HEALTH POLICY COMMISSION

Registration of Provider Organizations Program: Frequently Asked Questions

Issued 9/18/2014

Corporate and Contracting Affiliations

Q: My organization is an Independent Practice Association (IPA) that has individual Physician Participation Agreements with all of our members. We contract on behalf of the individual physicians and do not contract on behalf of any group or organizations. How should we complete the Contracting Affiliations File in Part 1?
A: A Provider Organization that only contracts on behalf of individual physicians – rather than physician practices – will not list any entities in the Contracting Affiliations File. This File has been designed to collect information at the organizational level, e.g., hospitals, physician practices, VNAs, etc. An IPA is not required to list each physician with whom it has a Physician Participation Agreement in the Contracting Affiliations File. The IPA should enter "None" in the first row in the "Legal Name of Corporate (or Contracting) Affiliate" column.

Q: My organization establishes contracts with Carriers or Third-Party Administrators on behalf of itself but does not establish contracts on behalf of any other group or organization. How do I complete the Contracting Affiliations File?
A: Your organization does not have any contracting affiliates. You do not need to list your own organization as a contracting affiliate in the Contracting Affiliations File. You should enter "None" in the first row in the "Legal Name of Contracting Affiliate" column in the file.

Q: My organization is an independent hospital that establishes its own contracts. The hospital does not have a Corporate Affiliation with any other entity. How do I complete the Corporate Affiliations File?
A: Your organization does not have any corporate affiliates. You do not need to list your own organization as a corporate affiliate in the Corporate Affiliations File. You should enter "None" in the first row in the "Legal Name of Corporate Affiliate" column in the file.

Q: My organization does not own any entities. It contracts on behalf of one hospital and fifteen physician practices with three commercial health plans. Who should I list in the Contracting Affiliations File, the providers or the health plans?
A: The entities on whose behalf you contract are your contracting affiliates. You should list the hospital and the physician practices.

Q: Am I required to list the names of our Provider Organization's executive officers on the corporate organizational chart?

A: No. The corporate organizational chart should **not** reflect the management structure within your organization. Rather, the corporate organizational chart should depict corporate affiliations that your organization has with other entities. Neither position titles nor names of individuals should appear on the chart.

Net Patient Service Revenue and Patient Panel Thresholds

Q: What revenue should my organization consider when determining whether it meets the $25,000,000 Net Patient Service Revenue (NPSR) threshold referenced in 958 CMR 6.04(1)(a)?
A: When determining whether it meets the $25,000,000 NPSR threshold, the Provider Organization must first determine which organizations' NPSR must be included in its calculation. The Provider Organization must include the total NPSR received from Carriers and Third-Party Administrators (TPAs) by each Entity on whose behalf it contracts. This includes both owned and un-owned entities on whose behalf the Provider Organization contracts.

Once the Provider Organization has identified the organizations that it should include in its calculation, it must then determine which contracts must be included in its calculation. The Provider Organization should use the following principles in determining which contracts must be included:

1. Provider Organizations should include all revenue received from Carriers and TPAs. This includes revenue associated with contracts with commercial payers (including TPAs), Medicare Advantage, and Medicaid Managed Care Organization. Medicare fee-for-service and revenue received under the Medicaid Primary Care Clinician (PCC) Plan should be excluded.

2. The relevant contracts do not have to include risk arrangements. Revenue received through fee-for-service arrangements (except Medicare fee-for-service and through Medicaid PCC Plans) should also be included.

3. The NPSR determination is not limited to the revenue received through contracts that the Provider Organization established.

In the example below, a hypothetical Provider Organization contracts on behalf of three entities: two hospitals and a physician group. For each of the three entities, the Provider Organization establishes contracts with two commercial payers (Payer A and Payer B), Medicare (fee-for-service) and the Medicaid PCC Plan. The Provider Organization also negotiates at least one Medicare Advantage (MA) contract on behalf of the three entities. In addition to the contracts negotiated by the Provider Organization, each of the three entities also has contracts with three other commercial payers (Payer C, Payer D, and Payer E).

In calculating its total NPSR, the Provider Organization includes all of the revenue received by the two hospitals and the physician groups, including the revenue associated with the contracts that it did not establish. The only revenue that is excluded is the revenue associated with its Medicare fee-for-service and Medicaid PCC Plan contracts. While the three entities' total NPSR adds up to $120 million, the Provider Organization's total NPSR for the purposes of the RPO Program is only equal to $90 million, because the $30 million received through Medicare fee-for-service contracts and Medicaid PCC Plan contracts is excluded.

Please note that Provider Organization is **not required** to report its NPSR to the Health Policy Commission. This calculation is only intended to determine whether the Provider Organization meets the

$25,000,000 NPSR threshold that, together with the 15,000 Patient Panel threshold, triggers registration. If your organization knows that it meets the threshold or is a Risk-Bearing Provider Organization, it does not have to calculate its NPSR.

Providers	Contracts established by the Provider Organization					*Contracts established by other organizations*			Total
	Payer A	**Payer B**	**MA**	**Medicare FFS**	**Medicaid PCC Plan**	***Payer C***	***Payer D***	***Payer E***	
Hospital A	$10M	$10M	$10M	$10M	$10M	*$10M*	*$10M*	*$10M*	**$60M**
Hospital B	$8M	$5M	$3M	$5M	$2M	*$5M*	*$1M*	*$1M*	**$23M**
Physician Group	$3M	$1M	$1M	$2M	$1M	*$2M*	--	--	**$7M**
Total:	**$21M**	**$16M**	**$14M**	**$17M**	**$13M**	***$17M***	***$11M***	***$11M***	**$90M**

Q: What should my organization consider when determining whether it meets the 15,000 Patient Panel threshold referenced in 958 CMR 6.04(1)(a)?
A: The regulation (958 CMR 6.02) defines Patient Panel as the total number of individual patients seen over the course of the most recent complete 36-month period. This definition varies from a more traditional definition of patient panel, which may be limited to those patients that have a designated primary care provider (PCP) within the organization, or those patients for whom the organization is at risk. Unlike these definitions, the RPO Program definition includes the total number of patients seen by any of the Providers on whose behalf the Provider Organization contracts over a 36-month period.

Additionally, the definition of Patient Panel refers to unique patients, not patient encounters. Therefore, a patient who visits multiple Providers on whose behalf the Provider Organization contracts (e.g., a primary care provider and multiple specialists) is counted the same way as a patient who only visits one Provider on whose behalf the Provider Organization contracts (e.g., a hospital). Both patients will only count as one individual in the Provider Organization's Patient Panel.

The example below shows four patients who have had varying interactions with a hypothetical Provider Organization.

The first patient does not have a PCP affiliated with the Provider Organization, but visited the Provider Organization's hospital in FY 2013.

The second patient has a PCP affiliated with the Provider Organization, whom the patient saw once each year from FY 2012 to FY 2014.

The third patient had multiple encounters with the Provider Organization, seeing both his PCP and a specialist in FYs 2012 and 2013, and his PCP in FY 2014.

The final patient has a PCP affiliated with the Provider Organization, but did not visit the PCP or have any other encounters with the Provider Organization between FY 2012 and 2014.

The right hand column shows that the first three patients each count as 1 total patient towards the 15,000 Patient Panel threshold. These patients all count toward the Provider Organization's total Patient Panel, regardless of the type of insurance they have. The fourth patient does not count toward the threshold because she was not seen by any Provider affiliated with the Provider Organization during the 36-month

period. The Provider Organization in this example has a total Patient Panel of 3 patients, because its Providers saw three unique patients over the course of the 36-month period.

Please note that Provider Organizations are **not required** to report their Patient Panel size to the Health Policy Commission. This calculation is only intended to determine whether the Provider Organization meets the 15,000 patient threshold that, together with the $25 million NPSR threshold, triggers registration. If your organization knows that it meets the threshold or is a Risk-Bearing Provider Organization, it does not have to calculate its Patient Panel size.

Patient Panel Calculation					
Patient	**Has PCP in Provider Org?**	**FY 2012**	**FY 2013**	**FY 2014**	**Total**
Patient 1	No	--	Hospital	--	**1**
Patient 2	Yes	PCP	PCP	PCP	**1**
Patient 3	Yes	PCP, Specialist	PCP, Specialist	PCP	**1**
Patient 4	Yes	--	--	--	**0**
Total:	--	--	--	--	**3**

Q: The definition of the term Patient Panel references the total number of unique patients seen over the course of the most recent complete 36-month period. However, 958 CMR 6.04(a) refers to a Patient Panel of more than 15,000 as of the end of the Provider Organization's prior Fiscal Year. What time period should I use when calculating my patient panel?
A. Provider Organizations should calculate their Patient Panel by adding the total number of unique patients seen by the Providers on whose behalf the Provider Organization contracts over a 36-month period. That 36-month period should end on the last day of the Provider Organization's most recent fiscal year. For example, if a Provider Organization's Fiscal Year runs from July 1 through June 30, it should calculate the total number of unique Patients that it saw between July 1, 2011 and June 30, 2014.

For the first year of the program, Provider Organizations should use the following chart to calculate their Patient Panels. Please note that Provider Organizations are **not required** to report their Patient Panel size to the Health Policy Commission. This calculation is only intended to determine whether the Provider Organization meets the 15,000 patient threshold that, together with the $25 million NPSR threshold, triggers registration. If your organization knows that it meets the threshold or is a Risk-Bearing Provider Organization, it does not have to calculate its Patient Panel size.

Patient Panel Calculation Timelines in Year 1	
Fiscal Year	**Calculation Timeframe**
January 1 – December 31	January 1, 2011 – December 31, 2013
April 1 – March 31	April 1, 2011 - March 31, 2014
July 1 – June 30	July 1, 2011 – June 30, 2014
October 1 – September 30	October 1, 2011 – September 30, 2014

Registration Logistics

Q: When will my organization receive its notice of registration?

A: A Provider Organization will not be considered officially registered until it has completed both Part 1 and Part 2 of Initial Registration. Provider Organizations will receive confirmation via e-mail that they have completed *Initial Registration: Part 1*, but will not receive their official notice of registration until they have completed *Initial Registration: Part 2*. Provider Organizations that are in the process of completing Initial Registration in accordance with the Data Submission Manual will be considered in compliance with the regulation.

Q: Will the HPC provide forms and templates to complete *Initial Registration: Part 1*?
A: Provider Organizations should use the forms and templates referenced in the Data Submission Manual. All required forms and templates are available on the Commission's website. In *Initial Registration: Part 1*, the corporate organizational chart is the only document that does not have a prescribed template. Provider Organizations may create their organizational chart using the software that they feel is most appropriate, but the chart must be saved and submitted as a .PDF file.

Q: How should I submit my *Initial Registration: Part 1* materials to the Commission?
A: All materials must be submitted electronically as e-mail attachments to HPC-RPO@state.ma.us. Full instructions on how to submit materials are included in the Data Submission Manual, available on the Commission's website. Hard copy submissions will not be accepted.

Q: My organization is planning to make changes to its organizational structure that will affect the materials we submit in Part 1. How do I alert the Commission about this change?
A: All Part 1 materials must be accurate as of the day the Provider Organization submits them to the Commission. If the change will go into effect between October 1 and November 14, the organization can plan to submit its Part 1 materials after the effective date of the change, but before the November 14 deadline.

If the change will go into effect after November 14 but before the close of *Initial Registration: Part 2*, the Provider Organization should submit Part 1 materials that reflect its structure before the change, but update the relevant documents when it submits its Part 2 materials. The Provider Organization will not have to inform the RPO Program about the change in the interim between Part 1 and Part 2.

If the change will go into effect after the close of *Initial Registration: Part 2*, the Provider Organization may be required to submit updated information to the Commission. This off-cycle update is only required if the change in question:

1. Required the filing of a Material Change Notice with the Health Policy Commission;
2. Required a Determination of Need by the Department of Public Health; or
3. Required an essential health services filing with the Department of Public Health.

Please note that this response refers only to a Provider Organization's responsibility to submit documents to the RPO Program. Provider Organizations must submit all appropriate notices and documents to the Health Policy Commission and the Department of Public Health under the relevant statutory and regulatory requirements.

Miscellaneous

Q: My organization meets Registration Threshold 1 (NPSR over $25,000,000 / Patient Panel over 15,000) and is a member of a local Physician-Hospital Organization (PHO). The PHO does some contracting on behalf of my organization. My organization is not owned or controlled by another entity. Is my organization required to register independently from the PHO?
A: Your organization is a contracting affiliate of the PHO. **If** your organization also establishes some of its contracts directly with Carriers or Third-Party Administrators, your organization is also a Provider Organization, and would have to register independently from the PHO. However, because your organization is also a contracting affiliate of the PHO, it will be able to file an abbreviated application in *Initial Registration: Part 2*. If your organization does not establish any contracts with Carriers or Third-Party Administrators independently, then you will be reported as a contracting affiliate by the PHO, and you are not required to file a separate registration.

Q: Our organization is a contracting organization that does not receive revenue for the provision of healthcare services. We receive funds from the health plans with which we contract and we distribute the funds to our members. What financial data should we report to HPC?
A: The Health Policy Commission is not collecting information about Provider Organizations' revenue in the first year of the Program.

Q: The Health Policy Commission has stated that for Provider Organizations that meet Registration Threshold 1 (NPSR over $25,000,000 / Patient Panel over 15,000), registration in the first year of the program is only required for Provider Organizations that negotiate on behalf of at least one hospital, physician group, or behavioral health provider. What types of providers are included in the term "physician group?"
A: The term physician group includes primary care physicians, specialists, ambulatory surgery centers, clinics, urgent care centers, and any network, alliance, or other structure that serves to unite said physicians into a group. The term does not include individuals that **only** provide ancillary services (e.g., outpatient dialysis clinics, clinical labs, diagnostic radiology) or non-physician-based providers (e.g., limited service clinics staffed by nurse practitioners).

Please note that the limiting of Year 1 registration to hospitals, physician groups and behavioral health providers **only** limits which entities are required to register. If a Provider Organization is required to register, it is required to report on all of its corporate and contracting affiliates, not just the hospitals, physician groups and behavioral health providers. For example, a chain of independent nursing homes that negotiates its own contracts and meets Registration Threshold 1 (NPSR over $25,000,000 / Patient Panel over 15,000) would be exempted from registering in Year 1 because it does not negotiate on behalf of a hospital, physician group, or behavioral health provider. If, however, a Provider Organization owns and negotiates contracts on behalf of a hospital **and** a nursing home, it must list both entities in the Corporate Affiliations File.