Atrius Health

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December 16, 2016

David Seltz
Executive Director
Health Policy Commission
50 Milk Street, 8th Floor
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Submitted Electronically

Dear Mr. Seltz:

On behalf of Atrius Health I am writing to provide input to the Health Policy Commission (HPC) on the proposed 2017 Data Submission Manual (DSM) filing requirements published on November 10, 2016.

Atrius Health, an innovative nonprofit healthcare leader, delivers an effective system of connected care for more than 675,000 adult and pediatric patients in eastern and central Massachusetts. Atrius Health's 29 medical practices, with more than 35 specialties and approximately 1300 eligible clinicians, work together with the home health and hospice services of its VNA Care subsidiary and in close collaboration with hospital partners, community specialists and skilled nursing facilities. Atrius Health provides high-quality, patient-centered, coordinated care to every patient it serves. By establishing a solid foundation of knowledge, understanding and trust with each of its patients, Atrius Health enriches their health and enhances their lives.

We appreciate the willingness of the HPC staff to take into consideration the viewpoints of providers subject to reporting as part of the Registration of Provider Organizations (RPO) in an effort to minimize administrative burdens.

We wish to respond specifically to HPC's request for feedback from providers on whether there were any challenges in completing exhibits related to financials developed by the Office of the Attorney General ("AGO") for pre-filed testimony for the annual Cost Trends Hearings, since HPC is also proposing to use this format. Atrius Health has been unable to complete the exhibit as requested by the AGO since it was first required in 2013; following discussions with AGO staff, we have submitted a modified form that allows us to be responsive.

Atrius Health strongly recommends that the HPC modify its proposed APM and Other Revenue File in the following way: under the column entitled "Risk Contracts," replace the column "Claims-Based Revenue" and "Budget Surplus/Deficit Revenue" with the following: "Net Capitation Revenue" and "Quality Incentive Revenue." We also encourage the HPC to work with the Center for Health Information and Analysis (CHIA) and the AGO to collect product margin information from payers who would be better able to provide this information in a consistent format across all providers in their respective networks.

Areas of potential confusion of provider reported Budget Surplus/ Deficit Revenue include:

- Facility / provider transfer pricing different from payer amounts
- Differences in payer provided services (e.g. delegation, patient outreach, etc.)

- Differences in services included in risk pool and the valuation of these services

Thank you again for your consideration. Should you have additional questions we are available to meet with HPC staff to more fully explore these suggestions. Please feel free to contact me at (617) 559-8323 or Kathy Keough, Director of Government Relations at (617) 559-8561 should you wish to schedule a follow-up conference call or meeting.

Sincerely,

Marci Sindell
Chief Strategy Officer and Senior Vice President, External Affairs

Beth Israel Deaconess
CARE ORGANIZATION

Affiliated with
Beth Israel Deaconess Medical Center
HARVARD MEDICAL SCHOOL TEACHING HOSPITAL

December 16, 2016

Mr. David M. Seltz
Executive Director
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Mr. Ray Campbell
Executive Director
Center for Health Information and Analysis
501 Boylston Street
Boston, MA 02116

RE: Massachusetts Registration of Provider Organizations Program: Proposed 2017 Data Submission Manual Comments

Dear Mr. Seltz and Mr. Campbell:

Thank you for providing Beth Israel Deaconess Care Organization (BIDCO) the opportunity to respond to the Health Policy Commission's (HPC) 2017 Data Submission Manual (DSM) proposed revisions. BIDCO is a value-based physician and hospital network and an Accountable Care Organization (ACO) made up of more than 2,500 physicians and eight hospitals in Eastern Massachusetts. As a registered Provider Organization in the Massachusetts Registration of Provider Organizations (MA-RPO) program, we appreciate this opportunity to provide comments and suggestions to improve the DSM.

BIDCO is in support of several changes proposed in the DSM. Namely, we support eliminating the requirement to provide EINs on the physician roster. Many providers currently use their Social Security Number (SSN) as their EIN, and since this information contained in the provider roster is publicly available, any effort to eliminate *any* risk of sharing personally identifiable information is highly prudent. Additionally, BIDCO supports submitting a filing that reports relationships in effect as of January 1, 2017 for the 2017 filing period. The HPC and CHIA are likely aware that these relationships will not necessarily be reflected in the financial statement and APM and Other Revenue File since they report on different timeframes.

Prior to finalizing its recommendations, BIDCO recommends the following amendments to the proposed 2017 DSM. First, the HPC and CHIA recommend adding a reporting requirement threshold for a Provider Organization's contracting affiliates that would only require Provider Organizations to report physician practices that include five or more physicians. BIDCO recommends modifying this requirement to allow a Provider Organization the *option* to report all physician practices, regardless of size, or those that include five or more physicians. Though BIDCO appreciates the limitation and would seek to comply with the modification in the future, the requirement — if implemented now — adds an unexpected level of administrative complexity to the physician roster development process. Therefore, BIDCO requests making

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this reporting feature optional until a Provider Organization develops the administrative capacity to comply.

Additionally, the MA-RPO program proposes incorporating new filing elements modeled off of an existing exhibit developed by the Office of the Attorney General that many Provider Organizations have submitted as part of their Cost Trends Hearing Pre-Filed Testimony ("APM and Other Revenue File"). BIDCO understands the role that transparency plays in addressing the rising costs of health care in Massachusetts, and our organization continues to contribute to the dialogue and submit data that supports these objectives. However, BIDCO respectfully requests modifying certain elements of the APM and Other Revenue File to further protect proprietary and other business interests of organizations participating in a rapidly evolving and competitive health care marketplace. Specifically, we suggest consolidating the following elements into one, sum-total item in the DSM to be reported at an aggregate level: Claims-Based Revenue, Budget Surplus/(Deficit) Revenue, Quality Incentive Revenue under the Risk Contracts columns. We recommend a similar aggregated reporting requirement for the P4P Contracts elements (Claims-Based Revenue and Incentive-Based Revenue). This modification satisfies the agencies' interest in transparency by showing the public in aggregate fashion how a Provider Organization distributed its revenue in a given year.

Thank you for giving us the opportunity to provide comments. If you have any questions, please do not hesitate to contact Cecilia Ugarte Baldwin, Director of Public Payer Programs and Policy, at 617-754-1098.

Sincerely,

Jeffrey R. Hulburt
President & Chief Executive Officer

BOSTON HEALTH CARE *for* *the* HOMELESS PROGRAM

December 20, 2016

David Seltz, Executive Director
Health Policy Commission
50 Milk Street, 8th floor
Boston, MA 02109

Dear Mr. Seltz:

I am pleased to offer comments on the 2017 Data Submission Manual (DSM) recently proposed by the Health Policy Commission (HPC), which establishes the data elements that Registered Provider Organizations (RPOs) will submit to satisfy their 2017 Registration Renewal with the HPC (958 CMR 6.05(5)) and 2017 filing requirements with CHIA (957 CMR 11.00). Boston Health Care for the Homeless Program (BHCHP) is a not-for-profit Community Health Center providing high-quality health care to homeless men, women, and children in the greater Boston area.

Criteria for Abbreviated Filings

Our main concern with this regulation, in its current form, is that—taken together with the reporting regulation recently proposed by CHIA—the requirements are not tiered adequately by provider size and scope of risk-based contracts. We believe that the HPC and CHIA, in thoughtfully and jointly crafting the RPO program requirements, are aiming to reduce administrative burden on providers while focusing on practices of a significant size. Boston Health Care for the Homeless Program has no reportable contracting affiliations, clinical affiliations, or acute care hospitals. It currently has no contracts involving downside risk. Its organizational structure is comprised of a single entity: the community health center, Boston Health Care for the Homeless Program. And it just barely met the financial threshold for reporting at all—and only when including its pharmacy revenue in the calculation of Net Patient Services Revenue. Yet, because BHCHP negotiates its own contracts with payers, it is ineligible for an abbreviated application and is required to fulfill the same reporting requirements as major health care systems comprised of much more complex corporate networks that include acute care hospitals.

Our suggestion is not that organizations like BHCHP should be exempted from this program, but that the criteria for an abbreviated application be revised to better reflect the broad range in size and complexity of, the financial risk assumed by, and the reporting capacity available to the provider organizations across the state. Reporting requirements with the HPC, to date, have been manageable for smaller providers like BHCHP precisely because the entities for which we must report are limited, but when layered with CHIA's proposed reporting—including, now or in future years, reporting on utilization, clinical quality, care coordination, and more comprehensive financial reporting (957 CMR 11.03(1)(d), 11.03(1)(e), 11.03(1)(g), and 11.03(1)(h))—the resources required to analyze, track and report on these requirements become more significant. We agree that these are critical topics to examine, and we continue to be committed to developing our capacity to explore them in more detail.

But when combined with the evolving requirements of other health reform programs, we are concerned that small, community-based health care organizations like ours may lack the administrative resources to adequately meet these reporting requirements, and patient care may be impacted.

Reporting Timeframes
You specifically sought feedback on new timeframes. While it is not impossible for us to report on relationships as of a certain date (e.g., 1/1/2017), it does add to reporting complexity. It is our recommendation that reporting is required to be accurate as of the date of filing, and that different parts of the filing should not each have different reporting timeframes. The filing requirements—particularly because they span two programs—are already complex enough.

Updated Organization Types and Available Services
The proposed changes to RPO-53 and RPO-87 seem reasonable.

Reporting Threshold for Small Physician Practices
The proposed threshold regarding Provider Organizations' contracting affiliates with physician practices that include fewer than five physicians seems helpful to reduce administrative burden on Provider Organizations with large contracting networks which include a significant number of one and two-physician practices. It is right to "focus on physician practices of a significant size for which the Commonwealth values having detailed data." Yet small Provider Organizations with limited resources should also be protected. See earlier comment on abbreviated filings.

EIN Removal
The HPC proposes to remove EINs from the physician roster and instead collect physician license numbers. This seems acceptable.

APM and Other Revenue File
We do not have concerns at this time about completing this exhibit. We anticipate being able to submit the CY2015 data by the proposed filing date of Summer 2017.

A final comment is that, with the advent of Medicaid ACOs, we hope that the DSM will clearly instruct providers like BHCHP who have contracted with an ACO but who are not formally part of the ACO. We appreciate the opportunity to provide these suggestions as you seek to finalize a registration and reporting program that will increase provider transparency across the state. We have shared similar comments with CHIA in response to their draft regulation. Please do not hesitate to contact me directly if you have further questions concerning our responses. I can be reached via email at bbock@bhchp.org or by phone at 857-654-1015.

Sincerely,

Barry Bock

Barry Bock
Chief Executive Officer
Boston Health Care for the Homeless Program
780 Albany Street
Boston, MA 02118

Comments from Massachusetts Health Quality Partners:

Thank you for offering us the opportunity to comment on the Registration of Provider Organizations draft 2017 Data Submission Manual (DSM).

MHQP worked with the HPC to include the following paragraph, in red below, in the Provider Roster section of the 2015 manual. The wording was the result of a careful comparison of the 2015 RPO Physician Roster File layout and the available fields in the MHQP Massachusetts Provider Database (MPD). We understand that many Provider Organizations will have already built the IT infrastructure in order to produce the provider roster. However, there may be new Provider Organizations who meet the filing requirements, and it could be helpful for them to know that their MPD roster could be the basis for their RPO filing.

If helpful, I would be very willing to speak to the appropriate HPC staff in more detail. Thank you for your consideration, and do not hesitate to contact me with any questions you may have.

From the 2015 DSM

Completing the Physician Roster File

The table below states that the secondary practice site, medical group, and Local Practice Group fields are not required. These fields have been marked as not required because not every physician will have a secondary site of practice, medical group, or Local Practice Group. However, if a physician does have a secondary site of practice, a medical group, or a Local Practice Group, the Provider Organization is required to complete these questions.

Many of the data elements included below are collected by Massachusetts Health Quality Partners (MHQP) from Massachusetts Carriers and Provider groups and stored in MHQP's Massachusetts Provider Database (MPD). MHQP works with Provider groups to validate the MPD every year to assure MHQP's measurement work accurately reflects Providers and organizational structures. Provider groups statewide have access to their MHQP physician data through the MHQP MPD password protected provider portal. Providers may want to use their existing MHQP physician data as a starting point to streamline the process of completing the RPO Physician Roster file. If you are interested in exploring this option, please contact MHQP at MPD@MHQP.org.

The Provider Organization will complete the Physician Roster file by completing an HPC-issued Microsoft Excel template with the relevant information and uploading the template as a file attachment in the online submission platform. The data in the Physician Roster will not be editable from within the online submission platform. If the Provider Organization needs to make an edit to the Physician Roster information, the primary reporter must make the edit within the Microsoft Excel template and upload the revised version to the online submission platform.

The HPC recognizes that the structure and organization of Provider Organizations' internal databases may not match the HPC's required format for the Physician Roster file. The HPC invites Provider Organizations that are unsure how to convert their internal databases into the required HPC format to contact program staff for assistance.

PARTNERS HEALTHCARE | FOUNDED BY BRIGHAM AND WOMEN'S HOSPITAL AND MASSACHUSETTS GENERAL HOSPITAL

December 16, 2016

David M. Seltz
Executive Director
Health Policy Commission
Commonwealth of Massachusetts
50 Milk Street,8th Floor
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Submitted via HPC-RPO@state.ma.us

Re: Massachusettts Registration of Provider Organization (MA-RPO) Program - Proposed 2017 Data Submission Manual

Dear Mr. Seltz,

Thank you for the opportunity to comment on the proposed 2017 data submission manual for the MA-RPO Program. We appreciate the Health Policy Commission's (HPC's) efforts to minimize the administrative burden associated with the MA-RPO Program, including by narrowing the scope of reportable clinical affiliations to focus on those relationships most likely to be strategic. We do not agree, however, that the establishment of a provider-to-provider discount arrangement is an indicator of a strategic relationship—often, these arrangements are put in place in response to competitive market requests. As such, we do not believe that all provider-to-provider discount arrangements should be required to be reported as part of the MA-RPO Program. Rather than adding provider-to-provider discount arrangements as a separate category of reportable clinical affiliations, we suggest that HPC limit the reporting of provider-to-provider discount arrangements to those that are part of a preferred provider relationship reported in the clinical affiliations file.

Thank you for the opportunity to comment. If you should have any additional questions, please - do not hesitate to reach out to Xiaoyi Huang, Director of Payer Strategy, at xhuang9@partners.org or 857-282-0623.

Sincerely,

David McGuire
Vice President, Payer Strategy and Contracting
Partners HealthCare

Comments from Sturdy Memorial Hospital

Thank you for the opportunity to comment on the proposed regulation related to the Massachusetts Registration of Provider Organization (R-PO). Our comments are as follows:

- We appreciate that provider organizations would not be required to complete a mid-year update if they acquire a new physician practice.
- Section H in the draft regulation states "financial statements must be made available no later than 100 days after the Entity's fiscal year end." The HPC should be aware that only draft financial statements may be available 100 days after the Entity's fiscal year end. Final financials are often not yet available at that time.