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of Community Health Centers

August 7, 2015

Jenifer Bosco, Director
Office of Patient Protection
Health Policy Commission
Two Boylston Street, 4th Floor
Boston, MA 02116

Director Bosco:

On behalf of Health Law Advocates, Health Care For All, the MA Hospital Association, the National Association of Social Workers – MA Chapter, Association for Behavioral Healthcare, MA Medical Society, the MA League of Community Health Centers, and MA Psychiatric Society, thank you for the opportunity to submit testimony to the Office of Patient Protection (OPP) regarding proposed amendments to 958 CMR 3.000: Health Insurance Consumer Protection and 958 CMR 4.000: Health Insurance Open Enrollment Waivers.

958 CMR 3.101: Carrier’s Medical Necessity Guidelines

The consumer protections provided in 958 CMR 3.000 aim to achieve a fair and accessible appeals process for Massachusetts health plan members. A vital aspect of a fair and accessible appeals process is health plan transparency, including transparency and disclosure of medical necessity criteria, level of care guidelines, and other policies used by health plans during utilization review. We support the proposed amendments to 958 CMR 3.00 that bring the Health Policy Commission (HPC) regulations into compliance with M.G.L. Ch. 6D, §16, as amended in the final FY2015 state budget. HLA and HCFA collaborated with a group of consumer advocates, providers, insurers and utilization review organizations on language that would maintain the Chapter 224 goal of increasing transparency within the health care system and providing avenues for consumers to be informed about and engage in health care decision-making. The amended statute clarifies that health plan members and health care providers may obtain medical necessity criteria, including proprietary criteria, from a health plan to assist with determining coverage for a planned or possible health care service.

These regulatory changes are critical to ensuring that health plan members, providers and advocates are fully informed about health insurance benefits, and able to identify when a carrier has wrongfully denied coverage for needed health care services. Consumers have a right to know what their health plan covers and how their health insurance carriers make decisions about coverage for a specific treatment or service. In line with the intent of these statutory and regulatory changes, we have additional recommendations that would ensure consumers and providers have access to the information they need to make critical health care decisions

Electronic search mechanisms

We recommend that consumers and providers be allowed to make online requests for accessing medical necessity criteria. We appreciate that the regulations allow a consumer or provider to make a request for utilization review criteria upon oral or written request pursuant to 958 CMR 3.101(3)(c)-(d). We also urge the HPC to amend the regulation to allow consumers and providers to make an electronic request for proprietary utilization review criteria for a specific treatment or service via an online search function on the carrier's website. The online option would make this information more easily accessible and enable consumers who aren't able to easily make a phone call during work time, for instance, to do a quick search to find the information they need.

Ensure timely response to requests

We suggest that the HPC amend 958 CMR 3.101(5) so that the deadline for providing a copy of the criteria or protocol is changed from 30 days to 2 business days. The purpose of the statutory change was to ensure that patients and providers are able to identify and obtain a copy of the specific utilization review criteria, clinical review criteria, and medical necessity criteria and protocols to make a decision about care and treatment. Allowing a 30 day period to send a patient this information could prevent or delay many decisions about coverage and care that are not in the best interest of the consumer. We ask the HPC to adjust the outside timeframe to a more realistic period that reflects the intention of this regulatory change.

Ensure proper handling of requests

We appreciate that the proposed changes to 958 CMR 3.101(3)(d) preserve the right of consumers and providers to obtain copies of utilization review criteria and clinical review criteria, including criteria claimed as "proprietary," upon request. To ensure that this important consumer protection is effective, health plans must establish an operational process for insureds (members), prospective insureds and providers to request such information. Often, health plan documents will state that medical necessity criteria or other information is "available upon request," and direct members to contact a members' services department using the phone number listed on their member identification card. However, in our experience, when members do call member services to request medical necessity or other relevant criteria, health plan staff do not understand what information the members are requesting, or do not know that the plan is responsible for providing such information, even if "proprietary." This leads to member confusion and frustration, and impedes the goal of increased health plan transparency. We propose that the regulation further require health plans to include in plan documents and in relevant plan notices a clear process, with specific contact information, which insureds, prospective insureds and providers may easily follow to request utilization review criteria and clinical review criteria. We also suggest that the regulation require carriers to train their Member

Services staff on the correct protocols of obtaining utilization review/medical necessity criteria and provide a direct number for consumers and providers to call to get this information within 2 business days.

Provide information on behavioral health parity compliance

The proposed regulation’s provisions on transparency of utilization review criteria may serve as an important tool in monitoring health plan compliance with the behavioral health parity laws. Most health plans subject to these regulations are also subject to the Massachusetts Mental Health Parity Law¹ and the federal Mental Health Parity and Addiction Equity Act (MHPAEA).² MHPAEA and its regulations require that a health plan’s medical management policies (including utilization review and clinical review) for behavioral health services be no more restrictive than the medical management policies for medical/surgical services.³ We would encourage the HPC to clarify that, when a health plan insured, prospective insured or provider requests utilization review criteria, clinical review criteria or other protocols relevant to a behavioral health service, that individual is entitled, upon request, to receive a copy of the utilization review criteria, clinical review criteria and other protocols that are relevant to comparable medical or surgical services. This will enable consumers and providers to better assess whether a health plan’s medical management policies for behavioral health meet parity requirements. This level of transparency is also consistent with requirements outlined in federal mental health parity regulations, and the Employee Retirement Income Security Act (ERISA), which regulates many fully-insured group health plans.⁴

Technical clarification

We ask that the HPC amend the regulation in 958 CMR 3.101(5) by fixing what we think may have been a technical error or oversight in the listing of the citation in the last line. Specifically, the proposed regulation provides that the carrier and utilization review company provide a copy of the requested criteria or protocols in accordance with 958 CMR 3.101(3)(a). We would ask that the proposed regulation fix this reference by removing the “(a)” and simply listing the

¹ Chapter 256 of the Acts of 2008; G.L. c. 175, §47B; G.L. c. 176A, §8A; G.L. c. 176B, §4A; G.L. c. 176G, §4M

² Pub. L. No. 110-343, Div C §§511-15, 122 Stat. 3861 (codified in scattered sections of 26, 29, and 42 U.S.C.). Health plans subject to MHPAEA include non-group and small-group policies sold on the Health Connector, and fully-insured large group health plans.

³ See, e.g., 45 CFR 146.136(c)(4)(ii)(A).

⁴ See, e.g., 45 CFR 146.136(d)(1); see also (d)(3) (“[I]n addition to those disclosure requirements, provisions of other applicable law require disclosure of information relevant to medical/surgical, mental health, and substance use disorder benefits. For example, ERISA section 104 and 29 CFR 2520.104b-1 provide that, for plans subject to ERISA, instruments under which the plan is established or operated must generally be furnished to plan participants within 30 days of request. Instruments under which the plan is established or operated include documents with information on medical necessity criteria for both medical/surgical benefits and mental health and substance use disorder benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply a nonquantitative treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan. In addition, 29 CFR 2560.503-1 and 29 CFR 2590.715-2719 set forth rules regarding claims and appeals, including the right of claimants (or their authorized representative) upon appeal of an adverse benefit determination (or a final internal adverse benefit determination) to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant’s claim for benefits. This includes documents with information on medical necessity criteria for both medical/surgical benefits and mental health and substance use disorder benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply a nonquantitative treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan.”).

citation as “3.101(3).” This will allow all situations where criteria or protocols may be requested to be covered, not just those pertaining to adverse determinations (in which the criteria and protocol must be included with the determination anyway). This would implement the actual legislative intent of the law.

958 CMR 4.000: Health Insurance Open Enrollment Waivers

We support the proposed changes the HPC has made to the open enrollment waiver regulations, as they integrate many of the comments Health Care For All and Health Law Advocates submitted during the regulatory comment period in 2013, and align definitions and requirements with those in the Affordable Care Act.



Thank you for the opportunity to provide testimony on the critical issues of promoting transparency within the health care system and ensuring access to coverage. If you have any questions, or need more information, please contact Alyssa Vangeli at avangeli@hcfama.org or 617-275-2922, Clare McGorrian at cmcgorrian@hla-inc.org or 617-275- 2983, or any of the undersigned organizations.

Sincerely,

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