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, or troubled asset purchase, but not including employment of a single Health Care Professional.

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 visions care services.

Center. The Center for Health Information and Analysis.

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 and sharing of hospitalists or intensivists.

Commission. The Health Policy Commission.

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.

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

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.

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; 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.

Material Change. The following types of proposed changes involving a Provider or Provider Organization:

(a) A Merger or affiliation with, or Acquisition of or by, a Carrier;

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

(c) Any other Acquisition, Merger, or affiliation (such as a Corporate Affiliation, Contracting Affiliation, or employment of Health Care Professionals) of, by, or with another Provider, Providers (such as multiple Health Care Professionals from the same Provider or Provider Organization), or Provider Organization that would result in an increase in annual Net Patient Service Revenue of the Provider or Provider Organization of ten million dollars or more, or in the Provider or Provider Organization having a near-majority of market share in a given service or region;

(d) Any Clinical Affiliation between two or more Providers or Provider Organizations that

each had annual Net Patient Service Revenue of $25 million or more in the preceding fiscal year; provided that this shall not include a Clinical Affiliation solely for the purpose of collaborating on clinical trials or graduate medical education programs; and

(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 or current or future contracting on behalf of one or more Providers or Provider Organizations.

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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 ⅓ 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 ⅓ 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.

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 for patient care from any third party Payer net of any contractual adjustments. For Hospitals, Net Patient Service Revenue should be as reported to the Center under M.G.L. c. 12C, § 8. For other Providers or Provider Organizations, Net Patient Service Revenue shall include the total revenue received for patient care from any third Party payer net of any contractual adjustments, including:

(a) prior year third party settlements; and

(b) premium revenue, which means per-member-per-month amounts received from a third party Payer to provide comprehensive Health Care Services for that period, for all Providers represented by the Provider or Provider Organization in contracting with Carriers, for all Providers represented by the Provider or Provider Organization in contracting with third party Payers.

Non-material Change: Any change to a Provider or Provider Organization's operations or governance structure which 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. An organization that pays Providers for the provision of Health Care Services; provided that Payer shall include both governmental and private organizations; provided further, that Payer shall not include excluded ERISA plans.

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 contiguous 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.

Provider. 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.

7.02: continued

Provider Organization. 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 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 Carriers for payment for Health Care Services.

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.

7.03: Requirement to File a Notice of Material Change; Timing of Filing

(1) Requirement for Filing. Any Provider or Provider Organization with $25 million or more in Net Patient Service Revenue in the preceding fiscal year shall provide 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 proposed Material Change. For purposes of 958 CMR 7.00, the effective date of a Material Change is the date when the proposed transaction will be consummated or closed. If the Commission determines that a Provider or Provider Organization has failed to file a Notice of Material Change pursuant to 958 CMR 7.03(1), the Commission may refer the Provider or Provider Organization to the Office of the Attorney General.

(2) Timing of Filing. A Provider or Provider Organization may file a Notice of Material Change earlier than 60 days before the effective date of the proposed Material Change; provided that if the Commission considers the Notice of Material Change to be incomplete, or if the Commission requires clarification of any information to make its determination, the Commission may, within 30 days of receipt of the Notice of Material Change, notify the Provider or Provider Organization of the information or clarification necessary to complete the notice.

7.04: Filing a Notice of Material Change; Completed Notice

(1) 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.

(2) A Notice of Material Change shall be complete upon filing of the Notice of Material Change form and any information requested by the Commission pursuant to M.G.L. c. 6D, § 13(c) and 958 CMR 7.03.

7.05: Notice of Cost and Market Impact Review

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(2), or by a later date set by mutual agreement of the Provider or Provider Organization and the Commission.

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;

7.06: continued

(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; and

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

7.07: Information Requests to Providers and Provider Organizations; Timing

(1) Within 21 days of issuance of a notice of Cost and Market Impact Review by the Commission, a Provider or Provider Organization shall submit a written response to the notice. The written response shall include the information requested by the Commission pursuant to such notice and may include additional information.

(2) The Provider or Provider Organization may request additional time to provide its written response or requested information; provided that 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) The Provider or Provider Organization shall certify substantial compliance with the Commission's requests for information on the date determined by the Commission.

7.08: Information Requests to Other Market Participants; Timing

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 other Providers, Provider Organizations, or Payers, which 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 Provider or Payer 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

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.

7.15: 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.