Atrius Health

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BY ELECTRONIC MAIL

December 21, 2019

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

Re: - Massachusetts Registration of Provider Organizations Program - Proposed 2019 Updates

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 2019 filing for Massachusetts Registration of Provider Organizations (MA-RPO) released on November 26, 2018.

Atrius Health is a practice located in Eastern Massachusetts: an innovative nonprofit healthcare leader; providing effective connected care to more than 720,000 adult and pediatric patients; 32 clinical locations, more than 50 specialties and 825 physicians; working together with home health and hospice services using its VNA Care subsidiary, and in close collaboration with hospital partners, community specialists and skilled nursing facilities. Our vision is to transform care to improve lives. Atrius Health provides high-quality, patient-centered, coordinated, cost effective care to every patient we serve. By establishing a solid foundation of knowledge, understanding and trust with each of its patients, Atrius Health enriches their health and enhances their lives. Learn more about Atrius Health at www.atriushealth.org.

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 feedback:

Facilities File (RPO-86A)

Given the emphasis in the state on reducing health care costs, we support greater transparency regarding facility fee payments. 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.

Roster of Employed Advanced Practice Providers (APPs)

As we have expressed to the HPC in the past, completing the Physician Roster is among the most time consuming of all of the RPO requirements; we anticipate that completing the APP roster will be at least as

challenging unless HPC makes available the templates for completion on or about January 1, the date for which we are required to report provider employment status. To date, because the template for reporting has not been available on January 1 which is the date in time providers are asked to provide a point in time for the roster of employed physicians, we are forced to engage in an onerous "clean up" process to remove from the report those individuals who left the practice between January 1 and the date we generate the roster report. Therefore we strongly recommend the HPC have both the final physician and APP roster Excel templates available no later than Jan. 1 of 2019 for RPO applicants so data can be pulled on that date to reduce the administrative burden and minimize reporting errors.

Charges by Payer Category (RPO-217)

The HPC should provide additional clarification and definitions for providers completing this section to ensure consistency in responses (for example "other government payers" "Medicare Managed" versus "Medicare Non-Managed".

Total Number of Visits (RPO-218)

The proposal for all claims on the same day at the same physician practice for the same patient to be counted as a single visit is of significant concern to Atrius Health. . Our systems track visits by patients to individual departments, so that if a patient visits multiple departments in a single day, each visit to a department is counted separately. A significant amount of systems and administrative work would be required to identify and aggregate multiple visits in a single day for an individual patient. In addition, Atrius Health typically would not report as a visit, lab tests (e.g. patient coming into the office for a cholesterol screen) or radiology tests as visits nor would routine visit reporting include procedures performed by Atrius' physicians in non-Atrius settings. It would be helpful if the HPC clearly defined the characteristics of "visits" to be counted particularly as the migration to telehealth continues. We strongly believe the HPC should remove this particular reporting requirement.

We appreciate HPC's requesting our feedback on these changes to the RPO program, and we support the HPC in its important work in reducing health care costs and providing data and analysis to state policymakers to facilitate informed decision-making; however, virtually every request for more or different data from providers requires us to commit and/or divert already limited resources that might otherwise be used to provide or improve the care we are committed to delivering to our patients. We respectfully request that the HPC take the incremental and cumulative administrative burden of these requests into account as it considers additional reporting requirements.

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.

Facilities File updates:
Removing RPO-86 and replacing with RPO 86A. We recommend that the HPC keep the current RPO-86. It is unclear what the HPC is trying to achieve in RPO-86A. Hospitals generally charge for both E&M and non E&M services; it seems an unlikely scenario where a hospital wouldn't bill for its services. Additionally, the hospitals charge the same regardless of payer. There is not variation between what is charged for the same service to BCBS, HPHC, Medicare, etc. However some payors may not pay facility fees. That information is generally 1) Publicly available in the payor's payment policies on their websites; the HPC could access that information rather than require providers to report on it; or 2) Hospital reimbursement is contractually negotiated between payer and provider and, as such, constitutes proprietary information. Finally, the question is not applicable to some sites; not every site in the facilities file generates an E&M service, by example rehabilitation sites.

Roster of Advanced Practice Providers

Provider Organization should only be required to submit the roster for those corporate affiliates that are direct providers of patient care. Additionally, the PO can only report APPs for corporate affiliates that are 100% owned/controlled by the RPO. Corporate affiliates that are partially owned or controlled by unaffiliated entities have their own human resources staff, policies, practices, etc. that are not within the purview of the RPO.

Some of the proposed data elements are NOT available internally for Advanced Practitioners: Baystate Health does not maintain the specialty of its employed APPs; a generic taxonomy is used. We would not be able to accurately respond to the pediatric or specialty field on the roster.

All other data elements can be reported for Baystate employed APPs. While the request is otherwise feasible, it is very burdensome as the data is complicated to obtain and compile; a generous timeline would be required.

Similar to the physician roster, the roster is outdated when it is submitted, so it is unclear how this information can be truly informative.

General Comments

We continue to advocate for collection of information that will help inform health policy and decision-making and respectfully request that the HPC evaluate how these new reporting requirements fulfill the goals and key strategies of Chapter 224 vs. simply fulfill the collection of interesting information. The RPO program is already time consuming, and these unfunded and burdensome provider mandates increase expenses and divert resources from health care delivery to administration cost.

Thanks.

Andréa Carey
Director, Managed Care
Baycare Health Partners & Baystate Health, Inc.

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Berkshire
Health Systems, Inc.

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December 21, 2018

Registration of Provider Organizations Program
Massachusetts Health Policy Commission
HPC-RPO@mass.gov

Re: Proposed 2019 RPO Requirements
Berkshire Health Systems, Inc.

To the Registry of Provider Organizations:

Berkshire Health Systems, Inc. has reviewed the proposed requirement changes to the 2019 Registry of Provider Organizations Submission. Based on what has been proposed, BHS has the following concerns:

- BHS is concerned with the data requested in RPO-86A: Facility Fees for the reasons stated below:
    - The purpose and value of the request is unclear. Whether hospitals charge a facility fee for E/M and non-E/M codes would not provide insight into the impact on patients as insurance plans have very divergent reimbursement rules for these services. Many do not pay a facility fee at all and some pay a global fee for professional services rather than a split payment. Medicare rules require that hospitals charge consistently for all services across all payors, so gathering this data is very misleading if trying to assess the impact on patients.
    - Payments received from payors outside of MassHealth and Medicare for facility fee billings are part of contract negotiations and subject to confidentiality clauses. Providing any information about contracted rates violates these agreements and provides access to information about competitor plan arrangements.
    - RPO-86A encompasses a tremendous span of codes. Hospitals are required to publish their charge masters as of 1/1/19. As such, this information would be accessible to the HPC through web sites. It is disturbing that there is little appreciation for the time and effort that is required to comply with increasing data requests from providers. Much of the data requested is already provided to State agencies through other data requests. This increases the administrative burden on hospitals and detracts from our ability to focus on our business.
- BHS is concerned with the additional Provider Roster request for the Advanced Practice Providers. Currently, the data requested does not exist in one report or system, therefore, making the completion of the physician roster the most time consuming of all the data elements in the current RPO Data Submission Manual. Having to gather the same level of data on the APPs would only increase the administrative burden of the Provider Roster data elements. APP's are not credentialed or boarded in a specialty as physicians are and therefore can work with many diverse specialties. We would only be able to report an APP by specialty given their current work location. These providers are free to move to other specialty practices based on their desired work interest. Many APPs are not engaged in direct patient care and it is unclear how those individuals would be reported.

- BHS is concerned with the data requested in the proposed in RPO-217, Payor Mix file for physician's practices. There does not seem to be a clear definition as to which plan types or payors would fall into the proposed charge categories. Physician practices do not track payor groupings with the same granularity as hospitals as reimbursement methodologies for physicians are more standard among plan types. Without such guidance, it is difficult to say how obtainable to data actually is and could place further administrative burden on provider organization resources.
- BHS is concerned with the way the HPC has defined a "visit" for the purposes of RPO-218. We currently do not aggregate visit data in the manner proposed by the HPC. It would be extremely difficult to provide the information in this way.

Thank you for taking the time to review and assess the concerns of Berkshire Health System with regard to the HPC's proposed request changes to the 2019 Registry of Provider Organization submission. If the HPC has any further questions, please contact Deborah Delaney by either telephone (413)447-2721 or email ddelaney@bhs1.org.

Sincerely,

Darlene Rodowicz
Chief Financial Officer
Berkshire Health Systems, Inc.

Beth Israel Deaconess
CARE ORGANIZATION

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

December 21, 2018

By email to HPC-RPO@mass.gov

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 2019 Updates

Dear Mr. Seltz and Mr. Campbell:

Beth Israel Deaconess Care Organization ("BIDCO") appreciates the Health Policy Commission's ("HPC") invitation to provide comments on the proposed 2019 changes (the "Update") to the requirements of the Massachusetts Registration of Provider Organizations Program ("RPO Program"), released for public comment on November 26, 2018. BIDCO believes that the Update reflects the HPC's continued thoughtful and collaborative approach to balancing the needs and concerns of providers with the important goals of transparency embodied by the RPO Program.

BIDCO does wish to provide feedback, however, as to some of the difficulties and potential unintended consequences of the Update's proposal to "requir [e] information about [Advanced Practice Providers] employed by a Provider Organization's contracting affiliates in future years" on physician- and hospital-based accountable care organizations like BIDCO.

BIDCO has eighteen associations that are classified as "contracting affiliations" by the Data Submission Manual ("DSM"), including acute hospitals, such as Beth Israel Deaconess Medical Center ("BIDMC") and Anna Jaques Hospital, as well as physician organizations, such as Harvard Medical Faculty Physicians and Cambridge Health Alliance Physicians Organization. Many of BIDCO's contracting affiliates employ Advanced Practice Providers ("APPs") whose information BIDCO would be obligated to report in future years under the proposal. This would lead to several administrative difficulties:

1. BIDCO does not contract directly with APPs, and so does not currently have a standardized means to collect roster information on APPs of contracting affiliates. In order to collect APP roster information from contracting affiliates, BIDCO would need to develop a uniform reporting, tracking, and data maintenance system to be used by all

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contracting affiliates that does not currently exist. Creating and maintaining such a system would require a significant investment of employee time and resources for BIDCO, as well as a significant burden on contracting affiliates to amass, transmit, and timely update such information to BIDCO.

2. BIDCO is concerned that it will be difficult for a provider organization that does not directly contract with APPs to report timely, accurate data when relying on contracting affiliates to provide such data. In BIDCO's experience, APPs have a high rate of mobility between contracting affiliates, which would require contracting affiliates to update roster information frequently. The Update's proposal to include part-time APPs within the reporting obligation could exacerbate this issue by including additional, potentially highly-mobile APPs that contracting affiliates would need to track and report accurately to BIDCO.

3. Reporting of APP roster information for contracting affiliates could lead to duplicative reporting in a sizeable number of cases unless the DSM were modified in future updates to exclude such reporting. For example, BIDMC is a contracting affiliate of BIDCO. BIDMC is thus responsible to report APPs employed by BIDMC and would, under the Update, also report APP roster information for corporate affiliates such as Beth Israel Deaconess Hospital – Milton, Plymouth, and Needham. Each of these is also a contracting affiliate of BIDCO.

   BIDCO therefore suggests that, if the HPC decides to require APP roster information reporting in relation to contracting affiliates, provider organizations should be exempted from any requirement to report such data with respect to a contracting affiliate for which reporting is already required as a corporate affiliate of any provider organization.

We hope that the HPC will take account of the administrative difficulties of APP roster information reporting of contracting affiliates as it continues to refine its plans for future years. Additionally, we look forward to additional clarity on how such future requirements impact each Registered Provider Organization so that there is sufficient advanced notice to staff and implement the HPC's reporting requirements. BIDCO thanks you for the opportunity to provide comments, and we would be happy to discuss these issues further with the HPC.

Sincerely,

Cecilia Ugarte Baldwin,
Director of Public Payer Programs & Policy

CHA Cambridge Health Alliance

HARVARD MEDICAL SCHOOL TEACHING HOSPITAL

December 21, 2018

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

Re: Proposed Changes to 2019 Massachusetts Registration of Provider Organization Filing

Dear Mr. Seltz:

Thank you for reaching out to various stakeholders regarding the proposed changes to the 2019 Massachusetts Registration of Provider Organization (RPO) filing. Cambridge Health Alliance was pleased to attend meetings in person at which we discussed these changes with your team before they were released for public comment. We would like to take this opportunity to reiterate these considerations for consideration before finalizing the proposed updates.

In general, we believe that many providers view it as significant incremental administrative work to compile and submit the proposed changes related to facility fees, service availability, expanding the provider roster requirements for advanced practice providers (APPs), and physician payer mix and visits. With the dual goals of administrative simplification and balanced data collection to inform policymakers and stakeholders, we suggest that the HPC weigh the potential benefit of additional information and the administrative burden that the new requirements represent. Information shared at the technical advisory group discussion largely described the proposed expanded reporting as of value to researchers with questions remaining about the value to other stakeholders.

As detailed in our letter, we request that HPC consider reducing the number of new elements any given year and include as much information as possible in the portal to verify as part of each annual submission.

Lastly, in making the decision about new elements and the timeline for implementing them, would it be helpful to work together to put together a grid of all of the required elements of the various provider and ACO submissions and discuss any possible synergies, duplication, or missing elements that could be of benefit to both regulators and providers alike?

More specifically, we woud like to highlight the following specific feedback.

Proposed Update to the Facilities File on Facility Fee Information

The proposed change would require reporting of information on which payers, public and private, pay "facility fees." Facility fees are contractually negotiated and reflect 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.

Various payers may reflect payment for the technical component of outpatient care via different payment and billing methods, which may include separately payable technical facility fees or global reimbursement for the physician office visit. For this reason, we are concerned that this proposed reporting mechanism may not capture comparable information across payers and providers, due to the way that payment contracts vary across providers and may be unique to a contract.

It would be of concern for some providers to face a requirement for reporting a separately payable facility fee, while other providers who also receive reimbursement recognizing the facility or technical component but receive such payment as part of a global reimbursement would not be captured in the same way through the proposed new reporting requirement. Isolating facility fees specifically may prove difficult for contracts under which a provider is paid global fees/payments, as these fees/payments may contain elements covering professional and technical fees, including revenue for operational and enhanced capacities found at satellite clinics or outpatient care sites. In addition, as contractually negotiated provisions, the public reporting of these agreements by payer is subject to proprietary information.

As state policy discussions are expected to continue next year with respect to last session's health care bill, it is possible that policy on facility fees will be incorporated in the upcoming legislative session. Therefore, it is recommended that the proposed reporting update on facility fees not move forward at this time.

Provider Roster

The provider roster reporting requirements are among the most time-intensive and administratively burdensome of the RPO filing.

Extending this requirement to include employed Advanced Practice Providers (APP) including certified nurse practitioners, physician assistants, certified nurse midwives, certified registered nurse anesthetists, clinical nurse specialists and psychiatric clinical nurse specialists will involve considerable additional resources. At the same time, we do not have a full understanding of the use for this new information, which may be of limited value to the public or policy makers. We ask that this proposed change not be incorporated into the 2019 requirements.

Physician Payer Mix and Visits

We recommend that the implementation of the proposed physician payer mix and visit requirements be delayed until at least 2020 in order to develop the necessary standard definitions and preparation of the data. Our organization has a planned major upgrade to our electronic medical record system during the 2019 timeline, which will be impacted by this proposal.

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In closing, thank you for the opportunity to provide comments. We are confident that there is much to learn from the existing data we collectively provide and are open to exploring areas of future data collection which could be of benefit to the system as a whole. Cambridge Health Alliance looks forward to continuing to work together on the RPO program.

Sincerely,

Jill Batty
Senior Vice President and Chief Financial Officer
Cambridge Health Alliance

Lisa m. Trumble
Lisa m. Trumble (Dec 21, 2018)

Lisa Trumble
Senior Vice President Accountable Care Performance
Cambridge Health Alliance

MEMORANDUM

To: David Seltz, Executive Director, Health Policy Commission

CC: Michael Lee, Interim Executive Director, Children's Hospital Integrated Care Organization, Boston Children's Hospital
Joshua Greenberg, Vice President, Government Relations, Boston Children's Hospital

From: Daniel Viens, Senior Project Manager, Children's Hospital Integrated Care Organization, Boston Children's Hospital

RE: Massachusetts Registration of Provider Organizations ("MA-RPO") Program Proposed 2019 Updates, Release for Public Comment

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General Feedback

Thank you for the opportunity to comment on the proposed additions to the 2019 MA-RPO. While we appreciate the efforts of the Health Policy Commission (HPC) on provider reporting and cost containment in the Commonwealth, we have concerns about the proposed filing largely related to administrative burden and ensuring that data collected is done so in line with intended use.

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?

We have concerns regarding the proposed data request related to facility fees. First, we expect that issues around facility fees will continue to be a major focus of health reform efforts in the next legislative session as well as at the federal level. As such, we would prefer to delay any facility fee reporting requirements while the issue is being addressed in the legislature.

Additionally, 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. One way to address this, should the HPC maintain this requirement, is to broaden the reporting categories and combine the commercial payers, resulting categories such as "all commercial payers", MassHealth, and Medicare.

Lastly, we do appreciate that the HPC plans to populate the facilities file section with information from the Department of Public Health (DPH) and we wonder whether some of the other data requests could be fulfilled by other sources. For example, MassHealth and the commercial insurers could provide the HPC with information on facility fees. This would help to minimize the burden on RPOs.

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

In general, the new requirements require clarification or better definition. Without clear definition around what the HPC is seeking, the data that is submitted will likely be inconsistent

across provider organizations as a result of their individual interpretations of what is required. For example, regarding the addition of RPO-86A, the HPC should provide specific revenue or procedure codes for the non E&M codes. Without this, the resulting data will be inconsistent and subject to misinterpretation. Additionally, how does the HPC interpret global payments, in which the technical and professional components are rolled into one payment to the provider?

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. Are there any scenarios where a response of "not applicable" would be appropriate in response to the proposed RPO-86A: Facility Fees question?

While a response of "not applicable" is unlikely they variance between categories (i.e. BCBS vs Medicare vs MassHealth) for this new data element is unnecessary. Hospitals and clinics must charge the same to all payers; what they are actually paid by the insurer is a result of the payer policy as well as what the provider and carrier ultimately negotiate. As such, it is not clear how obtaining this information will assist the HPC since what is charged varies greatly from what is reimbursed.

Every payor has its own policy regarding how facility fees are handled, with many plans no longer paying facility fees at all for E &M codes. Perhaps the most efficient option for collecting this information if for the HPC to find out directly from the commercial health plans whether and under what circumstances they pay facility fees.

4. Are there any areas in which your organization would need additional information or guidance in order to respond? The MA-RPO Program would appreciate specific examples so that it can issue standard guidance. For instance, if any of your organization's APPs are engaging in work that may straddle the line between clinical and non-clinical, please provide job titles or brief position descriptions, so that the MA-RPO Program may provide guidance on whether this would be considered a reportable APP.

None at this time.

5. What assumptions or definitions would your organization use to produce a total visit count for its owned physician practices?

We would calculate a total visit count by leveraging existing data within our enterprise data warehouse. Specifically we would establish this count by tallying contact serial numbers (CSN) by unique admission dates across our owned physician practices. Contact serial numbers are a unique identifier used to capture each time a patient was seen by a one of our clinicians. Similar to our comments on other proposed data elements 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.

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December 21, 2018

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

Re: Proposed Updates - 2019 filing for Massachusetts Registration of Provider Organizations

Dear Mr. Seltz:

On behalf of the Conference of Boston Teaching Hospitals (COBTH and its member hospitals, I offer comments on the proposed updates to the 2019 filing for Massachusetts Registration of Provider Organizations (RPO) published on November 26, 2018. We appreciate the willingness of the HPC staff to take into consideration the viewpoints of providers who are subject to RPO reporting 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 such, our member hospitals are concerned that public reporting of this confidential and privileged information concerning contractual relationships with payers may impact future negotiations between our members and the payers with which they contract.

Of additional concern to COBTH member hospitals is a lack of standardization in billing procedures and payment contracts varying from contract to contract. Isolating facility fees specifically may prove difficult or impossible for contracts under which a provider is paid global fees/payments, as these fees/payments may contain payments of professional and technical fees, including fees charged to cover operational expenses and enhanced capacities found at satellite clinics or outpatient care sites.

As you are aware, facilities fees were the subject of legislation considered by the Senate and the House in 2018, and will likely be a major focus of health reform efforts in the next legislative session beginning in 2019. 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, certified nurse midwives, certified registered nurse anesthetists, clinical nurse specialists and psychiatric clinical nurse specialists, 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.

Particularly for larger health systems, including academic medical centers and large teaching hospitals, accurately populating the RPO Provider Roster has proven onerous, duplicative, and costly owing to the sheer number of advanced practice providers (APPs) spread over numerous facilities and corporate affiliates. Additionally, while providers do typically collect the employee data required to populate the roster, this data is collected across multiple systems and often requires manual aggregation, entailing expansive staff time and administrative cost to comply with the proposed RPO reporting requirements in the prescribed format. Coupled with the time required for this data aggregation, APP rosters are already out of date by the time they are reported, which further limits their value.

Payer Mix File

For many physician practices, the new Payer mix file reporting requirements may prove difficult to meet. Though payer mix data from hospitals has previously been collected by CHIA, physician practices have not previously had to report this data to any state agencies. As a result, many physician practices registration processes and IT systems in place are not currently capturing this data in the form required by the proposed RPO regulations.

To alleviate this issue, we recommend that the payer categories be more strictly defined by the HPC and CHIA to ensure accurate and uniform reporting. Additionally, we recommend that the implementation of these requirements be delayed until at least 2020 to allow physician practices to strengthen their data collection infrastructure and realign their registration processes.

RPO Scope & Timing

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." Our member organizations have expressed concerns regarding the ever-expanding scope of RPO reporting requirements. COBTH member hospitals are committed to improving the healthcare environment of the Commonwealth, and recognize the need for regulators and legislators to be informed by accurate data in order to do so. However, we would also caution that each expansion of reporting requirements expands the administrative burden shouldered by providers, increasing the monetary and time cost of compliance. New additions of licensed provider groups to the APP Roster in particular will require a great deal of time and effort to collect and report new data. Many providers have expressed concerns with meeting the July RPO reporting deadline under the proposed 2019 updates due to the increased reporting requirements. **We recommend that the proposed 2019 updates be delayed by at least one year to allow providers to make internal adjustments to prepare to meet new reporting standards.**

As you are aware, organizations just recently completed their 2018 RPO filing, the third 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
Conference of Boston Teaching Hospitals

To Whom it May Concern:
Attn: Susan M. Flanagan-Cahill, Deputy General Counsel

We hereby submit the following comments on behalf of Greater Lawrence Family Health Center (GLFHC):

Data Element RPO-33, Provider Organization's Corporate Parent, requires entities to register at the uppermost level of their corporate structure, provided, that the primary business purpose of this uppermost corporate Entity is health care delivery or management. This Data Element is inconsistent with RPO regulation, 958 CMR 6.04(2) which provides " [a] Provider Organization that meets the criteria for Registration set forth in 958 CMR 6.04(1) and which is partially or completely owned or controlled by **another Provider Organization also subject to 958 CMR 6.04(1)** shall meet its obligation to register with the Commission through the Registration of the Provider Organization that owns or controls it." (**Emphasis added)**. The regulation is clear as highlighted above that the uppermost entity also must meet the registration requirements in 958 CMR 6.04(1). To require an uppermost tier entity that does not meet the registration requirements in 958 CMR 6.04(1) to register is inconsistent with this regulatory requirement. GLFHC respectfully requests that the HPC amend the DSM to require reporting in accordance with 958 CMR 6.04(2)

Thank you
Jennifer Gallop

Mount Auburn
Cambridge
Independent Practice
Association, Inc.

MOUNT AUBURN HOSPITAL

December 21, 2018

Liz Reidy
Program Manager
Health Policy Commission
Two Boylston Street, 6th Floor
Boston, MA 02116

RE: Registered Provider Organization Proposed 2019 Updates

Dear Ms. Reidy,

On behalf of Mount Auburn Hospital and Mount Auburn Cambridge Independent Practice Association, Inc. (MACIPA), we appreciate the opportunity to comment on the proposed 2019 updates to the Registration of Provider Organizations (MA-RPO) Program. As we have comments, we will address the areas that the HPC seeks comments under each of the RPO line items:

RPO-86A
The proposed 2019 Facilities file asks RPOs to "Select each payer, and procedure type(s), that this facility charges facility fees to.
Comments: Hospitals are required to charge all payers the same amount based on its chargemaster. We believe that what the HPC may be trying to ascertain is whether a hospital accepts payment from certain payers for certain facility fees billed. We would recommend that the HPC eliminate this proposed update. First, we believe that responders may interpret this differently, resulting in non-credible information. Second, if hospitals have negotiated to receive facility fees or not from certain payers, we believe this to be proprietary information. The answers for Medicaid and Medicare should be the same for all hospitals. Third, you've divided the requested responses by E&M and Any Non-E&M. Most hospitals would likely receive some payments from all payers for non E&M codes. We're not sure answers to this question gain you any useful information. Further, if can't be persuaded to remove this update, it would be helpful if there was a list of revenue codes/procedure codes mapped to each of the columns.
Lastly, we believe that the answers to this question would be available through the APCDW.

Requiring a roster of employed Advance Practice Providers (APPs)
This would be a very time-consuming and burdensome requirement to fulfill putting a strain on other priorities. Unlike physicians who may be captured in a contracting or medical staff data base, APPs, many of whom do not bill for services could be captured in multiple data bases. The APP file is extremely complex for any organization. The HPC is looking only for those who have a clinical role, so an organization could not just create this roster based on license type. Some APPs may be serving in a clinical role not connected to their license. What does it mean if the APP has a non-traditional relationship with the Provider Organization? We recommend that this proposed update be eliminated.

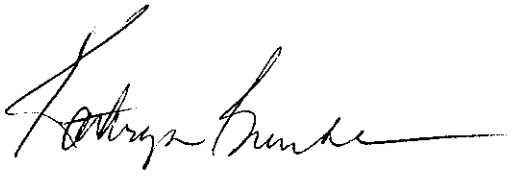
For MACIPA we have only started accepting CNMs as members to MACIPA. If you approve the request for APPs, we would request clarification that RPOs are only required to report APPs who are either members or employees of the RPO.

Collecting physician payer mix information from physician practices.
We would recommend that you define the physician practice as the corporate affiliate by tax ID number to make it clear as to what level this needs to be reported. It should be stipulated that this requirement is only for employed physicians. Further, a RPO's provider mix will skew the payer categories potentially drawing the wrong conclusions. A RPO with a high proportion of Pediatricians and OB/GYNs will naturally have less Medicare volume than one with Geriatricians and Cardiologists.
You may also consider asking for percentage of total charges by payer category versus actual charges.

Total number of visits
We would recommend that you define total visits as the number of office-based E&M codes (specify range of codes) billed by the corporate affiliate that is a physician practice over a given period of time (either a CY or FY). We do not believe capturing other E&Ms, like Emergency Department or Inpatient will be of value or going beyond E&Ms like minor procedures or diagnostic testing. Otherwise, we would be concerned that you would not know how to compare visit counts across entities. Further, a RPO's provider mix will skew the payer categories potentially drawing the wrong conclusions. A RPO with a high proportion of Pediatricians and OB/GYNs will naturally have less Medicare volume than one with Geriatricians and Cardiologists.

You asked: "Does your organization have any concerns regarding data consistency/accuracy as an end-user of this information?" As most of our comments are around the complexity of the data you are requesting and how different RPOs may not report this consistently, we are very concerned how end users may interpret this information.

Respectfully submitted,



Kathryn Burke
Vice President, Contracting and Business Development
Mount Auburn Hospital

Barbara Spivak, MD
President
Mount Auburn Cambridge Independent Practice Association, Inc.

December 21, 2018

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

re: **Massachusetts Registration of Provider Organizations (MA-RPO) Program Proposed 2019 Updates**

Dear Director, Seltz:

On behalf of the Massachusetts Association of Health Plans (MAHP), which represents 16 health plans that provide health care coverage to 2.6 million Massachusetts residents, I am writing to offer comments on the proposed updates to the Massachusetts Registration of Provider Organizations (MA-RPO).

Updating an existing question to include information about facility fees paid by different payers

We strongly support updating an existing question seeking to include information on facility fees from additional payers including commercial plans. Facility fees have become much more prevalent as physician practices are increasingly being bought up by big hospital systems. As noted by regulators including the Attorney General, patients are being charged facility fees of up to hundreds of dollars out-of-pocket without warning and without the ability to contest them. Facility fees bring in a considerable flow of cash and have the secondary benefit of incentivizing hospitals to buy independent practices, which then increases the hospitals' market power and allows greater leverage when negotiating reimbursements. Greater disclosure of facility fees from the system will result in cost savings for consumers.

Collecting physician payer mix information

In addition to a new Payer Mix file that the Provider Organization will complete for each corporate affiliate that is a physician practice, we urge the HPC to consider requiring

provider organizations to detail how much risk they are taking across their organizations (as a percentage of total revenue), and by product, inclusive of Medicare Advantage.

Requiring a roster of employed Advanced Practice Providers

As providers enter into alternative payment contracts, requiring disclosure of employed advanced practice providers will increase access to members enrolled in such plans. We believe that as participation in alternative payment models such as ACOs increases, the need for finding providers willing to manage the total cost of care and health outcomes through population health strategies will require identifying providers beyond physicians.

Once again, we appreciate the opportunity to share our comments with you on the proposed update to the MA-RPO. Please let me know if you have any other questions or comments.

Sincerely,

Norman Han
Massachusetts Association of Health Plans (MAHP)
Director of Health Care Policy and Research
40 Court Street
Boston, MA 02128

MASSACHUSETTS Health & Hospital ASSOCIATION

December 21, 2018

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 2019 updates to the Registration of Provider Organizations (MA-RPO) Program. As we noted in last year's comments, while we appreciate that the HPC and the Center for Health Information Analysis (CHIA) have worked together to create a single filing requirement, the fact is that the incorporation of CHIA's *annual* requirements combined with the proposed 2019 additional required elements results in a very time consuming and increasingly administratively burdensome project for our members at a time when they must meet numerous additional demands.

General Comments

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". MHA certainly supports these principles. In line with that, we strongly urge the HPC to focus on the feasibility, administrative burden, and ultimate usefulness of the data collection requirements. It would be helpful to MHA and our members to better understand the underlying purpose and potential benefits to the public of the new information as well as why it is necessary to inform decision making.

We do appreciate that the HPC plans to populate the facilities file section with information from the Department of Public Health (DPH) and we encourage the HPC to consider which other data requests could be fulfilled by other sources. For example, MassHealth and the commercial insurers should be able to provide the HPC with information on facility fees. This would help to minimize the burden on RPOs.

In its list of questions, the HPC asks whether RPOs have any concerns regarding data consistency/accuracy. Our members note that the new requirements require clarification or better definition. Without clear definitions around what the HPC is seeking, the data that is submitted will vary greatly and be difficult to compare as provider organizations form their own interpretations of what is required. MHA's recommendations will be further delineated in our specific comments on each section.

Facility Fees

The HPC appears to be seeking information on which facilities charge facility fees to various payers for both E&M as well as any non E&M codes. MHA offers the following feedback regarding this new requirement:

- Hospitals and clinics must charge the same to all payers; what they are actually paid by the insurer is a result of the payer policy as well as what the provider and carrier ultimately negotiate. It is not clear how obtaining this information will assist the HPC since what is charged and what is actually paid are two completely different things.
- All of our members who would be subject to this reporting requirement requested that if it does stand, the HPC must provide specific revenue or procedure codes for the non E&M codes. Otherwise the resulting data will be inconsistent and subject to misinterpretation. Is the HPC considering technical component for an MRI or xray performed in a clinic setting as a facility fee? How is the HPC defining non E&M codes?
- How does the HPC interpret global payments, in which the technical and professional components are rolled into one payment to the provider?
- In the interest of administrative simplification, MHA encourages the HPC to get any facility payment policy information directly from MassHealth. Likewise, the Medicare payment policies can be researched directly through CMS.
- Every payer has its own policy regarding how facility fees are handled, with many plans no longer paying facility fees at all for E &M codes. MHA encourages the HPC to find out directly from the commercial health plans whether and under what circumstances they pay facility fees.
- As noted in MHA's 2017 comments, 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. One way to address this, should the HPC maintain this requirement, is to not name the commercial payers but to keep the categories as "all commercial payers", MassHealth, and Medicare.
- We expect that issues around facility fees will continue to be a major focus of health reform efforts in the next legislative session as well as at the federal level. As such, MHA encourages the HPC to delay any facility fee reporting requirements while the issue is being addressed in the legislature.

Advanced Practiced Provider (APP) Roster

MHA members report that collecting and reporting information for the physician provider roster already represents a significant administrative burden. Adding all advanced practice providers to the requirements with details about practice status, specialty, location of practices, etc. will create an enormous additional workload and in our opinion provide questionable value to the public. As was noted last year, many providers stated that this would be one of the most onerous parts of the submission requirements because:

- The information that is being requested is generally not captured all in one data file. Because the information is housed in multiple systems it becomes extremely time consuming to collect the information and often input it manually into the HPC database. It would be helpful to understand why the HPC needs this detailed level of information.
- Whether or not someone is a primary care practitioner can be difficult to assess. Most midlevel practitioners don't have board certification in specific specialties (so it is unclear what the HPC is seeking under the specialty category on the template) but may practice in a particular area such as orthopedics, OB/GYN, neurology etc. As part of their role, they may provide some primary care or they may be solely primary care clinicians. This will result in inconsistent responses from different provider groups. In addition, they often practice at multiple locations, making it even more burdensome to complete the required elements.

Charges by Payer Category

For some physician based RPOs, reporting charges by payer category will be challenging. Although CHIA has been collecting this data from hospitals for many years, physician practices have not been reporting this data to CHIA nor do they necessarily categorize payers in the same way that CHIA requires. In addition, in order for these charges to be uniform across RPOs for comparison purposes, it will be necessary for CHIA to clarify what is included in each payer category. MHA is actually working with CHIA staff to refine the definitions of payer categories for hospitals given that there have been many changes in health insurance products and in MassHealth over the past several years and the current CHIA instructions offer little guidance. This will be an important step in being able to collect reliable data from physician practices. MHA also strongly recommends that these requirements be delayed until at least 2020 so that physician practices have an opportunity to revise their registration processes and IT systems to allow the data to be easily sorted into the appropriate categories.

Total Number of Visits

The HPC is requesting that RPOs report an aggregate number of visits, stating that all claims on the same day at the same physician practice for the same patient should be reported as a single visit. For many practices, this would entail completely changing the way data is captured. If a patient comes in for an immunization and then sees a nurse practitioner or a PCP and specialist, that is counted as two visits. To change the way these are counted would be extremely challenging for many practices and it's not clear why the HPC wants visits reported in this manner. In addition, it would be helpful to clarify how physician practice is defined – is it at the MD level, the site level or the tax ID level?

As always, MHA appreciates the opportunity to provide the HPC with feedback on proposed RPO requirements. If you have any questions, please don't hesitate to contact Karen Granoff at KGranoff@mhalink.org or 781-262-6035.

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

December 21, 2018

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 2019 Updates

Dear Mr. Seltz:

In response to the recently released MA-RPO Program proposed 2019 updates, Partners HealthCare System (Partners) is submitting comments regarding the proposed areas of expansion for the 2019 filing of the Registration of Provider Organizations (RPO) Program:

1. Adding a data element to the Facilities File to capture information about facility fees paid to the provider organization by different payers.
2. Adding new data elements to the Facilities File to capture information on service availability at hospitals and clinics.
3. Adding Nurse Practitioners (NPs), Physician Assistants (PAs), Certified Nurse Midwives (CNMs), Certified Registered Nurse Anesthetist (CRNAs), Clinical Nurse Specialist (CNSs), Psychiatric Clinical Nurse Specialists (PCNSs) to the Provider Roster.
4. Adding physician payer mix and volume information to the submission requirement.

Scope and Timing

Partners is concerned with the ever-expanding scope of the MA-RPO Program. We have had to devote increasing levels of resources each time the Health Policy Commission (HPC) and the Center for Health Information and Analysis (CHIA) expanded the scope of the program. The current program already requires multiple FTEs working over an 8-12 week period in order to collect and report the requested information. The proposed 2019 updates are particularly concerning because they would require Partners to add 10 additional FTEs for 12 months to develop the systems and workflow necessary to capture the information requested, 1 additional FTE on a permanent basis to maintain the information, and 2 additional FTEs for the 8-12 week period to report the information requested in the 2019 update. Partners has worked hard to reduce costs around the system and to stay under the health care cost growth benchmark. The proposed

2019 updates would require provider organizations like Partners to incur significant administrative costs and would adversely impact provider organizations' ability to meet the goal behind Chapter 224 of controlling the rate of growth of total health care expenditure. Given the significant increase in required resources to comply with the proposed 2019 reporting requirements, Partners seeks to better understand how the proposed 2019 updates meet two of the MA-RPO Program's guiding principles—i.e., "administrative simplification" and "balancing the importance of collecting data elements with the potential burden to Provider Organizations."[1] Specifically, Partners would like to understand HPC and CHIA's rationale for proposing each additional reporting requirement and to encourage the agencies to publish a regulatory impact analysis of the administrative burden on provider organizations.

In light of these concerns and in addition to the specific comments offered below, Partners urges HPC and CHIA to (1) delay the proposed 2019 updates by at least one year to allow provider organizations to make internal adjustments to meet the new reporting requirements and (2) return to a biennial submission process. In addition, before HPC and CHIA finalize additional changes to the MA-RPO Program, Partners also requests that HPC and CHIA examine the costs related to the program and whether the data has been used in a manner that supports public policy goals.

Facilities File

HPC and CHIA propose adding a data element to the Facilities File to capture information about whether the provider organization charges facility fees to individual payers for different procedure types. Hospitals and clinics charge the same to all payers, what they are paid are contractually negotiated and/or governed by the payer's payment policies. As the question is currently structured, Partners is concerned that this proposed data element would require provider organizations to disclose proprietary information about individual payers that is confidential and privileged. Moreover, the included category of "Other Commercial Payers" expands the scope to include all payers, including those in other localities. The proposed definition of facility fee also is vague with respect to whether global payments with professional and technical components would count as a facility fee. Without understanding HPC and CHIA's goal behind this proposal, it is difficult to suggest alternatives that can meet the agencies' goals. With respect to Medicare and MassHealth, instead of asking individual provider organizations to respond to how Medicare and MassHealth pay for facility fees, HPC and CHIA should seek this information from their sister agencies in the state and federal governments.

HPC and CHIA also propose adding new data elements to the Facilities File to capture information on service availability at hospitals and clinics. As noted by HPC and CHIA, this information is already available to the agencies. As such, Partners urges the agencies to consider the administrative burden on provider organizations and instead obtain the requested information from the Department of Public Health, rather than adding a new data element to the Facilites File.

[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/

Provider Roster File

HPC and CHIA propose requiring provider organizations to submit detailed information about the following types of Advanced Practice Providers (APPs): Nurse Practitioners (NPs), Physician Assistants (PAs), Certified Nurse Midwives (CNMs), Certified Registered Nurse Anesthetist (CRNAs), Clinical Nurse Specialist (CNSs), and Psychiatric Clinical Nurse pecialists (PCNSs). Examples of the details requested include: APP's specialty, primary care provider status, pediatrician status, hospitalist status, among others. In order to accurately populate the Provider Roster with the requested information, provider organizations like Partners will have to collect information it does not current maintain and manually aggregate existing information that are kept in multiple systems. Without a better understanding of HPC and CHIA's goal for collecting this level of detail for each APP, it is hard for Partners to suggest alternatives that would offer a better balance between the goals of the agencies and the administrative burden placed on provider organizations. Given the time consuming nature of this request, we urge HPC and CHIA not to expand the Provider Roster to include APPs.

Should HPC and CHIA decide to move forward with this proposal in any manner, Partners urges HPC and CHIA to clearly articulate the goal of this proposal and work with the provider community to determine the best way to meet the agencies' goals. We also urge HPC and CHIA to clarify the request wherever possible. E.g., one requested element is an APP's specialty. Unlike physicians, APPs do not have board certification in specific specialties. Thus, without additional clarification from the agencies, it is unclear how provider organizations will be able to respond consistently to render the resulting data useful.

Physician Payer Mix File

HPC and CHIA propose adding physician payer mix and volume information to the submission requirement. Physician practices have not previously had to report this data to any state agency. As a result, many practices do not have the systems or workflow in place to capture the data in the form required by the proposal. We again urge HPC and CHIA to articulate the rationale behind this proposal so that provider organizations can offer suggestions for how the agencies might achieve their goal. In addition, Partners urges the agencies to clearly define the payer categories so that any resulting data can be compared across provider organizations. At a minimum, HPC and CHIA should clarify the definition for "Commercial Non-Managed" since the term "non-managed" is used in Medicare and Medicaid to refer to FFS (i.e., non-managed care) but it is unclear what this term means in the commercial payer context. We request that HPC and CHIA delay this proposal until the agencies have received input on a clearly defined set of data specficiations and the provider organizations have had the time to make the necessary system adjustments to collect the information requested.

Closing Statement

We urge HPC and CHIA to give its utmost consideration to these comments and to weigh the benefits of collecting the information against the administrative burden these requests have on provider organizations. Partners remains committed to transparency, providing the highest quality care to patients across the Commonwealth, and helping to reduce the statewide rate of growth of total health care expenditure. We also acknowledge HPC and CHIA's commitment and responsibility to a more transparent, accountable health care system. We look forward to partnering with HPC and CHIA as the agencies seek to improve the MA-RPO Program.

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

Sincerely,

Xiaoyi Huang, Esq.
Vice President, Payer Strategy & Contracting

Cc: Peter Markell

Good Afternoon,

Southcoast has been involved with MHA in the review of the proposed 2019 RPO filing requirements so our feedback is being address through the MHA submission.

Thank you,
Karen DeMedeiros | Contract Manager
Contracting Department
South Coast Business Center
Southcoast Health | 200 Mill Road, Suite 190 | Fairhaven, MA 02719
phone: 508.973.2951 | fax: 508.973.2177
email: demedeirosk@southcoast.org | www.southcoast.org
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December 21, 2018

Submitted Electronically

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

Re: Proposed Updates to the 2019 Filing for Massachusetts Registration of Provider Organizations

Dear Executive Director Seltz:

We appreciate the opportunity to respond to the HPC's proposed updates to the 2019 filing for the Massachusetts Registration of Provider Organizations (RPO). Below are our comments on the Advanced Practitioner Provider (APP) roster.

Advanced Practitioner Provider Roster

Although we understand the interest and rationale behind collecting information on Advanced Practitioner Providers (APPs), we believe the reporting requirement, as currently written, will provide an incomplete picture of these practitioners and increase the administrative burden associated with this part of the filing. In particular, we are concerned about the ability for provider organizations to consistently report the following APPs:

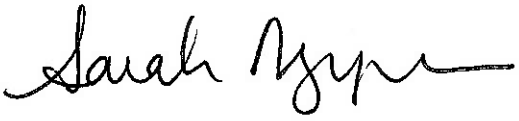
1. Certified Nurse Midwife (CNM);
2. Certified Registered Nurse Anesthetist (CRNA);
3. Clinical Nurse Specialist (CNS); and
4. Psychiatric Clinical Nurse Specialist (PCNS).

Information on the above APPs is not uniformly collected for the facilities and corporate affiliates across our system. Much of the data would have to be manually collected and may not accurately reflect the extent to which we use APPs to provide care to our patients. In addition, similar to the physician roster, the APP roster will likely be out of date shortly after being reported.

We support the HPC's efforts to have an open dialogue with provider organizations as the RPO program continues to be modified. We look forward to working with you to refine the requirements

to ensure that the data are collected in a productive and useful manner while minimizing provider burden.

Sincerely,



Sarah Nguyen
Vice President Policy, Strategy, and Government Relations
Steward Health Care System LLC

December 17, 2018

Thank you for soliciting feedback from hospitals and health care organizations regarding the proposed changes to the Registered Provider Organization (RPO) Program. Sturdy Memorial Hospital would like to make the following comments:

RPO 86A (Facility Fees)

The State is proposing to ask for information regarding which payers pay facility fees to each facility and whether a facility fee is charged for E&M services and/or any non-E&M services. Hospitals charge for items and services that are not always reimbursed by payers, so whether or not a hospital charges for something is not a good indicator of payment or reimbursement for services.
In addition, answering this question could potentially violate contract stipulations. Perhaps a better way of obtaining this data could be to obtain this information directly from the payers or for hospitals to answer the question but only in terms of Medicare, Medicaid, Commercial payer.

RPO-87A (Inpatient Beds (Satellite Facilities))

The RPO is proposing to ask the question "Does this facility have staffed inpatient beds?" and "Does this facility have an emergency department or is this facility a Satellite Emergency Facility?" This information is present on hospital licenses. As the State issues hospital licenses, the State would already have this information and should not be asking facilities to answer these questions.

RPO-217 (Charges by Payer Category)

Total charges are a less than optimal metric and many organizations may not want to share that information. Percents by payer would give the HPC the same information and would be more valuable to use than charges by payer. Percents would be standardized across all reporting entities, while charges would not necessarily be standardized. As the HPC is well aware, charges vary significantly by facility and are often determined by payer contracts. For these reasons, organizations should be required to report payer mix by percent, rather than charges.

APP Roster

Roster preparation and maintenance are burdensome and do not provide much useful information. In addition, many APPs provide services at multiple locations and fill in elsewhere (often times on a per diem basis) when the need arises. Trying to account for these circumstances would add to the burden already placed on providers. To add to the complexity, APPs may be employed by a provider and may work in a clinical setting, but the organization may not bill for the services provided by the APP. How do providers handle these types of situations?

If you have any questions regarding these comments, please contact me at (508) 236-8171 or jlevinson@sturdymemorial.org .

Regards,

Jeanine Levinson
Director, Budget & Reimbursement
Sturdy Memorial Hospital

Good afternoon and thank you for the opportunity to comment on the proposed changes to the 2019 Registration of Provider Organizations Program.

As I've mentioned in the past, completing the RPO filings is a significant administrative burden for us and any additional requirements increase that burden even further. This was exacerbated when the filing requirement changed from every other year to every year. Even though the proposed changes for 2019 may seem relatively minor to you, when added to the existing RPO submission requirements, they are significant. In order to enable us to meet the target for annual cost growth, we are always trying to reduce overhead expenses whenever possible. Increasing the administrative requirements and time commitment related to the RPO seems to be inconsistent with the goal of controlling health care cost growth in Massachusetts.

In terms of some of the proposed changes for 2019, we would like to suggest that the facility fee data be obtained from the payers. It would seem like that would help with the consistency of the data reported to you. For the proposal to add a roster for Advanced Practice Providers, I would hope that you would not go forward with this addition to the RPO. The provider rosters are the most burdensome component of the RPO, requiring us to pull data from multiple sources in order to complete all of the required fields. For the 2018 filing, we were required to submit 4 physician rosters. Adding rosters for APP's would significantly increase the time required to complete the RPO. I would hope that if there are to be any additional requirements related to the provider rosters that you would reduce the number of data elements you are currently collecting for each provider.

Feel free to reach out if you have any questions about these comments or would like to discuss them with me.

Thank you.

Lynn LeVecque