958 CMR 6.00: REGISTRATION OF PROVIDER ORGANIZATIONS

Section

6.01: General Provisions

Scope and Purpose. 958 CMR 6.00 governs the procedures and criteria used to administer the provider organization registration program as required by M.G.L. c. 6D, § 11 and 12. 958 CMR 6.00 specifies the criteria that determine which Provider Organizations must register with the Health Policy Commission and what information must be submitted by each Provider Organization to complete Registration.

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.

Advanced Care Settings. Sites at which more complex care can be provided for one or more clinical services.

Behavioral Health Services. Supplies, care, and services for the diagnosis, treatment, or management of patients with mental health or substance use disorders.

Board. The governing board of the Health Policy Commission, established in 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, but not including 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 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 and sharing of hospitalists or intensivists.

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

(MA REG. #1265, Dated 7-18-14)

6.02: continued

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: *Policies and Procedures for Patient and Family Advisory Council* or community benefits advisory boards.

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 Carrier or Third-party Administrator.

Corporate Affiliation. Any relationship between two Entities that reflects, directly or indirectly, a partial or complete controlling interest or partial or complete common control.

Data Submission Manual. A manual published by the Commission 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 Carriers and Third-party Administrators, 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 Services. Supplies, care and services of medical, Behavioral 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; 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.

Initial Registration. The first time a Provider Organization submits an application for Registration, which application may include one or more parts.

Joint Training Programs. A training program, including but not limited to student education and graduate medical education, jointly sponsored by one or more Providers or Provider Organizations.

6.02: continued

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).

Major Service Category. A set of service categories as specified in the *Data Submission Manual*, including:

(a) Acute Hospital inpatient services, by major diagnostic category;

(b) outpatient and ambulatory services, by categories as defined by the Centers for Medicare and Medicaid, or as specified in the *Data Submission Manual*, not to exceed 15, including a residual category for "all other" outpatient and ambulatory services that do not fall within a defined category;

(c) Behavioral Health Services;

(d) professional services, by categories as defined by the Centers for Medicare and Medicaid, or as specified in the *Data Submission Manual*; and

(e) sub-acute services, by major service line or clinical offering, as specified in the *Data Submission Manual*.

Net Patient Service Revenue. The total revenue received in a Fiscal Year for patient care from any Carrier or Third-party Administrator 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 36-month period.

Practice Site. Any site at which members of a Local Practice Group provide care.

Provider Organization or Health System or System. Any corporation, partnership, business trust, association or organized group of persons, 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 Carriers or Third-party Administrators for the payment of Health Care Services; provided that the definition 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 Carriers or Third-party Administrators for payment for Health Care Services.

Registration. The process of becoming a Registered Provider Organization as established by the Commission pursuant to M.G.L. c. 6D, § 11, including Initial Registration and Registration Renewal.

Registration Renewal. The process for a Registered Provider Organization to renew its Registration every 24 months.

Registered Provider Organization or RPO. 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.

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

6.03: Applicability

(1) 958 CMR 6.00 applies to a Provider Organization that negotiates, represents, or otherwise acts on behalf of one or more Providers or Provider Organizations, which may include itself, in establishing contracts for the payment of Health Care Services with Carriers or Third-party Administrators, that collectively received $25,000,000 or more in Net Patient Service Revenue from Carriers or Third-party Administrators in the prior Fiscal Year.

6.03: continued

(2) 958 CMR 6.00 also applies to a Risk-bearing Provider Organization subject to the requirements of the Division pursuant to M.G.L. c. 176T and any regulations promulgated thereunder.

6.04: Requirement to Register

(1) The following Provider Organizations shall register with the Commission pursuant to 958 CMR 6.00:

(a) a Provider Organization that negotiates, represents, or otherwise acts on behalf of one or more Providers or Provider Organizations, which may include itself, in establishing contracts for the payment of Health Care Services with Carriers or Third-party Administrators, that collectively:

1. received $25,000,000 or more in Net Patient Service Revenue from Carriers or Third-party Administrators in the prior Fiscal Year; and

2. had a Patient Panel of more than 15,000 as of the end of the Provider Organization's prior Fiscal Year; and

(b) a Risk-bearing Provider Organization.

(2) A Provider Organization that meets the criteria for Registration set forth in 958 CMR 6.04(1) and which is partially or completely owned or controlled by another Provider Organization also subject to 958 CMR 6.04(1) shall meet its obligation to register with the Commission through the Registration of the Provider Organization that owns or controls it.

(3) A Provider Organization that meets the criteria for Registration set forth in 958 CMR 6.04(1) and on whose behalf another Provider Organization, also subject to 958 CMR 6.04(1), negotiates, represents, or otherwise acts to establish contracts with Carriers or Third-party Administrators for the payment of Health Care Services, may, at the discretion of the Commission, meet its obligation to register with the Commission through the submission of an abbreviated application for Registration in a format prescribed by the Commission.

6.05: Registration

(1) A Provider Organization that meets the criteria set forth in 958 CMR 6.04(1) as of July 18, 2014 shall file an application for Registration with the Commission as specified in the *Data Submission Manual*, subject to the provisions of 958 CMR 6.04(2) and (3).

(2) The following Provider Organizations that meet the criteria set forth in 958 CMR 6.04(1) shall begin and complete Initial Registration by no later than the dates specified in the *Data Submission Manual*:

(a) A Provider Organization that negotiates, represents, or otherwise acts on behalf of one or more Providers or Provider Organizations, which may include itself, that is a physician group, Acute Hospital, rehabilitation hospital, long term acute care hospital, or that provides inpatient or outpatient Behavioral Health Services, to establish contracts for the payment of Health Care Services with Carriers or Third-party Administrators; and

(b) A Risk-bearing Provider Organization.

A Provider Organization specified in 958 CMR 6.05(2) that does not meet the criteria set forth in 958 CMR 6.04(1) as of July 18, 2014, but that meets these criteria at any time after July 18, 2014 shall complete Initial Registration not later than 180 calendar days after meeting the criteria set forth in 958 CMR 6.04(1), subject to the provisions of 958 CMR 6.04(2) and (3), unless otherwise authorized by the Commission in writing.

(3) A Provider Organization that meets the criteria set forth in 958 CMR 6.04(1) as of July 18, 2014 but that is not specified in 958 CMR 6.05(2) shall not be required to file an application for Registration until the Commission publishes a notice of deadline for Initial Registration, including in the *Data Submission Manual* and on the Commission's website. The Commission shall publish the notice of deadline for Initial Registration at least 180 calendar days prior to requiring such Provider Organization to file an application for Initial Registration.

6.05: continued

(4) Every two years after completing Initial Registration, a Registered Provider Organization that meets the criteria set forth in 958 CMR 6.04(1) shall file an application for Registration Renewal by the date specified in the *Data Submission Manual*, subject to the provisions of 958 CMR 6.04(2) and (3).

(5) A Provider Organization's Registration shall be valid for a 24-month period, beginning on the date of the notice issued by the Commission pursuant to 958 CMR 6.05(10), unless otherwise specified by the Commission or as provided in 958 CMR 6.05(11).

(6) A Provider Organization that negotiates, represents, or otherwise acts on behalf of one or more Providers or Provider Organizations, which may include itself, in contracting with Carriers or Third-party Administrators, that collectively received $25,000,000 or more in annual Net Patient Service Revenue from Carriers or Third-party Administrators in the prior Fiscal Year, but that does not have a collective Patient Panel of more than 15,000 as of the end of the prior Fiscal Year, shall submit to the Commission in writing, prior to the applicable deadline for Registration as established by the Commission, evidence that 958 CMR 6.00 does not apply to that Provider Organization, as specified by the Commission. After receiving such evidence from a Provider Organization, the Commission may require the Provider Organization to provide additional information. A Provider Organization shall respond to any such request for additional information within 21 calendar days of the date of the Commission's request, unless otherwise specified in writing by the Commission.

(7) A Provider or Provider Organization not otherwise required to register by 958 CMR 6.04(1) and 6.05(2) may voluntarily submit an application for Registration.

(8) The application for Registration shall be certified by two duly authorized representatives of the Provider Organization, one of whom shall be the Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, or equivalent. Unless otherwise specified by the Commission, the application shall include the following information for the Provider Organization and any Entity with which it has a Corporate Affiliation or Contracting Affiliation, subject to the specifications and instructions detailed in the *Data Submission Manual*:

(a) Information about ownership, governance, and operational structure, including, organizational charts, narrative descriptions of the type and kind of Corporate and Contracting Affiliations, information on incentive structures and compensation models, including Funds Flow within the Provider Organization, 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 or 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;

(d) For Risk-bearing Provider Organizations, a statement certifying that the RBPO has received a risk certificate or a waiver from the Division from the requirements of M.G.L. c. 176T or any regulations promulgated thereunder;

(e) Information on utilization by Major Service Category;

(f) Total revenue by payer under pay for performance arrangements, risk contracts, and other fee-for-service arrangements; and

(g) A registration fee payable to the Health Policy Commission as specified by the Commission.

(9) After receiving an application for Registration, the Commission may, within 30 calendar days, require an applicant to provide additional information to complete or supplement the application for completeness or clarification. A Provider Organization shall respond to any request for additional information from the Commission within 21 calendar days of the date of the Commission's request, unless otherwise specified in writing by the Commission.

6.05: continued

(10) The Commission shall determine whether an application is complete within 45 calendar days of receipt of the application or any supplementary material, whichever is later, and the Commission shall provide written notice of completed Registration to the applicant. An application will not be considered complete until all materials required by the Commission have been received by the Commission.

(11) A Registered Provider Organization shall update its Registration on file with the Commission pursuant to 958 CMR 6.05(8) within 21 calendar days after the effective date of any change to the Registered Provider Organization that directly affects the Registration information on file with the Commission and:

(a) required a Determination of Need by the Department of Public Health;

(b) required a Material Change Notice to be filed with the Commission; or

(c) required an essential health services filing with the Department of Public Health pursuant to 105 CMR 130.000: *Hospital Licensure*.

The Commission may require in writing, at any time, additional information reasonable and necessary to determine the financial condition, organizational structure, business practices or market share of a Registered Provider Organization pursuant to M.G.L. c. 12C, § 9(d). A Registered Provider Organization shall respond to a request for additional information by the Commission within 21 calendar days of the date of the Commission's request, unless otherwise specified in writing by the Commission.

(12) The Registration requirements set forth in 958 CMR 6.05(8) may be fulfilled through the reporting of such information to other Commonwealth of Massachusetts agencies, as may be specified by the Commission.

(13) The Commission may issue administrative bulletins necessary to implement 958 CMR 6.00.

6.06: Non-compliance

(1) If the Commission determines that a Provider or Provider Organization that has not registered with the Commission pursuant to 958 CMR 6.00 might meet the eligibility criteria set forth in 958 CMR 6.04(1), the Commission may send written notice to the Provider or Provider Organization. Within 30 calendar days of the date of the notice, a Provider or Provider Organization that receives such a notice from the Commission shall:

(a) Submit an application for Registration in compliance with 958 CMR 6.05; or

(b) Submit adequate supporting documentation to demonstrate that the Provider or Provider Organization does not meet the eligibility criteria set forth in 958 CMR 6.04(1). The documentation must demonstrate to the satisfaction of the Commission that the Provider or Provider Organization does not meet the criteria established in 958 CMR 6.04(1).

(2) If a Provider Organization required to register pursuant to 958 CMR 6.00 fails to submit a completed application for Registration to the Commission as required, fails to submit any additional information requested by the Commission pursuant to 958 CMR 6.05(6), (9), (10) or (11), or otherwise fails to comply with the requirements of 958 CMR 6.00, the Commission may provide written notice to the Provider Organization of non-compliance. A Provider Organization that receives a notice of non-compliance from the Commission may, within 21 calendar days of the date of the notice:

(a) Submit the required documentation in compliance with 958 CMR 6.00; or

(b) Submit documentation that demonstrates that the Provider Organization has fully complied with the requirements of 958 CMR 6.00 or explains why the Provider Organization is not required to comply with 958 CMR 6.00. Any such additional documentation shall be certified by two duly authorized representatives of the Provider Organization, one of whom shall be the Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, or equivalent.

The Commission shall review any such documentation and shall determine whether the Provider Organization has met all of the requirements of 958 CMR 6.00, and if so, shall provide a written notice of completed Registration to the applicant.

6.06: continued

(3) If the Commission determines that a Provider Organization that meets the criteria set forth in 958 CMR 6.04(1) has failed to submit a completed application for Registration as required, the 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 Carrier or Third-party Administrator. The Commission may provide notice of a Provider's or Provider Organization's non-compliance with 958 CMR 6.00 to Carriers, Third-party Administrators and the Division.

(4) If a Provider Organization has submitted documentation to the Commission pursuant to 958 CMR 6.06(2), the Provider Organization shall not be deemed non-compliant, if applicable, until after the Commission has made a determination pursuant to 958 CMR 6.06(2).

(5) With respect to those Provider Organizations that are required to register pursuant to 958 CMR 6.00, and that are also subject to the requirements of M.G.L. c. 176T or any regulations promulgated thereunder, the Commission may provide notice to the Division of a Provider Organization's non-compliance with 958 CMR 6.00.

6.07: 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. c. 6D, § 11 and 12.

NON-TEXT PAGE