957 CMR 11.00: REGISTERED PROVIDER ORGANIZATION REPORTING REQUIREMENTS

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11.01: General Provisions

(1) Scope and Purpose. The purpose of 957 CMR 11.00 is to specify the reporting requirements for the registration of provider organizations program jointly administered by the Center for Health Information and Analysis and the Health Policy Commission, as required by M.G.L. 12C and M.G.L. c. 6D. The Commission's regulation, 958 CMR 6.00, specifies the criteria that determine which Provider Organizations must register with the registration of provider organizations program, the manner of registration, and what information must be submitted to complete Registration.

(2) Applicability. 957 CMR 11.00 applies to Registered Provider Organizations as defined in section 11.02.

(3) Authority. This regulation is issued pursuant to M.G.L. c. 12C, including but not limited to, §§ 3, 5, 9, and 11.

11.02: Definitions

All defined terms in 957 CMR 11.00 are capitalized. Any other term used in this regulation but not defined herein shall have the meaning given to the term by M.G.L. c. 12C, other CHIA regulations, or Sub-Regulatory Guidance.

As used in 957 CMR 11.00, unless the context requires otherwise, the following words 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.

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Adjudicatory Proceeding. A proceeding before an agency in which the legal rights, duties or privileges of specifically named persons or entities are required by constitutional right or by any provision of the General Laws to be determined after an opportunity for an agency hearing.

Annual Filing. The information that a Provider Organization subject to the registration requirements of 958 CMR 6.00 must submit to the MA-RPO Program, in a form specified in the *Data Submission Manual*, pursuant to M.G.L. c. 6D, §11 and M.G.L. c. 12C, § 9 and 11.

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).

CHIA or Center. The Center for Health Information and Analysis established under 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. This definition applies to all forms of the term, including "Clinical Affiliates" and "Clinically Affiliated."

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 130.1800 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. A 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. This definition applies to all forms of the term, including "Contracting Affiliates."

Control. The possession, direct or indirect, of the power, partial or complete, to direct or cause the direction of the management, administrative functions, assets, or policies of an Entity, whether through the ownership of voting securities or rights, the power to appoint, designate, or remove board members or directors, control, either directly or indirectly, by contract (except a commercial contract for goods or non-management services) or otherwise; but no person shall be deemed to possess such Control solely by reason of being an officer or director of an Entity. Control shall be deemed to exist if any person or Entity directly or indirectly owns, has rights over, or holds with the power to vote ten percent or more of the voting securities of an Entity. This definition applies to all forms of the word, including "Controls," "Controlling," and "Controlled."

Corporate Affiliation. A relationship between two Entities that reflects, directly or indirectly, a partial or complete Controlling interest or partial or complete common Control. This definition applies to all forms of the term, including "Corporate Affiliates" and "Corporately Affiliated."

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, 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 Real Estate Investment Trust. A real estate investment trust, as defined by 26 U.S.C. section 856, whose assets consist of, in whole or in part, real property held in connection with the use or operations of a provider or provider organization.

Health Care Services. Supplies, care and services of medical, behavioral health, substance use disorder, mental 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, pharmacy 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 by a health maintenance organization.

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

Massachusetts Registration of Provider Organizations Program or MA-RPO Program. The Commonwealth program, jointly administered by the Commission and the Center, pursuant to their respective authorities under M.G.L. c. 6D and M.G.L. c. 12C and regulations promulgated thereunder.

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 and Third Party Administrators; and provided further, that "Payer" shall include

self-insured plans to the extent allowed under the Employee Retirement Income Security Act of 1974.

Practice Site. The physical location where the clinician is providing Health Care Services.

Presiding Officer. The individual(s) authorized by law or designated by the Center to conduct an Adjudicatory Proceeding.

Private Equity Company. Any Entity, however organized, that collects capital investments from individuals or Entities and purchases, as a parent company or through another Entity that the company completely or partially owns or Controls, a direct or indirect ownership share of a Provider, Provider Organization or Management Services Organization; provided, however, that "Private Equity Company" shall not include venture capital firms exclusively funding startups or other early-stage businesses.

Provider Organization. Any corporation, partnership, business trust, association or organized group of persons, and all corporate affiliates thereof, which is in the business of health care delivery or management, whether incorporated or not, that represents one or more Health Care Providers in contracting with Payers for the 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 Payers for payment for Health Care Services.

Registration. The process of becoming a Registered Provider Organization as established by the MA-RPO Program pursuant to M.G.L. c. 6D, § 11.

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.

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.

Significant Equity Investor. Any Private Equity Company with a financial interest in a Provider, Provider Organization or Management Services Organization; or an investor, group of investors or other Entity with a direct or indirect possession of equity in the capital, stock or profits totaling more than 10 per cent of a Provider, Provider Organization or Management Services Organization; provided, however, that "Significant Equity

Investor" shall not include venture capital firms exclusively funding startups or other early-stage businesses.

Sub-Regulatory Guidance. An Administrative Bulletin, notice, manual, guide, or other document, including the *Data Submission Manual*, that specifies deadlines, technical submission requirements, or contains methodological explanations and examples to facilitate understanding of and compliance with adopted regulations.

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

Uppermost Corporate Parent. An Entity with a primary business purpose of health care delivery, management, ownership or investment that is not itself owned or Controlled, partially or completely, directly or indirectly, by any other Entity.

11.03: Registered Provider Organization Reporting Requirements

(1) General. A Provider Organization that meets the Registration criteria in accordance with 958 CMR 6.00 shall register with the Commission and shall submit data and information to the MA-RPO Program in accordance with the procedures provided in 957 CMR 11.00, 958 CMR 6.00 and Sub-Regulatory Guidance.

(a) A Provider Organization required to register with the Commission shall meet its reporting obligations through the submission by its Uppermost Corporate Parent of an Annual Filing.
(b) At the discretion of the MA-RPO Program, a Provider Organization that meets the Registration criteria may meet its reporting obligations through the submission of an abbreviated Annual Filing in a format prescribed by the MA-RPO Program if another Registered Provider Organization negotiates, represents, or otherwise acts to establish contracts with Payers for the payment of Health Care Services on its behalf.

(2) Reporting Requirements. Subject to the specifications and instructions detailed in Sub-Regulatory Guidance, and unless otherwise specified by the MA-RPO Program, an Annual Filing shall include the following information about the Provider Organization:

(a) Information about the ownership, governance, and operational structure, including, organizational charts, narrative descriptions of the type and kind of Corporate Affiliations and Contracting Affiliations, information on incentive structures and compensation models, including Funds Flow within the Provider Organization, information on Significant Equity Investors, Real Estate Investment Trusts, and Management Services Organizations, and information on the characteristics of any Clinical Affiliations and the role of Community Advisory Boards;

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(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 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) The name, address and capacity of all other locations where the Provider Organization delivers Health Care Services, including those services listed in subsection (a) of section 22 of chapter 6D;

(e) Comprehensive financial statements, including Audited Financial Statements, Consolidating Schedules and standardized filings that shall include a balance sheet and a statement of operations, and including information on the Uppermost Corporate Parent, including their out-of-state operations, and Corporate Affiliates, including Significant Equity Investors, Health Care Real Estate Investment Trusts and Management Services Organizations as applicable, and including details regarding annual costs, annual receipts, realized capital gains and losses, accumulated surplus and accumulated reserves;

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

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

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

(i) For Risk-Bearing Provider Organizations, a statement certifying that the RBPO has received a Risk Certificate or a waiver from the Division as required by M.G.L. c. 176T or any regulations promulgated thereunder;

(j) Information regarding other assets and liabilities that may affect the financial condition of the Provider Organization or the Provider Organization's Facilities including, but not limited to, real estate sale-leaseback arrangements with Health Care Real Estate Investment Trusts;

(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 Health Care Services;

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

(m) Information on utilization by major service category;

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

(o) Attestations completed by two duly authorized officers of the Provider Organization that the information is true and accurate; and

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

(3) At any time, the MA-RPO Program may, by written request, require additional information reasonable and necessary to determine the financial condition, organizational structure, business practices, clinical services, or market share of a Registered Provider Organization, including total adjusted debt and total adjusted earnings. The MA-RPO Program may require a Registered Provider Organization with direct or indirect private equity investment to report required information quarterly or require the disclosure of relevant information from any Significant Equity Investor associated with a Registered Provider Organization. The MA-RPO Program may modify uniform reporting requirements. A Registered Provider Organization shall respond to a request for additional information within 21 calendar days of the date of the request, unless otherwise specified in writing by the MA-RPO Program.

(4) The reporting requirements set forth in 957 CMR 11.03(2) may be fulfilled through the reporting of such information to other Commonwealth of Massachusetts agencies, as may be specified in Sub-Regulatory Guidance.

11.04: Data Submission Procedures

(1) General. Registered Provider Organizations shall submit data and information to the MA-RPO Program in accordance with the procedures, deadlines, and schedules provided in 957 CMR 11.00 or Sub-Regulatory Guidance from the MA-RPO Program. In the event a data submission deadline falls on a Saturday, Sunday, or Commonwealth holiday, the data shall be due on the business day immediately thereafter.

(2) Sub-Regulatory Guidance. The MA-RPO Program will issue Sub-Regulatory Guidance to clarify its requirements, policies, and procedures under 957 CMR 11.00 and to set forth the required technical information, such as: data file format, record specifications, data elements, definitions, code tables and edit specifications for data and information submitted pursuant to 957 CMR 11.00.

The MA-RPO Program may also issue Sub-Regulatory Guidance to specify or amend data and information required to be submitted; to specify or amend the procedures for submitting data and information; and to specify or amend the timeframes for submitting data and information.

(3) Amended Data Submissions. Registered Provider Organizations may amend data submissions, subject to the approval of the MA-RPO Program, upon notice of the proposed amended data submissions, and the reasons for such changes. Amended data submissions shall be made in accordance with the procedures provided in Sub-Regulatory Guidance.

(4) Data Review, Verification, and Resubmission. If necessary, Registered Provider Organizations may be required to review, verify, or resubmit certain data and information previously submitted. The MA-RPO Program will notify a Registered Provider Organization of when such data and information must be reviewed, verified, or resubmitted and will provide to applicable Registered Provider Organization such health care data and information, or summary reports of such data and information, for review, verification, or resubmission.

(5) Additional Documentation. The MA-RPO Program may request that Registered Provider Organizations submit additional documentation related to reported data and information through Sub-Regulatory Guidance or by written request.

(6) Accuracy. The Registered Provider Organization (i) certifies that an authorized representative of the Registered Provider Organization submitted information and data to the MA-RPO Program, and (ii) attests that information and data submitted to the MA-RPO Program is true, correct, and complete.

(7) Extension Requests. The MA-RPO Program may grant, for good cause, an extension in time to Registered Provider Organizations to submit health care data and information.

(8) Waivers. The MA-RPO Program may grant waivers from certain annual reporting requirements under 957 CMR 11.00 based on criteria specified in Sub-Regulatory Guidance.

(9) 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.

(10) Notification to Health Policy Commission and Department of Public Health. The Center is required by M.G.L. c. 12C § 11 to notify the Health Policy Commission and the Department of Public Health if a Provider or Provider Organization has failed to timely report required data or information.

11.05: Penalties

The Center will provide written notice to Registered Provider Organizations that fail to comply with the reporting deadlines established in 957 CMR 11.00.

(1) The Center will notify Registered Provider Organizations that failure to respond within two weeks of the written notice, without just cause, may result in penalties. In accordance with M.G.L. c. 12C, § 11, Registered Provider Organizations may be subject to a penalty

of up to $25,000 per week for each week that they fail to provide the required data and information.

(2) Any remedy available under 957 CMR 11.00 is in addition to other sanctions and penalties that may apply under the provisions of other statutes and regulations.

(3) Registered Provider Organizations that fail to comply with the requirements of 957 CMR 11.00 will be subject to all penalties and remedies allowed by law and the Center will take all necessary steps to enforce 957 CMR 11.00, including a petition to the Superior Court for an order enforcing the same.

(4) Before assessing a penalty, the Center shall notify the Registered Provider Organization that has failed to comply with the requirements of 957 CMR 11.00 that it has the right to request a hearing in accordance with M.G.L. c. 30A, § 10.

(5) If a hearing is timely requested in writing, the Center, including through a Presiding Officer, will conduct the hearing in accordance with 801 CMR 1.00: *Standard Adjudicatory Rules of Practice and Procedure*. After the hearing, the Center shall render a written decision and may assess a civil penalty pursuant to 957 CMR 11.05(1).

(6) After the issuance of a final decision, except where any provision of law precludes judicial review, a Registered Provider Organization aggrieved by such final decision may seek judicial review thereof in accordance with M.G.L. c. 30A, § 14.

11.06: Severability

The provisions of 957 CMR 11.00 are severable. If any provision or the application of any provision is held to be invalid or unconstitutional, 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: M.G.L. c. 12C