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BY ELECTRONIC MAIL

May 23, 2018

David Seltz
Executive Director
Health Policy Commission
50 Milk Street
8th Floor
Boston, MA 02109

Re: 958 CMR 11.00 – Internal Appeals Process and External Review Process for Risk-bearing Provider Organizations and Accountable Care Organizations.

Dear Mr. Seltz:

On behalf of Atrius Health, thank you for the opportunity to provide comments to the Health Policy Commission (HPC) proposed regulations at 958 CMR 11.00 – Internal Appeals Process and External Review Process for Risk-bearing Provider Organizations and Accountable Care Organizations.

Atrius Health, an innovative nonprofit healthcare leader, delivers an effective system of connected care for more than 720,000 adult and pediatric patients in eastern and central Massachusetts. Atrius Health's 32 medical practices, with more than 50 specialties and 825 physicians, work together with the home health and hospice services of its subsidiary, VNA Care, and in close collaboration with hospital partners, community specialists and skilled nursing facilities. Atrius Health provides high-quality, patient-centered, coordinated care to every patient it serves. Establishing a solid foundation of knowledge, understanding and trust with each of its patients, Atrius Health enriches their health and enhances their lives. Learn more about Atrius Health at www.atriushealth.org

We appreciate the willingness of the HPC staff to take into consideration the viewpoints of providers subject to the proposed regulations and offer the following comments:

General Comments

Effective Date of the Proposed Regulations

Our understanding is the HPC Board is expected to vote on the final regulations at its July 18th meeting, and that the proposed effective date of the regulations is August 10, 2018. We do not

believe this is sufficient time for affected organizations to develop and implement new signage and internal processes in order to comply with the new regulations. Atrius Health strongly recommends that the effective date of the final regulations be postponed until September at the earliest.

Specific Comments:

958 CMR 11.02: Definitions

The proposed definition of "Alternative Payment Contract" includes "any contract between a Provider or Provider Organization and …an employer or individual." This appears to be inconsistent with, and broader than, MGL c. 6D § 1. We recommend the definition be changed to be consistent with the statutory definition ("Any contract between a provider or provider organization and a health care payer which utilizes alternative payment methodologies.").

958 CMR 11.07(2): Time Limits for Resolution of Internal Appeals

Atrius Health is not currently staffed to review and process appeal requests outside of normal business days and hours. Requiring review of and response to expedited internal appeals within 3 calendar days will require us to identify additional resources over weekends and holidays, at additional expense. We respectfully recommend amending the language to read "business days" rather than "calendar days" to allow sufficient time for us to respond to expedited internal appeals.

958 CMR 11.09(2) (c): Form of Written Resolution of the Internal Appeal

We recommend that this provision be revised to clarify that the RBPO or ACO will provide a list of "other documents and information relied upon by the RBPO and ACO … in the internal appeal *which may be provided to the Patient by the RBPO or ACO pursuant to applicable state or federal law.*" (See similar provision at 958 CMR 3.307(3)(c)).

958 CMR 11.10: External Review

We understand that the language here mirrors provisions of 958 CMR 3.400 related to external review of carrier decisions; however, we believe the use of the word "aggrieved" implies that the internal decision was not appropriate and harmed the patient; , and suggest that the language be modified to read instead:

"A Patient or a Patient's Authorized Representative whose internal appeal has been denied by an RBPO or ACO may request an external review of the internal appeal decision by filing a request in writing with the Office of Patient Protection within 30 calendar days of the Patient's receipt of the written resolution of the internal appeal decision."

958 CMR 11.11: Expedited External Review

We are seeking clarification of the process for requesting an expedited external review. As drafted, the Patient is instructed to submit such requests directly to the External Review Agency, not the Office of Patient Protection (OPP) (see 958 CMR 11.11(1): the patient "may apply to the External Review Agency to seek an expedited external review"); however, 958 CMR 11.11(4),

11.15, 11.16, and 11.17 suggest that OPP must first vet all requests (including requests for expedited external review), assign eligible requests to a selected External Review Agency, and send requests for expedited external review to the External Review Agency. We respectfully suggest that it may make sense to move 958 CMR 11.11 after 958 CMR 11.18.

958 CMR 11.12: Fees

We understand that MGL c. 176O, s. 24 is silent regarding the allocation of fees for external review; however, we believe that Patients should be required to pay some element of the cost of external review to help discourage frivolous or redundant/repetitive appeals. While we do not want to create a barrier to an external review, there should be some mechanisms in place to encourage Patients to be thoughtful about when they utilize this process. Asking RBPO's or ACO's to absorb the entirety of this expense in addition to the resources required to implement the administrative provisions of these regulations, just adds to the cost of care. We think a minimal fee of $25 as is required for external appeals of carrier decisions is reasonable.

958 CMR 11.13(2): Consent to Release of Medical Records

We believe the requirement to ensure that patients have access to medical information and records relating to them and in possession of the RBPO or ACO should be clarified as "in accordance with applicable law."

958 CMR 11.19(1) (b) and 11.19(2): Medical Records and Other Information

We recommend revision of the first sentence of 11.19(1) to clarify that the records to be forwarded should be only those authorized by the patient for release (i.e., "The RBPO or ACO shall forward the Patient's medical and treatment records … to the identified External Review Agency *as authorized by the Patient.")*

Many providers such as Atrius Health do not have staff available to process written communications and compile documentation except during normal business hours/days. To meet the response time frames set forth in this section, we will need to identify additional resources, at additional expense. We recommend expansion of the time frames to three business days for non-expedited review and two business days, at a minimum.

With respect to 958 CMR 11.19(2), in the interest of fairness and transparency, the RBPO or ACO should also receive copies of all information, including "additional medical evidence," that a patient or the patient's authorized representative submits to the External Review Agency.

958 CMR 11.21(2): Decisions and Notice

We reiterate the concerns we have raised previously to the HPC about adopting the subjective standard of "likely to produce a more clinically beneficial outcome for the Patient" for overturning a decision by an RBPO or ACO. We are concerned that this standard, and the identified factors the External Review Agency is tasked to consider, will result in inconsistent decision-making. For example, when considering a patient's "prior clinical relationships," what time frames will be applied? What constitutes a "prior clinical relationship" warranting consideration? We also think that the enumerated factors omit a critical element - the type of health plan product in which the patient is enrolled. As we have discussed with HPC, patients

often do not understand that their health plan may require and/or permit use of a limited network of referral providers, and that they have the ability to change PCPs if they wish to see someone outside of the limited network. We think the more traditional "medical necessity" standard would help ensure objectivity and consistency in decision-making.

958 CMR 11.21(9): Decisions and Notice

Our concerns about the resource commitment required for us to comply with the required response time frames throughout the proposed regulations apply to this provision as well.

Thank you for the opportunity to provide comments on these important regulations. If you have any questions or require further information, please feel free to contact me at (617) 559-8013 or Kathy Keough, Director of Government Relations at (617) 559-8561.

Sincerely,

Marci Sindell
Chief Strategy Officer and Senior Vice President, External Affairs