December 20, 2013

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

Re: 958 CMR 3.00, Health Insurance Consumer Protection

Dear Director Bosco:

On behalf of the Massachusetts Association of Health Plans (MAHP), I am writing in response to your request for feedback on the Office of Patient Protection's (OPP) draft regulations governing Internal and External Appeals. We are pleased to provide you with the following comments.

The Massachusetts Association of Health Plans represents 16 health plans that provide health care coverage to approximately 2.5 million Massachusetts residents, including Medicare beneficiaries, Medicaid and Commonwealth Care recipients, participants in employer-sponsored plans, and individuals purchasing non-group coverage. MAHP member health plans consistently distinguish themselves from those in other parts of the country with innovative programs designed to improve quality and lower costs within the health care system.

We are proud that our member health plans have consistently been rated the best in the nation. In its annual report card ranking the clinical quality and member satisfaction of health plans across the country, the National Committee for Quality Assurance (NCQA) rated members of MAHP among the top health plans in the country for all three categories – commercial, Medicare and Medicaid – including the #1 health plans for commercial and Medicaid coverage. The rankings are based on data evaluating nearly 300 health plans on issues such as access to care, prevention efforts and treatment of diseases, such as diabetes and heart disease.

NCQA Accreditation standards are the most rigorous in the industry, and are developed with the help of health plans, providers, purchasers, unions, regulatory agencies and consumer groups. Massachusetts has also implemented the most stringent internal and external appeals requirements in the nation. Massachusetts General Laws Chapter 176O, Sections 13 and 14, and Division of Insurance (DOI) regulations 211 CMR 52, and 958 CMR 3.000 contain requirements

related to adverse determinations, carrier internal and external appeals requirements as well as consumer notification and accreditation requirements.

Medical Necessity – 3.101

Section 3.101(C) of the proposed regulations requires that carriers make utilization review (UR) and medical necessity (MN) criteria and protocols available to OPP and to members of the public upon request and at no charge.

Chapter 224 included provisions governing the disclosure of UR and MN criteria. Section 199 required carriers to disclose UR criteria on the carrier's website, however included an exception for proprietary information. Proprietary information is not required to be included on a carrier's website, however must be made available to providers and subscribers upon request. Section 202 required carriers to disclose MN criteria on the carrier's website and did not include the exception for proprietary information. Section 15 (Section 16 of Chapter 6D), grants OPP the authority to promulgate regulations governing the disclosure of UR and MN criteria that are consistent with, and do not duplicate or overlap with regulations promulgated by the Division of Insurance (DOI).

We are concerned that the proposed draft regulations go beyond and may be inconsistent with the approach of the DOI. The DOI has held public sessions to discuss the potential regulations implementing these sections and is in the process of promulgating regulations. Therefore we urge OPP to amend the Proposed Regulations to include the protections for proprietary information.

Information on Internal Grievance Process – 3.301

Section 3.301 (C) expands the information carriers are required to provide in a notice of adverse determination when the carrier or utilization review organization relies on new information or rationale during the internal grievance process. Carriers are required to provide the insured with the information as soon as possible but not fewer than 7 days prior to the date for the final adverse determination and give the insured a reasonable opportunity to respond. We have some questions regarding how this process will work and the timeframes by which they are to be completed. First, this section does not include any further guidance as to whether the date of the final determination will be extended, and how the information is to be transmitted to the member. Additionally, it is also unclear as to whether the use of new information will be considered a "reconsideration" by OPP. We request that OPP provide additional clarification as part of this section.

Qualifications of Review – 3.306

During the hearing some of the participants raised concerns regarding the experience and expertise of the individuals within the health plan reviewing internal grievances and recommended that the terms 'or similar" be stricken from the language and others asked that the term "typically" be stricken from the section. Pursuant to state law (211 CMR 52.08(3)(c)), adverse determinations are required to be made by a person licensed in the appropriate specialty related to such health care service and, where applicable, by a provider in the same licensure category as the ordering provider. 958 CMR 3.306(B) requires that grievances of adverse

determinations be reviewed by an "actively practicing health care professional in the same or similar specialty who typically treat the medical condition, perform the procedure or provide the treatment that is the subject of the grievance." Additionally, NCQA requires that these decisions be made by a professional actively practicing in the same or similar specialty.

It was unclear from the remarks made at the session as to the specific concern. Health plans are in compliance with these requirements and no data or evidence was presented to the contrary. There was however a suggestion made that the regulations require not only that the reviewers be actively practicing health care professionals in the same or similar specialty who typically treat the medical condition but that they themselves have experience with the specific treatment or service being sought. This is an important distinction. We have concerns that such a requirement would not be practical and only lengthen the review process as it could take time to locate the right practitioner. There is no evidence to suggest that the current standards do not afford consumers appropriate protections. We would oppose any such change to the regulations.

Form of Written Resolution - 3.307

Section 3.307 expands the information required to be included as part of an adverse determination notice. Our specific comments and concerns are outlined below.

Subsection (B)(1) requires that such notices include information that is sufficient to identify the claim involved and requires that carriers include information such as the date of the service, the health care provider, claim amount (if applicable) and the diagnosis and treatment codes. We are concerned with the inclusion of diagnosis and treatment codes in the adverse determination notices.

The approach taken by the proposed regulations is inconsistent with where the federal rules landed on this issue. We recognize that state regulations may exceed federal rules; however we support the federal Amended Interim Final Rules and agree with the rationale behind the change. Initially, the Interim Final Rules (July 23, 2010) required that the diagnosis and treatment codes be included in an adverse determination notice. However, the Departments received numerous comments from a range of stakeholders, including consumer advocates and health plans that expressed privacy concerns including the diagnosis and treatment codes. According to the preamble of the Amended Interim Final Rules (June 24, 2011), a number of consumer advocacy groups raised concerns about including diagnosis codes that could reveal sensitive diagnosis information, including mental health issues. Commenters pointed out the fact that plan documents are often sent to individuals who may not be patients, and this is even more important for dependents under 26 who remain on their parents plan. We believe that the approach taken by the Amended Interim Final Regulations represents an appropriate balance between providing sufficient information to consumers regarding their appeal and protecting individual privacy. For these reasons, we ask that you amend the proposed rules to conform to the Amended Interim Final Rules.

Subsection (B)(7) requires that carriers provide the insured with a summary of the reviewer's professional qualifications, and a certification that the reviewer meets the qualifications specified at 958 CMR 3.306(B). It is unclear what the regulations are requesting in the form of a "certification" and what would qualify as a certification. Carriers today provide insureds, in each

notice, with a description of the reviewers qualifications, as required under state law today. If OPP is intending to go beyond current practice, it would be helpful for OPP to provide the carriers with additional guidance.

Section 3.307(B)(5) requires that carriers provide a copy of "any other standard, guidance, policy or memoranda used in making the decision." It is unclear what is expected to be included by this language. Moreover, internal policies are often considered to be proprietary and not subject to public release. Additional clarification on this section would be helpful.

Section 3.307(B)(6) requires that carriers specify alternative treatment options covered by the carrier, including the identity of providers in the insured's geographic area and their language. We have concerns with this requirement given that it goes beyond what is required by the ACA and would be extremely burdensome for carriers to provide, assuming that carriers capture the information and that it is even available. Carriers may not always capture the provider's language and alternative treatment options are sometimes not available.

Reconsideration – 3.308

Section 3.308 governs reconsideration of a carrier's final adverse determination. Subsection (A)(3) sets forth the circumstances for which an insured in a group plan may request a reconsideration, including for "other good cause". This language is vague and could apply in any number of circumstances. We therefore request additional clarification to provide guidance on what would constitute any "other good cause". Additionally, while we recognize that the ACA limits reconsideration to members of group health plans, we strongly urge OPP to examine expanding this option to non-group members as well. Reconsideration is a benefit to enrollees because it gives them another chance to appeal. Additionally, it is challenging for carriers to operationalize two separate policies (one for small group and one for non-group).

Expedited Internal Review - 3.309

Section 3.309(A)(4) allows for an insured to file a request for an expedited external review at the same time as the insured files a request for an expedited internal review of the grievance. We would like additional clarification as to how this process would work. Section 3.300(C) allows an insured to waive the internal grievance process and seek an immediate external review. We do not see such a similar allowance pertaining to the insured's right to file a request for concurrent expedited external review. While there may be instances where the carrier would opt to complete an expedited internal review and complete it in advance of the expedited external review, there may be instances where the carrier's review would be overturned. Given that the outcome of the expedited external review would trump the outcome of the expedited internal appeal, having such an option could avoid a potential unnecessary administrative step. We ask that OPP consider allowing carriers to waive the expedited internal review in certain circumstances.

Time Limits – 3.311

The proposed regulations remove the ability of carriers and insureds to extend the time limit for the review by mutual written agreement.[1] We have concerns with this proposed change, as we do not read the federal rules as prohibiting the ability of carriers and consumers to mutually extend the time line, and such extensions may be in the best interest of the consumer.

[1] References to the time limit extension removed in Sections 3.302, 3.305(C), and 3.311(B).

Nothing in the Amended Interim Final Rules specifically prohibits the ability of carries and consumers to mutually extend the time period. In fact, this question was included in the US Department of Labor's Benefit Claims Procedure Regulations Frequently Asked Questions (FAQ):

> C-5.May a claimant agree to an extension or further extension of the time period within which a plan must decide a claim?
>
> Yes. The only limits on extensions of time established by the regulation are imposed on plans. Claimants may voluntarily agree to provide a plan additional time within which to make a decision on a claim, even under circumstances where the plan could not unilaterally extend the decision making period, such as in the case of a claim involving urgent care or a claim on appeal.[2]

We support this continued flexibility. While such extensions are rare and represent the exceptions to the 30 day process, as noted in the scenarios below, they are always requested when it is in the member's best interest and that extensions are only granted if the member approves.

- Scenario #1:
  During the appeal process the carrier will send the member a complete copy of their case file. This is usually sent to the member the week before the case is set to be reviewed. The member is asked to review the case file and respond with any additional information they would like to be reviewed. There are times when the member decides that they need extra time to obtain some additional information. The carrier would ask the member if they would like to extend the case to allow for the gathering of additional information or send the case to be reviewed as is. The members generally choose to extend the case.

- Scenario #2:
  The member is requesting coverage of services with an out-of-network (OON) provider. The specialist will contact the OON provider and request medical information. As these providers are non-contracting it sometimes takes a while to obtain medical records. The carrier may have to send over a written fax requesting the medical information, and if the provider is OON they generally note it will take two weeks or longer to send the medical information and they will only send by regular mail. If the case is based on medical necessity once the carrier receives the information the carrier may have to send to an outside consultant for review. Then the member is sent the complete appeal file allowing for at least 5 days for the member to review the file. The carrier would be in contact with the member during the appeal and if it appears the carrier will not receive the medical information in enough time to have it reviewed by the outside consultant and the member, the carrier will ask the member if they would like to extend the case.

[2] See "FAQs About The Benefit Claims Procedure Regulation" http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html

- Scenario #3:
  A case is being reviewed by the carrier or its utilization review committee and the carrier or committee comes up with a question which requires clarification. The specialist may have to contact a provider to see if the provider can clarify a question. This may take a few days, but the clarification may be the difference in paying an issue or denying.

- Scenario #4:
  The carrier had difficulty reaching the member's surgeon, an extension was requested to connect with the physician and obtain additional clinical information. Without the additional information the appeal would have been denied, but with additional clinical information that was reviewed by the same/similar specialist, a procedure request was reviewed as medically necessary for an appeal approval.

Reporting Requirements – 3.600

Section 3.600 includes a number of administratively burdensome reporting requirements. We are concerned with the scope of the proposed reporting requirements as they are already included in information that is reported to the DOI as part of the accreditation process and mental health parity reporting. Section 3.600(A)(4)(b) does include language that allows carriers to state to OPP when information required in that subsection is already provided to the DOI, however subsection 3.600(A)(5) includes a list of information that is already submitted to the DOI as part of the accreditation and licensure process.

Current practice is, for information required by OPP and that is currently filed with the DOI, carriers may submit an attestation so there is no need to file twice. We ask that the OPP allow for this practice to continue and that the regulations include a statement allowing such attestation. The HPC has, on several occasions stated its commitment to reducing unnecessary and duplicative reporting by relying on existing sources of information. We strongly encourage that OPP coordinate with the DOI to collect this duplicative information and require carriers to report information that is not already collected by another agency, department or authority.

Translation Services – 3.700

Section 3.700 includes requirements for providing translation services. We are concerned with the potentially costly and administratively burdensome requirements that go above and beyond those required under the ACA and may already be included as part of a carrier's EOC.
The Amended Interim Final Rules require that carriers sending notices to addresses in a county that meets the 10 percent language threshold must include a one-sentence statement in the relevant non-English language about the availability of language services. The Amended Interim Final Rules go on to require that carriers provide a customer assistance process with oral language services in the non-English language and provide written notices in the non-English language upon request. The rules also remove the so-called tagging and tracking requirements, which required the carriers, in the event an insured requested a document in a non-English language, to "tag and track" the insured and ensure that any future notices would be automatically provided in the non-English language.

By contrast the proposed regulations require (C) carriers to include in the English version of all notices a statement in English and in the languages specified in the regulation about the

availability of language services. This goes beyond the Amended Interim Final Rule, whereby a statement is only required when the carrier sends a notice to a member located in a county which meets the 10 percent language threshold and carriers are required to provide that statement in English and in the requested language. Finally, we would like to note that Section 3.700 (C) includes an incorrect regulatory reference. We believe it was intended to refer to the languages referenced in 958 CMR 3.700 (B)

Additionally, (D) requires that if a member requests written translation services, then the carrier must provide all subsequent written notices in the language requested. This is similar to the tagging and tracking requirement which was removed from the Amended Interim Final Rule.

The federal Amended Interim Final Regulations were scaled back in response to serious concerns raised regarding the potential administrative costs associated with the original requirements and concerns about the ability to comply with the more stringent requirements, especially the so-called tagging and tracking requirements within the prescribed time period. Again, we recognize that state regulations may exceed federal rules; however we support the federal Amended Interim Final Rules and agree with the measured rationale behind the changes. We believe that the Amended Interim Final Rules struck the appropriate balance between minimizing administrative burdens and ensuring that consumers are able to access information regarding their coverage in their own language. For these reasons we request that OPP amend the proposed regulations to be consistent with what the Amended Interim Final Rules require today.

<u>Provider Reimbursement for Appeals Costs</u>

During the December 16th hearing, it was recommended to OPP that providers be compensated for the time involved in a member appeal and for any direct costs associated with an appeal. We strongly oppose such a mandated reimbursement. First, we find no statutory basis on which to require health plans to reimburse providers for appeals costs. Additionally, carriers reimburse providers for contractually performed services and treatments, in many contracts administrative costs are included as part of the contract. Requiring carriers to separately reimburse providers for any time spent sending inpatient medical records to the carrier for the review could result in double payment if administrative costs which are included in the contract. At a time when our focus is controlling the increase in health care costs, requiring health plans to reimburse providers for additional administrative duties of office practices is moving us in the wrong direction and will increase costs for consumers and employers.

Again, we thank you for the opportunity to provide you with these comments. The Massachusetts external appeals process is a robust program that affords strong protections to MA consumers. We look forward to working with OPP and the HPC in continuing to ensure that Massachusetts consumers are afforded these critical protections and have access to high quality and affordable health care. If you or your staff have any questions or would like any additional information, please don't hesitate to contact me.

Sincerely,

Sarah Gordon Chiaramida, Esq.
Vice President of Legal Affairs
Massachusetts Association of Health Plans

Cc: John Polanowicz, Secretary, Executive Office of Health and Human Services
David Seltz, Executive Director, Health Policy Commission
Marylou Sudders, Chair, Quality Improvement and Patient Protection Committee, Health Policy Commission
Carole Allen, Commissioner, Health Policy Commission
Wendy Everett, Commissioner, Health Policy Commission
Veronica Turner, Commissioner, Health Policy Commission