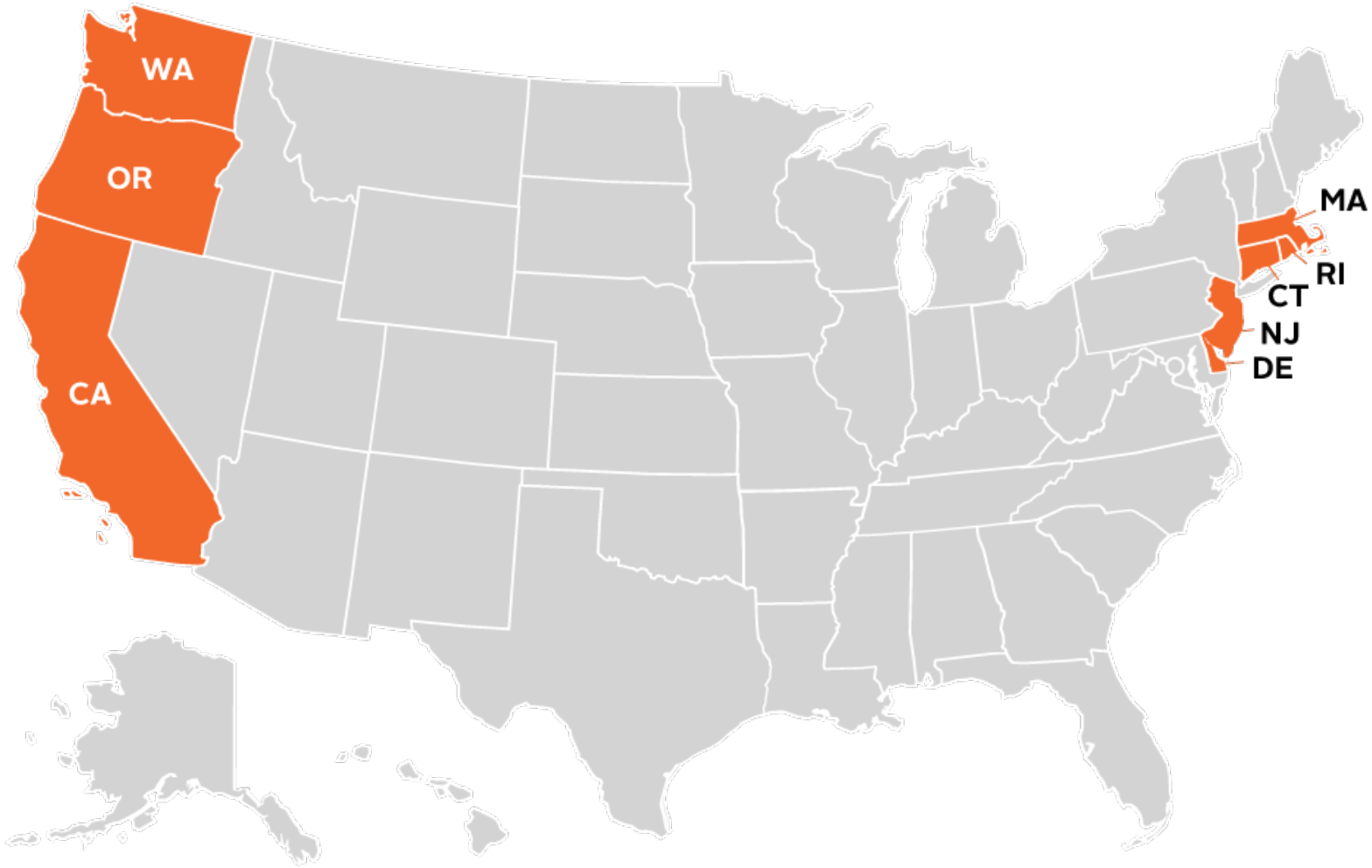
# Summary of Public Testimony

| ORGANIZATION | POSITION |
|---|---|
| Associated Industries of Massachusetts (AIM) | 3.6% |
| Association of Behavioral Healthcare (ABH) | Not specified; benchmark needs to account for historically underfunded behavioral health services |
| Blue Cross Blue Shield of Massachusetts (BCBSMA) | Do not increase above 3.6% |
| Community Care Cooperative | Not specified; emphasis on increasing primary care spending and access |
| Conference of Boston Teaching Hospitals | Not specified; suspend application of the benchmark in 2025 |
| Eileen McAnneny, Esq. (Individual) | Lower than 3.6% |
| Health Care for All (HCFA) | Between 3.1% - 3.6% |
| The Health Equity Compact | Not specified; emphasis on utilization of racial health equity approach to address affordability and health equity concerns |
| Kendra Perkins (Individual) | Not specified; shared perspective as a mental health provider and a parent |
| Massachusetts Association of Health Plans (MAHP) | 3.6% |
| Massachusetts Health and Hospital Association (MHA) | Not specified; modernize current benchmark process |
| Massachusetts Medical Society (MMS) | Not specified; restructure benchmark formula to utilize greater discretion in evaluating costs |
| National Federation of Independent Business | Not specified; examine policies to rein in costs for small employers |
| Retailers Association of Massachusetts (RAM) | 3.1% |

**Eight states have now established statewide health care cost growth targets, cumulatively representing one in five residents in the U.S.**

**Among the states who have established growth targets for calendar year 2025, the range is 2.9% to 3.6%.**

States have established growth targets for 2025 between 2.9% and 3.6%.

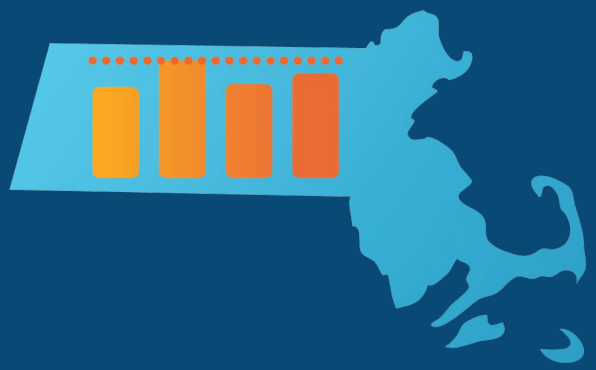



How states use cost-growth benchmark programs to contain health care costs. The National Academy for State Health Policy. (2022, February 1). Retrieved from https://www.nashp.org/how-states-use-cost-growth-benchmark-programs-to-contain-health-care-costs/

# 2023 Health Care Cost Trends Report Policy Recommendations

1. Modernize the Commonwealth's Benchmark Framework to Prioritize Health Care Affordability and Equity For All.
2. Constrain Excessive Provider Prices.
3. Enhance Oversight of Pharmaceutical Spending.
4. Make Health Plans Accountable For Affordability.
5. Advance Health Equity For All.
6. Reduce Administrative Complexity.
7. Strengthen Tools to Monitor the Provider Market and Align the Supply and Distribution of Services With Community Need.
8. Support and Invest in the Commonwealth's Health Care Workforce.
9. Strengthen Primary and Behavioral Health Care.

# 2023 Health Care Cost Trends Report Policy Recommendations



## 1 Modernize the Commonwealth's Benchmark Framework to Prioritize Health Care Affordability and Equity For All.

The Commonwealth should strengthen the accountability mechanisms of the benchmark such as by updating the metrics and referral standards used in performance improvement plan (PIP) process and enhance transparency and PIP enforcement tools. The state should also modernize its health care policy framework to promote affordability and equity including through the establishment of affordability and equity benchmarks.

- **Strengthen the Health Care Cost Growth Benchmark**
- **Establish New Affordability Benchmark(s)**
- **Establish New Health Equity Benchmark(s)**

# VOTE

## 2025 Health Care Cost Growth Benchmark

### MOTION

That, pursuant to G.L. c. 6D, § 9, the Commission hereby establishes the health care cost benchmark for calendar year 2025 as _____, subject to the further process set forth in G.L. c. 6D, § 9 (e).

# Agenda

Call to Order

Board Operations

Executive Session (VOTE)

Market Oversight

Potential Policy Solutions Regarding Private Equity in Health Care

2025 Health Care Cost Growth Benchmark (VOTE)

**EXECUTIVE DIRECTOR'S REPORT**

Adjourn

# HPC Publications

## RECENTLY RELEASED

- **HPC Shorts**: The Massachusetts Health Care Cost Growth Benchmark (March 2024)
- **DataPoints**: Trends in Ambulatory Surgical Centers in Massachusetts (February 2024)
- **Evaluation Report**: SHIFT-Care Challenge (January 2024)
- **Report**: 2023 Summer Fellowship Report (January 2024)
- **DataPoints**: Sites of Vaccine Administration (November 2023)
- **HPC Shorts**: 2023 Cost Trends Report, Chapter 3: Opportunities to Reduce Excess Spending – Prices (November 2023)

## UPCOMING

- **Report**: Office of Patient Protection Annual Report
- **White Paper**: Potential Policy Solutions to Address the Role of Private Equity in Health Care
- **DataPoints**: ACO Certification Program Update: Evolution of Risk Contracting and Care Delivery Innovations
- **Report:** Assessment of Health Care Needs and Supply in Massachusetts
- **Chartpack:** Massachusetts Primary Care Workforce
- **Annual Report**: 2024 Health Care Cost Trends Report

# Potential Discussion Topics at Policy Committee Meetings


## Thursday, May 9, 2024

### Market Oversight and Transparency (12:00 PM)

- Assessment of Health Care Needs and Supply in Massachusetts
- Primary Care Workforce

### Care Delivery Transformation (1:30 PM)

- Severe Maternal Mortality and Morbidity in Massachusetts
- Remote Blood Pressure Monitoring Opportunities

# Agenda

Call to Order

Board Operations

Executive Session (VOTE)

Market Oversight

Potential Policy Solutions Regarding Private Equity in Health Care

2025 Health Care Cost Growth Benchmark (VOTE)

Executive Director’s Report

**ADJOURN**

# Schedule of Upcoming Meetings

## BOARD

June 13

July 18

September 19

December 12

## COMMITTEE

May 9

July 15 (ANF)

October 10

## ADVISORY COUNCIL

June 27

September 26

December 5

## SPECIAL EVENTS

November 14
*Cost Trends Hearing*

Mass.gov/HPC

HPC-info@mass.gov

@Mass_HPC

tinyurl.com/hpc-linkedin

# 2024 Public Meeting Calendar

HPC

### – JANUARY –

| S | M | T | W | T | F | S |
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### – FEBRUARY –

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### – MARCH –

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### – APRIL –

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### – JULY –

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### – AUGUST –

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### – SEPTEMBER –

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### – OCTOBER –

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### – NOVEMBER –

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### – DECEMBER –

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## BOARD MEETINGS

Thursday, January 25
Thursday, April 11
Thursday, June 13
Thursday, July 18
Thursday, September 19
Thursday, December 12

## COMMITTEE MEETINGS

Thursday, February 15
Thursday, May 9
Monday, July 15 (ANF)
Thursday, October 10

## ADVISORY COUNCIL

Thursday, February 29
Thursday, June 27
Thursday, September 26
Thursday, December 5

## SPECIAL EVENTS

Thursday, March 14 – Benchmark Hearing
Thursday, November 14 – Cost Trends Hearing

All meetings will be held virtually unless otherwise noted. This schedule is subject to change, and additional meetings and hearings may be added.