Quality Improvement and Patient Protection

Health Policy Commission

Committee Meeting

July 23, 2013

QIPP Agenda

- **Approval of minutes for April 26 and June 10**
- Status of Behavioral Health Task Force Report
- Overview of Office of Patient Protection and external review process
- Listening session on Office of Patient Protection internal and external review procedures
- Schedule of next QIPP Committee meeting

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- Approval of minutes
- **Status of Behavioral Health Task Force Report**
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Who we are and what we do

History of the Office of Patient Protection (OPP)

- Created 13 years ago to protect Massachusetts managed care consumers
- OPP operated within the Department of Public Health (DPH)
  - Consumer rights to challenge health plan coverage denials
  - Massachusetts fully-insured plans only
- Chapter 224 of Acts of 2012 moved OPP from DPH to HPC

Main responsibilities

- Regulating internal and external review for fully-insured plans (including ACA compliance)
- Administering external review for fully-insured plans
- Consumer assistance and education
- Administering open enrollment waivers – *role depends on final ACA rules*
- Receiving and analyzing annual reports from health plans about appeals, disenrollment of providers, quality of care, medical loss ratio
- Developing and regulating an appeals process for patients in accountable care organizations (ACOs) and risk bearing provider organizations (RBPOs)

HPC and OPP

- Consumer protection: OPP will continue to build on its consumer protection role, and will create new appeal process as part of regulating ACO's and RBPO's
- Consumer education: OPP plans to expand our consumer education efforts, in collaboration with stakeholders
- Access to care: as payment reform is implemented, OPP's connection with consumers provides a direct source of information about health care access

How an internal review is processed

When initiated: consumer has been denied coverage for treatment based on medical necessity, and may file a verbal or written internal grievance with the insurance carrier

OPP role: regulate process and monitor outcomes

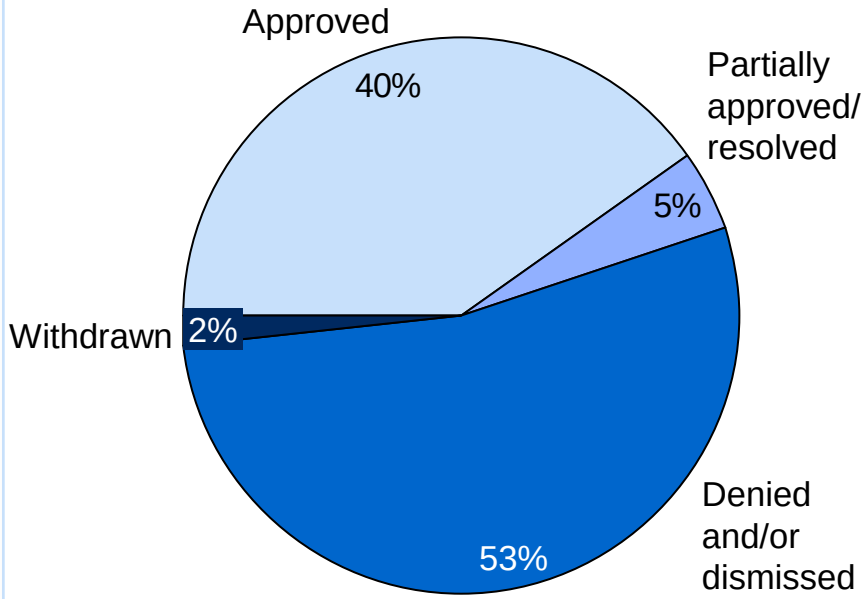
Process

- Carrier has 30 days to respond to a grievance
- Expedited grievance if treatment is urgently needed, to be decided within 48 hours
- Continuation of coverage may be available for the duration of the internal grievance
- Written adverse determination and notice of external review rights if carrier denies the internal grievance

Results in 2012*

Results for grievances received by carriers

100% = 12,783



* Preliminary data as reported by carriers

How an external review is processed

When initiated: if after internal review the insurance carrier still does not cover the treatment, the consumer has the right to an external appeal for eligible claims

OPP role: regulate and administer external review process

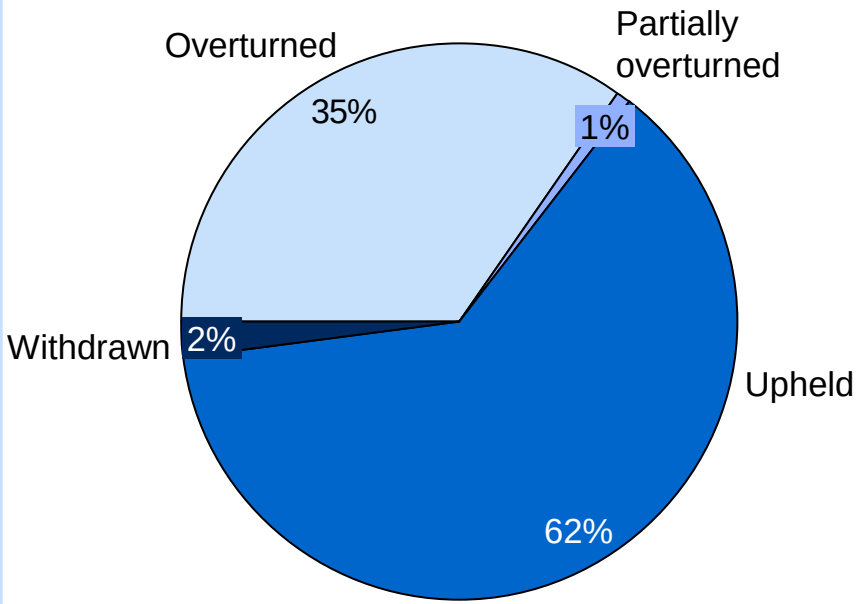
Process

- Consumer has four months to request external review
- Expedited review and continuing coverage for urgently needed care
- Expedited external review may be requested concurrently with expedited internal review
- OPP sends the external review request to one of three external review agencies, which then assigns the case to a medical reviewer who decides if care is medically necessary
- If treatment is found to be medically necessary, the carrier's prior decision is overturned and the carrier must pay for the treatment

Results in 2012*

Results for external reviews received by OPP

100% = 287



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What is medical necessity?

- Appeals are based on whether treatment is medically necessary and a covered benefit
- Medical necessity standard in Massachusetts law*: Medical Necessity or Medically Necessary means health care services that are consistent with generally accepted principles of professional medical practice as determined by whether the service:
  - is the most appropriate available supply or level of service for the insured in question considering potential benefits and harms to the individual
  - is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes
  - for services and interventions not in widespread use, is based on scientific evidence
- Carriers may develop or use medical necessity criteria (level of care guidelines), but legal definition controls

* OPP Consumer Protection Regulations, 958 CMR 3.020

OPP and ACA implementation

- ACA creates minimum standards for state external review processes
- OPP is currently considered “NAIC-similar,” transitional status available until January 1, 2016
- Some changes have been made to ensure full compliance:
  - Shorter timelines for decisions on external reviews
  - Expedited internal review and external review requests may be filed simultaneously
  - Maximum fees of $75/plan year
  - Refund of $25 fee if insured’s case is overturned

Other health insurance appeal rights

Self-insured plans

- Self-insured plans are regulated by the federal government, not the state
- Self-insured employer-sponsored plans – non-grandfathered plans may have appeal rights under the ACA
- Federal law requires an external review process where carriers contract with independent review organizations
- Enforcement agency is US Department of Labor

Non-federal government employees

- Fully-insured Group Insurance Commission (GIC) plans have OPP appeal rights
- Self-insured GIC plans use the federal process or a process administered by US Department of Health and Human Services (HHS)
- Self-insured non-federal government plans -- enforcement agency is US HHS

Medicaid/MassHealth

- No appeal through OPP
- MassHealth medical necessity issues can be appealed to the MassHealth Board of Hearings
- Enforcement agency is MassHealth

Other appeal rights

- External review decisions are final and binding
- Other legal rights may be available outside of the external review process

Specific issues as they relate to behavioral health

- Mental health and substance use disorder treatment claims are the single largest category of external reviews filed with OPP
- External review through OPP considers medical necessity of treatment
- Federal mental health parity complaints:
  - Complaints about fully-insured plans can be brought to Massachusetts Division of Insurance (DOI)
  - Complaints about MassHealth can be brought to MassHealth Customer Service
  - Complaints about self-insured plans can be brought to US DOL Employee Benefits Security Administration (EBSA)

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Contact information

For more information about the Health Policy Commission and the Office of Patient Protection:

- Visit us: http://www.mass.gov/hpc
- Follow us: @Mass_HPC
- E-mail us: HPC-OPP@state.ma.us or HPC-info@state.ma.us