

December 24, 2013

VIA ELECTRONIC MAIL

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

RE: Testimony on Proposed Amendments to 958 CMR 3.000 –
Health Insurance Consumer Protection

Dear Director Bosco:

On behalf of Health Law Advocates (HLA) and Health Care For All (HCFA) and the following organizations: Association for Behavioral Healthcare, Children's Mental Health Campaign, Gosnold on Cape Cod, Massachusetts Advocates for Children, Massachusetts Psychiatric Society, Massachusetts Society for the Prevention of Cruelty to Children, Mental Health Legal Advisors Committee, National Alliance on Mental Illness Massachusetts,¹ we 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.

At the outset we wish to acknowledge our appreciation of the many revisions to the Health Insurance Consumer Protection regulations, which bring them in line with the Patient Protection and Affordable Care Act (ACA) and afford greater protection for health care consumers in the Commonwealth. HLA and HCFA submitted detailed comments on the existing regulation in August, and we are pleased to see that the OPP carefully considered and adopted a number of our proposals. We further appreciate the helpful guidance the OPP has issued on review of services considered experimental, carrier responsibilities to obtain medical records, and implementation of changes to G.L. c. 176O pursuant to chapter 35 of the Acts of 2013. It is evident that Director Jenifer Bosco and the OPP take seriously the obligation of administering and enforcing the standards and procedures established by G.L. C 176O, 13-16 including oversight of managed care grievances and appeals.

In the comments that follow, we highlight additional changes we support and propose recommended amendments in order to make the internal and external review processes clearer and more accessible for patients.

¹ Please see Appendix 1 attached hereto for brief descriptions of each signing organization.

3.020: Definitions

Authorized representative

Where an insured cannot designate a representative due to incapacity or incompetence, a family member with whom the insured does not have a trusting relationship (e.g., an abusive partner) should not qualify as the insured's representative. We request that OPP amend this definition to protect against the possibility of an abusive (or incompetent) family member being treated as the insured's representative. The OPP in conjunction with the insured's treating medical provider should use a substituted judgment standard to determine whether the insured, but for his/her incapacity, would consent to appoint the family member in question. The following factors should be considered in arriving at the substituted judgment decision:

1. the insured's expressed preferences;
2. any history or evidence of abuse of the insured by the family member, whether physical, verbal, financial or otherwise;
3. any financial or other conflict of interest between the insured and family member;
4. the compatibility of the insured's approach to medical care and that of the family member.

Days

We support the clarification that "days" means "calendar days," unless otherwise specified. Time is of the essence in review of health care denials. G.L. c. 176O specifies limited instances in which business days apply. We believe the legislature intended calendar days to apply in all other cases so as not to unfairly lengthen the review process. We therefore support the amended definition and the amendments striking the word "business" under sections 3.304, 3.305(A), (B) and (C), 3.308(A) and 3.415(C) of the regulation. Consistent with those amendments, we further recommend that section 3.310(1) be amended to strike the word "business" in reference to the timeframe for resolutions of grievances submitted by an insured with a terminal illness.

Material professional affiliation

We support amending the definition of "material professional affiliation" to refer to a "health care professional" instead of a "physician." We recommend that, to the extent permitted by statute, the word "physician" be replaced throughout the regulation with "health care professional" in order to include, as appropriate, mental health professionals and other licensed or certified providers that are not physicians. *See* 958 CMR 3.100, 3.101, 3.309, 3.310, 3.312, 3.504, 3.600. HLA recently represented a child with autism spectrum disorder in an appeal from a denial of applied behavior analysis therapy. The carrier employed a psychiatrist, without experience with children or ASD, to review the claim. A certified BACB (applied behavior analyst) would have the most appropriate "health care professional" to assess the claimant's need for treatment.

3.101: Carrier's Medical Necessity Guidelines

Section 3.101 requires that a carrier's medical necessity guidelines be developed with input from practicing physicians in the carrier's service area. We recommend that OPP further require that the physicians have credentials, expertise and current clinical experience treating the diagnosis relevant to the particular guideline on which they consult (e.g., board-certified child psychiatrists should be consulted on guidelines for inpatient psychiatric hospitalization of children). In addition, we recommend that the word "physician" be replaced with "health care professional" for the reasons noted in our comments on 958 CMR 3.020 (material professional affiliation.)

We disagree with the comments of McKesson and the Massachusetts Association of Health Plans (MAHP) at the December 16th public hearing criticizing the public availability of licensed and/or proprietary utilization review or medical necessity criteria pursuant to 958 CMR 3.101(3). OPP's responsibilities and powers are established pursuant to M.G.L. c. 6D § 16, enacted by Section 15 of Chapter 224 of the Acts of 2012. Section 16 specifically directs the Health Policy Commission (HPC) to establish regulations that protect the confidentiality of certain "proprietary" information; however, the law also states that "utilization review criteria, medical necessity criteria and protocols *must be made available to the public at no charge regardless of proprietary claims.*" M.G.L. c. 6D § 16(a) (emphasis added). While we understand that McKesson seeks to protect its financial interests, the obligation to disclose utilization review and medical necessity criteria, whether or not claimed as "proprietary," has been clearly decided by the legislature.

Furthermore, the requirements under M.G.L. c. 6D § 16 and 958 CMR 3.101(3) 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. The heightened disclosure pursuant to state law is particularly important in the context of state and federal mental health parity laws, which require carriers to cover mental health and substance use disorder services in the same manner as medical/surgical services.² The transparency requirements will facilitate enforcement of the mental health parity laws by allowing health plan members and providers access to the information necessary to identify a violation of mental health parity and to support a complaint of non-compliance. In HLA's experience, consumers often have difficulty accessing utilization review criteria. Below are two examples:

Example 1: HLA represented a commercial health plan member in an appeal of the health plan's denial of residential mental health treatment. The carrier utilized medical necessity guidelines through a third party vendor, and did not make these guidelines available on the carrier website. HLA encountered substantial difficulty obtaining a copy of the guidelines specific to residential treatment for mental health care. The HLA

² See Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity (MHPAEA), Pub. L. No. 110-343, Div C §§511-15, 122 Stat. 3861 (codified in scattered sections of 26, 29, and 42 U.S.C.); see also Massachusetts Mental Health Parity Laws, G.L. c. 175, §47B; G.L. c. 176A, §8A; G.L. c. 176B, §4A; G.L. c. 176G, §4M.

attorney was first advised that the guidelines were "proprietary" and not available for distribution. Thereafter the attorney was directed to several different departments, none of which was able (or willing) to disclose the requested information. The process to obtain the guidelines took three consecutive days of phone calls to various departments.

Example 2: HLA received a call from a patient who was admitted to the hospital for complications related to Crohn's disease. The patient received a letter in the mail after discharge that her employer-sponsored health plan was denying coverage for all but the first night of her hospital stay. The health plan denied coverage on the grounds that the admission was not medically necessary citing the plan's level of care utilization review criteria as the reason for the decision. The patient, through her authorized representative, repeatedly requested the utilization review criteria. After a written request and phone calls over several months, the patient never received the utilization review criteria.

Ensuring that consumers understand how to access utilization review and medical necessity information is essential to achieving the goal of increased transparency under M.G.L. c. 6D, § 16. Access to adequate information is a prerequisite to enforcement – unless a health plan member or provider can obtain and review a copy of utilization review policies and procedures, it is impossible to determine whether those policies and procedures are being applied in a way that complies with state and federal laws, including mental health parity laws. In addition, since utilization review criteria vary from carrier to carrier, potential insureds, particularly those with chronic health conditions, may wish to view a plan's specific criteria prior to selecting and purchasing a plan.

3.302: Form and Manner of Request

We support the amendment under section 3.302(2) which specifies that carriers must provide the insured with a release form within one business day following the day of receipt of the grievance.

3.305: Time Limits for Resolution of Non-Expedited Internal Grievances

We recommend that OPP clarify that a carrier must use good faith efforts to obtain a signed release from the patient/insured before deciding a grievance without the necessary medical records pursuant to section 3.305(2).

3.306: Review of Internal Grievances

We support the amendments to 3.306(1) which provide for additional qualifications for each reviewer of an internal grievance. We recommend, however, that 3.306(2) be amended to further specify the qualifications for each reviewer of an adverse determination. The phrase "who typically treats the medical condition" (emphasis added) implies that a specific reviewer need not actually treat the condition or provide the service at issue as long as other practitioners in the

same/similar specialty as the reviewer “typically” do so. HLA has encountered cases in which a clinical reviewer was not qualified to review the care at issue. For example, in one case a health plan member’s internal appeal involving a claim for outpatient physical therapy was reviewed by a physician with board certification in plastic surgery, and no stated physical therapy experience. (See also example provided in comments on 958 CMR 3.020 (“material professional affiliation”).) MHLAC has also encountered such cases, including a psychiatrist who treats only depression and anxiety reviewing a treatment denial for someone with associative identity disorder (multiple personality disorder). To provide an informed and fair review, we believe that a clinical reviewer must have actual and current experience treating the condition or providing the medical service at issue. We therefore recommend striking the word “typically” so that each reviewer must be an “actively participating health care professional in the same or similar specialty who treats the medical condition, performs the procedure or provides the treatment that is the subject of the grievance.”

We further recommend that section 3.306(3) be amended to require carriers to assemble a “materially” complete medical record “for the purposes of” its internal review. The term “reasonably complete” does not ensure that the carrier will compile all information that is “material” or “relevant” to the claim at issue.

3.307: Form of Written Resolution of the Internal Grievance

We support the amendments to section 3.307 which clarify the information that must be included in the written resolution of an internal grievance. In our experience, carriers do not always provide the information in benefit denials that is required by the regulation. For example, adverse determinations frequently fail to clearly explain the reasons for benefit denial or to tie plan criteria to the specifics of the case. As advocates, we see carriers barely, if at all, address our detailed arguments for coverage, and rarely do adverse determinations identify covered alternative treatment options, as required. In addition, carriers frequently omit the diagnosis and treatment codes from the written resolution of the internal grievance. This omission hurts members who are not always privy to the codes their providers submit. Moreover, the meaning of the codes is not freely accessible. The diagnosis and treatment codes are often directly relevant to the reasons for denying coverage and thus knowledge of the codes and their significance is imperative for appeal. HLA’s experience shows that obtaining relevant diagnosis and treatment codes is fraught with delay and confusion on the part of the carrier. We therefore support the requirements for greater clarity and transparency in denial notices, clinical criteria and documents relied on by carriers in deciding grievances, as specified in 3.307(2). We further support the amendments to 3.307(3), which provide that final written adverse determinations must also include information on filing requests for external appeals and other available resources.

We recommend that adverse determination notices be required to more prominently display deadlines for action, especially for expedited appeal and continued coverage for ongoing treatment. In a case involving ongoing treatment of autism spectrum disorder a carrier’s initial denial contained no reference to expedited review or continuation of coverage. The time frame

for internal appeal was not highlighted or emphasized in any way. The deadline for external review in the final adverse determination was underlined. However, while this final notice referred to expedited review it did not alert the recipient to the possibility of continued coverage. Finally, in the initial denial and the final determination, notice of the member's right to obtain all documents relevant to the claim, including applicable guidelines, was not set off in any way from the text of each multi-page letter.

3.308: Reconsideration of Carrier Decisions on Internal Grievances

We support the amendment to section 3.308(1), which clarifies that the opportunity for reconsideration of a carrier's final adverse determination may be available when the insured or insured's authorized representative offers other good cause, in addition to when a carrier lacks sufficient information. As noted in our August comments, "good cause" may exist for a number of reasons which merits the opportunity for reconsideration. For example, an insured could fail to submit complete and timely information due to illness or lack of capacity. In addition, a patient may have good cause for reconsideration if s/he has retained an attorney/ advocate after unsuccessfully pursuing an appeal. Permitting the member to resubmit the appeal with assistance may avert the need for external review. Even if the carrier again denies the claim the patient will have had the opportunity to flesh out the record and his arguments for further appeal.

We oppose the amendment to section 3.308(4), which provides that reconsideration is not available to members of individual health plans. While we understand that this provision has been interpreted as required under the ACA, we urge the OPP to seek flexibility from the Department of Health and Human Services in order to allow Massachusetts to continue to offer the option of reconsideration to members of individual plans. In HLA's experience, the current system, which allows for reconsideration in group and non-group products, is working effectively for consumers. HLA's experience does not show that the reconsideration process is being used improperly by carriers to delay members' access to care. Likewise, HLA's experience shows that reconsideration is entirely voluntary on the part of the member. In fact, reconsideration can provide important benefits to members who choose to take advantage of this option. In particular, for members who have grievances that are not eligible for external review, the reconsideration process provides a second level of review that would not be available otherwise. In addition, reconsideration allows members to submit additional information in response to the carrier's written decision to address the carrier's specified reason for denying coverage. Therefore, due to the benefits provided to members and the lack of evidence showing abuse of this process by carriers, we recommend continuing to offer the option of reconsideration to members of individual plans.

3.310: Grievance Process for Insured with Terminal Illness

We recommend that section 3.310 be amended to explicitly authorize a patient's treating physician or provider to participate in the conference, in addition to the patient and any authorized representative. A recent HLA case provides insight into why provider participation may be helpful for patients with terminal illness. The patient was denied coverage for a visiting

nurse on grounds of medical necessity. The patient's wife was acting as the patient's authorized representative, while working full time and caring for her terminally ill husband. The patient's wife was not able to gather the necessary documentation to refute the carrier's determination, and there was insufficient time to allow for the patient's providers to submit detailed letters of support. In the case of a member with a terminal illness, the timeliness of the appeal is of the utmost importance. Requiring that a terminally ill patient's treating provider be permitted to participate in the appeal conference would guarantee the presentation to the carrier of essential medical evidence, not able to be submitted in written form due to time constraints. Therefore, we recommend that section 3.310 be amended to explicitly authorize a patient's treating physician or provider to participate in the internal appeal conference.

3.314: Internal Review Conference

The regulation currently allows a conference at internal review for a terminally ill insured. *See* 958 CMR 3.310. Terminal illness requires special appeal timelines and rights per G.L. c. 176O, §§ 13 and 14, which we fully support. Yet there is other good cause – including but not limited to life-threatening illness and prohibitively expensive treatment – to permit a conference on internal appeal. In our experience, a patient and/or his advocate can more effectively communicate compelling facts and arguments in an in-person meeting or phone conference (if necessary for logistical reasons). We therefore recommend that section 3.314 provide language regarding availability of a conference similar to the detailed language under section 3.310. While carriers are mandated to grant a conference upon request under 3.310, we believe that requiring carriers to offer an insured the option to request a conference under section 3.314 would be sufficient.

3.401: Expedited External Review

Expedited review process

We support the amendments to section 3.401 that provide for concurrent internal and external expedited reviews and the requirement that decisions must be issued within 72 hours of receiving the request for expedited external review.

Provider certification

A treating provider's certification that a patient requires expedited review based on a serious and immediate threat to health should be presumed valid without the need for further assessment by the carrier, OPP or the ERA. We therefore support the amendments to sections 3.401(2)-(3), which provide that the OPP shall qualify requests as eligible for expedited external review upon receiving a properly executed certification from a health care professional responsible for the treatment or proposed treatment that delay poses a serious and immediate threat to the insured.

3.402: Fees

We support the amendment to section 3.402 that no insured shall be required to pay more than \$75 per plan year, regardless of the number of external review requests submitted.

Given expanded income eligibility under the Affordable Care Act, we respectfully suggest that the income level for waiver of the external review filing fee be raised from 300 percent to 400 percent of federal poverty level.

3.406: Requests Ineligible for External Review – Notification

We recommend that section 3.406(2)(e) be clarified to allow for external review when an insured has been improperly charged cost-sharing based on a medical determination by the carrier. The Affordable Care Act and implementing regulations mandate that certain preventive services be covered with no cost-sharing attributed to the insured. Examples of preventive services are certain blood tests, screening colonoscopies and mammograms, and annual well visits with a primary care physician. Since this mandate was implemented, at least twenty consumers have contacted HLA for assistance appealing determinations by carriers that services did not fit within the guidelines of the ACA's preventive services mandate. In deciding to attribute cost-sharing to members, carriers are engaging in medical determinations. For example, under the preventive services mandate, a blood test to determine cholesterol levels is covered at no cost for women younger than 45 years old who are at increased risk of heart disease. The determination of whether the member is at such increased risk involves medical judgment, assessment of medical records, and consultation with the ordering physician. Likewise, distinguishing whether a colonoscopy is preventive, and thus covered at no cost-sharing, or diagnostic, requires a detailed, medical determination. When faced with a carrier's assignment of cost-sharing based on such a medical determination, the proper procedure to challenge this determination is the appeals and grievance process. HLA has successfully represented consumers at both internal and external appeals who were wrongfully denied the full benefit of the ACA's preventive services guidelines.

HLA and HCFA are concerned that the proposed regulation at 3.406(2)(e) will prevent consumers from seeking external review of such determinations through OPP in the future, leaving them with no recourse to resolve their individual cases. Where carriers' determinations regarding preventive services challenge the medical necessity of the services through attribution of cost-sharing, we recommend that 3.406(2)(e) be clarified to allow for external review when an insured has been improperly subjected to cost-sharing based on a medical determination by the carrier.

3.410: Review Panel

Consistent with our comments regarding the qualifications for clinical reviewers for internal grievances under 958 CMR 3.306, external reviewers must also be "actively practicing" health care professionals in the "same or similar specialty" as the treating provider. We therefore similarly recommend that each external reviewer should be required to have actual and current experience treating the condition or providing the medical service at issue on appeal, and thus the word "typically" should be deleted.

3.413: Informal Meeting

Under section 3.413, external review agencies have sole discretion to grant “informal meetings” at external review. We recommend that OPP also set “good cause” standards for which an insured may request an informal meeting with the ERA, similar to the standards we recommend for internal review conferences in our comments under 958 CMR 3.314.

3.414: Continuation of Services

Under section 3.414(1), the insured may have insufficient time to request continued coverage of ongoing treatment pending completion of external review, especially if s/he is not provided clear and timely notice of the option to request continued coverage of ongoing treatment. Patients that require ongoing treatment are particularly vulnerable and require special protection in the appeals process because their medical condition is more likely severe. When coverage for a course of treatment is interrupted based on an alleged lack of medical necessity, good cause for continued coverage pending appeal should be presumed. The presumption should be overcome only by evidence that the contract explicitly prohibits coverage – for example, when the requested coverage exceeds the set number of visits in the plan.

A hospitalized patient often lacks the capacity to gather within two business days the documentation needed for appeal. For inpatient care, we propose a period of 72 hours (or, if that period ends on a weekend day, until the first business day following the 72 hour period) to request continued coverage pending external review. Where the denied service must be performed on an outpatient basis over time (e.g., chemotherapy treatments), an insured may not realize that an immediate response is required and may lose the right to continued coverage. For this reason, we propose that OPP authorize more time for requesting continued coverage of outpatient services. We suggest 10 days from the receipt of the adverse determination.³

Permitting more time to document medical necessity will allow reviewers to make more informed determinations that better protect patients. At the very minimum, the carrier should be required to provide clear information to the insured of the option to request continued coverage of ongoing treatment and the applicable time limit in the final adverse determination notice, as discussed in our comments on 958 CMR 3.307 above.

External review agencies (ERAs) have too much discretion to decide whether to authorize coverage pending resolution of external review. We therefore support the amendment to section 3.414(1) that *mandates* the ERA to order the continuation of coverage or treatment where it determines that substantial harm to the insured’s health may result absent such continuation or for such other good cause. (The ERA’s decision to continue services upon a finding of substantial harm or other good cause was previously optional.) We further support the

³ MassHealth allows 10 days from the date of a denial or termination notice for a member to request continued assistance pending the appeal. *See* 130 CMR 610.036(A). We believe this is a reasonable timeframe for ongoing outpatient treatment in private insurance cases as well.

amendments in section 3.414(3), which provide that if continued coverage is granted during the internal review process, any continued coverage ordered during external review must follow immediately so that there is no gap in coverage between the internal and external review processes.

In order to ensure more consistent and fair decisions on continuation of coverage during the appeal process, we recommend that the regulation define the terms “substantial harm” and “other good cause” inclusively and broadly to provide guidance to ERAs and protect patients. As part of developing additional guidance, we encourage the OPP to amend section 3.414 to direct ERAs to approve continuation of services where OPP has determined that the case is eligible for expedited external review. In such cases, the OPP now must approve an application for expedited external review where the treating provider certifies that a delay in continuation of health services “would pose a serious and immediate threat to the health of the insured.” Compare the foregoing language with the standard under section 3.414(1), which requires ERAs to approve continuation of coverage where there may be a “substantial harm to the insured’s health” or for “other good cause.” Because a “serious and immediate threat to the health of the insured” should de facto qualify as “substantial harm”, we propose that the OPP direct ERAs to approve any request for continuation of services where OPP has approved expedited external review. This clarification to the regulation would reconcile the standards provided under 3.401 and 3.414, and lead to a more uniform and fair application of these protections.

The need for clearer and more uniform standards for the provision of continued services is illustrated by a recent case at HLA. In that case, a young woman with an eating disorder was admitted to a residential facility specializing in treatment of her condition. Shortly after admission, the woman’s health plan initiated a concurrent review, and denied continued treatment. Her treating providers submitted an internal appeal, and were successful in overturning the health plan denial. Several days later, the health plan again initiated concurrent review, and again denied continued treatment on the grounds it was not medically necessary. The treating provider submitted two expedited internal appeals to the health plan, but was unsuccessful. The woman would be likely to qualify for expedited external review through OPP; however, the health care facility was reluctant to continue treatment because of fear that the request for continued services would ultimately be denied if the appeal was unsuccessful. Though the provider admitted that it was “poor treatment” to discharge the woman, the provider and the patient were unwilling to risk the financial exposure of non-covered treatment.

As shown by this example, providers and patients are abstaining from utilizing the expedited external review process for fear that they will incur uncovered medical expenses. This encourages “poor treatment” and premature patient discharge with potentially serious health risks. If continued services were authorized once an expedited external review is approved, the provider could have proceeded with the external review process with more confidence, and the patient would not have been abruptly and inappropriately discharged from treatment. This presumptive eligibility would not be abused by providers or patients, because there remains a threshold requirement that the patient meets the “serious and immediate threat” standard necessary for expedited external review.

3.415: Decisions and Notice

We support the amendment to section 3.415(7), which specifies that the binding nature of external review decisions does not preclude other remedies available under state or federal law and does not preclude carriers from making a payment on the claim or providing benefits at any time. This language brings the regulation in line with ACA regulations. More importantly, the amendment puts the insured and the carrier on notice that they may pursue settlement of the claim at issue following the ERA's decision.

We further support the amendments under section 3.415(8), which provide for additional review opportunities to retract or revise a decision at the discretion of OPP due to a clear procedural or factual error.

3.500: Disenrollment of Primacy Care Provider and 3.503: Coverage for the Newly Insured

HLA and HCFA receive many calls from consumers who cannot obtain necessary treatment due to a provider being "out of network." Often, the caller has experienced an involuntary change in coverage and a long-standing provider does not participate in the new plan. Mental health providers in particular are often underrepresented in carrier or carve-out networks. Yet building and maintaining a patient-clinician alliance is critical to favorable therapeutic outcomes in the mental health context.⁴

The following HLA case provides a compelling example of the need for smooth transitions in mental health care:

A 16 year old girl was denied continued outpatient visits with her long-term therapist after the girl mother's employer-sponsored coverage changed. The girl has seen the therapist since age 10 for severe anxiety and abandonment issues. The mother has been advised that abrupt disruption of the daughter's treatment with this trusted provider may lead to severe decompensation.

Because of the inadequacy of mental health provider networks, we propose that OPP add provisions for temporary continued coverage of disenrolled and excluded mental health providers under 958 CMR 3.500 and 3.503. We suggest that patients be provided transitional coverage for a minimum of 90 days, or until such time as a qualified mental health provider in-network is available to treat the insured.

⁴ See, e.g., A.O. Horvath and L. Luborsky, The Role of the Therapeutic Alliance in Psychotherapy, *Journal of Clinical and Consulting Psychology*, Vol. 61, No. 4, pp. 561-573 (American Psychological Association, Inc., 1993), at p. 569 (positive relation between good alliance and successful therapy outcome is reasonably well documented across variety of different therapies).

3.504: Carrier's Coverage Conditions

Section 3.504 permits a carrier to condition temporary coverage of treatment of a non-participating provider on the provider's acceptance of the in-network reimbursement rate. This policy effectively prohibits a provider billing the patient for any amount above the carrier rate (other than plan-approved copayment or coinsurance). While we want consumers protected from high cost-sharing, prohibiting balance billing in such transitional care cases may result in a provider refusing to continue treatment, even for a limited time. As explained above, this is particularly important in the context of continuation of care in mental health treatment.

3.508: Denial of Provider Application

Providers should be able to request review of rejection from a carrier network under this section. As mentioned in our comments above, continuity of care for mental health services is an essential part of treatment and the recovery process. The unique role of the establishment of trust for confidentiality and the creation of the therapeutic relationship makes it clinically unwise and costly to force patients who are in the middle of treatment to begin again with a new provider. Disruptions in care may occur when a provider leaves a carrier's network either voluntarily or involuntarily, or when a patient switches health plans voluntarily or involuntarily through job termination, and the new health plan does not include the patient's existing provider in its network. As noted above, mental health providers are often underrepresented in carrier or carve-out networks. Thus, allowing providers to request review of rejection from a carrier network is especially important.

3.600: Reporting Requirements

We support the amendments to section 3.600, including the reporting requirement for breakdown of types of care involved in internal grievances, whether or not continued to external review. We additionally suggest that carriers also be required to report the percentage of practitioners in specialties where access to care is a problem based on delays or other indicators (e.g., mental health). Required carrier data should be accessible to the public via the OPP website and carriers should be required to provide a link to the OPP data on their websites.

3.700: Required Oral Interpretation and Written Translation Services

We strongly support the amendments under section 3.700 to expand requirements for oral interpretation and written translation services. We reject the position of MAHP that the language access provisions of the OPP regulation are too burdensome and exceed requirements under the ACA. To the extent that Massachusetts has adopted more consumer-friendly provisions with respect to language access, this is both permissible and commendable.

We recommend that all notices and services required by this regulation be available, at a minimum, in all languages spoken by five (5) percent or more of the population in the carrier

service area, as well as the languages listed under section 3.700(2).⁵ We further recommend that carriers publicize the availability of interpreter services through a website in addition to all notices. This will ensure that health plan members are aware that these services are available and know how to access them in the event that a written notice is misplaced or lost.

We also suggest that OPP publish on its website and in written public notices that translation and interpreter services may be obtained by calling a specified toll-free telephone number. We recommend that key information on OPP services (e.g., FAQs) be made available on-line in Spanish and other widely-spoken languages.

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Thank you for the opportunity to comment. We request that you carefully consider our proposals. We are available to answer any questions you might have. We look forward to working with the Office of Patient Protection and the Health Policy Commission to enhance consumer protections for members of managed care plans in the Commonwealth.

Sincerely yours,

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⁵ The ACA requires group health plans and carriers to provide culturally and linguistically appropriate notice to members in areas where 10 percent of the population is literate only in the same non-English language. *See, e.g.*, 29 C.F.R. § 2590.715-2719. Pre-existing guidance from the Office of Civil Rights within the Department of Health and Human Services (as amended August 3, 2003) proposes a more generous threshold of five percent or 1000, whichever is less. *See* <http://www.hhs.gov/ocr/civilrights/resources/laws/revisedlep.html>

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