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May 14, 2015

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

Dear Mr. Seltz,

The Conference of Boston Teaching Hospitals (COBTH) and its fourteen members hospitals appreciate this opportunity to provide comments on the Health Policy Commission's (HPC or the Commission) proposed Data Submission Manual (DSM). Our comments on Part 2 of the proposed DSM, like those we submitted for Part 1 of the Registration of Provider Organizations (RPO) process, are offered in a spirit of cooperation and commitment toward containing healthcare cost growth and avoiding unnecessary administrative cost and duplication.

COBTH and its members recognize the time and effort the Commissioners and the HPC staff have dedicated to the creation of the proposed DSM, and appreciate that the HPC made several modifications to the DSM requirements after convening several stake holder meetings. However, even with these modifications we feel the proposed data elements required in Part 2 are overly burdensome on providers and require submission of a great amount of duplicative information that is already submitted to other state agencies. We are also concerned that the amount and complexity of the information requested exceeds the statutory requirements of M.G.L. c. 6D §11. As such we ask the Commission to reevaluate the scope of the required data elements.

COBTH and its members are also concerned that the volume of information requested will place an undue strain on providers. This is especially concerning given the proposed timeline for submission of Part 2 information. Providers must complete Part 2 of the RPO process at the end of their fiscal year, a time when other state agencies, such as the Division of Insurance (DOI), as well as the Commission itself for its annual Cost Trend Hearing, already request significant filings. For this reason we ask that the Commission push back the timeline for submission of Part 2 data to the end of the calendar year.

**Reduce and streamline its requests as the same information is sometimes required multiple times in multiple formats over several RPO sections**

Spread throughout the sections of the proposed DSM certain RPO data elements are asked to be repeated under slightly different formats. Requiring provider to enter the same information multiple times is time consuming and burdensome. The following are a few examples of where these redundancies arise:

- RPO 51-53 reuses the name of the contracting entity responsible for contracting on behalf of the corporate affiliate. In the following section the HPC requires more detailed information of the providers contracting affiliates and entities.
- RPO 71 also repeats the same questions asked in the contracting affiliations file.
- RPO 204 and RPO 122 are another example of requests for duplicative data. RPO 104 asks for the primary medical office where a physician provides care, where are RPO 122 asks for the name of the medical group with which the physician is affiliated.

Within the RPO there is no opportunity for providers to opt out of a question asking for repetitive data, or allowing them to refer back to a previous answer. We ask that the HPC remove these and other duplicative data requests.

**Obtain information which providers have already submitted to other state agencies from those agencies**

While we realize the HPC has many responsibly and reporting duties that it must accomplish in a timely fashion, requiring providers to submit information which they have already provided to other state agencies in the HPC's chosen format only serves to increase their administrative burden. There are several examples in the proposed DSM where data can be accessed through other state agencies. For example, facility licensure data is available directly through the Department of Public Health (DPH). Likewise when the HPC requests physician information, this data is available directly through the Board of Registration in Medicine (BORIM) and MassHealth's provider enrollment databases.

**Eliminate RPO 50 from the proposed DSM as requiring providers to report on unassociated corporations**

It appears that when a reporting provider reports an affiliation and that affiliated organization in turn has an affiliated entity, the original reporting provider must report on that third entity even if it does not have a direct affiliation with it. It is unclear what purpose this reporting will serve. Moreover this information is often not readily accessible to reporting providers. We feel this information is not beneficial to the RPO process and outside the scope of what is statutorily required. We ask the HPC to remove this unfair burden from providers.

**Eliminate or reduce scope of requested information about global payments in RPO 73-77**

COBTH and its member hospitals share the Commission's commitment to transparency. However, data requested by RPO 73-77 may include proprietary information such as how these payments are dispersed across contractual affiliates, but would be subject to public disclosure. Should the Commission feel this information is necessary we would encourage the Commission to seek out the information DOI collects on alternative payment methodologies it collects through the risk bearing certification process. It is essential that RPO 73-77 provide protection of proprietary information.

**Establish a materiality threshold for reportable clinical affiliations**

COBTH's member teaching hospitals by their very nature have hundreds of clinical affiliations. These affiliations may be routine, such as between two physicians from different organizations working collaboratively or a hospitalist renting space, or be only sporadic and intermittent coverage or call coverage relationships that have little bearing on clinical services. As written these non-material affiliations are required to be reported to the HPC. Not only is this overly burdensome on providers but it is also not relevant to the RPO process. As such we recommend the Commission establish a materiality threshold to reduce the number of affiliations requiring reporting.

In closing, we would ask the HPC to consider the executive order released by Governor Baker for the initiation of regulatory reform. While we realize that the Commission is not subject to this executive order, it is our hope that the HPC embrace its spirit and eliminate those data elements being collected that

are not expressly required by law or essential to the "health, safety, environment, or welfare of the Commonwealth's residents." Regulations that increase the administrative burden on hospitals do have an impact on health care costs. We ask the Commission to be mindful in its data collection and require only that information whose relevance and materiality is lasting.

Thank you for your consideration of our comments and recommendations. We appreciate the work of the HPC as a partner in achieving our shared goal of reducing health care cost growth. We look forward to continuing to work with the Commission and the HPC staff in implementing the provisions of Chapter 224.

Sincerely,

John Erwin
Executive Director