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May 12, 2015

David Seltz
Executive Director
Health Policy Commission
50 Milk Street, 8th Floor
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Dear Executive Director Seltz and Members of the Health Policy Commission:

On behalf of Atrius Health, I am pleased to provide comments to the Health Policy Commission (HPC) on the proposed draft Data Submission Manual (DSM) containing the Initial Registration Part 2 submission requirements for the Registered Provider Organizations (RPO) Program. We recognize and appreciate the hard work by the HPC commissioners and staff over the past year on this issue and willingness to solicit feedback.

Atrius Health is the Northeast's largest nonprofit independent multi-specialty medical group. The Atrius Health practices—including Dedham Medical Associates, Granite Medical Group, and Harvard Vanguard Medical Associates—together with VNA Care Network & Hospice serve 675,000 patients across eastern Massachusetts. A national leader in delivering high-quality, patient-centered coordinated care, the Atrius Health medical groups and home health agency and hospice work together, and in collaboration with hospital partners, community specialists and skilled nursing facilities, to develop innovative, effective and efficient ways of delivering care in the most appropriate setting, making it easier for patients to be healthy. Atrius Health is also a Pioneer ACO.

Although we are concerned about the amount of work required of providers to compile the various data elements for the RPO Program and wish to encourage the HPC to consider alternative ways to collect this information from other state agencies (in particular, the facility file and physician roster files), we have two specific suggestions on the DSM:

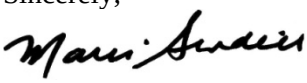
1. Facility File - RPO-92 (Service Lines). We appreciate that HPC is interested in understanding the scope of services provided by all licensed facilities; however, at least with respect to DPH licensed clinics, the DSM service line data element submission guidelines do not correspond with the service categories established by DPH. As a result, HPC's information will not conform to what is reported to and recorded by DPH. For example, while we employ surgeons and perform certain procedures on-site at our DPH licensed clinic practices, DPH does not consider those services "surgical" for the

purposes of clinic licensure and does not require us to be licensed for surgical services. We suggest that HPC modify this data request to be consistent with DPH service lines, or provide an option for DPH licensed clinics to report only those service lines for which they are licensed. For the broad DPH category of "medical services," we would be prepared to itemize within that category the specific specialties we offer (e.g., internal medicine, dermatology, etc.).

2. Clinical Affiliation File – We would recommend the HPC further clarify the the instructions to this section to make it clear that clinicial affiliation reporting is required for Provider Organizations with acute hospitals only, not from other providers. The current language is confusing.

Thank you again for the opportunity to provide information to the Health Policy Commission on this important matter. Please feel free to contact me at (617) 559-8323 should you have any questions or if we can be of further assistance.

Sincerely,



Marci Sindell
Chief External Affairs Officer
Atrius Health

Memorandum

Baycare Health Partners

101 Wason Avenue, Suite 200, Springfield, Massachusetts 01107
Telephone 413.794.8200 Facsimile 413.787.5232

TO: Commonwealth of Massachusetts Health Policy Commission

FROM: Ray McCarthy, CFO Baycare Health Partners and Baystate Medical Practices
Andréa Carey, Manager, Contracting, Baycare Health Partners

DATE: May 13, 2015

RE: **Comments on the Registration of Provider Organization Draft Part 2 Data Submission Manual**

Thank you for the opportunity to review and comment on the draft Data Submission Manual (DSM) for Registration of Provider Organizations (RPO) Initial Registration - Part 2. We appreciate the changes that have been made to the DSM since the original version of April 2014. However, we have ongoing concerns regarding the type and extent of information being requested, the duplicative nature of some of the data elements, the administrative burden it is placing on provider organizations, and ultimately how the information will be used. The Health Policy Commission (HPC) is charged with developing policy to reduce health care cost growth and improve the quality of patient care. The RPO Part 2 registration process is burdensome and adds significant administrative costs to the healthcare delivery system with unclear value in the improvement in patient care. We look forward to continuing to work together to make the provider registration process accessible and meaningful, for the providers, state and community.

On behalf of Baystate Health and Baycare Health Partners, we would like to make the following comments.

Administrative Complexity and Duplication

Several sections of the DSM require detailed information that is available from other state agencies. By example, the Facilities File requests licensure information reported to the Department of Public Health (DPH); the Physician Roster File requests information on file with the Massachusetts Health Quality Partners (MHQP) and the Board of Registration in Medicine (BORIM); the Contracting Entity File requests information reportable to the Division of Insurance (DOI) for Risk Bearing Provider Organizations (RBPO). All of these reporting obligations represent significant amounts of information, requiring updates on a bi-annual or, in many cases, on an annual basis. Recognizing that the information is only accurate as of the day it is submitted, this will serve to create duplicate databases with inconsistent information. The goal should be to work on maintaining one central data repository from which all state agencies can access the applicable data.

We appreciate that Part 1 files will pre-populate Part 2, and would request that Part 2 files pre-populate each other as appropriate to reduce the need to enter duplicate information.

Timing

The proposed timetable for submission is aggressive, given the extent of the information that RPOs will need to gather. The data being collected across a large organization like Baystate Health will require interdepartmental and facility coordination. Additionally, the deadline coincides with DOI's RBPO, HPC's Patient Centered Medical Home (PCMH), fiscal year end for our hospitals and many others, HPC cost-trend hearings, and CMS Medicare Shared Savings Program (MSSP)/Next Generation Accountable Care Organization (ACO) applications, to name a few of the other significant projects. Finally, RPOs will be using a new submission platform, and we expect that there will be a learning curve for both the RPO and HPC with this tool. The proposed reporting time period includes only 42 business days, half of which fall during the peak summer months. For these reasons, we would recommend that the reporting deadline be extended through year-end, or at least through the end of October.

We appreciate the opportunity for education and training sessions, and would be happy to make Baycare's facilities in Western Massachusetts available for any proposed sessions.

Confidential and Proprietary Information

Information requested in several areas of the DSM, but most importantly related to the funds flow, is proprietary information (data elements RPO-74 to 77). We are troubled by these requests due to the public disclosure requirement, and we feel this will compromise competitive positions of RPOs and lead to possible disruption of provider alignment strategies, as well as have serious consequences to regional partnerships. Specifically, data element RPO-75, which requests RPOs to disclose those providers who are responsible for deficits, will put some entities that hold providers responsible or liable for deficits at a distinct disadvantage to those entities that absorb any risk through reserves or other vehicles that buffer, in some manner, the individual providers or practices from downside risk. In addition, we strongly believe that this data element will be adequately addressed with information the DOI is required to obtain related to the regulation focused on RBPO and the actuarial certification process. <u>We strongly request that the HPC reconsider and eliminate the reporting requirements related to funds flow due to the proprietary and confidential nature of the information.</u>

Appeals Process

The penalty for non-compliance is severe, and as a result we request that the HPC develop an appeals and resolution process for situations when the HPC determines non-compliance.

File-Specific Comments

We would also like to submit the following file-specific comments:

B. Corporate Affiliations File

Questions 56-57 are already answered on the corporate organizational chart.

Questions 58-61 - The RPO should not be accountable to report on those other entities that are NOT corporately affiliated with the RPO for the following reasons:

- Administratively burdensome to collect the information;
- Many of these entities do not fall within the oversight of the HPC;
- RPO is uncomfortable publically reporting on organizations for which we do not have corporate control or ownership
- Information that RPO reports on unaffiliated entities could have unintended consequences.

C. Contracting Affiliations File

The RPO is the contracting entity for physician group practices as well as solo physician practices. Therefore, individual physicians will be listed in the contracting affiliations file and in the physician roster file, causing duplication of information.

Question 66 – RPO should be required to report on only those contracting entities that are corporately affiliated with the RPO.

D. Contracting Entity File

Question 69 - The Contracting Entity is being asked to report on contracts for Medicare ACOs when Medicare is not included in the regulatory definition of a reportable carrier, so we believe this is outside the scope of review.

Question 70 – It will be administratively burdensome to identify the start year of each contract type for each contracting entity. This does not appear to be a statutory requirement; it is unclear why this information is necessary and what purpose it will serve.

Questions 74-77 – This information, as previously commented, constitutes confidential and proprietary information relative to how the Carriers, RPO and providers conduct

business. Public reporting of this information will 1) compromise the RPO's ability to contract successfully with provider groups; and 2) violate contractual obligations between the RPO and carriers relative to confidentiality of plan proprietary information. The DOI RBPO certification requires summary responses relative to risk-sharing; this will meet any reporting requirements of the HPC and the RPO regulation. For these reasons, we request that the HPC limit the information requested to a level of detail no greater than that represented in Questions 72 and 73 to protect sensitive and anti-competitive information from public disclosure. Alternatively, the HPC could include language that keeps confidential and does not allow for public disclosure of all non-public information obtained in this section.

Question 78 - Uploading a physician roster per Contracting Entity will produce duplicative data for any Contracting Affiliates who have more than one Entity contracting on their behalf (e.g. a hospital and a PHO).

E. Facility File

Much of the information in this section is already available on the facility licenses through the Department of Public Health (DPH). In addition, the definition of the main structure "footprint" or campus locations for larger organizations will be extensive so limiting the physical locations to those areas immediately adjacent to the main buildings or structures or within 250 yards is too limiting. We request that the HPC coordinate with DPH, as required under Chapter 224 to minimize duplicative reporting requirements that are costly and burdensome or expand the definition of main campus or footprint requirements. (i.e. in miles not yards).

F. Physician Roster File

The resources and coordination that are required to comply with the annual update of the MHQP Massachusetts Physician Database (MPD) are already extensive. Our organization currently meets the MPD annual update requirement each December by dedicating resources to review and update the data, so placing an additional burden on that process for Part 2 of the DSM is the definition of duplication. Baystate dedicates a resource to review the data annually and it takes 4-5 days for one person to complete this process. It should be the responsibility of the HPC to coordinate and utilize an already existing process and database. To meet the obligation of the regulation the HPC should simply request from RPOs that they have reviewed and validated the MHQP MPD (i.e. an attestation process). After carefully reviewing the fields already contained in the MHQP data, we would agree that many of the elements in DSM Physician Roster File are available.

Question 125 - Please clarify the definition Local Practice, as compared to Medical Group and Practice site.

G. Clinical Affiliations File

The scope of this section remains extremely broad in nature and should reflect materiality, using either a financial threshold, or an affiliation which is strategic in nature, of which the public might be generally aware in a way that might affect how they seek care (e.g. co-branding). As part of normal operations on a day to day basis, provider groups (especially physician practices) provide clinical services to other healthcare entities through moonlighting, call and coverage, and purchased service arrangement engagements. Reporting such information and those relationships as part of the Part 2 DSM process will be administratively complicated, because generally those healthcare services and arrangements for larger institutions are handled in a decentralized manner (managed at the department chair or at a division service line level). Ensuring a complete list of all these relationships would require a great deal of coordination and effort involving every area within the health system.

Additionally, in some cases the information requested may constitute confidential and proprietary information relative to how the providers conduct business. Caution should be used in where information is not currently, and should not be, made publically available. Reporting at this level could have unintended business and operational consequences.

Co-located services do not necessarily constitute a clinical affiliation other than efficiency.

Again, we appreciate the opportunity to provide written comment on Part 2 of the DSM process, and we fully understand and appreciate that there are requirements contained in CH 224 with which the HPC needs to comply. However we urge you also to be advocates for the provider community and to better understand that placing an increased administrative burden on entities that are constantly looking to remove waste, duplication and seek efficiencies in delivering healthcare services, in the most cost effective and transparent manner should also be part of the objective in meeting the legislative requirements.

If you have any questions, please contact Ray McCarthy (413.794.7944 or Raymond.mccarthy@baystatehealth.org) or Andréa Carey (413.794.9303 or acarey@baycarehealth.org).

Beth Israel Deaconess
CARE ORGANIZATION LLC

Affiliated with
Beth Israel Deaconess
Medical Center

HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

May 15, 2015

The Commonwealth of Massachusetts
Health Policy Commission
Two Boylston Street
Boston, MA 02116

RE: Registration of Provider Organizations: Data Submission Manual Draft for Public Comment: April 16, 2015

Dear Chairman Altman and Members of the Health Policy Commission,

I am submitting this letter on behalf of Beth Israel Deaconess Care Organization (BIDCO) in response to your request for comment regarding the *Registration of Provider Organizations: Data Submission Manual (DSM)* Draft for Public Comment released on April 16, 2015. We are grateful to the Health Policy Commission (HPC) for allowing us the opportunity to share our comments, questions, and concerns.

Transparency and reporting are crucial elements in empowering the citizens of the Commonwealth to be well-informed, health care consumers. We strongly support a robust data collection effort that serves the Legislature's goal in gaining a greater understanding of the health care marketplace, in order to protect patient access and address consumer protection concerns.

Below are our specific comments regarding the draft reporting requirements. We urge the HPC to consider continuing important dialogue with Registration of Provider Organization (RPO) stakeholders to achieve our shared goal of transparency and accountability for the benefit of consumers in the Commonwealth without adding unnecessary administrative burden.

Summary: Reporting granular-level provider data with proprietary information is outside the scope of intent of the legislation and does not add value for the health care consumer.

We support the removal of the requirement to report FTE information and believe this change will reduce administrative burden for RPOs, particularly those who do not currently have this information and whose organizational structure is not conducive to collecting it.

, We are concerned about the governance related requirements for submission indicated in RPO-45 and RPO-138, which would require provider organizations to submit their corporate bylaws. Some organizations do not fit into the standard governance structures of corporate organization contemplated by the draft data submission manual requirements. For example, some organizations that are formed as Accountable Care Organizations and are structured by contracts rather than an ownership model may not have standard bylaws, but rather, operating agreements that contain much more detail than bylaws

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typically do. These operating agreements contain significantly more information than standard bylaws, and often include more confidential information than would be included in more traditional corporate bylaws. This information goes well beyond what is needed for verifying corporate organizational structure and provider relationships. For this reason, BIDCO requests and recommends that RPO-45 and RPO-138 be amended to add a third category for submitting a summary of the RPO's operating agreement instead of bylaws or the Attorney General filing, where those do not apply.

Additionally, BIDCO respectfully asks the HPC to clearly disclose and outline its plans for using the information collected during the RPO process. We understand the importance of this information for research and for policy development, but are concerned that in the wrong hands, the information could lead to market distortions that contradict the intentions of Chapters 224.

Thank you for the opportunity to offer comments, questions, and concerns on this important process, and we look forward to continued collaboration and partnership with the HPC in this important effort.

Please contact me at cseverin@bidmc.harvard.edu or (617) 754-1002 should you have questions or interest in further discussion.

Sincerely,

Christina Severin
President and Chief Executive Officer

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May 14, 2015

David Seltz
Executive Director
Health Policy Commission
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Dear Mr. Seltz,

The Conference of Boston Teaching Hospitals (COBTH) and its fourteen members hospitals appreciate this opportunity to provide comments on the Health Policy Commission's (HPC or the Commission) proposed Data Submission Manual (DSM). Our comments on Part 2 of the proposed DSM, like those we submitted for Part 1 of the Registration of Provider Organizations (RPO) process, are offered in a spirit of cooperation and commitment toward containing healthcare cost growth and avoiding unnecessary administrative cost and duplication.

COBTH and its members recognize the time and effort the Commissioners and the HPC staff have dedicated to the creation of the proposed DSM, and appreciate that the HPC made several modifications to the DSM requirements after convening several stake holder meetings. However, even with these modifications we feel the proposed data elements required in Part 2 are overly burdensome on providers and require submission of a great amount of duplicative information that is already submitted to other state agencies. We are also concerned that the amount and complexity of the information requested exceeds the statutory requirements of M.G.L. c. 6D §11. As such we ask the Commission to reevaluate the scope of the required data elements.

COBTH and its members are also concerned that the volume of information requested will place an undue strain on providers. This is especially concerning given the proposed timeline for submission of Part 2 information. Providers must complete Part 2 of the RPO process at the end of their fiscal year, a time when other state agencies, such as the Division of Insurance (DOI), as well as the Commission itself for its annual Cost Trend Hearing, already request significant filings. For this reason we ask that the Commission push back the timeline for submission of Part 2 data to the end of the calendar year.

Reduce and streamline its requests as the same information is sometimes required multiple times in multiple formats over several RPO sections

Spread throughout the sections of the proposed DSM certain RPO data elements are asked to be repeated under slightly different formats. Requiring provider to enter the same information multiple times is time consuming and burdensome. The following are a few examples of where these redundancies arise:

- RPO 51-53 reuses the name of the contracting entity responsible for contracting on behalf of the corporate affiliate. In the following section the HPC requires more detailed information of the providers contracting affiliates and entities.
- RPO 71 also repeats the same questions asked in the contracting affiliations file.
- RPO 204 and RPO 122 are another example of requests for duplicative data. RPO 104 asks for the primary medical office where a physician provides care, where are RPO 122 asks for the name of the medical group with which the physician is affiliated.

Within the RPO there is no opportunity for providers to opt out of a question asking for repetitive data, or allowing them to refer back to a previous answer. We ask that the HPC remove these and other duplicative data requests.

Obtain information which providers have already submitted to other state agencies from those agencies

While we realize the HPC has many responsibly and reporting duties that it must accomplish in a timely fashion, requiring providers to submit information which they have already provided to other state agencies in the HPC's chosen format only serves to increase their administrative burden. There are several examples in the proposed DSM where data can be accessed through other state agencies. For example, facility licensure data is available directly through the Department of Public Health (DPH). Likewise when the HPC requests physician information, this data is available directly through the Board of Registration in Medicine (BORIM) and MassHealth's provider enrollment databases.

Eliminate RPO 50 from the proposed DSM as requiring providers to report on unassociated corporations

It appears that when a reporting provider reports an affiliation and that affiliated organization in turn has an affiliated entity, the original reporting provider must report on that third entity even if it does not have a direct affiliation with it. It is unclear what purpose this reporting will serve. Moreover this information is often not readily accessible to reporting providers. We feel this information is not beneficial to the RPO process and outside the scope of what is statutorily required. We ask the HPC to remove this unfair burden from providers.

Eliminate or reduce scope of requested information about global payments in RPO 73-77

COBTH and its member hospitals share the Commission's commitment to transparency. However, data requested by RPO 73-77 may include proprietary information such as how these payments are dispersed across contractual affiliates, but would be subject to public disclosure. Should the Commission feel this information is necessary we would encourage the Commission to seek out the information DOI collects on alternative payment methodologies it collects through the risk bearing certification process. It is essential that RPO 73-77 provide protection of proprietary information.

Establish a materiality threshold for reportable clinical affiliations

COBTH's member teaching hospitals by their very nature have hundreds of clinical affiliations. These affiliations may be routine, such as between two physicians from different organizations working collaboratively or a hospitalist renting space, or be only sporadic and intermittent coverage or call coverage relationships that have little bearing on clinical services. As written these non-material affiliations are required to be reported to the HPC. Not only is this overly burdensome on providers but it is also not relevant to the RPO process. As such we recommend the Commission establish a materiality threshold to reduce the number of affiliations requiring reporting.

In closing, we would ask the HPC to consider the executive order released by Governor Baker for the initiation of regulatory reform. While we realize that the Commission is not subject to this executive order, it is our hope that the HPC embrace its spirit and eliminate those data elements being collected that

are not expressly required by law or essential to the "health, safety, environment, or welfare of the Commonwealth's residents." Regulations that increase the administrative burden on hospitals do have an impact on health care costs. We ask the Commission to be mindful in its data collection and require only that information whose relevance and materiality is lasting.

Thank you for your consideration of our comments and recommendations. We appreciate the work of the HPC as a partner in achieving our shared goal of reducing health care cost growth. We look forward to continuing to work with the Commission and the HPC staff in implementing the provisions of Chapter 224.

Sincerely,

John Erwin
Executive Director

Registration of Provider Organizations Draft Data Submission Manual

May 15, 2015

Hallmark Health PHO, Inc. would like to provide the following feedback on the Health Policy Commission (HPC) Data Submission Manual (DSM):

- Extremely time-consuming and complex
- Reasons for collecting data are not clear
- Definitions are not clear
- Data will very difficult to collect

Following are some specific examples:

- **RPO 51-53** asks for the name of the contracting entity that establishes contracts on behalf of the corporate affiliate although this is followed in the next section by an entire file with multiple questions on contracting affiliates and entities.
- **RPO 56-57** is duplicative.
- **RPO 66** requires us to provide the name of each contracting entity that establishes contracts on behalf of a contracting affiliate. We do not have all of this information for all our affiliates and will be very burdensome to collect.
- **Physician Roster File:** Many of our physicians belong to multiple contracting entities so we will be providing the same information multiple times.
- **RPO 126 and RPO 130** require us to list each organizational NPI associated with Local Practice Groups. As this information is requested for each physician, the same information will need to be provided multiple times (i.e., for each physician in each Local Practice Group). This reporting also appears to duplicate information already provided in the Physician Roster File.
- **RPO 58-61** requires reporting on unassociated corporation: This will be very difficult to collect from all our affiliated health system and provider entities.
- **PO73-77 requires detailed information about global payments** and how they are dispersed across contractual affiliates. Why is this information being requested? The DOI already collects this information.

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May 11, 2015

Kara Vidal
Registration of Provider Organization Program Manager
Massachusetts Health Policy Commission
50 Milk Street, 8th Floor
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Via Email: HPC-RPO@state.ma.us

Dear Ms. Vidal:

We have been asked by a number of our hospital and health system clients to submit comments on the Health Policy Commission's Registration of Provider Organizations Draft Data Submission Manual released on April 16, 2015.

Purpose and intent of the Registration of Provider Organization process

The Registration of Provider Organization ("RPO") process to date, including the Draft Data Submission Manual ("DSM"), has been very in-depth and taxing on providers. M.G.L. 6D § 11 directed the Health Policy Commission ("HPC") to "develop and administer a registration program for provider organizations" and to "coordinate with state agencies . . . to minimize duplicative reporting requirements."

The DSM is 50 pages long and specifies 141 data elements for reporting. While most of the data elements are factual, some require legal or accounting advice for completion.

The statute requires collection of three distinct elements: (i) organizational charts showing the ownership, governance and operational structure of the provider organization, including any clinical affiliations, parent entities, corporate affiliates, and community advisory boards; (ii) the number of affiliated health care professional full-time equivalents and the number of professionals affiliated with or employed by the organization; (iii) the name and address of licensed facilities; and (iv) such other information as the commission considers appropriate.

The statutorily-required elements imply a program intended to collect baseline information about Massachusetts providers and provider organizations, not competitive business information at the level of detail proposed in the DSM. The listing of the three specific items should be interpreted to limit the

discretion of the Commission to require other types of data that are inconsistent or broader than the listed items. It is well settled law that when elements or items are listed in a series, the rules of statutory construction require the general phrase to be construed as restricted to elements or items similar to the specific elements listed. Santos v. Bettencourt, 40 Mass. App. Ct. 90, 92 (1996). This principle, *ejusdem generis*, "allow[s] the specific words to identify the class and [restricts] the meaning of general words to things within the class." 2A N.J. Singer & J.D. Shambie Singer, Sutherland Statutory Construction § 47.17, at 379 (7th ed. 2007).

For example, while statute requires organizational charts to show ownership, governance, and operational structure, the HPC proposes to have providers complete a Corporate Affiliations File complete with geographic information and tax status for each corporate affiliate as well as employer identification numbers information about third parties contracted with providers for joint ventures – all beyond the scope necessary to achieve the statutory purpose. Additionally, statute requires only total number of employed and affiliated physicians, while the draft DSM proposes each hospital submit a roster for the Physician File with full primary practice, secondary practice and physician specialty information for each and every physician. The HPC should not use the RPO process to compel providers to submit more information than is statutorily required or that may infringe upon a provider's operating resources or business strategy.

The DSM in its current form requires provider organizations to collect and produce information that is already publicly available, and also requires the disclosure of other information that should be treated as proprietary. The former adds significant administrative burdens and higher costs, which is inconsistent with the HPC's purpose, while the latter is inappropriate and beyond the intent of the authorizing statute.

Publicly available data sources

If adopted in its current form, the DSM would require providers to invest precious financial and human resources compiling and submitting data elements already available to the public via numerous public sources, among several state agencies. Some of our clients have estimated that an organization could easily expend at least $30,000 in legal and consulting fees for the initial submission, and over $5,000 annually for ongoing updates. At a time when providers must operate as efficiently as possible, the proposed data elements will result in unnecessary spending of health care dollars.

Moreover, requiring reporting of information that interested parties can locate at other state agencies runs counter to both administrative simplification and cost containment efforts. Many of the HPC's sister state agencies maintain websites and non-electronic files with many of the draft DSM elements. For example, the state's Board of Registration in Medicine ("BORIM") maintains a robust physician profile website. According to the BORIM Physician Profile, "both The Joint Commission and the National Committee on Quality Assurance consider the Massachusetts Board of Registration to be a primary source provider for license status information." With excellent and updated public databases available, the HPC should minimize duplicative reporting requirements and utilize both public sources and interagency agreements for data information exchanges with other state agencies to provide RPOs with some relief from the proposed duplicative and administratively burdensome reporting requirements.

A full list of Draft Data Submission Manual data elements and corresponding public data sources is provided below.

Public Data Source	Draft Data Submission Manual Data Elements
IRS: http://www.irs.gov/Charities-&-Non-Profits/Search-for-Charities	RPO-32 RPO Organization Tax Exempt Status RPO-50 Corporate Affiliate Tax-Exempt Status
DPH: http://www.mass.gov/eohhs/gov/departments/dph/programs/hcq/healthcare-quality/	RPO-55 Organization Type – Subcategories (Ex: Acute Hospital, Ambulatory Surgery Center, etc.) RPO-65- Organization Type (Ex: Acute Hospital, Ambulatory Surgery Center, etc.) RPO-79 through RPO-90 (Name, address, EIN, license number, license type, facility type, etc.) RPO-93 Facility Type – Non-Acute Hospital
CMS' National Plan and Provider Enumeration System (NPPES): https://nppes.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do	RPO-97 Physician NPI RPO-106 Primary Practice Site NPI and RPO-115 Secondary Practice Site NPI RPO-122 through RPO-124 Medical Group Name, EIN and NPI
BORIM Physician Profile website: http://profiles.ehs.state.ma.us/Profiles/Pages/FindAPhysician.aspx	RPO-97 Physician NPI RPO-98 Physician Specialty 1 and RPO-99 Physician Specialty 2 RPO 94-96, 98-102, 104-121, 122-130 Physician practice information RPO-104 through RPO-121 Geographic and background information about primary and secondary practice sites
Secretary of the Commonwealth of Massachusetts' Corporations Division Database: http://corp.sec.state.ma.us/corpweb/CorpSearch/CorpSearch.aspx	RPO-54 Organization Type (Ex: MSO, Holding Company, Professional Liability Organization, etc.) RPO-106 Primary Practice Site NPI and RPO-115 Secondary Practice Site NPI RPO-122 through RPO-124 Medical Group Name, EIN and NPI RPO-125 through RPO-130 Local Practice Group 1 and 2 Name, EIN, and NPI
HPC Material Change Notices beginning in 2013: http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/material-change-notices-cost-and-market-impact-reviews/	RPO-134 Clinical Affiliation Start Date RPO-135 Description of Clinical Affiliation Briefly describe the nature, scope and scale of the Clinical Affiliation RPO-136 Service Lines Involved in Clinical Affiliation

Confidential and proprietary information

A number of Draft DSM requirements require the submission of confidential and proprietary data elements that should not be included in a publicly searchable database or disclosed to state government. For example, some of the data elements require disclosure of financial arrangements, such as contracts to distribute surplus or deficits under global payments, that are typically subject to non-disclosure agreements, e.g. RPO-74 through RPO-77. Many of the items in the data elements would be subject to protection from disclosure under the public records law if submitted in connection with a Notice of Material Change, but could become public records if reported under the RPO process. In the normal course of business, our clients would not readily share documentation related to their business operations, clinical agreements, or payment and risk sharing information. A list of Draft Data Submission Manual data elements that reasonably could be considered confidential and proprietary is provided below. Each of these data elements should be excluded from the RPO application.

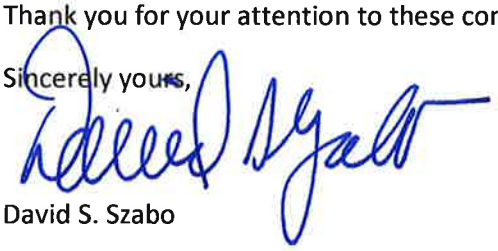
- RPO-45 Governance Structure (for entities that are not public charities, including IPAs, PHOs, network companies and investor owned health care facilities)
- RPO-58 Legal Name of Other Entity(ies) with a Direct Ownership or Controlling Interest (External Corporate Parent)

- RPO-68 Governance Structure
- RPO-70 Contract Start Year
- RPO-71 & 72 – Contracting for Affiliated providers + Services offered
- RPO-73 Global Payment
- RPO-74 Global Payments – Eligibility for Surplus
- RPO-75 Global Payments – Responsibility for Deficits
- RPO-76 Global Payments – Withholds
- RPO-77 Global Payments – Distribution of Surplus / Deficit
- RPO-103 Employed Status
- RPO-136 Service Lines Involved in Clinical Affiliation
- RPO-137 Services Included in the Clinical Affiliation

While our clients recognize the Commission's statutory mandate and the importance of its mission, the current form of the DSM imposes unnecessary administrative burdens and costs on providers, and exposes proprietary information to public scrutiny. We ask that the DSM be revised accordingly. I would be pleased to meet with the Commission's staff to discuss these concerns.

Thank you for your attention to these comments.

Sincerely yours,



David S. Szabo

MHA MASSACHUSETTS HOSPITAL ASSOCIATION

The leading voice for hospitals.

Registration of Provider Organizations Draft Data Submission Manual

May 15, 2015

The Massachusetts Hospital Association (MHA) on behalf of its member hospitals and health systems, appreciates the opportunity to provide comments to the Health Policy Commission (HPC) on its proposed Data Submission Manual (DSM). We recognize and appreciate that the HPC has convened several stakeholder meetings and has continued to modify the requirements in response to comments since the initial DSM was first published a year ago. We also understand that some of the information requested is necessary to inform the HPC and other state agencies regarding analysis of the overall health care environment. However, we continue to have concerns regarding the amount, nature, and complexity of the information being collected as well as the fact that a significant amount of the required elements duplicates what can be obtained from other state agencies.

As stated in Governor Baker's press release regarding his executive order initiating regulatory reform, "Only those regulations which are mandated by law or essential to the health, safety, environment, or welfare of the Commonwealth's residents shall be retained or modified." The order asks state agencies to eliminate or modify regulations where the costs exceed the benefits and result in duplicative, intrusive, or restrictive requirements, are anti-competitive, or could adversely affect the citizens and customers of the commonwealth. We ask that the HPC be mindful of the intent of this executive order as it considers the best way to move forward on the registered provider organization (RPO) regulatory process.

General comments

Our members continue to struggle with the length and complexity of the 49 pages long DSM and the fact that the HPC requires information that goes far beyond what is statutorily required. For example:

- The definitions and the elements are often confusing and must be read multiple times in order to discern what is actually being requested. The DSM sometimes uses the defined (capitalized) terms and other times uses the same words without capitalization. It is difficult to determine HPC's intent based on the inconsistent usage of defined terms.

- **RPO 51-53** asks for the name of the contracting entity that establishes contracts on behalf of the corporate affiliate although this is followed in the next section by an entire file with multiple questions on contracting affiliates and entities. In fact there are several sections where it appears that the RPO will have to repeat information that has already been provided.
- **RPO 56-57** appears to duplicate information that is available from the corporate organizational chart.
- **RPO 66** requires the RPO to provide the name of each contracting entity that establishes contracts on behalf of a contracting affiliate. The RPO is not always in a position to know all of the entities that establish contracts on behalf of their contracting affiliates and this should be outside the scope of the RPO's filing.
- Regarding the **Physician Roster File**, the DSM states that a separate physician roster must be submitted for each of the RPO's contracting entities. In some cases, the RPO will have multiple contracting entities that establish contracts on behalf of the same physicians (e.g., a PHO and a physician organization) resulting in the same that the same information being reported multiple times.
- **The Physician Roster File** requires the EIN in several locations. In the case of a solo practitioner, it is possible that this could be the social security number. Providing this information in a file that can be publicly disclosed is not acceptable.
- In some instances, the elements or definitions are duplicative or appear to actually conflict with one another. For example, **RPO 104** asks for the primary medical office where the physician provides care. **RPO 122** asks for the name of the medical group with which the physician is affiliated. What is the difference? Some of the information in the corporate and contracting affiliations file (organization type, legal name) is repeated in the facility files (facility name, license type). **RPO 71** duplicates questions already answered in the contracting affiliations file. Again, it is unclear what the HPC is trying to ascertain with this particular question.
- **RPO 126 and RPO 130** require the RPO to list each organizational NPI associated with Local Practice Groups. As this information is requested for each physician, the same information will need to be provided multiple times (i.e., for each physician in each Local Practice Group). This reporting also appears to duplicate information already provided in the Physician Roster File.

The DSM needs to be further streamlined so that the information is asked clearly, concisely, and most importantly is not duplicated in numerous sections.

<u>Duplicate Reporting Requirements</u>

Chapter 224 states that "The commission shall coordinate with state agencies including, but not limited to, the center, the division of insurance, the executive office of health and human services, the office of Medicaid and the department of public health to minimize duplicative

reporting requirements. The commission may enter interagency service agreements to perform these functions including but not limited to the sharing of data collected. The commission, in consultation with the center, shall promulgate such regulations as may be necessary to ensure the uniform reporting of data collected under this section."

Although the HPC has repeatedly stressed that it strives to minimize the administrative burden placed on providers and will work to reduce duplication and to obtain information from other state agencies whenever possible, there are still significant challenges posed in the DSM. For example, instead of obtaining facility licensure information directly from DPH, the DSM requires each provider organization to supply this information. Instead of getting physician information from BORIM or from Mass Health provider enrollment, the provider organization is expected to duplicate what has already been provided to the state. Obtaining this information from the relevant state agency would reduce the significant administrative and financial burden that the HPC is placing on providers with these duplicative requirements. It would also fulfill the goal in Chapter 224 that stresses sharing of data collected by state agencies to ensure the uniform reporting of the data. Rather than transferring the burden to providers, the HPC should be working with the other state agencies to develop a single process for collecting and sharing this information, eliminating redundancy, and creating one "source of truth" for information.

Additional Concerns

- **RPO 58-61 requires reporting on unassociated corporations**. MHA members question the necessity of providing this information and would like to understand its value to the HPC and how it will be used, as it is an additional burden to collect this significant and detailed amount of information on entities that have no direct affiliation to the registering provider organization. Collecting information solely for the sake of collecting information is a poor use of everyone's time.

- **RPO73-77 requires detailed information about global payments** and how they are dispersed across contractual affiliates. This is not statutorily required. Like some of the other information that is requested, this is burdensome to provide for each contracting entity and due to the possibility for public disclosure, can have serious unintended consequences, particularly where businesses compete and services overlap. MHA urges the HPC to eliminate this requirement entirely or to allow for a very high level general response (eg. RPO-73 only) that will not compromise each provider organization's proprietary information and create an anti-competitive environment. Additionally, the DOI collects information on alternative payment methodologies from all entities that are certified as risk bearing provider organizations.
- **RPO-70** asks for the **date range when the contracting entity first began establishing at least one contract in that group**. While MHA appreciates that the HPC simplified this question, we are still unclear why this information is even necessary since virtually every provider organization will have established contracts with the major commercial payers. The relevant fact should be whether the entity *currently* has contracts within each of the specified categories, not when those contracts were initiated.

Clinical affiliations file

MHA continues to have concerns regarding the broad based requirements for providing information about each clinical affiliation as defined in the DSM. Similar concerns have been submitted to the HPC regarding the requirements for filing notices of material change. As with the notices of material change, there should be a materiality threshold that determines what should be reported. Provider organizations may literally have hundreds of what the HPC would consider a reportable clinical affiliation. Routine affiliations such as a shared coverage arrangement between two pediatric offices or a physician leasing office space should not have to be reported as clinical affiliations.

Additionally, any clinical affiliation that has already been reported to the HPC though a notice of material change should be exempt; instead the RPO should be able to indicate "already on file with the HPC."

Conflict with other state and federal requirements

In addition to the RPO requirements, many of these same provider organizations are subject to the DOI's risk bearing provider certification process, and/or will be working on the HPC's Patient Centered Medical Home certification standards, HPC cost trend hearings, HPC ACO certification process, as well as the CMS Medicare Shared Savings Program and Next Generation ACO program. All providers will have to comply with the move to ICD-10 in October. For many hospitals, the HPC timeframe also coincides with the close of the fiscal year. Given the many conflicting priorities, we would encourage the HPC to allow additional time beyond the September 30th deadline to complete the RPO process, ideally until the end of 2015.

We appreciate the opportunity to provide the HPC with comments that reflect the concerns of our members. In closing, we would again remind the HPC of Governor Baker's executive order that states "the citizens and customers of the Commonwealth will be better served by reducing the number, length, and complexity of regulations, leaving only those that are essential to the public good." The order also states that each Agency shall insure that every regulation is clear, concise, and written in plain and readily understandable language. We sincerely hope that the HPC will consider the financial and administrative burdens that the DSM requirements are placing upon the entire provider community, often without clear benefit, and will comply with the spirit of Governor Baker's executive order. We strongly encourage the HPC to streamline and simplify the proposed DSM through eliminating duplicative requirements, confusing language, and the reporting of superfluous information that does not serve to improve the health, safety, or welfare of the Commonwealth. Thank you.

MASSACHUSETTS MEDICAL SOCIETY
Every physician matters, each patient counts.

Comments of the Massachusetts Medical Society
To The Health Policy Commission
May 15, 2015

RE: Registration of Provider Organizations Data Submission Manual

The Massachusetts Medical Society appreciates the opportunity to provide comment for second part of the Health Policy Commission's Registration for Provider Organization (RPO) Data Submission Manual (DSM). The Medical Society appreciates being involved in the stakeholder engagement process whereby many preliminary concerns raised by the Society have been adequately addressed by the Commission. However, the MMS still has concerns about the length and complexity of the registration process. While the administrative burden of some of these specific programs such as RPO may be justified in abstract, the burden of these programs in aggregate is immense, never mind other external administrative pressures on provider organizations. In sum, the request in our comments and those of others to find ways to streamline this process are vitally important.

Background Files
There appear to be many instances of duplicative questions throughout the 51 page manual. A question-by-question review for the entire DSM to eliminate duplication would be an important first step before final publication of the registration manual. For example, the MMS questions whether RPO-40 through RPO-47 are unnecessary given questions in the contracting affiliations file such as RPO-69 which asks for the same information about payers with which the contract entity contracts. Additionally, in this Background Files section, a reduction in the scope of information requested for "community advisory boards" of the provider organization or any of its corporate affiliates (RPO-44) would be helpful as a requirement of a description of the composition, mission, and purpose of each board seems excessive and without justification.

Contracting File
In RPO-69, determining the "Start Year" for each category selected can be difficult and require finding original contracting files, and does not appear to be a statutory mandate. A compromise could be asking if any of the listed contracts began in the prior year or two, to determine this information about new contracts as the registration program moves forward. Additionally, the detailed questions about the nature of risk in global payment contracts seem to ask for similar information as contained in the Risk-Based Provider Certification program. Any information sharing or streamlining with the Division of Insurance that could reduce these questions on either process would be helpful.

Physician Roster File
The Physician Roster File has several confusing data elements. The difference between the Primary Site of Practice, Medical Group Name, and Local Practice Group 1 and 2 should be streamlined, or at least, better defined. Any details about the physicians that can be obtained from the Board of Registration in Medicine should not be requested on this roster form. Since both entities will have unique NPIs, the

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information should be able to be shared. Lastly, any assistance that the HPC can provide, such as tutorials or "how-to guides", about how to convert MHQP physician data files, once verified, to the HPC templates would be helpful given the scope of this request.

Support Services for Part II

The MMS commends the HPC staff for their willingness to meet individually with provider organizations for Part I of the registration process. We wish to request that an equal or great outreach and support program takes place for Part II, including more technical assistance for some data conversion, such as the MPQP issue referenced above. An ongoing "Frequently Asked Questions" for further clarification as other provider organizations submit questions would also be beneficial. Lastly, ensuring that the twenty pages of "technical notes" are easily accessible is important, especially since the "definitions" section at the beginning can lead one to assume that there is not additional clarification.

The Medical Society strongly encourages the Health Policy Commission to continue the process of reducing the scope of the endeavor that will be "RPO Part II." Whether this is through prioritizing certain elements of information and eliminating others, or through collaborations with other state agencies to leverage existing data points, any and all means to reduce the scope of this process are valuable to the provider community. The failure to simplify will likely result in only large entities being able to administratively fulfill these and other like requirements resulting in potential increased consolidation in the marketplace.

Thank you for the opportunity to provide feedback for this important program.

The Massachusetts Medical Society, with more than 24,000 physicians and student members, is dedicated to educating and advocating for the patients and physicians of Massachusetts. The Society, under the auspices of NEJM Group, publishes the New England Journal of Medicine, a leading global medical journal and web site, and NEJM Journal Watch alerts and publications covering 13 specialties. The Society is also a leader in continuing medical education for health care professionals throughout Massachusetts, conducting a variety of medical education programs for physicians and health care professionals. Founded in 1781, MMS is the oldest continuously operating medical society in the country.

Partners HealthCare System, Inc. Comments on the Draft Data Submission Manual for the Registration of Provider Organizations

While Partners HealthCare System recognizes and appreciates the steps that HPC has already taken to lessen the administrative burden associated with the reporting requirements of the Registration of Provider Organizations (RPO) program, Partners remains concerned about certain aspects of the latest draft Data Submission Manual (DSM). A general concern of Partners is that the DSM continues to have duplicative reporting requirements that are an administrative burden for RPOs. The draft DSM requires RPOs to report on information that can be obtained from other state agencies or even from other places within the RPO filing itself (i.e., the same information is requested multiple times in the filing). Our specific comments regarding the DSM are as follows:

1. The DSM does not use defined terms consistently throughout the document (e.g., Contracting Entity is a defined term, but the term is rarely capitalized in the DSM). To avoid confusion, defined terms should be used consistently throughout the document.

2. Does the definition of Contracting Entity include a PHO or IPA that facilitates contracts for its participating physicians through the messenger model but does not negotiate payer contract terms or enter into/execute any payer contracts itself? We propose that the definition of Contracting Entity be revised to explicitly exclude such organizations.

3. RPO-54 in the Corporate Affiliations File requires the RPO to select an option describing each Corporate Affiliate's organization type. We suggest that an option be added for organizations that have no current activities.

4. RPO-57 and the checkbox in RPO-56 request information that is also reported on the Corporate Organizational Chart. We propose that RPO-57 and the checkbox in RPO-56 be deleted.

5. RPO-58 through RPO-61 requires the RPO to report on organizations that are neither Corporate Affiliates nor Contracting Affiliates of the RPO. Gathering and reporting this information poses an unnecessary administrative burden on RPOs. We propose that these elements be deleted.

6. RPO-65 in the Contracting Affiliations File requires the RPO to select an option describing each Contracting Affiliate's organization type. We suggest that an option be added for organizations that are Contracting Organizations or Managed Services Organizations. This option was given in RPO-55 for Corporate Affiliates, but is also potentially applicable for Contracting Affiliates (e.g., if an RPO has a Contracting Affiliate that is a PHO or IPA).

7. RPO-66 in the Contracting Affiliations File requires the RPO to identify each "contracting entity" that establishes contracts on behalf of the contracting affiliate. The RPO should not be required to report on all contracting entities that establish contracts on behalf of their Contracting Affiliates as the RPO is not in a position to know which other (unaffiliated) contracting entities may establish contracts on behalf of their Contracting Affiliates. If HPC is intending to limit this request to contracting entities that are Corporate Affiliates of the RPO, HPC should make that limitation clear through the use of defined terms or through instructions.

8. For purposes of clarity, we propose that HPC add and use a defined term for Contracting Entities that are Corporate Affiliates of the RPO (e.g., Contracting Corporate Affiliate).

9. The Physician Roster File requires the RPO to submit a separate physician roster for each of the RPO's contracting entities. This is unduly burdensome and will result in the same information being reported multiple times by the same RPO. For instance, a physician may participate in contracts established by their physician organization as well as by one or more Contracting Organizations that are Corporate Affiliates of the RPO.

10. RPO-122 through RPO-124 in the Physician Roster File requires reporting on the name, EIN and NPI of a physician's "medical group." What does HPC intend by this element? How is this different from the reporting in RPO-104 through RPO-106 and in RPO-113 through RPO-115 where the RPO is required to report on the name, EIN and NPIs of the physician's primary and secondary sites of care? Reporting the same information multiple times is unduly burdensome for RPOs.

11. RPO-130 in the Physician Roster File requires reporting on each organizational NPI associated with a physician's Local Practice Group. Local Practice Groups that are defined by a PHO or an IPA will have many physicians (and their associated organizational NPIs) associated with the Local Practice Group. Requiring the RPO to report each organizational NPI associated with a physician's Local Practice Group in each physician's file is duplicative and administratively burdensome.

12. Partners remains concerned that the Clinical Affiliations File will require RPOs to gather and report information on "clinical affiliations" that are not material and are not relevant to HPC's objectives. HPC should explicitly exclude routine coverage arrangements and physician office space leasing/sharing from the reporting requirement.

13. RPO-134 requires RPOs to report the date range that best describes when each Clinical Affiliation began. We propose that HPC delete this requirement as we don't see the additional value to HPC of understanding the date a Clinical Affiliation began.

Thank you for the opportunity to provide input on the draft Data Submission Manual.

Respectfully submitted,
Andrea Re

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Christopher R. Philbin, Esq.
Vice President for Government
and Community Relations

May 15, 2015

Kara Vidal
Program Manager, Registration of Provider Organizations
Health Policy Commission
50 Milk Street 8th Floor
Boston, Ma 02109

Dear Ms. Vidal,

Thank you for allowing provider organizations to submit comments on the draft Data Submission Manual (DSM) containing the initial registration part 2 submission requirements for the Registration of Provider Organizations (RPO) Program.

Senior leadership of UMass Memorial Health Care (UMMHC) has reviewed the proposed DSM and while we appreciate your efforts to streamline this newest version, we as an organization have significant concerns with the size, scope, complexity and timing of this required submission. We have shared our concerns with the Massachusetts Hospital Association and are in full agreement with their submitted comments on our behalf.

While we understand the Health Policy Commission's need to obtain certain information directly from providers to adhere to state law, the current version of the DSM goes far beyond that. To provide the information you are mandating in this filing on behalf of all of our owned or affiliated corporations and contracting affiliates would be an overwhelming task. Much of the information requested in the draft DSM is already provided de-centrally by our owned and affiliated entity level providers to various Massachusetts state agencies (DOI, DPH, MassHealth, etc.) in the regular course of business. In order to comply with the requirements of the DSM, we would need to hire additional staff to work with our corporate offices as well as our owned and affiliated entities to collect, report and maintain the information you are requesting.

UMMHC strongly supports the goals of improving quality, increasing efficiency and lowering health care costs in the Commonwealth. The requirements of this DSM will do nothing to further those worthy objectives. It will simply increase our administrative costs and add no value to our provision of care to the residents of central Massachusetts.

Thank you for your thoughtful consideration of these comments.

Sincerely,

Christopher R. Philbin, Esq.
Vice-President for Government and Community Relations