MASSACHUSETTS MEDICAL SOCIETY
Every physician matters, each patient counts.

COMMENTS ON PROPOSED REGULATION
958 CMR 11.00 – INTERNAL APPEALS PROCESS AND EXTERNAL REVIEW PROCESS FOR RISK-BEARING PROVIDER ORGANIZATIONS AND ACCOUNTABLE CARE ORGANIZATIONS

The Massachusetts Medical Society (MMS) appreciates the opportunity to comment on these proposed regulations. We commend the work of the Health Policy Commission (HPC) to develop this system for appealing denials of referrals and services within ACOs. MMS has long held policy to promote adequate and fair appeals processes for matters such as inadequate networks. We hold that the process delineated in these regulations would better serve Massachusetts patients if several changes were made. We have developed those suggested changes with particular attention to vulnerable patient populations, particularly as more than one million Medicaid beneficiaries in the Commonwealth have recently transitioned into newly formed ACOs. MMS policy states that "The goal of an Accountable Care Organization (ACO) is to increase access to care, improve the quality of care and ensure the efficient delivery of care. Within an ACO, a physician's primary ethical and professional obligation is the well-being and safety of the patient." Accordingly, "physicians must be free to refer out of the network if it is in the patient's best interest."

We commend the decision to set the standard for successful appeals at whether or not a given intervention or referral would be of clinical benefit to the patient. We wish to emphasize that the accurate implementation of such a standard for successful appeals requires that the reviewer of the claim have clinical expertise to accurately and reliably assess whether or not a given intervention would be of clinical benefit to a patient. The regulations currently state that an internal reviewer ought to be "an individual…who has a clinical background with an active license to practice." That definition could allow persons such as social workers or radiology technicians, for example, to serve as internal reviewers. We therefore urge the HPC to modify that language to read, "a physician…with clinical expertise and an active license to practice." Likewise, the definition of an External Review Agency should be modified to include that at least one physician with clinical expertise be part of the agency reviewing claims. We also wish to note that, since the internal reviewer has the responsibility of determining whether or not a patient has an Urgent Medical Need, the reviewer ought to be a physician with clinical expertise.

We would also urge the HPC to add physicians to the list of persons able to initiate appeals, so that physicians may appeal and may initiate external review on behalf of their patients. The regulations state that patients and authorized representatives may initiate appeals and external reviews; physicians with clinical expertise ought to be added to that list (Internal appeals--11.05: Form and Manner of Request; External review—11.14: Form and Manner of Request). This is in keeping with long-held MMS policy that physicians ought to be able to initiate appeals: "Adequate and timely appellate mechanisms for both patients and physicians should be in place to address disputes regarding medically necessary care. In some circumstances, physicians have an obligation to initiate appeals on behalf of their patients."

We also have concerns with the provisions of these regulations that address the materials that ACOs are

860 WINTER STREET, WALTHAM, MA 02451-1411
TEL (781) 893-4610 TOLL-FREE (800) 322-2303 FAX (781) 893-8009 WWW.MASSMED.ORG

required to provide to patients (11.04: Information on Internal Appeals). As stated above, we are concerned with protecting vulnerable patient populations, and it is particularly vital that patients with lower health literacy be adequately informed of their right to appeal. We therefore suggest that the requirements on ACOs to provide notice of this process to patients be strengthened in ways that thoughtfully strike a balance between increasing notice to patients and not unduly burdening ACOs.

We also urge amendment of the provision that expedited internal review be completed within three calendar days. Patients whose claims receive expedited internal review have an Urgent Medical Need, the definition of which includes patients receiving emergency services and patients at the end of life. For some patients, a three-day appeal process may be appropriate; however, for the most acutely ill, an even more expedited process may be warranted, as three days may cause a significant difference in prognosis. Crafting policies to minimize delays in administrative processes such as appeals can help mitigate associated harms and can reduce unnecessary costs to health systems.

We are also concerned with the timeline for requests deemed ineligible for external review (11.16: Requests Ineligible for External Review—Notification). If a claim is submitted within the window of eligibility and is deemed ineligible, and the notification of eligibility arrives after the window of eligibility has closed, patients will lose their right to an appeal because of a technicality. We therefore suggest that the timeline for submitting a request for external review be reset following a notification of ineligibility.

The MMS remains encouraged by the promise of care delivered through ACOs, but believes that appropriate appeals processes are critical to assuring optimal patient care within those systems.