Massachusetts Department of Public Health
Office of Patient Protection
Annual Report: January 1, 2007 through December 31, 2007

Introduction

The Massachusetts Department of Public Health's Office of Patient Protection (OPP) operates pursuant to §217 of chapter 111 of the Massachusetts General Laws. Among its duties is enforcement of certain provisions of Chapter 176O of the Massachusetts General Laws, which provides protections to health insurance consumers. Chapter 176O governs insured health plans that are issued or delivered in the Commonwealth. The four Medicaid managed care plans offered through the Commonwealth Connector Authority (known as Commonwealth Care) are also subject to the consumer protections of Chapter 176O. In addition to the consumer protections, Chapter 176O contains health insurance licensure and accreditation requirements that are administered by the Massachusetts Division of Insurance.

It is important to note that because Chapter 176O does not apply to Medicare, Medicaid, federal employee health insurance, or self-insured employer health benefits, OPP has no jurisdiction over these plans.

Under Chapter 176O, OPP is responsible for:

- Monitoring and regulating health plan compliance with requirements for internal grievances and appeals;
- Maintaining contracts with at least three independent external review agencies and administering the external appeal process;
- Ensuring that health plans comply with regulations concerning continuity of coverage under specific circumstances;
- Receiving and posting information reported by health plans; and
- Creating and maintaining a website with information for consumers about managed care.

Chapter 176O provides an opportunity for independent review of any denial of coverage by a health plan based on medical necessity. Once an insured has exhausted the health plan's internal appeal process and received a final adverse determination, he or she may be eligible for an independent external review through OPP. Requests for external reviews must be received by OPP within 45 days of the date on which the insured receives the final adverse determination letter.

The Office of the Managed Care Ombudsman, which was created in 1998 under Executive Order 405, merged with OPP in January, 2001. As a result, OPP has an ombudsman and a nurse reviewer who work together to assist consumers with issues and problems concerning managed care.

External Review Agencies

DPH contracts with three independent external review agencies. OPP assigns cases on a random basis to one of the three agencies, which then forwards it to one or more physician reviewers who practice in the same or similar specialty as the physician providing the service in dispute. The three agencies with which DPH contracts are:

- Maximus Center for Health Dispute Resolution (Victor, NY)
- Island Peer Review Organization (Lake Success, NY) and
- Imedecs (formerly Hayes Plus) (Lansdale, PA).

All three agencies are accredited by URAC (the American Accreditation HealthCare Commission formerly known as the Utilization Review Accreditation Commission).

Except in cases of extreme financial hardship (which is determined by income based on the federal poverty level), the insured pays the first $25 of the cost of the review. The health plan pays the remainder of the cost, which averages $500 for a standard review and $700 for an expedited review. OPP waives the $25 filing fee for all members enrolled in Commonwealth Care, since the criteria for eligibility for Commonwealth Care is income below 300% of the federal poverty level.

Screening Requests for External Review

When OPP receives a request for external review, it screens the request to ensure that:

1. The insured is enrolled in a health plan that is governed by Chapter 176O;
2. The health plan has complied with all of the applicable requirements of 105 CMR 128.000 (the regulation that governs health plan appeals);
3. The insured has exhausted the health plan's internal appeal process;
4. The health plan's decision meets the definition of an adverse determination (medical necessity denial);
5. The request is submitted on the required form and is accompanied by the required signatures and a check for $25 (unless waived); and
6. The request does not involve a service or supply that has been explicitly excluded from coverage by the health plan in its evidence of coverage.

Summary of 2007 External Review Activity

In 2007, OPP received requests for external review of 346 cases. OPP sent 251 of these cases to the external review agencies for independent review. Sixty-four of the requests were not eligible for external review for a variety of reasons, usually because the health plan was not subject to the jurisdiction of OPP or the request was for services explicitly excluded by the health plan in its evidence of coverage. OPP worked with the health plans to resolve the other 31 cases, obviating the need for external review for those cases. These statistics are fairly consistent with those of previous years. Detailed information for 2001 through 2006 regarding specific health plans, categories of appeals, and aggregate data can be found at www.mass.gov/dph/opp.
When reviewing OPP statistics, it is important to understand that the numbers OPP reports are absolute numbers. They are not reported on a per-member basis Thus, although a very large

plan may have more appeal requests, when membership is considered, the actual percentage of appeals per claim or per member may be considerably lower that that of a small plan. For example, a plan with 850,000 members and 50 external reviews has fewer external appeals per member than a plan with 50,000 members and five external reviews.

Resolved Cases

In 2007, 31 of the requests for external review were resolved without being sent for review. In most of the cases, this occurred because the health plan decided to overturn its original denial following discussions with OPP or based on additional clinical information. In other cases, OPP noted compliance issues under 105 CMR 128.000 that required the health plan to resolve the case in favor of the member.

Decisions

In general, the three external review agencies overturned or partially overturned 32% of the health plan decisions, *i.e*., disagreed in whole or in part with the health plan's denial. Taken separately, the percentage of decisions overturned for cases involving behavioral health services is 43% while the percentage of overturns for non-behavioral health services is significantly smaller at 25%. As discussed below, behavioral health continues to be the number one category of external review requests, followed by cases involving services or supplies that the health plan considered to be experimental or investigational. Please refer to www.mass.gov/dph/opp for detailed information regarding external review decisions.

- **Behavioral Health**

Behavioral health continues to be the category with the highest number of requests for external review. The cases in this category include disputes over the medical necessity of continued inpatient care, acute residential treatment, and various levels of care for eating disorders, and requests for outpatient services with providers that are not in the health plan's network.

OPP sent out 103 external appeals for denials of coverage for behavioral health services. The plan with the highest number of requests was Blue Cross Blue Shield of Massachusetts, with 56 cases. The health plan with the second highest number of requests was Harvard Pilgrim Health Care with 19 cases, followed by United Health Care (United Behavioral Health) with 15 cases. The remaining health plans had five or fewer eligible requests for appeals involving behavioral health.

- **Experimental/Investigational**

The second largest category of appeal requests was for coverage of services deemed experimental or investigational by the health plan. In 2007, this category accounted for 27 eligible requests with a 37% overturn rate. This category reflects the rapid technological developments in medicine, with insureds often seeking coverage for services and procedures that are not yet in widespread use. The number of overturns by the external review agencies demonstrates that in the majority of cases, health plans have made decisions that can be supported by peer-reviewed journals and evidence-based medicine.

- **Assisted Reproductive Technology (ART)**

Massachusetts law requires that insurers provide coverage for medically necessary expenses for diagnosis and treatment of infertility, which is defined in the law as "the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year."

In 2007, OPP received 30 requests for ART services; 23 of these were eligible for external review and only 13% were overturned. The vast majority of these requests continue to be from women in their forties, and the disputes focused on whether their requests for ART fall within the state-mandated coverage, *i.e.*, was the appellant seeking treatment for a medical condition covered under the state mandate or were the ART services being requested by a patient whose age makes conception impossible without the assistance of technology.

Monitoring of Health Plan Compliance

After seven full years of operation, OPP sees very few issues involving compliance with the procedural requirements of chapter 176O, especially with the large local health plans. In 2007, OPP did continue to inspect health plan grievance files, but found minimal compliance issues. Where OPP noted deficiencies, it requested and received corrective action plans, as it does when it identifies compliance issues via consumer complaints. OPP's inspection reports, correspondence with health plans concerning compliance issues and the health plans' corrective action plans are on file with OPP and available to the public for review.

Outreach Activities

The Office of Patient Protection welcomes requests for informational presentations from consumer advocacy groups, hospital staff, and provider organizations. In past years, OPP has worked with various professional associations as well as with staff from individual hospitals. In 2007, OPP provided a series of workshops for members of the Massachusetts Association of Behavioral Health Systems.

Other Regulatory Activities

Throughout 2007, OPP continued to meet regularly with the Division of Insurance (DOI) to discuss managed care issues under Chapter 176O and to refer cases to DOI for investigation and enforcement. OPP and DOI also met regularly with the Department of Mental Health to discuss issues related to the provision of mental health services, to work toward a uniform definition of intermediate care services and to develop a consistent policy around provision and coverage of intermediate care services under mental health parity.

Office of the Managed Care Ombudsman

The Office of the Managed Care Ombudsman assists consumers in resolving disputes with health plans. These calls, primarily from consumers, involve questions about health plan denials, appeals, benefits, and policies. The Ombudsman's office also answers general questions from consumers and providers about managed care and Chapter 176O, and refers callers with other health insurance questions to the DOI or other appropriate state or federal agency.

Summary

As OPP enters its eighth year of operation, it continues to monitor compliance by health plans with Chapter 176O in addition to administer the external appeals process. OPP will continue to inspect health plan grievance files and to refer patterns of non-compliance to the DOI for enforcement. Through consultation with other state agencies, (DOI, DMH, and the Office of the Attorney General), OPP will continue to identify and address concerns about managed care.

OPP and the Ombudsman's office have developed excellent working relationships with health plans and will continue to work closely with health plans, provider organizations, hospitals and other state agencies to provide consumers with the means to resolve disputes with managed care organizations. Because OPP is mindful that every appeal will result in a final decision that will be in favor of only one of the two parties involved, it will continue to strive for a process that each party agrees is expedient and fair, regardless of the ultimate result.

Any questions regarding this report should be directed to:
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