957 CMR: Center for Health Information and Analysis

957 CMR 11.00: Registered Provider Organizations Reporting Requirements

Section

11.01: General Provisions

Scope and Purpose: 957 CMR 11.00 governs the reporting requirements for Registered Provider Organizations to submit data and information in accordance with M.G.L. c. 12C.

11.02: Definitions

All defined terms in 957 CMR 11.00 are capitalized. As used in 957 CMR 11.00 and the *Data Submission Manual*, unless the context requires otherwise, the following terms shall have the following meanings:

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.

Audited Financial Statements. A complete set of financial statements of an Entity, including the notes to the financial statements, which are subject to an independent audit in accordance with *Generally Accepted Auditing Standards (GAAS).* The independent auditor issues an opinion as to whether or not the accompanying financial statements are presented fairly in accordance with *Generally Accepted Accounting Principles (GAAP).*

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

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.

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.

Consolidating Schedule. A document that accompanies the consolidated Audited Financial Statements, which includes detailed financial statements of subsidiary hospital(s) and the other organizations that comprise the consolidated entity.

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 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 MA-RPO Program as an administrative bulletin, containing specifications, submission guidelines, and timelines for Registration and data collection.

Division. The Massachusetts Division of Insurance established in M.G.L. c. 26, § 1.

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

Facility. A licensed institution providing Health Care Services, or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

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

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

Funds Flow. The apportionment of Provider or Provider Organization funds, including payments from Payers 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.

Governmental Unit. The Commonwealth, any board, commission, department, division, or agency of the Commonwealth, and any political subdivision of the Commonwealth.

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 care provider, 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 provided 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.

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 Services, 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 Services, 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*.

Massachusetts Registration of Provider Organizations Program or MA-RPO Program. The Commonwealth program, jointly administered by the Commission and the Center, pursuant to M.G.L. c. 6D, § 11 and § 12 and M.G.L. c. 12C.

Patient Panel. The total number of individual patients seen over the course of the most recent complete 36-month period.

Payer. Any entity, other than an individual, that pays providers for the provision of health care services; provided, that "Payer" shall include both governmental and private entities; provided further, that "Payer" shall not include excluded ERISA plans.

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 ("RPO"). A Provider Organization, which includes a Risk-Bearing Provider Organization, that meets the criteria for Registration pursuant to 958 CMR 6.00: *Registration of Provider Organizations* and registers with the Commission.

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

Risk Certificate. A certificate of solvency issued by the Division 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-Bearing Provider Organizations*.

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

11.03: Reporting Requirements

(1) General Reporting Requirements. Each Registered Provider Organization shall provide information, as specified in the most recent *Data Submission Manual*, which may include:
    (a) Information regarding ownership, governance, and operational structure, including, organizational charts and narrative descriptions of the type and kind of Corporate and Contracting Affiliations; information regarding incentive structures and compensation models, including Funds Flow within the

Registered Provider Organization; and information regarding the characteristics of any Clinical Affiliations and the role of Community Advisory Boards;

(b) Information regarding the number of affiliated Health Care Professional Full-Time Equivalents by license type, 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 Registered 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, by license number, license type, tax identification number, national provider identifier, and capacity in each Major Service Category, or by any other relevant characteristic as defined in the *Data Submission Manual*;

(d) Information regarding utilization by Major Service Category;

(e) Comprehensive financial statements, including Audited Financial Statements, Consolidating Schedules and standardized filings that shall include a balance sheet, a statement of operations, and a cash flow statement;

(f) Information on stop-loss insurance and any non-fee-for-service payment arrangements;

(g) Information on clinical quality, care coordination and patient referral practices;

(h) Information regarding expenditures and funding sources for payroll, teaching, research, advertising, taxes or payments-in-lieu-of-taxes and other non-clinical functions;

(i) Information regarding charitable care and community benefit programs;

(j) For any risk-bearing provider organization, a certificate from the Division under chapter 176U;

(k) Information regarding any discounts, rebates or any other type of refunds or remuneration in exchange for, or in any way related to, the provision of heath care services; and

(l) Such other information as the MA-RPO Program considers appropriate.

(2) Administrative Simplification. The MA-RPO Program will coordinate with the Division and other Governmental Units to obtain information directly from such entities where available.

11.04: Submission Procedures

(1) General. Each Registered Provider Organization shall submit annually data and information to the MA-RPO Program in accordance with the procedures provided in the *Data Submission Manual*.

(2) Data Submission Process. Each Registered Provider Organization shall submit data and information at the time and in the manner specified in the *Data Submission*

Manual and in conformance with the specifications set forth in the *Data Submission Manual*. In accordance with the procedures set forth in the *Data Submission Manual*, the MA-RPO Program will notify a Registered Provider Organization as to whether the submission has been accepted or rejected and whether the Registered Provider Organization must correct and resubmit data or information.

(3) Filing Deadlines. Each year, each Registered Provider Organization must submit the required data and information on the dates specified in the *Data Submission Manual*.

(4) Certification of Submissions. Each individual that submits information in accordance with 957 CMR 11.00 on behalf of a Registered Provider Organization must represent and warrant that he or she is duly authorized and has full authority to make the submissions.

(5) Waivers. The Center may grant waivers from certain annual reporting requirements based on the criteria specified in the *Data Submission Manual*.

(6) Fees. The Center may assess administrative fees on Registered Provider Organizations in an amount to defray the Center's costs in collecting Registered Provider Organization data and information pursuant to 957 CMR 11.00.

11.05: Submission Review

Submissions under 957 CMR 11.00 may be subject to review by the MA-RPO Program to ensure accuracy and consistency in reporting. The MA-RPO Program will work with Registered Provider Organizations, as necessary, to address discrepancies uncovered through such review and, in doing so, may require Registered Provider Organizations to submit additional data, information and related documentation.

11.06: Compliance and Penalties

(1) If a Registered Provider Organization fails to submit required data and information to the MA-RPO Program on a timely basis, or fails to correct submissions rejected because of errors, the Center shall provide written notice to the Registered Provider Organization. If the Registered Provider Organization fails to provide the required information within two weeks of written notice, the Center will take all necessary steps to enforce 957 CMR 11.06 to the fullest extent of the law.

(2) Registered Provider Organizations that do not comply with the reporting requirements of 957 CMR 11.00 are subject to a penalty of up to $1,000 per week for each week that the Registered Provider Organization fails to provide the required data, up to a maximum of $50,000 in accordance with M.G.L. c. 12C, § 11.

(3) The Center will notify the Attorney General's Office to enforce the provisions of 957 CMR 11.06 and may provide notice of noncompliance to other Governmental Units.

11.07: Administrative Bulletins

The Center may issue administrative bulletins from time to time to clarify, add to, or change reporting requirements under 957 CMR 11.00.

11:08: Nonpublic Information

Information furnished pursuant to 957 CMR 11.03(1)(e) or 11.05 under an assurance of confidentiality in accordance with M.G.L. c. 12C, § 5 shall not be subject to the disclosure provision of the public records law. Any reasonable segregable portion of a record filed pursuant to this regulation shall be provided to any person requesting such records after deletion of the portions which are considered nonpublic under this paragraph.

11.09: Severability

The provisions of 957 CMR 11.00 are severable. If any such provisions or the applicability thereof is held to be invalid or unconstitutional by any court of competent jurisdiction, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 957 CMR 11.00 or the application of such provisions.

REGULATORY AUTHORITY

957 CMR 11.00: M.G.L. c. 12C.