Care Delivery and Payment System Reform Committee

Health Policy Commission

December 16, 2013

Agenda

- Approval of minutes from November 13, 2013 meeting
- Update on the registration of provider organizations (RPO) program and development of RPO regulation
- Schedule of next committee meeting

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Vote: Approving minutes

Motion: That the Care Delivery and Payment System Reform Committee hereby approves the minutes of the Committee meeting held on November 13, 2013, as presented.

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- **Update on the registration of provider organizations (RPO) program and development of RPO regulation**
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Registration of Provider Organizations

Policy Approach | **Operational Approach** | **Regulation Development** | **Review and Next Steps**

Overview

Process Goals

- Specify reporting requirements that support the "Who, What, Where, and with Whom" components of RPOs
- Support cross-agency needs aligned with the Commonwealth's priorities
- Avoid duplication and promote administrative simplification through cross-agency collaboration and provider engagement
- Enhance and standardize data on provider organizations in the Commonwealth.

Key Reporting Agencies

- HPC
- CHIA
- DOI
- AGO
- EOHHS and agencies
- MeHI
- Boards of Registration

Work to date

- Joint DOI-HPC Listening Sessions & Feedback Received
  - Different types of provider organizational structures, relationships with affiliated physicians
  - Nature of information ordinarily developed in the course of business, or reported to other agencies or health plans
- Ongoing collaboration with DOI and CHIA and other state agencies
  - *Developing streamlined reporting mechanisms and ensuring consistency in definitions*
  - *Developing single point of entry to CHIA and HPC for RPOs*
- Developing approach to regulation and data specification that ensures deep provider engagement, and allows for flexibility in reporting while standardizing data to ensure analytic value
- Held first of many stakeholder engagement session with provider organizations of varying size and regions

Three key aims

1. RPO **enhances transparency** of the health care marketplace in the Commonwealth by gathering information on the **composition, structure and relationships** among and within Massachusetts health care providers.

2. RPO **maps the provider delivery system,** including clinical affiliations, capacity, and market share; and it monitors change in these elements over time.

3. RPO creates a **centralized resource** for the Commonwealth and other stakeholders by compiling information about the provider market. RPO supports such functions as **health resource planning, determinations of need, cost and market impact reviews, evaluation of health care cost trends, health system investments, and certification programs.**

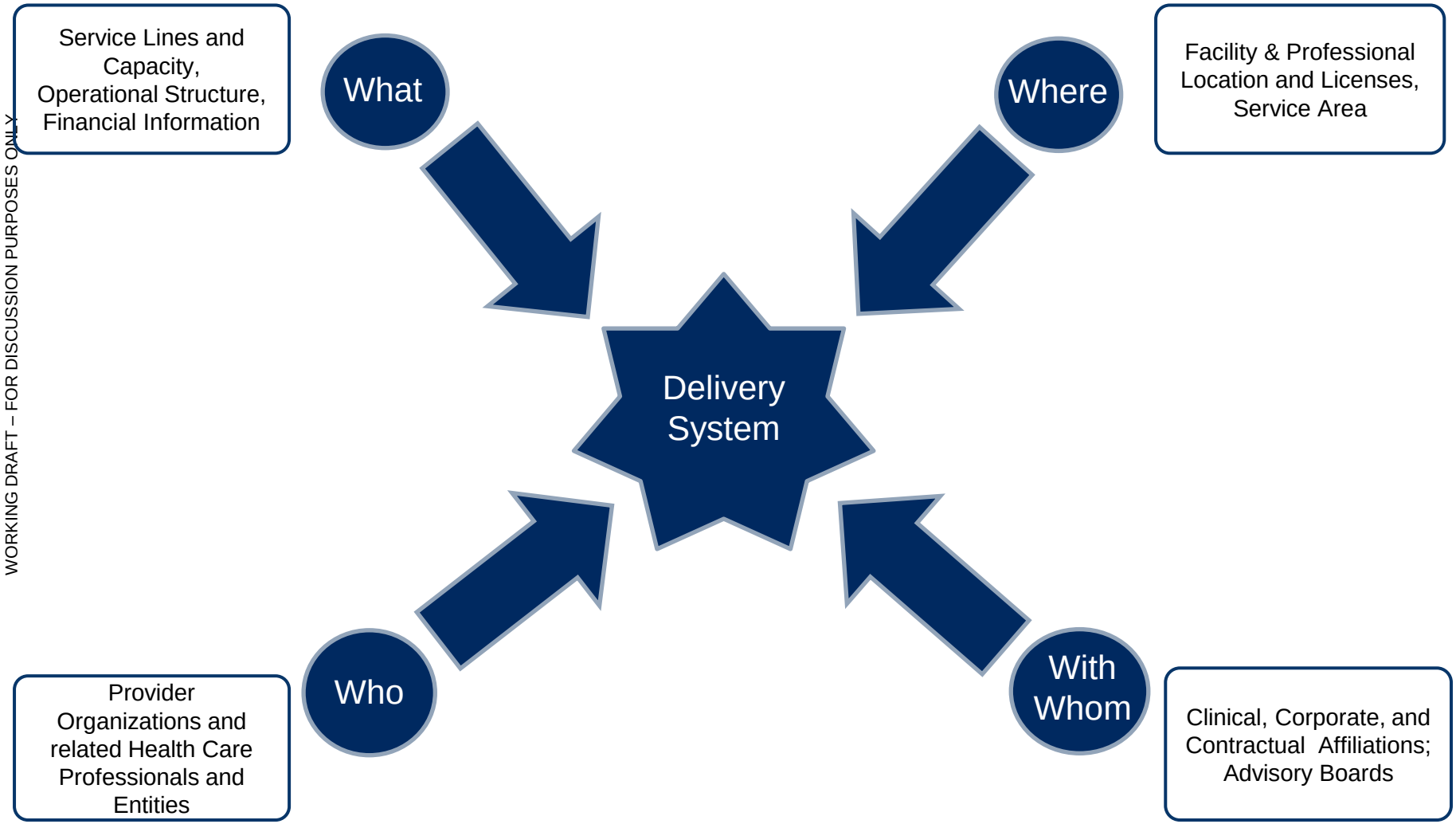
Provider organization – a new reflection of the health care market

"Provider Organization" is 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 1 or more health care providers** in contracting with carriers or third-party administrators for the payments of heath care services

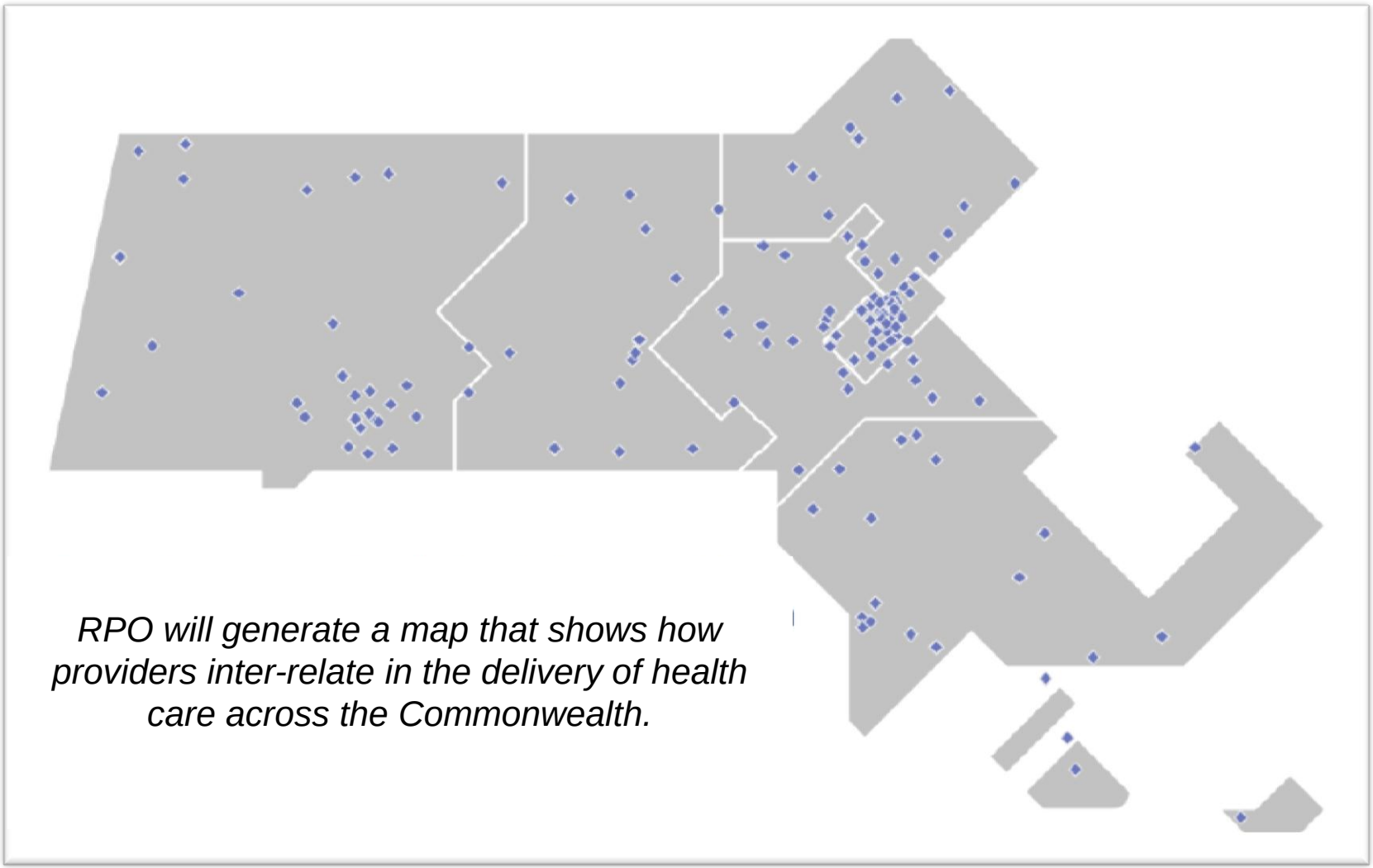
A Provider Organization includes but is not limited to the following types of common health care organizations:

hospitals
physician organizations
physician-hospital organizations
independent practice associations
provider networks
accountable care organizations
any other organization that contracts with carriers or third-party administrators for payment for health care services

Mapping the relationships of who, what, where, and with whom



Affiliations drive care delivery



RPO will generate a map that shows how providers inter-relate in the delivery of health care across the Commonwealth.

Source: http://bluecrossmafoundation.org/delivery-system-map/. Retrieved 12/12/2013

Registration of Provider Organizations

HPC – "Front End" Data Collection

- **Statutorily Mandated Requirements**
  - Organizational structure/governance/relationships
  - Number of affiliated health care professional FTEs
  - Name and address of licensed facilities
  - For risk-bearing provider organizations, a certificate from the Division of Insurance under chapter 176T
  - Other information as HPC deems appropriate

CHIA – "Back End" Data Collection

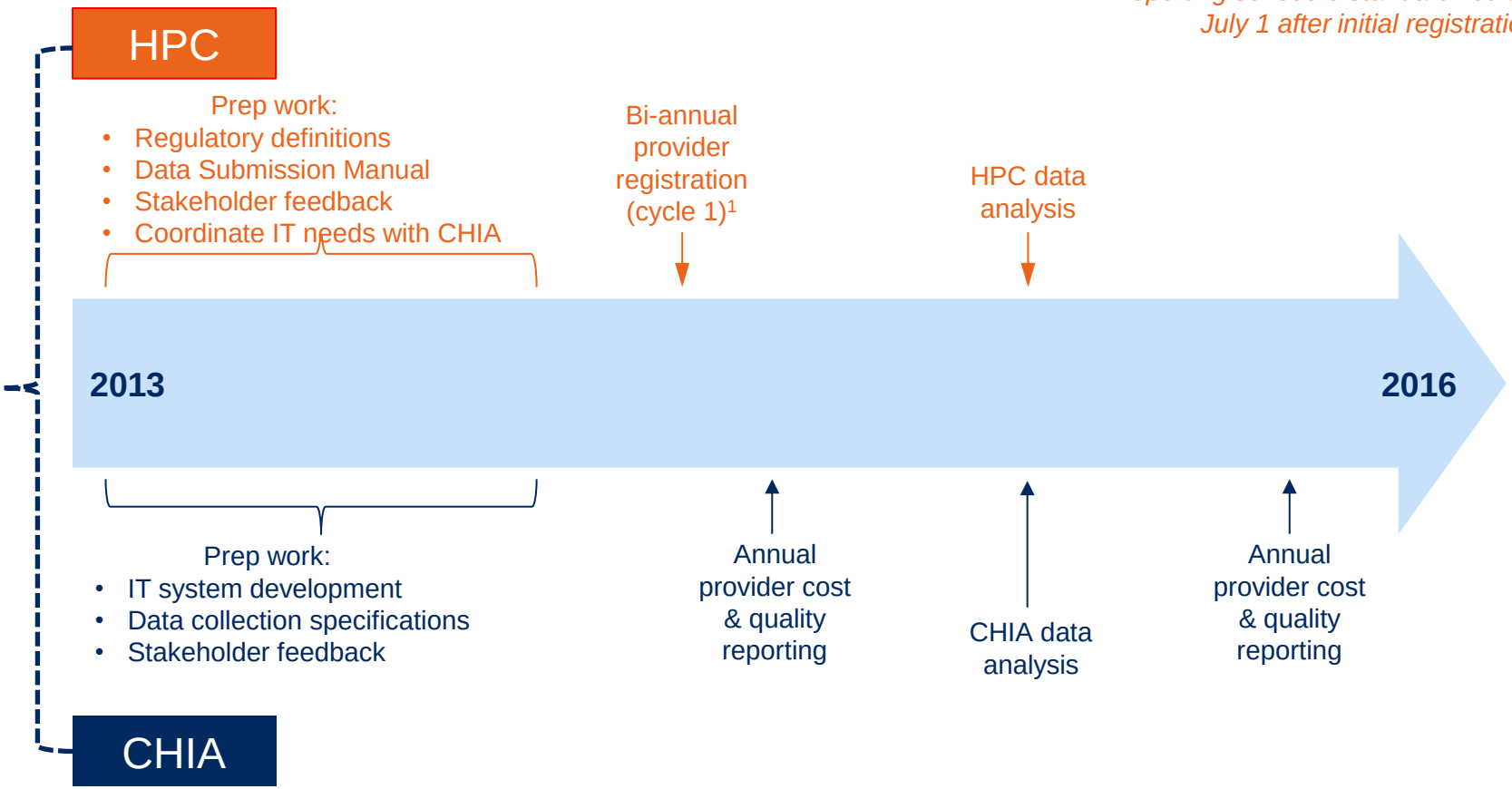
- **Statutorily Mandated Requirements:**
  - Cost reports and financial statements
  - Information on stop-loss insurance and any non-fee-for-service payment arrangements
  - Information on clinical quality, care coordination, and patient referral practices
  - Information regarding expenditures and funding sources for payroll, teaching, research, advertising, taxes or payments-in-lieu-of-taxes and other non-clinical functions
  - Information regarding charitable care and community benefit programs
  - Other information as CHIA deems appropriate

Reporting Continuum

A streamlined approach between HPC and CHIA for registration of Provider Organizations – cross-sharing responsibilities to maximize efficiency

Registration and data collection cycle *(dates are for example only)*

*[1]*Ongoing registration of "new" RPOs. Reporting schedule standardized to July 1 after initial registration*



Registration of Provider Organizations

Overview

Goals

- Identify appropriate specifications for reporting requirements
- Supply detailed reporting requirements to registering Provider Organizations early to allow for robust iteration to ensure clarity

Key Agencies

- HPC
- CHIA
- DOI

Deliverables

- ❑ Data Submission Manual
- ❑ Templates for registration reporting requirements
- ❑ Online platform for streamlined submission

Process

Drafting the Data Submission Manual

- Identify the programs served by RPO and the related data needs
- Where possible, create templates for submission requirements based on programs' needs
- Vet data submission templates with Provider Organizations and other market participants
- Release draft Data Submission Manual for broad public comment
- Release final Data Submission Manual well before registration deadline to allow for necessary activity in Provider Organizations

958 CMR 6.00

- **Regulation Framework**
- **Applicability and Phased Approach**
- **Reporting Requirements**
- **Non-Compliance**
- **Definitions**

Approach

Why are we collecting this information?

- Insufficient transparency around Provider Organizations exists. The first step in understanding how Provider Organizations function is understanding how they are organized.

What questions may be answered?

- How are the various Provider Organizations in the Commonwealth structured, both in terms of operations, corporate structure, and location?
- What is the utilization and capacity at each site of care?

Where else is this information available?

- To a limited extent, organizational charts depicting corporate affiliations can be found in audited financial statements, when they are publicly available
- To a limited extent, financial information and quality information is available on segments of Provider Organizations (e.g., hospitals)

Submission Elements

- Information on ownership, governance, operational structure, and affiliations of Provider Organizations (corporate, contractual, and clinical)
- High level descriptive Information on the flow of funds within provider organizations (e.g., distribution of surpluses from risk contracts to physician groups)
- Information on the type and location of health care professionals
- Information on the type and location of health care facilities and the services they provide
- Information on utilization and capacity of health resources in select major service categories
- Information on revenue in major categories in advance of cost and financial reporting
- Information on compliance with RBPO requirements (as applicable)

958 CMR 6.03-04

- Regulation Framework
- **Applicability and Phased Approach**
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Who must register?

- Any Provider or Provider Organization that is a **Risk-Bearing Provider Organization** (as defined by DOI), and
- Any Provider or Provider Organization
  - with a patient panel greater than **15,000** and
  - which **represents** providers who collectively receive **$25,000,000** or more in annual net patient service revenue from carriers or third-party administrators
- **Phasing: HPC anticipates rolling out the RPO program in phases,** beginning with those Provider Organizations that are principally comprised of physician groups, hospitals (acute and non-acute), or that provide behavioral health services. Additionally *all* RBPOs will be required to register from the outset.
  - Additional categories of providers will be rolled in over time in a schedule to be determined by the Commission
- **Demonstrating compliance – patient panels:** Any Provider or Provider Organization that meets the NPSR threshold but does *not* meet the patient panel threshold must submit information to the HPC demonstrating that the Provider Organization is not required to register.
- After the initial registration window, any PO must register within 90 days of becoming subject to the requirements of RPO

RPOs

958 CMR 6.04-05

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Contracting Entities & Parent–Child Dynamics

- Contracting Provider Organizations (defined) are required to report on behalf of those POs that they **represent** in payer negotiations ("contractual affiliates") – this includes *messenger models*.
- "Parent" Provider Organizations are required to report on behalf of all subsidiaries, including joint ventures ("corporate affiliates").
  - Reporting on behalf of clinical affiliates is *not* required, though some information describing those affiliations will be requested of the reporting entity.
- The reporting responsibilities of entities subject to this regulation will be met by the reporting on their behalf by a Corporate Affiliate ("Parent") or Contracting Provider Organization.
- The HPC and DOI anticipate that the reporting entity for RPO may differ from the reporting entity for RBPO – HPC staff will closely engage with Provider Organizations as needed to help determine the appropriate RPO reporting entity.

RPOs

958 CMR 6.05(10)

WORKING DRAFT – FOR DISCUSSION PURPOSES ONLY

- Regulation Framework
- Applicability and Phased Approach
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Ownership, Governance and Operational Structure

Information about the ownership, governance, and operational structure of the Provider Organization, including, but not limited ***to organizational charts, narrative descriptions of the type and kind of relationship with Corporate or 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 Organization. All preceding elements will be specified in the Data Submission Manual.*

- The HPC anticipates utilizing a standardized set of questions for collecting overview information on Provider Organizations, but not requiring a specific templates for most elements.
- The HPC anticipates utilizing a standardized template for collecting simple, high-level information from RPOs on clinical affiliations.
- A model template is below *for discussion purposes only*

Name of Provider Org	Affl. Service Lines (drop down)	Approx. number of clinical staff that provide cross-coverage (drop down)	Does the Affl. require exclusivity (Yes/No)?	Are trainees involved in the Affl. (Y/N)?	Does the Affl. include financial support, e.g., for infra-structure (Y/N)?	Do you Co-brand or jointly market with your Clinical Affiliate (Y/N)	Does the Affl. use the same EHR (Y/N)?
Hospital A	OB/GYN	5-10	Yes	No	No	Yes	No
Hospital A	Trauma Surgery	10-15	No	Yes	Yes	Yes	Yes
Hospital B	Pediatrics	20-25	No	Yes	Yes	No	No

958 CMR 6.05(10)

WORKING DRAFT – FOR DISCUSSION PURPOSES ONLY

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Ownership, Governance and Operational Structure: Funds Flow

Information about the ownership, governance, and operational structure of the Provider Organization, including, but not limited to organizational charts, narrative descriptions of the type and kind of relationship with Corporate or 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 Organization.*** *All preceding elements will be specified in the Data Submission Manual.*

- The HPC anticipates utilizing a standardized template for collecting simple, high-level revenue information from RPOs.
  - A description of the overall models for physician compensation and Funds Flow in place on your organization
    - E.g., *salary, capitation, budgeted cost or utilization, global fees, case rates, episode payments, withholds, shared savings arrangement, other*
    - Funds Flow is defined as *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.*
  - For risk contracts, the apportionment of any gains/losses across hospitals, local practice groups, and other entities

958 CMR 6.05(10)

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Details on Health Care Professionals

*The **number of** Health Care Professional **Full-time Equivalents by license type, 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 Organization and the nature of that relationship, including whether provisions exist in physician participation or employment agreements such as referral requirements.*

- The HPC anticipates utilizing a standardized set of questions for collecting overview information on Health Care Professionals. For physicians, nurse practitioners, and physicians assistants, a full roster will be required – for all other Health Care Professionals, a summary by category will be required.

958 CMR 6.05(10)

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Details on Facilities

The name and address of facilities licensed by the Department of Public Health or the Department of Mental Health that are owned or controlled by the Provider Organization or by a Contractual or Corporate Affiliate, including by license number, license type, and capacity in each Major Service Category

- The HPC anticipates utilizing a standardized template for collecting simple, high-level information on facilities within a given RPO. This will include such information as name, DPH/DMH license number, and license type
- The HPC will develop a template and standard definitions for capacity in each of a series of Major Service Categories in collaboration with the Health Resource Planning Council
- A set of characteristics (broad) describing activity towards accountability (e.g. PCHM, ACO, risk, etc.)

958 CMR 6.05(10)

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Details on Utilization and Capacity

Information on utilization by Major Service Category as specified in the Data Submission Manual.

- The HPC anticipates utilizing a standardized template for collecting simple, high-level utilization information from RPOs to standardize intermittent requests through other modes. This may be subsumed into other reporting requirements or data sources (e.g., obtained from the APCD) over time.
  - Units will be self-determined and reported by each RPO
  - Capacity definitions will be standardized by HPC

958 CMR 6.05(10)

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Details on Revenue

Total revenue by payer under pay for performance arrangements, risk contracts, and other fee for service arrangements as specified in the Data Submission Manual.

- The HPC anticipates utilizing a standardized template for collecting simple, high-level revenue information from RPOs to standardize intermittent requests through other modes. This may be subsumed into other reporting requirements (e.g., CHIA TME/APMs) over time, or obtained from the APCD.

958 CMR 6.05(10)

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RBPO Compliance

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.

- The HPC anticipates only requiring a statement of compliance with the RBPO registration process as applicable – HPC will then obtain risk certificate information directly from DOI

Registration Fee

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

- For at least the first year of registration, the HPC anticipates waiving any registration fee. As the RPO program is developed, a registration fee may be reconsidered.

Additional Requirements

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

- The HPC anticipates using this authority judiciously and additional guidance will be forthcoming

958 CMR 6.06

- Regulation Framework
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- Definitions

Non-compliance carries severe penalties not enforced by HPC

- "A Provider or Provider Organization that meets the criteria set forth…but that fails to submit a completed application for Registration with 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 or Provider Organization's non-compliance to Carriers and Third-Party Administrators or to DOI.
- Regulation establishes a process for HPC to request confirmation of non-applicability in cases in which the HPC believes a Provider or Provider Organization may be subject to the registration requirement.
- Anticipating that some market participants may place value upon registration in the future, HPC also allows for voluntary registrations of provider organizations not subject to the statutory requirements of RPO.

958 CMR 6.02

- Regulation Framework
- Applicability and Phased Approach
- Reporting Requirements
- Non-Compliance
- **Definitions**

HPC sought to use standard definitions where possible, but…

- The RPO regulation introduces a series of terms and concepts not previously codified in statute or regulation, and/or that allow for broad interpretation. These include:
  - *Clinical Affiliate*
  - *Contracting Provider Organization*
  - *Full-Time Equivalent*
  - *Funds Flow*
  - *Local Practice Group*
  - *Major Service Category*
  - *Patient Panel*

Registration of Provider Organizations

Policy Approach | Operational Approach | Regulation Development | **Review and Next Steps**

Key Takeaways

1 Regulation ensures cross agency alignment

- Close coordination with many state agencies
- Particular alignment with CHIA (RPO responsibilities) and DOI (RBPO responsibilities)
- Looks to existing definitions and data templates where possible – and where possible, allow provider self-determination (e.g., FTEs)

2 Approach seeks to minimize provider reporting burden

- Seeks to standardize many existing sporadic reporting requirements into a central routinized reporting framework that gives providers an understanding of anticipated requirements well in advance. Seeks to address gaps currently filled by such processes as:
  - Cost Trends Hearings Pre-Filed Testimony
  - Material Change Notices/Cost and Market Impact Reviews
  - AGO standard information requests

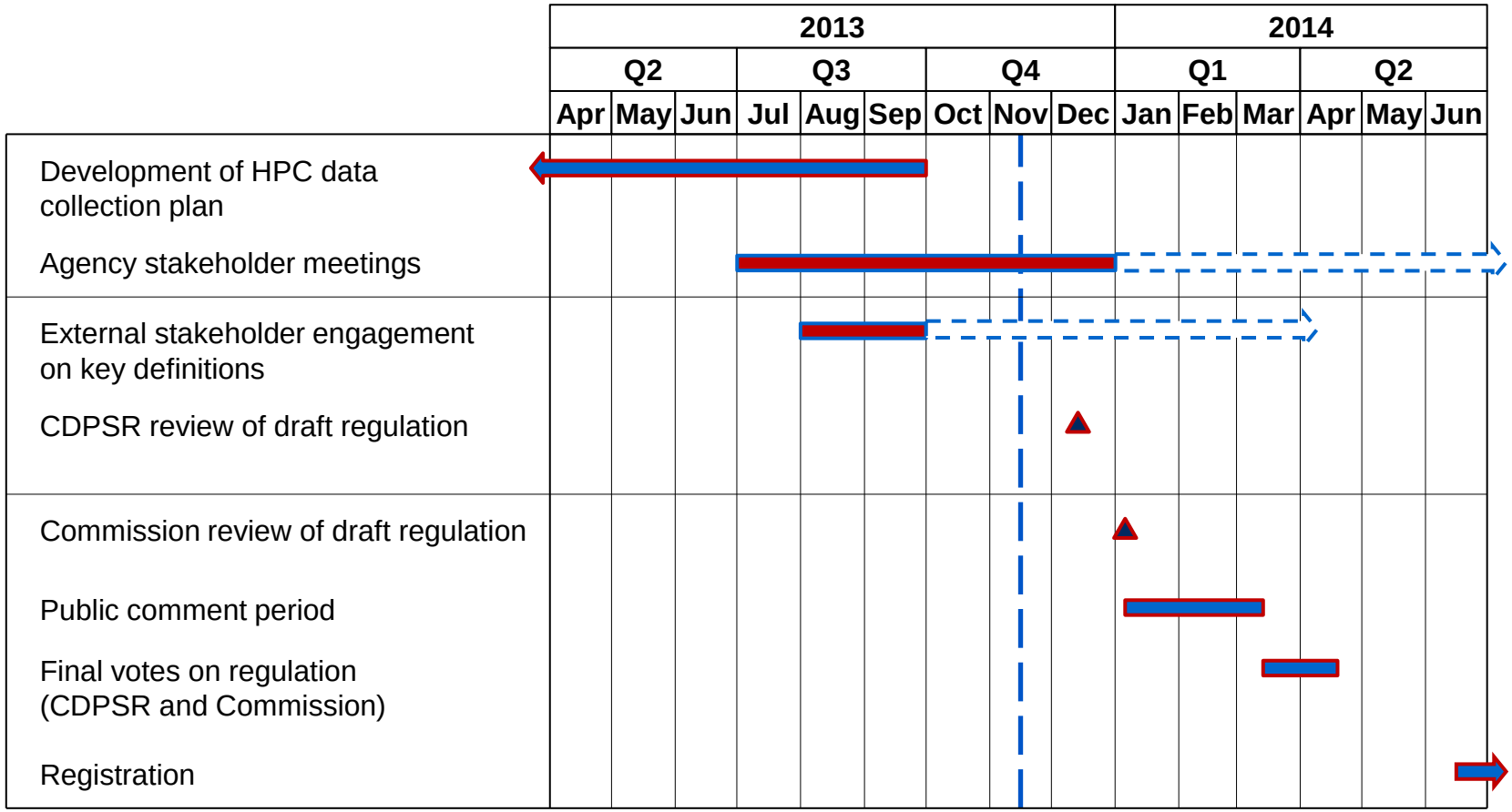
3 Phased approach to focus on high-yield elements

- Registration of RBPOs, physicians, hospitals and behavioral health early – add other providers meeting threshold as research/analytic/transparency needs arise
- Request only actionable information to be used by HPC, CHIA, DOI or other state agencies

4 Close provider engagement

- **Engage with Provider Organizations and other market participants early and often to ensure clarity of focus and reporting requirements, and to minimize operational burden**

Draft RPO timeline



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Contact information

For more information about the Health Policy Commission:

- Visit us: http://www.mass.gov/hpc
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