HEALTH POLICY COMMISSION BULLETIN HPC-OPP-2016-01

To: Risk-Bearing Provider Organizations, Provider Organizations Seeking Certification as Risk-Bearing Provider Organizations, and Other Interested Parties

From: David Seltz, Executive Director, Health Policy Commission
Steven M. Belec, Director, Office of Patient Protection

Date: May 6, 2016

Re: Office of Patient Protection Interim Guidance on M.G.L. c. 176O, §24 Establishing Appeals Process for Patients of Risk-Bearing Provider Organizations

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This Interim Guidance is being issued by the Office of Patient Protection to advise provider organizations that are certified as risk-bearing provider organizations (RBPOs) by the Division of Insurance of the legal requirement to establish an appeals process to address patient complaints and to provide guidance on minimum requirements of such a process. *See* M.G.L. c. 176O, §24, attached. Until such time as the Health Policy Commission ("Commission") issues a regulation implementing M.G.L. c. 176O, §24, any provider organization that is certified as a RBPO under M.G.L. c. 176T shall comply with the requirements in this Interim Guidance. Provider organizations seeking certification as Accountable Care Organizations (ACOs) by the Commission under M.G.L. c. 6D, § 15 shall also comply with this Interim Guidance.

For the purposes of this Interim Guidance, patients are defined as: primary care patients for whose care the RBPO or ACO is at risk through an alternative payment contract with a carrier, as defined under M.G.L. c. 176T, §1 but not including Medicare or Medicare Advantage patients of an RBPO or ACO for whom applicable Medicare consumer protections apply, as defined by the Centers for Medicare and Medicaid Services or members of an RBPO or ACO for whom applicable Medicaid (MassHealth) consumer protections apply, as defined in applicable federal and MassHealth regulations.

Pending the issuance of a final regulation, the RBPO shall be in compliance with M.G.L. c. 176O, §24 by establishing a process for patients, as defined above, to submit a complaint with the RBPO regarding issues that are not within the purview of the patient's insurance carrier or health plan sponsor.[1] Such appeals process must meet the following requirements consistent with the statute:

[1] See the Office of Patient Protection regulations at 958 CMR 3.000 or contact the insurance carrier or health plan sponsor for more information.

1. The RBPO shall provide patients with an opportunity to make a complaint about referral restrictions or other potential limitations of care, such as denials or restrictions on referrals to providers not affiliated with the RBPO; denials or restrictions on type or intensity of treatment or services; and denials or restrictions on timely access to treatment or services. Complaints subject to this appeals process are distinct from issues that are within the purview of the patient's insurance carrier or health plan sponsor, including grievances and adverse determinations defined in 958 CMR 3.020.

2. The RBPO shall make information about its appeals process available to patients and the public. At a minimum, the RBPO shall make such notice available in writing at all locations where patients regularly seek care, such as primary care physicians' offices, and, by request, in electronic or other requested format. The RBPO may use the attached sample notice as a guide.

3. The RBPO shall notify patients about how to make a complaint (e.g., providing a phone number or other contact information). In its notice to patients, the RBPO shall inform patients of the right to designate a third party to advocate on the patient's behalf during the appeals process including, but not limited to, a spouse or other family member, an attorney of record or a legal guardian. The RBPO may require patients to designate a third party in writing. In addition, the RBPO notice shall include contact information for the Office of Patient Protection.

4. The RBPO shall complete its review of each patient complaint within fourteen (14) days. For a patient with an urgent medical need including, but not limited to, terminal illness or an emergency situation, the RBPO shall provide an expedited review of each patient complaint, which shall be completed within three (3) days.

5. During the appeals process, the RBPO shall not: (i) prevent a patient from seeking medical opinions outside of that organization; or (ii) terminate any medical services being provided to the patient, including medical services which began prior to the patient complaint and are the subject of the appeals process.

6. After completing its review, the RBPO shall provide its decision to the patient in writing. The notice of decision shall include contact information for the Office of Patient Protection.

7. The RBPO shall submit two reports to the Office of Patient Protection. The first report shall be due on December 15, 2016 for complaints received during the period of September 1, 2016 through November 30, 2016. The second report shall be due on March 15, 2017 for complaints received during the period of December 1, 2016 through February 28, 2017. The reports shall contain the following information:

a. A copy of the patient notice used by the RBPO. The notice need only be provided in the RBPO's first report unless the notice has changed since the previous report.

b. A summary report of the patient complaints received by the RBPO involving referrals or other potential limitations of care not within the purview of the patient's insurance carrier or health plan sponsor. The list shall not include any information that identifies the patient, but shall include the number of complaints and the resolution of the complaint. The complaints shall be classified into the following categories: (1) denials or restrictions on referrals to providers not affiliated with the RBPO; (2) denials or restrictions on type or intensity of treatment or services; (3) denials or restrictions on timely access to treatment or services; and (4) other. For complaints categorized as "other," the RBPO shall include a brief description of the patient's concern.

c. A description of the RBPO's appeals process to resolve patient complaints. The description shall include at what organizational level (i.e., individual practice or provider organization) the appeals process is initiated and the title and clinical background of the individual(s) reviewing patient complaints. The description shall include the standard and guidelines used to review patient complaints. The second report shall identify any changes in the process since the previous report.

Please submit reports to the following mailing address or email address:

Health Policy Commission
Office of Patient Protection
50 Milk Street, 8th Floor
Boston, MA 01209

HPC-OPP@state.ma.us

Upon review of reports filed pursuant to this Interim Guidance, the Commission will evaluate the need for changes in report content and frequency. The Commission will consider such reports in in the development of a regulation regarding internal appeals and external review processes pursuant to M.G.L. c. 176O, §24. If you have questions regarding this Interim Guidance, please contact:

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M.G.L. 176O § 24

§ 24. Internal appeals processes for risk-bearing provider organizations; patient's right to third-party advocate; external review process

Effective: October 1, 2013

(a) All risk-bearing provider organizations certified under chapter 176U shall create internal appeals processes. The appeals processes shall be available to the public in written format and, by request, in electronic format.

(b) The internal appeals processes in subsection (a) shall be completed in a period not longer than 14 days; provided, however, that an expedited internal appeal shall be completed in a period not longer that 3 days for a patient with an urgent medical need including, but not limited to, terminal illness or emergency situations, as defined through regulations by the office of patient protection. During the appeals process, the risk-bearing provider organization shall not: (i) prevent a patient from seeking medical opinions outside of that organization; or (ii) terminate any medical services being provided to the patient, including medical services which began prior to the appeal and are the subject of such appeal. The decision on the appeal shall be in writing and shall notify the patient of the right to file a further external appeal.

(c) Risk-bearing provider organizations shall inform any patient of the right to designate a third party to advocate on the patient's behalf during the appeals process including, but not limited to, a spouse or other family member, an attorney of record or a legal guardian. If the patient does not elect a person to serve as his or her advocate such provider organization shall offer to contact the office of patient protection and the office of patient protection may designate an ombudsman to advocate on the patient's behalf.

(d) The office of patient protection shall establish by regulation an external review process for the review of grievances submitted by or on behalf of patients of risk-bearing provider organizations. The process shall specify the maximum amount of time for the completion of a determination and review after a grievance is submitted and shall include the right to have benefits continued pending appeal. The office of patient protection shall establish expedited review procedures applicable to emergency and urgent care situations

(e) The office of patient protection shall promulgate regulations necessary to implement this section.