

958 CMR 6.00: REGISTRATION OF PROVIDER ORGANIZATIONS

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6.01: General Provisions.

Scope and Purpose: 958 CMR 6.00 governs the procedures and criteria for the registration of provider organizations program jointly administered by the Health Policy Commission and the Center for Health Information and Analysis, as required by M.G.L. c. 6D § 11 and M.G.L. 12C. 958 CMR 6.00 specifies the criteria that determine which Provider Organizations must register with the registration of provider organizations program, the manner of registration, and what information must be submitted to complete Registration. The Center’s regulation, 957 CMR 11.00 et seq., also governs the reporting requirements for the registration of provider organizations program.

6.02: Definitions

As used in 958 CMR 6.00, the following words mean:

Acute Hospital. The teaching hospital of the University of Massachusetts Medical School and any hospital licensed under M.G.L. c. 111, § 51 and which contains a majority of medical-surgical, pediatric, obstetric, and maternity beds, as defined by the Department of Public Health.

Annual Filing. The information that a Provider Organization subject to the registration requirements of 958 CMR 6.00 must submit to the MA-RPO Program, in a form specified in the *Data Submission Manual*, pursuant to M.G.L. c. 6D, §11 and M.G.L. c. 12C, § 9 and § 11.

Center. The Center for Health Information and Analysis established in M.G.L. c. 12C.

Clinical Affiliation. Any relationship between a Provider or Provider Organization and another Entity for the purpose of increasing the level of collaboration in the provision of Health Care Services, including, but not limited to, sharing of physician resources in hospital or other ambulatory settings, co-branding, expedited transfers to advanced care settings, provision of inpatient consultation coverage or call coverage, enhanced electronic access and communication, co-located services, provision of capital for service site development, joint training programs, video technology to increase access to expert

resources, or sharing of hospitalists or intensivists. This definition applies to all forms of the term, including “Clinical Affiliates” and “Clinically Affiliated.”

Commission. The Health Policy Commission established in M.G.L. c. 6D.

Community Advisory Board. Committees, boards, or other oversight and governance bodies engaging the community of a Provider Organization, including, but not limited to, patient and family advisory councils as defined in 105 CMR 130.1801 or community benefits advisory boards.

Contracting Affiliation. A relationship between a Provider Organization and another Provider or Provider Organization for the purposes of negotiating, representing, or otherwise acting to establish contracts for the payment of Health Care Services, including for payment rates, incentives, and operating terms, with a Payer. This definition applies to all forms of the term, including “Contracting Affiliates.”

Control. The possession, direct or indirect, of the power, partial or complete, to direct or cause the direction of the management, administrative functions, assets, or policies of an Entity, whether through the ownership of voting securities or rights, the power to appoint, designate, or remove board members or directors, control, either directly or indirectly, by contract (except a commercial contract for goods or non-management services) or otherwise; but no person shall be deemed to possess such Control solely by reason of being an officer or director of an Entity. Control shall be deemed to exist if any person or Entity directly or indirectly owns, has rights over, or holds with the power to vote ten percent or more of the voting securities of an Entity. This definition applies to all forms of the word, including “Controls,” “Controlling,” and “Controlled.”

Corporate Affiliation. A relationship between two Entities that reflects, directly or indirectly, a partial or complete Controlling interest or partial or complete common Control. This definition applies to all forms of the term, including “Corporate Affiliates” and “Corporately Affiliated.”

Data Submission Manual. A manual published by the MA-RPO Program as an administrative bulletin, containing specifications, submission guidelines, and timelines for Registration.

Division. The Massachusetts Division of Insurance.

Entity. A corporation, sole proprietorship, partnership, limited liability company, trust, foundation, or any other organization formed for the purpose of carrying on a commercial or charitable enterprise.

Facility. A licensed institution providing Health Care Services, or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory

surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

Fiscal Year. The 12-month period during which a Provider Organization keeps its accounts and which is identified by the calendar year in which it ends.

Full-Time Equivalent. The ratio of the total payroll hours for employees to the standard number of annual full-time payroll hours, and the equivalent for contracted individuals.

Funds Flow. The apportionment of Provider or Provider Organization funds, including payments from Payers, across affiliated Entities, which shall include apportionment across hospitals and physicians, across physician groups, across primary care physicians and specialists, and across employed versus affiliated physicians.

Health Care Provider or Provider. A provider of Health Care Services or any other person or organization that furnishes, bills or is paid for Health Care Services delivery in the normal course of business or any person, corporation, partnership, governmental unit, state institution or any other Entity qualified under the laws of the commonwealth to perform or provide Health Care Services.

Health Care Professional. A physician or other health care practitioner licensed, accredited, or certified to perform specified Health Care Services consistent with law.

Health Care Real Estate Investment Trust. A real estate investment trust, as defined by 26 U.S.C. section 856, whose assets consist of, in whole or in part, real property held in connection with the use or operations of a provider or provider organization.

Health Care Services. Supplies, care and services of medical, behavioral health, substance use disorder, mental health, surgical, optometric, dental, podiatric, chiropractic, therapeutic, diagnostic, preventative, rehabilitative, supportive or geriatric nature including, but not limited to, inpatient and outpatient acute hospital care and services, pharmacy services, services provided by a community health center, home health, and hospice care provider, or by a sanatorium, as included in the definition of “hospital” in Title XVIII of the federal Social Security Act, and treatment and care compatible with such services, or by a health maintenance organization.

Local Practice Group. A group of Health Care Professionals that functions as a subgroup of a Provider Organization (i.e., groups broken out from the larger Provider Organization for purposes of data reporting and market comparisons).

Management Services Organization. A corporation or other business organization that provides management or administrative services to a provider or provider organization for compensation.

Massachusetts Registration of Provider Organizations Program or MA-RPO Program. The Commonwealth program, jointly administered by the Commission and the Center, pursuant to M.G.L. c. 6D and M.G.L. c. 12C and regulations promulgated thereunder.

Net Patient Service Revenue. The total revenue received in a Fiscal Year for patient care from any Payer net of any contractual adjustments, using best available data.

Patient Panel. The total number of individual patients seen over the course of the most recent complete 5-year period.

Payer. Any Entity, other than an individual, that pays providers for the provision of Health Care Services; provided, however, that “Payer” shall include both governmental and private Entities and Third-Party Administrators; and provided further, that “Payer” shall include self-insured plans to the extent allowed under the Employee Retirement Income Security Act of 1974.

Practice Site. The physical location where the clinician is providing Health Care Services.

Private Equity Company. Any Entity, however organized, that collects capital investments from individuals or Entities and purchases, as a parent company or through another Entity that the company completely or partially owns or Controls, a direct or indirect ownership share of a Provider, Provider Organization or Management Services Organization; provided, however, that “Private Equity Company” shall not include venture capital firms exclusively funding startups or other early-stage businesses.

Provider Organization. Any corporation, partnership, business trust, association or organized group of persons, and all corporate affiliates thereof, which is in the business of health care delivery or management, whether incorporated or not that represents one or more Health Care Providers in contracting with Payers for the payment of Health Care Services; provided that the definition shall include, but not be limited to, physician organization, physician-hospital organization, independent practice association, Provider network, accountable care organization, and any other organization that contracts with Payers for payment for Health Care Services.

Registration. The process of becoming a Registered Provider Organization as established by the MA-RPO Program pursuant to M.G.L. c. 6D, § 11.

Registered Provider Organization. A Provider Organization that meets the criteria for Registration pursuant to 958 CMR 6.00 and has registered with the Commission.

Risk-Bearing Provider Organization or RBPO. An Entity subject to the requirements of the Division pursuant to M.G.L. c. 176T and any regulations promulgated thereunder.

Significant Equity Investor. Any Private Equity Company with a financial interest in a Provider, Provider Organization or Management Services Organization; or an investor, group of investors or other Entity with a direct or indirect possession of equity in the

capital, stock or profits totaling more than 10 per cent of a Provider, Provider Organization or Management Services Organization; provided, however, that “Significant Equity Investor” shall not include venture capital firms exclusively funding startups or other early-stage businesses; and provided that “Significant Equity Investor” shall not include individuals licensed to provide Health Care Services who are or will be actively engaged in the practice of medicine, dentistry, or other health care profession as a full or partial owner of the Provider or Provider Organization.

Third-Party Administrator. An Entity that administers payments for Health Care Services on behalf of a client in exchange for an administrative fee.

Uppermost Corporate Parent. An Entity with a primary business purpose of healthcare delivery, management, ownership, or investment, that is not itself owned or Controlled, partially or completely, directly or indirectly, by any other Entity.

### 6.03: Requirement to Register

(1) Registration Criteria. Subject to and in accordance with the provisions of 958 CMR 6.03 (2), (3), and (4), a Provider Organization that meets one or both of the following Registration criteria shall register with the MA-RPO Program:

(a) a Provider Organization that negotiates, represents, or otherwise acts to establish contracts for the payment of Health Care Services with Payers on behalf of one or more Providers or Provider Organizations, which may include itself, that collectively:

1. received \$25,000,000 or more in Net Patient Service Revenue from Payers in the prior Fiscal Year; and
2. had a Patient Panel of more than 15,000;

(b) a Risk-Bearing Provider Organization.

(2) A Provider Organization that meets one or both of the Registration criteria shall meet its Registration and reporting obligations through the submission by its Uppermost Corporate Parent of an Annual Filing.

(3) At the discretion of the MA-RPO Program, a Provider Organization that meets one or both of the Registration criteria may meet its Registration and reporting obligations through the submission of an abbreviated Annual Filing in a format prescribed by the MA-RPO Program if another Registered Provider Organization negotiates, represents, or otherwise acts to establish contracts with Payers for the payment of Health Care Services on its behalf.

(4) A Provider Organization that meets the Registration criteria defined in 958 CMR 6.03(1)(a) shall register if it negotiates, represents, or otherwise acts to establish contracts with Payers on behalf of one or more Acute Hospitals, physician groups, or any other Health Care Provider type specified in the most recently published *Data Submission Manual*.

6.04: Annual Filing

- (1) A Provider Organization that meets one or both of the Registration criteria in 958 CMR 6.03(1) as of January 1 in a calendar year shall submit an Annual Filing for that calendar year, as specified in the *Data Submission Manual*, subject to the provisions of 958 CMR 6.03(2), (3), and (4) unless otherwise directed by the HPC.
- (2) A Provider Organization that does not meet the Registration criteria in 958 CMR 6.03(1) as of January 1 in a calendar year, but that meets the criteria at any time after January 1 shall submit an Annual Filing not later than 180 calendar days after meeting the Registration criteria, subject to the provisions of 958 CMR 6.03(2) and (3), unless otherwise authorized by the MA-RPO Program in writing.
- (3) A Provider Organization's Registration shall be valid for a 24-month period, beginning on the date of the notice issued by the MA-RPO Program pursuant to 958 CMR 6.04(10), subject to the satisfactory completion of the Annual Filing requirement in 958 CMR 6.03(1), unless otherwise specified by the MA-RPO Program or as provided in 958 CMR 6.04(7).
- (4) A Provider or Provider Organization not otherwise required to register by 958 CMR 6.03(1) and 6.04(2) may voluntarily submit an Annual Filing.
- (5) Subject to the specifications and instructions detailed in the *Data Submission Manual*, and unless otherwise specified by the MA-RPO Program, an Annual Filing shall include the following information about the Provider Organization:
  - (a) Information about the ownership, governance, and operational structure, including organizational charts, narrative descriptions of the type and kind of Corporate Affiliations and Contracting Affiliations, information on incentive structures and compensation models, including Funds Flow within the Provider Organization, information on Significant Equity Investors, Real Estate Investment Trusts, and Management Services Organizations, and information on the characteristics of any Clinical Affiliations and the role of Community Advisory Boards;
  - (b) The number of Health Care Professional Full-Time Equivalents by license type and specialty, each Health Care Professional's name, address of principal location of work, national provider identifier, or other identifying information, and whether the Health Care Professional is employed by or affiliated with the Provider Organization and the nature of that relationship, including whether provisions exist in physician participation or employment agreements such as referral requirements;
  - (c) The name and address of each Facility and Practice Site, including by license number, license type, tax identification number, national provider identifier, and capacity in each major service category;

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- (d) The name, address, and capacity of all other locations where the Provider Organization delivers Health Care Services, including those services listed in subsection (a) of section 22 of chapter 6D;
  - (e) Comprehensive financial statements, including audited financial statements, consolidating schedules and standardized filings that shall include a balance sheet and a statement of operations, and including information on the Uppermost Corporate Parent, including their out-of-state operations, and Corporate Affiliates, including Significant Equity Investors, Health Care Real Estate Investment trusts and Management Services Organizations as applicable, and including details regarding annual costs, annual receipts, realized capital gains and losses, accumulated surplus and accumulated reserves;
  - (f) Information on clinical quality, care coordination and patient referral practices;
  - (g) Information regarding expenditures and funding sources for payroll, teaching, research, advertising, taxes or payments-in-lieu-of-taxes and other non-clinical functions;
  - (h) Information regarding charitable care and community benefit programs;
  - (i) For Risk-Bearing Provider Organizations, a statement certifying that the RBPO has received a risk certificate or a waiver from the Division as required by M.G.L. c. 176T or any regulations promulgated thereunder;
  - (j) Information regarding other assets and liabilities that may affect the financial condition of the Provider Organization or the Provider Organization's Facilities including, but not limited to, real estate sale-leaseback arrangements with Health Care Real Estate Investment Trusts;
  - (k) Information regarding any discounts, rebates or any other type of refunds or remuneration in exchange for, or in any way related to, the provision of health care services;
  - (l) Information on stop-loss insurance and any non-fee-for-service payment arrangements;
  - (m) Information on utilization by major service category;
  - (n) Total revenue by payer under pay for performance arrangements, risk contracts, and other fee-for-service arrangements;
  - (o) Attestations completed by two duly authorized officers of the Provider Organization that the Registration information is true and accurate; and
  - (p) A registration fee payable to the Health Policy Commission as specified by the Commission.
- (6) After receiving an Annual Filing, the MA-RPO Program may, within 30 calendar days, require a Provider Organization to provide additional information to complete or supplement the Annual Filing for completeness or clarification. A Provider Organization shall respond to a request for additional information within 21 calendar days of the date of the request, unless otherwise specified in writing by the MA-RPO Program.
- (7) The MA-RPO Program shall determine whether an Annual Filing is complete within 45 calendar days of receipt of the filing or any supplementary material, whichever is later, and shall provide written notice of completion to the Provider Organization. An

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Annual Filing will not be considered complete until all materials required by the MA-RPO Program have been received.

- (8) The MA-RPO Program may require in writing, at any time, additional information reasonable and necessary to determine the financial condition, organizational structure, business practices, clinical services, or market share of a Registered Provider Organization. The MA-RPO Program may require a Registered Provider Organization with direct or indirect private equity investment to report required information quarterly or require the disclosure of relevant information from any Significant Equity Investor associated with a Registered Provider Organization. A Registered Provider Organization shall respond to a request for additional information within 21 calendar days of the date of the request, unless otherwise specified in writing by the MA-RPO Program.
- (9) The Registration requirements set forth in 958 CMR 6.04 may be fulfilled through the reporting of such information to other Commonwealth of Massachusetts agencies, as may be specified in the *Data Submission Manual*.
- (10) The Commission may issue administrative bulletins necessary to implement 958 CMR 6.00.

6.05: Compliance and Penalties

- (1) Failure to Submit an Application for Registration. If the MA-RPO Program determines that a Provider or Provider Organization that has not submitted an Annual Filing may meet the Registration criteria in 958 CMR 6.03(1), the MA-RPO Program may send written notice to the Provider or Provider Organization. A Provider or Provider Organization that receives such a notice shall, within two weeks of receipt of the notice:
  - (a) Submit confirmation to the MA-RPO Program that the Provider or Provider Organization shall submit an Annual Filing in compliance with 958 CMR 6.04 by the deadline established by the MA-RPO Program; or
  - (b) Submit adequate supporting documentation to demonstrate that the Provider or Provider Organization does not meet the Registration criteria in 958 CMR 6.03(1). The documentation must demonstrate to the satisfaction of the MA-RPO Program that the Provider or Provider Organization does not meet the Registration criteria in 958 CMR 6.03(1).
- (2) Non-Compliance, Notice. If, after the process described in 958 CMR 6.04 (6) & (7) or 6.05(1), the MA-RPO Program determines that a Provider Organization: (a) has failed to submit a completed Annual Filing as required, (b) failed to submit any additional information requested by the MA-RPO Program pursuant to 958 CMR 6.04(6), (8), (9), or (10), or otherwise failed to comply with the requirements of 958 CMR 6.00 or 957 CMR 11.00, the MA-RPO Program will provide written notice to the Provider Organization that failure to comply within two weeks of receipt of the written notice may result in penalties.

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- (3) Penalties. Penalties for non-compliance may include: (a) in accordance with M.G.L. c. 12C, § 11 and any regulation promulgated thereunder, a Provider Organization may be subject to a penalty of up to \$25,000 per week for each week of delay that it fails, without just cause, to comply with the MA-RPO Program requirements after the two-week notice period; (b) in accordance with M.G.L. c. 6D, § 12, a Provider Organization may not negotiate, represent, or otherwise act on behalf of any Provider or Provider Organization for the purposes of establishing contracts for the payment of Health Care Services with any Payer or Third-Party Administrator. The MA-RPO Program may provide notice of a Provider's or Provider Organization's non-compliance with 958 CMR 6.00 to Payers and the Division.
- (4) If a Provider Organization submits additional documentation within the two-week period described in 958 CMR 6.05 (2), the Provider Organization shall not be deemed non-compliant, if applicable, until after the MA-RPO Program has reviewed the documentation and determined whether the Provider Organization has met the requirements of 958 CMR 6.00.

6.06: Severability

If any section or portion of a section of 958 CMR 6.00 or the applicability thereof is held invalid or unconstitutional by any court of competent jurisdiction, the remainder of 958 CMR 6.00 or the applicability thereof to other persons, entities, or circumstances shall not thereby be affected.

REGULATORY AUTHORITY

958 CMR 6.00: M.G.L. 6D, §11 and 12.