

TO: Health Policy Commission Care Delivery and Payment System Reform Committee

FROM: David Seltz, Executive Director
Iyah Romm, Director, System Performance and Strategic Investment

DATE: December 16, 2013

RE: Proposed Regulation 958 CMR 6.00 on the Registration of Provider Organizations

Introduction

The purpose of this memo is to provide context for the Health Policy Commission's (Commission) proposed draft regulation 958 CMR 6.00, *Registration of Provider Organizations*, to members of the Care Delivery and Payment System Reform Committee. Pursuant to Section 11 of Chapter 224 of the Acts of 2012, *An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency and Innovation*, this draft regulation creates the framework for Provider Organization registration,¹ including applicability, registration and reporting processes, and specifies the type of information that will be collected by the Commission upon registration.

Background

Chapter 224 requires that certain Providers and Provider Organizations register biennially with the Commission and report on elements of their organizational, operational, and financial practices annually. While the responsibility of administering the registration process lies with the Commission, the Commission and the Center for Health Information and Analysis (CHIA) jointly share the data collection responsibilities pursuant to their respective enabling statutes. As data collection responsibilities are jointly shared between agencies, CHIA and the Commission are engaging in a collaborative process to ensure a streamlined registration and reporting process for Provider Organizations.

¹ M.G.L. c. 6D, §11 defines "provider organization" as 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 for payment for Health Care Services.

Broadly speaking, data submitted to the Commission by Provider Organizations pertain to the variety of relationships and affiliations that occur within and between Provider Organizations in ownership arrangements, as well as contracting for reimbursements with payers, and contracting around the delivery of care with clinical affiliates. These data will serve a variety of analyses, providing high-level descriptive information on compensation models and the flow of funds with Provider Organizations as well as a more complete understanding of geographical distribution of the health care workforce. All of this information will be available across agencies, supporting programs such as health resource planning, Risk-Bearing Provider Organization certification, and Cost and Market Impact Reviews.

Applicability and Registration

As specified in statute, there are two criteria that obligate a Provider Organization to register with the Commission. First, Provider Organizations bearing significant downside risk in the management of patient care and thereby subject to the requirement to register with the Division of Insurance under 211 CMR 155.00 as a Risk-Bearing Provider Organization, must also register with the Commission. Second, any Provider Organization with a patient panel of greater than 15,000² and a Net Patient Service Revenue (NPSR) of \$25,000,000 or more from Carriers or Third Party Administrators, both statutorily defined terms, must register. Through data provided by CHIA, the Commission is able to identify which Provider Organizations meet or exceed the NPSR threshold.³ Any Provider Organization that is owned or controlled by another Provider Organization may meet its obligation to register through the registration of the Provider Organization that owns or controls it. Any Provider Organization that fails to comply with the requirement to register is by statute prohibited from contracting with payers.

As noted above, Provider Organization, as defined in M.G.L. c. 6D and 958 CMR 6.01 emphasizes the “business of health care delivery or management” and the function of “contracting with carriers for the payments of health care services.” This definition aligns with the goal of understanding contracting practices and the network of affiliations within and among provider systems. Another definition critical to determining applicability is “Carrier.” The statute

² 958 CMR 6.00 defines “patient panel” as the total number of individual patients seen by a Provider Organization over the course of the most recent complete 36 month period.

³The draft regulation requires Provider Organizations that meet the NPSR threshold to register with the Commission unless they are able to proactively demonstrate that they do not meet the patient panel minimum.

stipulates that NPSR calculations be based on revenue from “Carriers or Third-Party Administrators,” the definitions of which are also both set in statute. The statutory definition of Carrier encompasses commercial payers, Medicaid Managed Care Organizations, and Medicare Advantage, but does not encompass direct government fee-for-service agreements between Provider Organizations and Medicaid or Medicare. Consequentially, Provider Organizations with a predominant public payer mix that reach the NPSR threshold due to revenue generated through direct contracting with the government, such as certain skilled nursing facilities, would not be subject to the requirement to register with the Commission if they do not reach the NPSR threshold through revenue received from commercial Carriers.

Registration and Reporting Process

Recognizing the substantial breadth of the definition of Provider Organization, 958 CMR 6.00 proposes a staggered Registration Schedule based on type of Provider Organization. Physician groups, Acute Hospitals, rehabilitation hospitals, long-term acute care hospitals, and Provider Organizations that provide inpatient or outpatient Behavioral Health Services must register by July 1, 2014. Registration for all other Provider Organizations that meet the criteria for registration will occur according to a Board-approved Registration Schedule.

Reporting requirements align with the stated goals of understanding the contracting and compensation practices within and among Provider Organizations, and supporting health planning efforts. In an effort to reduce the administrative burden on Provider Organizations, whenever possible, the Commission will collect data related to the statutorily defined reporting requirements from other agencies.

Additionally, the statute confers authority to the Commission to require a fee from Provider Organizations upon registration, and this authority is codified in the draft regulation. In at least the first year of registration, however, we propose waiving this fee. We anticipate this initial registration process will require a highly collaborative process between the Commission and Provider Organizations.

Information Collected upon Registration.

While the reporting requirements are stipulated in regulation, the data specifications for these reporting requirements are not. The Commission will include data specifications in a sub-regulatory *Data Submission Manual* that will be released for comment this winter. Consistent with the policy development process to date, we anticipate ensuring these specifications are balanced in providing necessary information to the Commission and the public, while recognizing the many reporting requirements providers face. The *Data Submission Manual* will undergo a public review process, available for comment from stakeholders for a reasonable period of time before registration. We anticipate that 958 CMR 6.00 will not be promulgated until Provider Organizations have had an opportunity to comment upon the *Data Submission Manual*.

Timeline and Next Steps.

Should the Care Delivery and Payment System Reform (CDPSR) Committee approve this draft regulation for the registration of Provider Organizations, the regulation would then be formally proposed at the January 8, 2014 Commission meeting, with a request for approval to issue the draft regulation for public comment.⁴ After the *Data Submission Manual* is completed and public comments on the regulation received and reviewed, we anticipate proposing a final regulation for approval next spring.

⁴ Based upon this timeline, staff would anticipate holding a public hearing in mid-February 2014.

958 CMR 6.00: REGISTRATION OF PROVIDER ORGANIZATIONS

Section

6.01	General Provisions
6.02	Definitions
6.03	Applicability
6.04	Requirements to Register
6.05	Registration
6.06	Noncompliance
6.07	Severability

6.01: General Provisions.

- (1) 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. 958 CMR 6.00 specifies the criteria that determine what Provider Organizations must register with the Health Policy Commission and which information must be submitted by each Provider Organization to complete Registration.
- (2) Authority: 958 CMR 6.00 is adopted pursuant to M.G.L. c. 6D, § 11.

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 1 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 Affiliate: Any Provider or Provider Organization which has a relationship with another Provider 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 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 Provider Organization: A Provider Organization that acts on behalf of one or more Health Care Providers or Provider Organizations for the purpose of establishing contracts, including for payment rates, incentives, and operating terms, with a Carrier or Third-Party Administrator.

Contractual Affiliate: A Provider or Provider Organization on whose behalf a Contracting Provider Organization acts for the purpose of establishing contracts, including for payment rates, incentives, and operating terms, with a Carrier or Third-Party Administrator.

Corporate Affiliate: Any Entity which has a partial or complete controlling interest in, or is under common control of, a Provider Organization.

Data Submission Manual: A manual published by the Commission containing detailed specifications and submission guidelines 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 twelve month period during which a Provider Organization keeps its accounts and which ends in the calendar year by which it is identified.

Full-Time Equivalent: The ratio of the total payroll hours to the standard number of hours worked annually for employees and the equivalent for contracted individuals, by category of Health Care Professional.

Funds Flow: The apportionment of funds, or payments, from payer contracts across affiliated providers, including apportionment across hospitals and physicians, among physician groups, across primary care physicians and specialists, and across employed versus affiliated physicians.

Gross Patient Service Revenue: The total dollar amount of a Provider Organization's charges for services rendered in a Fiscal Year.

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 Service 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.

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

Local Practice Group: A group of physicians 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: (i) Acute Hospital inpatient services, by major diagnostic category; (ii) 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; (iii) Behavioral Health Services; (iv) professional services, by categories as defined by the Centers for Medicare and Medicaid, or as specified in the Data Submission Manual; and (v) sub-acute services, by major service line or clinical offering, as specified in the Data Submission Manual.

Net Patient Service Revenue: Gross Patient Service Revenue less contractual adjustments.

Patient Panel: The total number of individual patients seen by a Provider Organization 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 person or 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.

Registration Schedule: A schedule published by the Board indicating the sequence in which a given type of Provider Organization will be required to comply with 958 CMR 6.00.

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: A Provider Organization subject to the requirements of the Division pursuant to 211 CMR 155.00.

Risk Certificate: A certificate issued by the Division of Insurance that demonstrates that a Risk-Bearing Provider Organization has satisfied the certification requirements of M.G.L. c. 176T and 211 CMR 155.00.

Risk Certificate Waiver: A waiver granted by the Commissioner of Insurance to a Risk-Bearing Provider Organization from the requirement to obtain a Risk Certificate under 211 CMR 155.00.

Transitional Period Waiver: A waiver granted by the Commissioner of Insurance in his or her discretion to a Risk-Bearing Provider Organization from the requirement to obtain a Risk Certificate during the transitional period pursuant to 211 CMR 155.00.

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 Provider Organizations that represent one or more Health Care Providers that collectively receive \$25,000,000 or more in annual Net Patient Service Revenue from Carriers or Third-Party Administrators.
- (2) 958 CMR 6.00 also applies to Risk-Bearing Provider Organizations subject to the certification requirements of the Division of Insurance pursuant to 211 CMR 155.00.
- (3) 958 CMR 6.00 also applies to Providers that collectively receive \$25,000,000 or more in annual Net Patient Service Revenue from Carriers or Third-Party Administrators.

6.04 Requirement to Register

- (1) The following Providers and Provider Organizations must register with the Commission pursuant to 958 CMR 6.00: (a) Risk-Bearing Provider Organizations; (b) a Provider or Provider Organization that received \$25,000,000 or more in annual Net Patient Service Revenue from Carriers or Third-Party Administrators in the prior Fiscal Year and which has a collective Patient Panel of more than 15,000 as of the end of the prior Fiscal Year; and (c) Contracting Provider Organizations that represent Contractual or Corporate Affiliates 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 and which have a collective Patient Panel of more than 15,000 as of the end of the prior Fiscal Year. Each of the preceding Providers or Provider Organizations is required to register with the Commission on behalf of its Corporate Affiliates, Contractual Affiliates, or any other owned, controlled, or represented Providers or Provider Organizations.
- (2) A Provider or Provider Organization that meets the criteria for Registration set forth in 958 CMR 6.04(1) and which is owned or controlled by another Provider or Provider Organization also subject to 958 CMR 6.04(1) may meet its obligation to register with the Commission through the Registration of the Provider or Provider Organization that owns or controls it.

- (3) A Provider or Provider Organization that meets the criteria for Registration set forth in 958 CMR 6.04(1) but which is a Contractual Affiliate may meet its obligation to register with the Commission through the Registration of the Contracting Provider Organization.
- (4) Providers or Provider Organizations operated by the Commonwealth of Massachusetts are not required to register under 958 CMR 6.00.

6.05 Registration

- (1) Each Provider or Provider Organization that meets the criteria set forth in 958 CMR 6.04(1) as of April 1, 2014 shall file an application for Registration with the Commission according to the Registration Schedule.
- (2) A Provider or Provider Organization that is principally comprised of physician groups, Acute Hospitals, rehabilitation hospitals, long term acute care hospitals, or that is in the business of providing inpatient or outpatient Behavioral Health Services, or any Contracting Provider Organization for any of the preceding Entities, and any Risk-Bearing Provider Organization, shall initially be required to Register with the Commission by no later than July 1, 2014. All other Providers or Provider Organizations not specified in 958 CMR 6.05(2) shall register according to the Registration Schedule.
- (3) Every two years after initial registration, each Registered Provider Organization that meets the criteria set forth in 958 CMR 6.04(1) shall file an application by April 1 with the Commission for the renewal of Registration effective July 1.
- (4) An initial Registration shall be valid from the date of the notice issued by the Commission pursuant to 958 CMR 6.05(10) through the last day of June of the next biennial Commission Registration. Each subsequent Registration by a Registered Provider Organization shall be valid for 24 months, ending on the last day of June, accordingly, unless otherwise specified by the Commission.
- (5) A Provider or Provider Organization that does not meet the criteria set forth in 958 CMR 6.04(1) as of April 1, 2014, but that meets these criteria at any time after April 1, 2014 shall file an application for Registration with the Commission not later than 90 days after meeting the criteria set forth in 958 CMR 6.04(1) or as specified in the Registration Schedule.
- (6) A Provider or Provider Organization that received \$25,000,000 or more in annual Net Patient Service Revenue from Carriers or Third-Party Administrators in the prior Fiscal Year or a Contracting Provider Organization that represents Contractual or Corporate Affiliates 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 in 958 CMR 6.05(1)-(3), evidence that 958 CMR 6.00 does not apply to that Provider Organization.

- (7) A Provider or Provider Organization not otherwise required to register by 958 CMR 6.04(1) may voluntarily submit an application for Registration.
- (8) The application for Registration shall be certified by two authorized representatives of the Provider or Provider Organization and, unless otherwise determined by the Commission, shall include the following information by Practice Site level, Local Practice Group level, or Provider Organization level as indicated in the Data Submission Manual and subject to the specifications and instructions detailed in the Data Submission Manual:
 - a. Information about the ownership, governance, and operational structure of the Provider or Provider Organization, including, but not limited to organizational charts, narrative descriptions of the type and kind of relationship with Corporate and Contractual Affiliates, information on the characteristics of relationships with Clinical Affiliates and the role of Community Advisory Boards, and information on incentive structures and compensation models, including Funds Flow within the Provider or Provider Organization, each as specified in the Data Submission Manual.
 - 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 Identification Number, and similar 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 that is owned or controlled by the Provider or Provider Organization or by a Contractual or Corporate Affiliate, including by license number, license type, and capacity in each Major Service Category.
 - d. For Risk-Bearing Provider Organizations, a statement certifying that the RBPO has received a Risk Certificate, Risk Certificate Waiver, or Transitional Period Waiver as applicable.
 - e. Information on utilization by Major Service Category as specified in the Data Submission Manual.
 - f. Total revenue by payer under pay for performance arrangements, risk contracts, and other fee for service arrangements as specified in the Data Submission Manual.
 - 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 days, require an applicant to provide additional information to complete or supplement the application for completeness or clarification. A Provider or Provider Organization shall respond to any request for additional information by the Commission within 21

days of the date of the Commission's request, unless otherwise authorized by the Commission.

- (10) The Commission shall determine whether an application is complete within 45 days of receipt of the application or receipt of 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. Data submissions shall be subject to a validation process by the Commission through whatever mechanisms the Commission deems appropriate.
- (11) 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 days of the date of the Commission's request, unless otherwise authorized by the Commission.
- (12) As specified by the Commission, 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.

6.06 Noncompliance

- (1) If the Commission determines that a Provider or Provider Organization that has not registered with the Commission pursuant to 958 CMR 6.00 may meet the eligibility criteria set forth in 958 CMR 6.04(1), the Commission may send written notice to the Provider or Provider Organization. A Provider or Provider Organization that receives such a notice from the Commission shall, within 30 days of the date of the notice:
 - a. Submit an application for Registration in compliance with 958 CMR 6.05; or
 - b. Submit adequate supporting documentation that demonstrates that the Provider or Provider Organization does not meet the eligibility criteria set forth in 958 CMR 6.04(1). Such 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 or Provider Organization required to register pursuant to 958 CMR 6.00 fails to submit a completed application for Registration to the Commission as required, or fails to submit any additional information requested by the Commission, the Commission may provide written notice to the Provider or Provider Organization of non-compliance.
- (3) A Provider or Provider Organization that meets the criteria set forth in 958 CMR 6.04(1) but that fails to submit a completed application for Registration to the Commission as required is prohibited from negotiating or engaging in network contracts 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 and Third-Party Administrators.

- (4) With respect to those Providers or Provider Organizations that are required to register pursuant to 958 CMR 6.00, and are also subject to the requirements of 211 CMR 155.00, the Commission may provide notice of a Provider or Provider Organization's non-compliance with 958 CMR 6.00 to the Division.

6.7 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.