Atrius Health

Riverside Center
275 Grove Street, Suite 3-300
Newton, MA 02466-2275
617-559-8000 tel
617-559-8099 fax

www.atriushealth.org

BY ELECTRONIC MAIL

November 27, 2017

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

Re: Proposed Updates - 2018 filing for Massachusetts Registration of Provider Organizations

Dear Mr. Seltz:

On behalf of Atrius Health, I am writing to provide input to the Health Policy Commission (HPC) on the proposed updates to the 2018 filing for Massachusetts Registration of Provider Organizations (MA-RPO) published on October 23, 2017.

Atrius Health, an innovative nonprofit healthcare leader, delivers an effective system of connected care for more than 740,000 adult and pediatric patients in eastern and central Massachusetts. Atrius Health's 34 medical practices, with more than 50 specialties and 900 physicians, 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 enhances their health and enriches 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) and offer the following general comments as well as some responses to the HPC's specific questions:

Facilities File

Given the emphasis in the state on reducing health care costs, we support greater transparency regarding the scope of facility fee payments in the state. We believe it is critical for the HPC to collect this information in order to make more informed policy decisions surrounding these payments and their overall impact on health care costs.

Provider Roster

Completing the Provider Roster is already among the most time consuming aspects of the RPO filing. At this time it would be burdensome to add Nurse Practitioners, Physician Assistants and Certified Nurse

Midwives to the Provider Roster, and we strongly oppose the collection of inclusion of any of the additional data elements in the proposed update, specifically RPO-99A through RPO-99-E. The majority of these data elements are not readily available and would require manual retrieval from hundreds of clinician files. In addition, it is not clear what the value or utility of this information is from a public policy and/or research perspective. Finally, we note that there is pending legislation that would eliminate the requirement for a supervising physician for NPs; we are hopeful this legislation will be enacted this legislative session, rendering this requirement moot. We strongly recommend the HPC remove RPO-99A through RPO-99E from its proposed requirements.

Our responses to HPC's specific questions are as follows:

1. **Does your organization recommend any modifications or instructions to the proposed updates described above?**

   Yes. Remove RPO-99A through RPO-99E.

2. **Does your organization have any concerns regarding data consistency/accuracy as an end-user of this information?**

   To date we have not utilized any of the information contained within the MA-RPO annual filings. We would like some transparency as to the end-users of this information and how the information has been utilized since the MA-RPO began..

3. **Is there any data in the Provider Roster requirements that your organization currently tracks for physicians, but not for NPs, PAs, or CNMs?**

   No.

4. **Would your organization prefer to submit a combined Provider Roster that includes physicians (MDs and DOs), NPs, PAs, and CNMs, or would your organization prefer to submit a separate roster for NPs, PAs, and CNMs?**

   If HPC retains the newly proposed data elements in RPO-99A through RPO-99E, we would have a strong preference to submit a separate roster for NPs, PAs and CNMs solely because the level of effort required to collect this information would require the work of multiple people and a process completely different from that required to produce the current Provider Roster fields.

5. **In the existing data elements in the 2017 DSM, are there any answer options or instructions that your organization believes should be added or modified to better reflect changes to your organizational structure or contracting and clinical relationships that may have resulted from changes in care delivery and payment models (e.g., Accountable Care Organizations, increase in risk-based contracts, etc.)?**

   No.

6. **Provider Organizations have previously indicated a preference for a summer submission deadline rather than a fall submission deadline. Please include any feedback regarding the feasibility of providing data in the summer of 2018.**

   We prefer a June or July 2018 deadline given the number of other state regulatory filings due in the fall (e.g., pre-filed testimony in advance of the annual Cost Trends Hearings; application to the Division of Insurance as a Risk Bearing Provider Organization). We appreciate the

amount of lead time provided in 2017 to complete the RPO submission and ask that providers be provided a similar lead time in 2018 to prepare this information.

Thank you for the opportunity to provide comments on these important regulations. If you have any questions regarding this testimony or require further information, please contact me at (617) 559-8323 or Kathy Keough, Director of Government Relations at (617) 559-8561.

Sincerely,

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

Thank you for the opportunity to offer feedback on the proposed changes to the Health Policy Commission's Registration of Provider Organizations.

We would like to request that state delay for one year (until 2019) any new reporting requirements.

- Significant new reporting requirements were added to the RPO in 2017, along with increasing the frequency from a bi-annual filing to an annual filing. The 2017 filings have not yet been completed. It seems unreasonable to be adding additional items when we are still addressing questions related to the 2017 filing.
- The ACOs across the state, from which much of the data is required, are in the midst of implementing the MassHealth ACO program and transitioning to limited MCO options affecting over 1.2 million MassHealth members. As a result, ACOs are subject to a considerable number of new and expanded regulations, including ACO certification and RBPO certification. The RBPO certification and appeals processes, HPC review of Total Medical Expense, ACO Certification and RPO, all unfunded and often duplicative regulations, are drawing heavily on existing resources. There will be significant disruption in the market over the next 7 months related to the launch of the MassHealth ACO program impacting all aspects of healthcare delivery - primary care, specialists, hospitals, MCO's, members/patients, and front and back-end operations. Attention to making this transition as smooth as possible for all stakeholders should take priority over new reporting requirements for the RPO.
- It is not clear what value the new reporting requirements add.

Feedback specific to the proposed additional reporting requirements:

RPO 86-A: Facilities File

- Medicare regulates how facilities are paid, and Medicare Advantage plans are required to follow Medicare regulations. Requesting POs to report on Medicare Advantage plans is unnecessary. The same holds true for Medicaid plans.

Physician Roster - Adding Advanced Practitioners (Nurse Practitioners, Physician Assistants, Certified Nurse Midwives)

Generally, these additional requirements are extremely burdensome and are not consistent with how Baystate Health, and its subsidiary PHOs, Baycare Health Partners (Baycare) and Noble Health Alliance (NHA), operate. Baystate Health employs hundreds of Advanced Practitioners throughout the organization, and Baycare and NHA do not enroll the advanced practitioners of their Contracting Affiliates. Many of the proposed data elements are not currently maintained at the level requested, which would make it impossible, if not extraordinarily burdensome to collect the data, when resources are already stretched in a time when health care providers are challenged to continually look for ways to improve quality, safety and the experiences of our patients, all in the context of reduced reimbursements and increased expenses. Additionally, Baystate Health is not privy to some of the information being requested from Contracting Affiliates, and this will be perceived as burdensome, invasive, and concerning to private practices that are not part of the Health System.

RPO-99B - Billing practices

- It is extremely burdensome to identify the percent of services billed at an individual provider level, and nearly impossible to identify this percentage for hospital-billed advanced practitioners vs. those advanced practitioners who are billed by the medical practice.

- In the event HPC goes forward with this proposed data element, it should be reported at the TIN level and not at the individual practitioner level.

RPO-99C – RPO 99E Identification of Supervising physician

- Identification of supervising physicians is used only at initial enrollment and when re-credentialed, and is not constantly maintained. This data would be extremely burdensome to collect for a large health system like Baystate outside of its normal course of business. The same is true for Baycare and Noble Health Alliance, neither of which collect this information at all.

Data elements of current Physician Roster that are not tracked for Advanced Practitioners:
Baystate Health does not maintain the specialty of its employed Advanced practitioner; a generic taxonomy is used. We would not be able to accurately respond to the pediatric or specialty field (for both employed and contracted APs) on the roster. All other data elements would not be an issue for Baystate employed providers. Baycare and NHA do not enroll advanced practitioners, so none of the data would be available.

Submission deadline
We would prefer a summer submission deadline.

Again, thank you for the opportunity to provide feedback. Should you have any questions or follow-up, please let me know.

Sincerely,

Andréa Carey
Director, Managed Care
Baycare Health Partners & Baystate Health, Inc.
101 Wason Avenue, Suite 200
Springfield, MA 01107
Phone: (413) 794-9303 Fax: (413) 787-5232
acarey@baycarehealth.org

MEMORANDUM

To: David Seltz, Executive Director, Health Policy Commission

CC: Jean Yang, Executive Director, Children's Hospital Integrated Care Organization, Boston Children's Hospital
Joshua Greenberg, Vice President, Government Relations, Boston Children's Hospital

From: Rebekah Diamond, Senior Manager of ACO Policy and Business Relations, Children's Hospital Integrated Care Organization, Boston Children's Hospital

RE: Massachusetts Registration of Provider Organizations ("MA-RPO") Program Proposed 2018 Updates, Release for Public Comment

---

General Feedback

Thank you for the opportunity to comment on the proposal for the 2018 RPO filing and additional data fields. While we appreciate the efforts of the Health Policy Commission (HPC) on provider reporting and cost containment in the Commonwealth, we have several concerns about the proposed filing.

Given 2015 and 2017 RPO filings, a 2018 filing would constitute a shift to a more frequent cadence (annually vs. bi-annually). This proposed change falls at a particularly resource-constrained time for provider organizations. Boston Children's Hospital, among other providers in the Commonwealth, is in the midst of implementing the MassHealth Accountable Care Organization (ACO) program with the Executive Office of Health and Human Services (EOHHS). ACO implementation is a significant body of work and the primary policy and operations priority for the organizations undertaking it. In the case of Boston Children's, the same personnel are involved in both ACO implementation and RPO filings. Requiring an additional RPO filing at this time strains staff capacity and takes attention away from other key state initiatives, namely ACO implementation.

Furthermore, if creating additional data fields for the RPO filing, and if asking for more frequent reporting, we would be interested in understanding the use of such data by HPC in furthering its mission and benefit to end-users of this information.

Below please find our responses to those questions posed by the HPC in their Notice of Public Comment.

1. Does your organization recommend any modifications or instructions to the proposed updates described above?

> Providers and administrators have provided feedback that the percentage billed to the NP would likely be the most onerous and difficult information to collect, because different plans require different billing practices. Some plans now require NPs and PAs to bill under their own NPI (MassHealth), but others do not require it. Therefore we are unsure how we would account for the discrepancy if this information isn't required by all plans. Furthermore, we do not have a data set that would be easy to pull from to get this data, and it is not clear that we would be able to pull this data without considerable effort, if at all.

We also have concerns regarding the proposed data request related to facility fees. First, in addition to pending state legislation on facility fees, there is also federal legislation that affects these fees. As such, we would recommend the HPC not gather data on these pending this activity. Second, the definition of "outpatient" is not clear and, as a result, it is not clear what the intent is for gathering this data.

2. Does your organization have any concerns regarding data consistency/accuracy as an end-user of this information?

We would note that when downloading our submission form the portal for 2017, we found that the 2015 submission data in the portal had not been updated to reflect the latest information provided to the HPC for the 2015 RPO submission. We would like to separately ensure that the portal reflects the correct information provided to HPC, however, such inaccuracies in the data reflected on the portal brings into question the rigor with which this data is being stored and the usefulness of this data for its eventual intended purpose. We would like to highlight this point as it addresses the accuracy of the data on our organization. Furthermore, we would like to request that the HPC provide greater detail regarding why information in filing sections is collected so that we can best report that information in line with its intended use.

3. Is there any data in the Provider Roster requirements that your organization currently tracks for physicians, but not for NPs, PAs, or CNMs?

See answer to question 1.

4. Would your organization prefer to submit a combined Provider Roster that includes physicians (MDs and DOs), NPs, PAs, and CNMs, or would your organization prefer to submit a separate roster for NPs, PAs, and CNMs?

For better coordination internally, we would prefer one provider roster that includes physicians, NPs, PAs and CNMs.

5. In the existing data elements in the 2017 DSM, are there any answer options or instructions that your organization believes should be added or modified to better reflect changes to your organizational structure or contracting and clinical relationships that may have resulted from changes in care delivery and payment models (e.g., Accountable Care Organizations, increase in risk-based contracts, etc.)?

We appreciate the HPC taking into account areas where we have sought clarity on the DSM language to make this process easier in subsequent filing years. We have also found it helpful to understand the use of the data in each section so we understand the purpose of the data we are collecting so that we can best report that information in line with its intended use.

With respect to reporting on care delivery and payment models, we expect that the majority of data coming from MassHealth ACOs would not become relevant until a 2019 RPO filing given that these plans do not go into effect until March 1, 2018. For CY17, organizations will have had

minimal, if any, experience in the pilot program only. When we have ACO experience, it will be helpful to work with the HPC on how ACO entities would be reported in the RPO filing.

6. Provider Organizations have previously indicated a preference for a summer submission deadline rather than a fall submission deadline. Please include any feedback regarding the feasibility of providing data in the summer of 2018.

Per our above feedback, any submission in 2018 will be challenging, particularly in the summer given the overlap in resources that support the RPO filing and those involved in MassHealth ACO implementation and operation. Furthermore, summer is a time during which staff is more likely to take time off and coordinating availability across schedules is more challenging.

11 Beacon Street, Suite 710
Boston, MA 02108
Phone: 617-723-6100
Fax: 617-723-6111
www.cobth.org

November 30, 2017

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

Re: Proposed Updates - 2018 filing for Massachusetts Registration of Provider Organizations

Dear Mr. Seltz:

On behalf of the Conference of Boston Teaching Hospitals, I offer comments on the proposed updates to the 2018 filing for Massachusetts Registration of Provider Organizations (RPO) published on October 23, 2017. We appreciate the willingness of the HPC staff to take into consideration the viewpoints of providers subject to reporting as part of the RPO and offer the following comments on the proposed changes.

Facilities File

The proposed change would require reporting entities to provide information on which payers, public and private, pay "facility fees". Facility fees are the contractually negotiated recognition that hospital based facilities are extensions of the hospital with full financial, clinical, and operational integration and warrant a payment structure that is distinct from a physician fee schedule. As contractually negotiated provisions, the public reporting of these agreements by payer is proprietary information.

As you are aware, facilities fees are the subject of pending legislation approved by the Senate and likely to be considered by the House in 2018. We recommend that any reporting on facility fees be held off until the issue is addressed by the legislature.

Provider Roster

For many reporting entities, the provider roster portion of the RPO filing is the most difficult and administratively burdensome of the entire filing. To expand this requirement to include nurse practitioners, physician assistants and certified nurse midwives as well as information about supervision and billing, would involve considerable work and, in our view, provide little value to the public or policy makers.

In addition, there is pending legislation related to nurse practitioners that would eliminate the requirement that at they be supervised by a physician, something that is being proposed to be reported RPO 99C-99E. We strongly recommend the HPC remove RPO-99A through RPO-99E from its proposed requirements.

Two of the guiding principles of the RPO program are "administrative simplification" and "balancing the importance of collecting data elements with the potential burden to Provider Organizations". As you are aware, organizations just recently completed their 2017 RPO filing, the second full filing

under the RPO regulations. Given that covered entities now have considerable experience complying with the regulation and the HPC with reviewing and using the data collected, we feel it may be a good time to examine the costs related to the program and how the data has been used. We would be interested in exploring this idea with you and your staff and how best we could achieve our common goals.

Thank you again for the opportunity to provide comments and I look forward to continuing to work with you and the HPC staff on the RPO program.

Sincerely,

John Erwin
Executive Director

Beth Israel Deaconess
CARE ORGANIZATION

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

November 30, 2017

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 2018 Updates

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) proposed 2018 updates. BIDCO is a value-based physician and hospital network and an Accountable Care Organization (ACO) made up of more than 2,600 physicians and eight hospitals in Eastern Massachusetts. As a registered Provider Organization in the Massachusetts Registration of Provider Organizations (MA-RPO) program, BIDCO appreciates this opportunity to provide comments and suggestions to the proposed updates for the 2018 submission.

In response to Question 1 *(Does your organization recommend any modifications or instructions to the proposed updates?)*, BIDCO respectfully requests eliminating the additional data elements proposed in the Provider Roster, RPO-99A through RPO-99E. BIDCO is a physician and hospital network that does not require its membership to provide advance practice provider (APP) information when enrolling into BIDCO established contracts. BIDCO could adopt enrollment policies and procedures to collect this information from its network membership, but BIDCO is concerned that this is an administrative function that it is not presently contemplated in project work plans for 2018.

Additionally, BIDCO does not receive, request, or require billing information from any of its members. *RPO-99B: Billing Practices* would require BIDCO to request specific billing information for APPs from its entire network. Completing this task places considerable administrative burden on the organization as it would require BIDCO to (1) build the infrastructure to capture and retain this information, (2) create policies and procedures for how the data will be captured and stored, and (3) perform on-going monitoring to ensure the data is accurate and up to date.

247 Station Drive, Suite NW1
Westwood, MA 02090

(617) 754-1000 Phone
(617) 754-1040 Fax
www.bidco.org

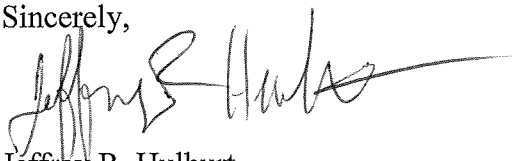
Lastly, it is unclear what the underlying purpose is as to why these data elements are being added to the Provider Roster. The potential benefits this information provides to the public or the rationale for why this information is important to drive decision-making has not been clearly defined by the HPC.

It is for these reasons that BIDCO respectfully requests to eliminate the proposed data elements to the Provider Roster, RPO-99A through RPO-99E. BIDCO is a strong proponent of the work the HPC is doing to promote transparency in the Commonwealth, and would like to assist in future data element proposals as they relate to the MA-RPO program.

In response to Question 6 *(Please include any feedback regarding the feasibility of providing data in the summer of 2018*), BIDCO proposes an earlier submission deadline in late spring. This will provide additional flexibility in the summer months to prepare for the fall Cost Trends Hearing. BIDCO would also support a summer submission deadline as opposed to a fall one for similar reasons as previously stated.

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

November 30, 2017

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

Dear Director Seltz:

On behalf of the Massachusetts Coalition of Nurse Practitioners (MCNP) and the more than 9,000 licensed Nurse Practitioners (NPs) in Massachusetts we represent, I am writing to provide feedback on the proposed updates for the 2018 filing for Massachusetts Registration of Provider Organizations (MA-RPO).

MCNP seeks to be a partner as Massachusetts continues to prioritize health care reform, access to care and cost savings measures. We continue to advocate for those initiatives that provide the Commonwealth with the flexibility needed to optimize resources and to position the provider workforce to address consumer demand, while simultaneously promoting the type of provider transparency that informs quality and is requisite for value based payment models. We believe that Nurse Practitioners are an essential part of the solution, and empowering NPs to practice to the full extent of their licenses would close gaps in access experienced by vulnerable populations and contain costs by supporting innovative models of care.

MCNP has been advocating for a change in Massachusetts law that would allow NPs this flexibility and are encouraged that this legislation will be passed this session. Thus, our comments to the proposed 2018 MA-RPO filing are in this context.

The proposed changes to the Provider Registry offer a specific opportunity to further the discussion on our overall healthcare system and the role that NPs can play in that system, and we are encouraged by the inclusion of NPs in the Provider Registry.

With that said, we would urge that if NPs are listed in a Provider Registry, they are listed alongside physicians in one central Registry. To separately list NPs from their physician colleagues can inaccurately raise issues about different levels and quality of care.

Additionally, we adamantly oppose the inclusion of supplemental data related to supervising physicians in RPO-99A through RPO-99E, as NPs are independently licensed for all elements of their clinical practice, outside of prescribing. The aforementioned presents a false impression of less-adequate care. The proposed collection of this additional data does not benefit the public in any way, and we urge that this language be removed from the final reporting requirements.

On behalf of the more than 9,000 Nurse Practitioners across the state, and the thousands of patients we serve, I urge your careful consideration of these concerns.

Thank you for the opportunity to comment and I look forward to working with you more on this issue.

Respectfully,

Stephanie Ahmed, DNP, FNP-BC

Past President and Legislative Co-Chair
Massachusetts Coalition of Nurse Practitioners

November 30, 2017

The Massachusetts Health and Hospital Association (MHA), on behalf of our member hospitals, health systems and physician organizations, welcomes the opportunity to submit comments to the Health Policy Commission (HPC) regarding its proposed 2018 updates to the Registration of Provider Organizations (MA-RPO) Program. We appreciate that the HPC and the Center for Health Information Analysis (CHIA) have worked together to combine the statutorily required elements that support this program. However, the RPO program is already extremely time consuming and incorporating CHIA requirements, while a logical step, has resulted in a significant increase in reporting requirements for the 2017 MA-RPO program as well as a change from bi-annual to annual filings.

Providers are already struggling with the many competing and ongoing requirements and initiatives that the state is undertaking, including MassHealth ACO implementation, ACO certification, the Risk Bearing Provider Organization (RBPO) certification process , providing testimony for the annual Cost Trend Hearings as well as the tremendous uncertainty regarding the future of the Affordable Care Act. Given these significant challenges, we urge the HPC to be judicious as it determines what, if any, new requirements should be added to the MA-RPO program.

Provider Roster

The HPC is proposing that nurse practitioners (NPs), physician assistants and certified nurse midwives be added to the provider roster and that billing and supervision information be provided for NPs. As you are well aware, provider organizations have spent considerable time and limited resources to supply the HPC with physician rosters. For many organizations, this has not been easy to accomplish. The addition of mid-level practitioner rosters along with information about supervision and billing requirements would be extremely onerous and not

feasible for most organizations to provide. Many of these organizations employ hundreds of mid-level practitioners and the data elements requested are not maintained at the IPA or PHO level and would thus create burdensome demands on contracting entities and the practices they support without offering any apparent commensurate value to the public.

More importantly, it is unclear how collecting this information will help inform health policy and decision-making. It is also important to note that the Senate's health care cost containment legislation (SB2211), along with Governor Baker's healthcare cost containment proposal (HB3829), and House Bill 2451 /Senate Bill 1257 -- are all under consideration in the Legislature, and would remove the mandate for physician supervision of NPs for prescriptive practice, making this requirement obsolete. Given the enormous burden and questionable benefits of these requirements, MHA respectfully requests that the HPC eliminate RPO-99A through RPO-99E.

Facilities File

The HPC is seeking more detailed information on which payers pay facility fees. MHA has several significant concerns regarding this new requirement.

The HPC is proposing to remove the provider-based status element. Whereas the federal Centers for Medicare & Medicaid Services (CMS) has detailed, rigorous requirements to meet provider-based status that provide a clear context for which entities can bill facility fees and under what circumstances, RPO-86A completely eliminates this detail. Under CMS rules, in order to have this designation, the provider must be financially, operationally, and clinically integrated with the "main" hospital campus and can then have the ability to bill facility fees under Medicare. The HPC's definition of facility fees fails to take into consideration the many differences between outpatient settings not affiliated with a hospital and hospital-based outpatient departments. As written, the definition could include technical fees for radiology, emergency departments, outpatient clinics, and laboratories regardless of whether the facilities are located on or off of a hospital's campus or have provider-based status. When interpreted this way, any hospital-licensed facility could potentially be classified as receiving

so-called “facility fees” from carriers. Thus, the simple fact that an insurer pays a facility fee, without clear supporting information, can lead to misunderstanding by the public, especially if the provision of such data to the HPC does not accurately reflect the clinical, financial, and operational integration of provider-based facilities.

It is also important to note that facility fees are contractually negotiated between payer and provider and, as such, constitute proprietary information. Sharing this information among carriers and providers can put both at a competitive disadvantage. In addition, given that the data that would be provided to the HPC will only show which carriers have paid facility fees to certain entities -- without any context and without reflecting CMS provider based status -- MHA is left with the concern that any resulting conclusions that are drawn from this data may be misinterpreted. In lieu of adding RPO-86A, MHA strongly recommends that the HPC keep the current RPO-86: Provider-Based Status.

In summary, MHA strongly recommends that the HPC remove RPO-99A through RPO-99E as well as RPO-86A.

The HPC asks whether a summer submission deadline would be better than the current fall submission. MHA members subject to the RPO requirements have indicated that a summer submission deadline would be preferable.

Again, we appreciate the opportunity to submit comments and look forward to continuing to work with the HPC on the MA-RPO data submission process. Please don’t hesitate to contact Karen Granoff at (781) 262-6035 or KGranoff@mhalink.org if you require additional information.

Thank you for inviting organizations to comment on the proposed changes to the 2018 Registration of Provider Organization filing requirements. The Massachusetts Health Quality Partners works closely with providers throughout the Commonwealth to maintain our Massachusetts Provider Database (MPD). We continue to request that the following information be included in the Data Submission Manual. Some provider networks include both Nurse Practitioners and Physician Assistants when updating the MPD.

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.

We would also ask for additional clarity on the timing of the filings (annual vs. biennial, summer vs. fall).

Thank you again,

JIM COURTEMANCHE | *Vice President, Programs and Analytics*

Massachusetts Health Quality Partners | www.mhqp.org
42 Pleasant Street, Suite 3 | Watertown, Massachusetts 02472
617-600-4878 | jcourtemanche@mhqp.org
Connect with MHQP on Facebook and Twitter

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

800 Boylston Street | Suite 1150 | Boston, MA 02199-8001

By Electronic Mail

November 30, 2017

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

Re: Massachusetts Registration of Provider Organizations (MA-RPO) Program Proposed 2018 Updates

Dear Mr. Seltz:

In response to the recently released MA-RPO Program Proposed 2018 Updates, Partners HealthCare System ("Partners") is submitting comments regarding the proposed areas of expansion for the 2018 filing of the Heath Policy Commission's (HPC) Registration of Provider Organizations (RPO) Program:

1. Replacing a data element in the Facilities file to require additional data reporting about facility fees paid to the provider organization.
2. Adding Nurse Practitioners (NPs), Physician Assistants (PAs), and Certified Nurse Midwives (CNMs), including five new data elements, to the Provider Roster.

Current RPO program reporting requirements are already burdensome and require Partners to divert extensive resources across multiple departments to complete the submission for our network. We believe adding the proposed data elements will place excessive burden on our staff, as we do not have the resources in place to collect and report this data. Given the RPO program's guiding principle of "balancing the importance of collecting data elements with the potential burden to Provider Organizations,"[1] Partners hopes the HPC takes into consideration our concerns with the 2018 proposal.

Facilities File

The HPC proposes collecting additional information about payment of facility fees for services delivered in satellite locations by various payers. While our internal system includes a field indicating if a service was rendered at a satellite location, this field is not used for payment purposes. As such, we have reservations about using this information for reporting purposes. We

[1] http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/material-change-notices-cost-and-market-impact-reviews/registration-of-provider-organizations/

do not know whether this internal field is used consistently for all payers or if there are other data accuracy issues. HPC also proposes to expand the scope of RPO-86A to include "Other payers not listed above." This expansion greatly increases the scope of the proposed RPO-86A by requiring review for all payers (including payers in other localities). Given the administrative burden required to collect, validate, and maintain this information, Partners asks for continued use of the current RPO-86.

Provider Roster: Adding NPs, PAs, and CNMs

The HPC also proposes the addition of NPs, PAs, and CNMs to the RPO provider roster. Partners does not currently maintain complete data on all NPs, PAs, and CNMs. We collect provider roster information for physicians, as our payer arrangements require us to report physicians aligned with Partners for purposes of attributing beneficiaries to primary care physicians. Mid-level practitioners are not uniformly part of these arrangements and we have not had to maintain this level of information for our network. In addition, we do not have access to this information for our affiliate practices. Without a complete data set, we will not be able to reliably answer the HPC's proposed questions about whether the NPs, PAs, and CNMs have their own patient panel (RPO-99A), the percent of claims billed independently (RPO-99B), or the details on the supervising physician (RPO-99C-E). Furthermore, partial information on NPs, PAs, and CNMs may not be helpful to the end user, as the data would only cover a subset of our mid-level practitioners. Given the high administrative burden it would take to collect information on mid-level practitioners, we urge the HPC not to expand the provider roster to include NPs, PAs, and CNMs.

Summer Submission Deadline

The HPC requests input on the feasibility of a summer submission deadline. Partners is supportive of aligning the RPO submission with the HPC cost trends submission that is due in August, as portions of the RPO submission are very similar to the HPC cost trends submission. Partners would further urge HPC to align the scope for these two submissions – the RPO submission requires calendar year data (CY2015 data submitted in October 2017) and the HPC cost hearing submission requires fiscal year data (FY2016 data submitted in August 2017). Basing both submissions on the fiscal year and providing ample notice of submission requirements would make it easier to aggregate the large volumes of data requested for these two submissions.

Closing Statement

We urge the HPC to give its utmost consideration to these comments. Partners remains committed to transparency and providing the highest quality care to patients across the Commonwealth. We also acknowledge the HPC's commitment and responsibility to a more transparent, accountable, and innovative health care system.

Thank you in advance for your attention to these matters. I look forward to your responses.

Sincerely,

Xiaoyi Huang, Esq.
Director of Payer Strategy

Cc: Peter Markell
David McGuire