958 CMR 7.00: NOTICES OF MATERIAL CHANGE AND COST AND MARKET IMPACT REVIEWS

Section

7.01: General Provisions

Scope and Purpose. 958 CMR 7.00 governs certain procedures for filing of Notices of Material Change with the Commission by Providers and Provider Organizations, as required by M.G.L. c. 6D, § 13. 958 CMR 7.00 specifies the procedures by which the Commission shall review Notices of Material Change and conduct Cost and Market Impact Reviews.

7.02: Definitions

As used in 958 CMR 7.00, the following words mean:

Acquisition. A purchase or takeover of one organization by another, including a license substitution, standard asset purchase, troubled asset purchase, or purchase through bankruptcy proceedings, but not including employment of a single Health Care Professional.

Board. The governing Board of the Health Policy Commission, established by M.G.L. c.

6D, §2(b).

Carrier. An insurer licensed or otherwise authorized to transact accident or health insurance under M.G.L. c. 175; a nonprofit Hospital service corporation organized under M.G.L. c. 176A; a nonprofit medical service corporation organized under M.G.L. c. 176B; a health maintenance organization organized under M.G.L. c. 176G; and an organization entering into a preferred provider arrangement under M.G.L. c. 176I; provided, that this shall not include an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer; provided that, unless otherwise noted, the term Carrier shall not include any Entity to the extent it offers a policy, certificate or contract that provides coverage solely for dental care services or vision care services.

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 organization 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.

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

Contracting Affiliation. Any 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.

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 organizations 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 Affiliate" and "Corporate Affiliates."

Cost and Market Impact Review. A review conducted by the Commission pursuant to M.G.L. c. 6D, § 13 and 958 CMR 7.00.

Dispersed Service Area. A geographic region in which a multi-Provider Provider Organization functions and in which its market presence is likely to be meaningful to purchasers and Payer networks, as determined by the Commission based on best available data in a methodology set forth in a Technical Bulletin.

Dominant Market Share. A Provider's share of Health Care Services, including but not limited to inpatient services, outpatient services, or professional services, in such Provider's service area that is of significant importance to Payer networks. For inpatient general acute care services, a Provider or Provider Organization has Dominant Market Share if it has 40% of the commercial discharges in one or more of its hospitals' Primary Service Areas. For other services, thresholds for Dominant Market Share may be set forth in a Technical Bulletin, as determined by the Commission based on best available data.

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.

Executive Director. The Executive Director of the Health Policy Commission, as established in M.G.L. c. 6D, §1.

Final Report. A report issued by the Commission subsequent to a Preliminary Report on a Cost and Market Impact Review, pursuant to M.G.L. c. 6D, § 13 and 958 CMR 7.12.

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 Services. Supplies, care and services of medical, behavioral health, substance use disorder, mental health, surgical, optometric, dental, podiatric, chiropractic, psychiatric, 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.

Hospital. Any hospital licensed under M.G.L. c. 111, § 51, the teaching hospital of the University of Massachusetts Medical School, and any psychiatric facility licensed under M.G.L. c. 19, § 19.

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

Material Change. Any transaction requiring notice pursuant to 958 CMR 7.03(1).

Materially Higher Price. A Provider's price, as defined by the Center pursuant to M.G.L. c. 12C and 957 CMR 2.02: *Definitions* or as specified in a Technical Bulletin, for a Carrier or set of Carriers which constitute at least one-third of such Provider's total commercial revenue, which exceeds the weighted mean price of the similar Providers or Provider type for the same Carrier or set of Carriers. The methodology for the calculation of Materially Higher Price is set forth in a Technical Bulletin.

Materially Higher Health Status Adjusted Total Medical Expenses. A Provider's health status adjusted total medical expenses, as defined by the Center pursuant to M.G.L. c. 12C and 957 CMR 2.02: *Definitions* or as specified in a Technical Bulletin, for a Carrier or set of Carriers which constitute at least 1/3 of such Provider's total commercial revenue, which exceeds the weighted mean health status adjusted total medical expenses of the similar Providers or Provider type for the same Carrier or set of Carriers. The methodology for the calculation of Materially Higher Health Status Adjusted Total Medical Expenses is set forth in a Technical Bulletin.

MCN Filing Threshold: The financial threshold established by the Commission in 958 CMR 7.03(2) or a Technical Bulletin pursuant to M.G.L. c. 6D § 13(j) for the filing of a Notice of Material Change.

Merger. A consolidation or integration of two or more organizations, including two or more organizations joining through a common parent organization or two or more organizations forming a new organization, but not including the merger of a Corporate Affiliate into a sole member parent or a corporate re-organization within an existing Provider or Provider Organization.

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.

Non-material Change. Any change to a Provider or Provider Organization's operations or governance structure that is not a Material Change.

Notice of Material Change. Notification to the Commission by a Provider or Provider Organization prior to making a Material Change to its operations or governance structure, pursuant to M.G.L. c. 6D, § 13 and 958 CMR 7.00.

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 provided further, that "payer" shall include self-insured plans to the extent allowed under the Employee Retirement Income Security Act of 1974 and Third-Party Administrators.

Preliminary Report. A report issued by the Commission containing factual findings on a Cost and Market Impact Review, pursuant to M.G.L. c. 6D, § 13 and 958 CMR 7.10.

Primary Service Area. A geographic area from which a Provider draws a significant proportion of its volume, as determined by the Commission based on best available data in a methodology set forth in a Technical Bulletin. For general acute care Hospitals, a Primary Service Area shall be the contiguous geographic area from which the Hospital draws 75% of its commercial discharges, as measured by zip codes closest to the Hospital by drive time, and for which the Hospital represents a minimum proportion of the total discharges in a zip code, as determined by the Commission based on best available data in a methodology set forth in a Technical Bulletin.

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. Any person, corporation, partnership, governmental unit, state institution or any other Entity that is qualified under the laws of the Commonwealth to perform or provide Health Care Services.

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 payments of Health Care Services; provided, that a Provider Organization shall include, but not be limited to, physician organizations, physician-hospital organizations, independent practice

associations, Provider networks, accountable care organizations and any other organization that contracts with Payers for payment for Health Care Services.

Revenue Increase Threshold. The financial threshold established by the Commission in 958 CMR 7.03(2) or a Technical Bulletin pursuant to M.G.L. c. 6D § 13(j) for Material Changes involving an increase in the annual Net Patient Service Revenue of the Provider or Provider Organization.

Significant Equity Investor. Any Private Equity Company with a financial interest in a Provider, Provider Organization, or Management Services Organization, or that, following a proposed transaction, would have such a financial interest; or an investor, group of investors, or other Entity that has or, following a proposed transaction would have, 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.

Technical Bulletin. A sub-regulatory document containing methodological explanations and examples to facilitate understanding and compliance with the provisions contained in 958 CMR 7.00.

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

7.03: Requirement to File a Notice of Material Change

(1) Requirement for Filing. Any Provider or Provider Organization that meets the MCN Filing Threshold in the preceding fiscal year shall notify the Commission, the Center, and the Office of the Attorney General with a Notice of Material Change not fewer than 60 days before the proposed effective date of the following types of proposed Material Change:

(a) A Merger or other Corporate Affiliation between a Provider or Provider Organization and a Carrier, Acquisition of a Provider or Provider Organization by a Carrier, or Acquisition of a Carrier by a Provider or Provider Organization;

(b) A Merger with or Acquisition of a Hospital or hospital system, or a Merger with or Acquisition of a Provider or Provider Organization by a Hospital or hospital system;

(c) Any other Acquisition, Merger, other Corporate Affiliation, Contracting

Affiliation for establishing contracts with a Carrier or Third-Party Administrator, or employment of Health Care Professionals when:

i. Such affiliation is of, by, or with:
   1. A Provider or Providers (such as multiple Health Care Professionals from the same Provider or Provider Organization), or
   2. A Provider Organization, a Management Services Organization that provides support for negotiating or establishing contracts with Carriers or Third-Party Administrators, or an Entity representing providers of Health Care Services who are qualified under the laws of a state other than Massachusetts in contracting with Payers for Health Care Services; and

ii. Such affiliation would result in an increase in annual Net Patient Service Revenue of an amount equal to or greater than the Revenue Increase Threshold for any Provider, Provider Organization, or Entity representing providers of Health Care Services in a state other than Massachusetts, or in a Provider or Provider Organization having Dominant Market Share.

(d) A Clinical Affiliation between two or more Providers or Provider Organizations that each had annual Net Patient Service Revenue at or above the MCN Filing Threshold in the preceding fiscal year; provided that, for the purpose of this requirement, Clinical Affiliation includes the following:

i. Co-branding,
ii. Co-located services,
iii. Complete or substantial staffing of an Acute Hospital service line,
iv. The provision of funds to establish or enhance electronic health record (EHR) interconnectivity,
v. Establishment of a preferred Provider relationship,
vi. Regular and ongoing provision of telemedicine services,
vii. Establishment of a discount arrangement

For the purpose of this requirement, Clinical Affiliation does not include affiliations solely for the purpose of collaborating on clinical trials or graduate medical education programs.

(e) Any formation of a partnership, joint venture, accountable care organization, parent corporation, Management Services Organization, or other organization created for administering contracts with Carriers or Third-Party Administrators for current or future contracting on behalf of one or more Providers or Provider Organizations;

(f) A significant increase to a Provider or Provider Organization's capacity including, but not limited to:

i. Any increase to capacity that requires an Application for Substantial Capital Expenditure (as defined in 105 CMR 100) to be submitted to the Massachusetts Department of Public Health's Determination of Need

program. This includes proposals that would meet the monetary criteria for a Substantial Capital Expenditure, but which might be filed under a different Determination of Need category (e.g., "Significant Change in Services," "Emergency" applications and "Significant Amendments"); and

ii. Any increase to capacity that would result in an increase in annual Net Patient Service Revenue of the Provider or Provider Organization by an amount equal to or greater than the Revenue Increase Threshold, based on the expected revenue of the planned new capacity.

(g) Any transaction involving a Significant Equity Investor, including but not limited to a Private Equity Company, that results in a partial or complete change of ownership or Control of a Provider, Provider Organization, or Management Services Organization;

(h) A significant acquisition, sale or transfer of Provider or Provider Organization assets including, but not limited to, the sale of real property assets where Health Care Services are delivered for the purposes of a real estate lease-back arrangement; or

(i) Any conversion of a Provider or Provider Organization from a non-profit Entity to a for-profit Entity.

(2) Filing Thresholds.

(a) The MCN Filing Threshold as of April 16, 2026 is $25 million.

(b) The Revenue Increase Threshold as of April 16, 2026 is $10 million.

(c) The Commission shall annually adjust the MCN Filing Threshold and Revenue Increase Threshold based on the Personal Health Care – Overall index established by the United States Department of Health and Human Services, or if that index is no longer published, a similarly reliable index of health care inflation. The Commission shall establish and adjust such thresholds in a Technical Bulletin.

7.04: Time and Form of Filing a Notice of Material Change; Completed Notice; HPC Review

(1) Timing of Filing. Notices of Material Change must be filed not fewer than 60 days before the proposed effective date of the proposed Material Change. For purposes of 958 CMR 7.00, the effective date of a Material Change is the date when the proposed transaction would be consummated or closed. If a Massachusetts Department of Public Health Determination of Need filing related to the proposed Material Change is required under 105 CMR 100, the Notice of Material Change must be filed concurrently with the Determination of Need application.

(2) Form of Filing. A Notice of Material Change shall be filed in a manner and form prescribed by the Commission and shall identify any changes in Health Care Services anticipated in connection with the proposed Material Change.

(3) Information Requests. The Commission may require any Provider, Provider Organization, Carrier, or other party to the Material Change to submit documents and information in connection with a Notice of Material Change. For any Material Change involving a Significant Equity Investor, the Commission may specify certain information required to be submitted as part of the Notice of Material Change, including, but not limited to, information regarding the Significant Equity Investor's capital structure, general financial condition, ownership and management structure, and audited financial statements.

(4) Information Requests to Other Market Participants. The Commission may require Payers or other entities involved in the Material Change to submit documents and information in connection with a Notice of Material Change.

(5) Completeness of Filing. A Notice of Material Change shall be complete when:

(a) The Commission has received the Notice of Material Change form and all information requested pursuant to M.G.L. c. 6D, § 13(c) and 958 CMR 7.04(3); and
(b) The Commission determines that all parties subject to the requirements of 958 CMR 6.00 are in compliance with those requirements.

(6) Failure to File. If the Commission determines that a Provider or Provider Organization has failed to file a timely, complete Notice of Material Change pursuant to 958 CMR 7.03(1)-7.04(5), the Commission may refer the Provider or Provider Organization to the Office of the Attorney General.

(7) Commission Review of Material Change Notice. Within 30 days of receipt of a completed Notice of Material Change filed under 958 CMR 7.04, the Commission shall conduct a preliminary review to determine whether the Material Change is likely to result in a significant impact on the Commonwealth's ability to meet the Health Care Cost Growth Benchmark established under Section 9 of M.G.L c. 6D, or on the competitive market.

(8) Grounds for Cost and Market Impact Review. If the Commission finds that the Material Change is likely to have a significant impact on the Commonwealth's ability to meet the Health Care Cost Growth Benchmark, or on the competitive market, the Commission may conduct a Cost and Market Impact Review. Additionally, if the Commission finds, based on the Center's annual report under

M.G.L. c. 12C, § 16, that the percentage change in total health care expenditures exceeded the Health Care Cost Growth Benchmark in the previous calendar year, the Commission may conduct a Cost and Market Impact Review of any Provider Organization identified by the Center under M.G.L. c. 12C, §18.

(9) Initiation of a Cost and Market Impact Review. Initiation of a Cost and Market Impact Review shall occur either by vote of the Board or by the Executive Director. For Cost and Market Impact Reviews initiated by the Executive Director, the Board shall subsequently vote on whether to continue the Cost and Market Impact Review.

7.05: Notice of Cost and Market Impact Review; Information Requests

(1) Notice. The Commission shall inform each notifying Provider or Provider Organization of any determination to initiate a Cost and Market Impact Review within 30 days of its receipt of a completed Notice of Material Change, including all required information pursuant to 958 CMR 7.03(4), or by a later date set by mutual agreement of the Provider or Provider Organization and the Commission.

(2) Information Requests. The Commission may require that any Provider, Provider Organization, Carrier or other party to the Material Change submit documents and information in connection with the Cost and Market Impact Review. The Commission may additionally require submission of information from any Significant Equity Investor that is involved with the proposed Material Change.

7.06: Factors Considered in a Cost and Market Impact Review

A Cost and Market Impact Review may examine factors relating to the Provider or Provider Organization's business and its relative market position, including, but not limited to:

(1) The Provider or Provider Organization's size and market share within its Primary Service Areas by major service category, and within its Dispersed Service Areas;

(2) The Provider or Provider Organization's prices for services, including its relative price compared to other Providers for the same services in the same market;

(3) The Provider or Provider Organization's health status adjusted total medical expense, including its health status adjusted total medical expense compared to similar Providers;

(4) The quality of the services it provides, including patient experience;

(5) Provider cost and cost trends in comparison to total health care expenditures statewide;

(6) The availability and accessibility of services similar to those provided, or proposed to be provided, through the Provider or Provider Organization within its Primary Service Areas and Dispersed Service Areas;

(7) The Provider or Provider Organization's impact on competing options for the delivery of Health Care Services within its Primary Service Areas and Dispersed Service Areas including, if applicable, the impact on existing service Providers of a Provider or Provider Organization's expansion, affiliation, Merger or Acquisition, to enter a Primary or Dispersed Service Area in which it did not previously operate;

(8) The methods used by the Provider or Provider Organization to attract patient volume and to recruit or acquire Health Care Professionals or facilities;

(9) The role of the Provider or Provider Organization in serving at-risk, underserved and government Payer patient populations, including those with behavioral, substance use disorder and mental health conditions, within its Primary Service Areas and Dispersed Service Areas;

(10) The role of the Provider or Provider Organization in providing low margin or negative margin services within its Primary Service Areas and Dispersed Service Areas;

(11) Consumer concerns, including but not limited to, complaints or other allegations that the Provider or Provider Organization has engaged in any unfair method of competition or any unfair or deceptive act or practice;

(12) The size and market share of any Corporate Affiliates or Significant Equity Investors of the Provider or Provider Organization;

(13) The inventory of health care resources maintained by the Department of Public Health;

(14) Any related data or reports from the Office of Health Resource Planning; and

(15) Any other factors that the Commission determines to be in the public interest.

7.07: Responses to Information Requests; Timing

(1) Responses to Information Requests. Entities that received information requests pursuant to 958 CMR 7.05 shall provide information in response to such information requests within 21 days of receipt. The response shall include any written response, information and/or documents requested by the Commission pursuant to such information requests and may include additional information.

(2) Request for Additional Time. Entities that received information requests pursuant to 958 CMR 7.05 may request additional time to provide their written responses and requested information and documents. Any additional time granted by the Commission to submit information may be added to the time for completion of the Final Report, pursuant to M.G.L. c. 6D, § 13 and 958 CMR 7.12.

(3) Certification of Compliance. Entities that received information requests pursuant to 958 CMR 7.05 shall certify substantial compliance with the Commission's information requests on the date determined by the Commission.

7.08: Information Requests to Other Market Participants; Timing

(1) In connection with its review of a Notice of Material Change filed pursuant to M.G.L. c. 6D, § 13 and 958 CMR 7.03 or a Cost and Market Impact Review initiated pursuant to M.G.L. c. 6D, § 13 and 958 CMR 7.05, the Commission may request information of Providers, Provider Organizations, and Payers that are not parties to the transaction under review.

(2) Any information requested under 958 CMR 7.08 shall be provided within 21 days of a request by the Commission.

7.09: Confidentiality

The Commission shall keep confidential all nonpublic information and documents obtained in connection with a Notice of Material Change or a Cost and Market Impact Review and shall not disclose the information or documents to any person without the consent of the Entity that produced the information or documents, except in a Preliminary Report or Final Report if the Commission believes that such disclosure should be made in the public interest after taking into account any privacy, trade secret or anti-competitive considerations. The confidential information and documents shall not be public records and shall be exempt from disclosure under M.G.L. c. 4, § 7 cl. 26 or M.G.L. c. 66, § 10. Nonpublic information and documents shall not include information included on the Notice of Material Change form itself, prescribed by and filed with the Commission.

7.10: Preliminary Report

The Commission shall issue a Preliminary Report containing factual findings on a Cost and Market Impact Review, pursuant to M.G.L. c. 6D, § 13(e).

7.11: Written Response by Provider or Provider Organization; Certification of Truth

(1) Written Response. Within 30 days after the Commission issues a Preliminary Report, the Provider or Provider Organization may respond in writing to the findings in the Preliminary Report.

(2) Certification of Truth. In submitting a written response to the Preliminary Report, the Provider or Provider Organization shall certify that all information set forth in the written response is true and accurate to the best knowledge of the Provider or Provider Organization's chief executive officer. Further, the Provider or Provider Organization shall certify that none of the information included in the written response, or any information referred to therein, is responsive to the Commission's requests for information in connection with the notice of Cost and Market Impact Review and was previously available but not provided.

7.12: Final Report

The Commission shall issue a Final Report on a Cost and Market Impact Review subsequent to the issuance of a Preliminary Report and any written response timely submitted by the Provider or Provider Organization, which shall be within 185 days from the date that the Provider or Provider Organization filed a completed Notice of Material Change with the Commission; provided that the Provider or Provider Organization has certified substantial compliance with the Commission's requests for information within 21 days pursuant to M.G.L. c. 6D, § 13 and 958 CMR 7.07. If the Provider or Provider Organization has not certified substantial compliance within 21 days of the Commission's requests for information as provided in 958 CMR 7.07, the Commission may set a later date for the issuance of the Final Report that is commensurate with any additional time granted pursuant to 958 CMR 7.07.

7.13: Completion of Proposed Material Change

Any proposed Material Change shall not be completed until the Commission has informed the Provider or Provider Organization of any determination not to initiate a Cost and Market Impact Review pursuant to 958 CMR 7.05, or until at least 30 days after the Commission has issued its Final Report on a Cost and Market Impact Review.

7.14: Referral to the Office of the Attorney General or Other Agencies.

(1) Attorney General. The Commission shall refer a Final Report issued pursuant to 958 CMR 7.12 to the Office of the Attorney General pursuant to M.G.L. c. 6D, § 13(f) on any Provider Organization that has Dominant Market Share, Materially Higher Price, and Materially Higher Health Status Adjusted Total Medical Expenses, as defined in 958 CMR 7.02. The Commission may also refer a Final Report to the Office of the Attorney

General in other circumstances as appropriate.

(2) Department of Public Health. Upon issuance of its Final Report, the Commission shall provide a copy of said Final Report to the Department of Public Health.

(3) Other Agencies. The Commission may refer the Final Report to other state or federal government agencies as appropriate.

7.15: Post Transaction Review.

(1) The Commission may conduct post-transaction reviews of Material Changes.

(2) The Commission may require, for a period of 5 years following the completion of any Material Change, that any Provider, Provider Organization, Carrier or other party involved in the Material Change submit data and information necessary for the Commission to assess the post-transaction impacts of the Material Change.

(3) The Commission shall keep confidential all nonpublic information and documents obtained in connection with a post-transaction review, pursuant to 958 CMR 7.09.

(4) The Commission may report on the results of its post-transaction reviews as appropriate and may make referrals to other agencies based on such reporting in accordance with 958 CMR 7.14.

7.16: Severability

If any section or portion of a section of 958 CMR 7.00 or the applicability thereof is held invalid or unconstitutional by any court of competent jurisdiction, the remainder of 958 CMR 7.00 or the applicability thereof to other persons, entities, or circumstances shall not thereby be affected.

REGULATORY AUTHORITY

958 CMR 7.00: M.G.L. c. 6D, § 13.