

Frequently Asked Questions: Appeals Process for Patients of Risk-Bearing Provider Organizations

Issued 08/19/2016

This document is intended to provide additional guidance to risk-bearing provider organizations (RBPO) and accountable care organizations (ACO) establishing an appeals process pursuant to Health Policy Commission (HPC) Interim Guidance (Bulletins [HPC-OPP-2016-01](#) and [HPC-OPP-2016-02](#)). The Interim Guidance aims to enhance patient protections while recognizing that each provider organization has a unique organizational structure and may have existing practices for addressing patient concerns. Required reporting and ongoing stakeholder feedback will assist the Office of Patient Protection (OPP) in promulgating regulations, which will identify more specifically how the appeals process for patients of RBPOs and ACOs must be administered.

The HPC encourages stakeholders with specific questions to contact Steven Belec, Director of OPP, at Steven.M.Belec@state.ma.us or 617-979-1413.

Notice to Patients

Q1: Is it necessary to give notice to patients individually? Is posting the notice sufficient under the Interim Guidance?

A: The Interim Guidance does not require individual notice. Notice may be posted in primary care offices. In addition, patients should be able to obtain a hard copy or electronic copy of the notice, upon request. However, it is recommended that the RBPO/ACO take a proactive approach and provide notice in the methods that will best reach its patient population, which may include multiple methods, including mail, email, website and office postings, and handing the notice directly to patients with other paperwork related to that office visit.

Q2: May the RBPO/ACO require the designation of a third party to act on behalf of the patient be in writing?

A: Yes, the RBPO may require patients to designate an authorized representative to act on their behalf, in writing.

Q3: May the RBPO/ACO modify the [sample notice](#) to better suit the needs of its patient population?

A: Yes, the sample notice is meant to be a guide and can be altered and made more specific for each RBPO/ACO or individual practice. The RBPO/ACO should ensure that all components required by the Interim Guidance are included in the notice.

Q4: Can the RBPO/ACO require written appeals?

A: No, the RBPO/ACO may not require patients to submit an appeal in writing.

Q5: Who can file an appeal?

A: Patients with commercial insurance who have selected or who are otherwise attributed to a PCP participating in the RBPO/ACO may file appeals.

Q6: Does this process apply to Medicare or MassHealth patients? What about patients who have Medicare Advantage?

No, the appeals process does not apply to any MassHealth (Medicaid) or Medicare patients. Likewise, this process does not apply to Medicare Advantage patients.

Q7: Would the appeals process apply to the RBPO/ACO's primary care patients when these patients receive care from specialists?

A: The appeals process applies to patients who have selected a PCP or who are otherwise attributed to a PCP participating in the RBPO/ACO and applies to decisions of the PCP or RBPO/ACO related to all the care, including specialist care and referrals to inpatient care, SNF and home health services, that the patients receive or seek to receive.

Issues for Appeal

Q8: Is there a difference between an appeal and a complaint as those terms are used in the Interim Guidance?

A: No, the Interim Guidance describes one process that the RBPO/ACO must make available to patients. The appeals process is used to address certain disputes, complaints, or concerns that patients seek to appeal with the RBPO/ACO.

Q9: How should the RBPO/ACO distinguish between a carrier appeal and one that falls under this process?

A: At issue under the carrier appeals process are coverage determinations, such as out-of-network issues, cost-sharing concerns, and whether the treatment meets the health plan's medical necessity guidelines. The RBPO/ACO appeals process addresses concerns that patients have with decisions that are made by the PCP or RBPO/ACO, such as referral restrictions, the type or intensity of the recommended services, and timely access to care within the RBPO/ACO.

Q10: How does this new appeals process affect the responsibility for payment between carriers and provider organizations that take on risk?

A: The RBPO/ACO appeals process does not change the allocation of responsibility for payment between an RBPO/ACO and a carrier.

Standard of Review and Timeframes

Q11: Are the timeframes by which the RBPO must complete review of each appeal (14 days for a standard appeal and 3 days for an expedited appeal) measured by business days or calendar days?

A: Neither the statute nor the Interim Guidance defines days for the purposes of RBPO/ACO appeals. For carrier appeals, OPP's regulations at 958 CMR 3.020 define "days" as "calendar days unless otherwise specified." Consistent with existing regulations, the RBPO/ACO is encouraged to complete review of appeals within 14 calendar days or, for those involving urgent medical need, within 3 calendar days.

Q12: Is there a mandated standard of review?

A: There is no statutory standard of review. However, due to the fact that this process allows patients to raise concerns about decisions or actions that affect his or her health care, review of patient appeals should consider medical necessity and/or clinical appropriateness, as necessary.

Q13: What are the appropriate qualifications of those reviewing the appeals? Does the reviewer need to be at any particular organizational level within the RBPO/ACO?

A: Minimally, the reviewer should have a clinical background with an active license to practice in Massachusetts. In addition, the reviewer should not have been involved in the initial care decision and should not be under direct supervision of the individual who made the initial care decision. The RBPO/ACO may opt to manage appeals at whichever organizational level is appropriate given the unique business/staffing structure of the organization. For example, the reviewer could be the medical director of a local practice or a medical director at the RBPO/ACO administrative level.

Q14: Can a team of clinical reviewers, perhaps with different specialties, be tasked with reviewing appeals? Can an administrative person facilitate the assignment of appeals among the team of clinical reviewers?

A: Yes, either one reviewer, multiple, or a team may review the appeals. Please describe the chosen approach in the reporting submitted to OPP.

Q15: How is urgent medical need defined for the purposes of expedited review?

A: A clinical professional at the RBPO/ACO, independent from the initial decision maker, should determine whether the patient has an urgent medical need that warrants an expedited review. For further guidance in making this determination the RBPO/ACO may refer to OPP's regulatory definition of "immediate and urgently needed service" at 958 CMR 3.309(1)(a). Specifically, the clinical reviewer should determine whether the risk of serious harm to the patient is so immediate that the provision of such service should not await the outcome of the standard 14-day response time. This may occur when a patient is receiving emergency services, ongoing services, or the patient has a terminal illness and where a delay might seriously jeopardize the health of the patient or otherwise jeopardize the patient's ability to regain maximum function. A post-service appeal would generally not be construed as requiring expedited handling.

Reporting

Developed in collaboration with RBPO and ACO stakeholders, OPP has developed a [reporting template](#) to facilitate compliance with reporting obligations for provider organizations. Submission of the completed reporting template by the dates indicated below satisfies the reporting requirements in the Interim Guidance.

Q16: When must the RBPO/ACO begin administering an appeals process and collecting information for reporting?

A: Each certified RBPO must have an appeals process in place by October 1, 2016, as established by [HPC-OPP-2016-02](#). An ACO seeking certification by the HPC must have an appeals process in place that complies with the requirements of the Interim Guidance at the time of submission of an application to the HPC.

Q17: When is reporting due to OPP?

A: The first report is due on January 17, 2017 for appeals received during the period of October 1, 2016 through December 31, 2016. The second report is due on April 17, 2017 for appeals received during the period of January 1, 2017 through March 31, 2017.

Q18: Is an RBPO/ACO, which includes various practices, required to submit data for each practice or will one report for the entire RBPO/ACO suffice?

A: One report from the RBPO/ACO will suffice.

Q19: Should the RBPO/ACO report on issues that are resolved at the point of care or point of service?

A: No. If patient issues are resolved at the point of care/service, either with clinical or administrative staff, there is no need to report those issues to OPP as RBPO/ACO appeals. However, to the extent that a patient raises an issue that cannot be resolved at the point of care/ service or raises an issue after care delivery, via a phone call to the appeals contact for example, those issues should be reported as RBPO/ACO appeals.

Q20: How should the RBPO/ACO report on concerns that should be addressed to the carrier?

A: RBPOs/ACOs are not required to report on consumer concerns that fall outside of the scope of the RBPO/ACO appeals process, such as concerns related to a carrier's limited network. However, it would be helpful for OPP to better understand the breadth and magnitude of patient concerns, so OPP welcomes dialogue regarding the volume of inquiries the RBPO/ACO receives that fall outside of the RBPO/ACO appeals process.

Q21: Is the reporting subject to disclosure under the Massachusetts Public Records Law (MGL c. 66, § 10)?

A: Yes, the reports submitted are subject to disclosure under the Massachusetts Public Records Law, except to the extent statutory exceptions to disclosure may apply.

Q22: Must the RBPO/ACO report on information that has not changed since the last reporting period?

A: No, the reporting template indicates that certain information need only be submitted in the second report to the extent that the information has changed since the first report.

Role of OPP

Q23: Will OPP be involved in resolving individual patient appeals where the consumer is unhappy with the result of an RBPO/ACO appeal?

A: During implementation of the InterimGuidance, OPP's role is to provide general guidance to consumers about the appeals process, not to resolve individual consumer issues. OPP will also provide guidance to RBPOs and ACOs concerning the Interim Guidance.

Q24: When does OPP anticipate promulgating regulations?

A: OPP anticipates releasing proposed regulations in 2017, after completing review of the two reports submitted by RBPOs/ACOs in January and April 2017.

Q25: What are the recordkeeping requirements of these appeals?

OPP recommends that the RBPO/ACO retain records of patient appeals at least until OPP promulgates final regulations on the RBPO/ACO appeals process. OPP's final regulations on RBPO/ACO appeals will address the issue of records retention more specifically.