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.