MASSACHUSETTS
HEALTH POLICY COMMISSION

Frequently Asked Questions for RBPOs/ACOs: Appeals Process for Patients of Risk-Bearing Provider Organizations and Accountable Care Organizations

Issued November 2018

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 958 CMR 11.00: Internal Appeals Process and External Review Process for Risk-Bearing Provider Organizations and Accountable Care Organizations. For more details, please consult the regulation.

The HPC encourages provider organizations with specific questions to contact Nancy K. Ryan, Director of OPP, at Nancy.K.Ryan@mass.gov or 617-274-1844.

Notice to Patients

Q1: How must RBPOs/ACOs give notice to patients?

A: Notice must be available in writing at all locations where patients regularly seek care. In addition, patients must 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, patient portal or distributing the notice directly to patients during an office visit.

Q2: May the RBPO/ACO modify the OPP-issued 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 958 CMR 11.04 are included in the notice.

Q3: May the RBPO/ACO require that the designation of a third party to act on behalf of the patient be in writing?

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

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 use the appeals process?

A: Patients with commercial insurance who have selected a PCP participating in the RBPO/ACO or who are otherwise attributed to the RBPO/ACO, and for whom such services are paid under an alternative payment contract may file appeals.

Q6: Does this process apply to Medicare, Medicare Advantage, or MassHealth patients? What about MassHealth ACO patients?

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

Q7: Does 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 participating in the RBPO/ACO or who are otherwise attributed to the RBPO/ACO and applies to decisions of the PCP or RBPO/ACO participants related to all the care that the patients receive or seek to receive, including specialist care, referrals to inpatient care, skilled nursing facilities, and home health services.

Issues for Appeal

Q8: 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 carrier's medical necessity guidelines. The RBPO/ACO appeals process addresses concerns that patients have with decisions that are made by the PCP or other RBPO/ACO participants, such as referral restrictions, the type or intensity of the recommended services, and timely access to care within the RBPO/ACO.

Q9: 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.

Processing Internal Appeals

Q10: What are the timeframes by which the RBPO/ACO must complete review of each appeal?

A: The RBPO/ACO must complete the review of each appeal and provide notice within 14 calendar days of receiving an appeal. For expedited appeals, the RBPO/ACO must complete review and provide notice within 3 business days of receiving an appeal.

Q11: What are the appropriate qualifications of those reviewing the internal appeals? Does the internal reviewer need to be at any particular organizational level within the RBPO/ACO?

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

Q12: How is urgent medical need defined for the purposes of expedited review?

A: An individual with a clinical background with an active license to practice, not involved in the decision about which the patient appealed, should determine whether the patient has an urgent medical need that warrants an expedited review. The internal reviewer should determine whether the risk of serious harm to the patient is so immediate that the provision of appealed services 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 when 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.

Q13: May the RBPO/ACO modify the OPP-issued sample written resolution letter to better suit the needs of its patient population?

A: Yes, the sample written resolution letter 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 958 CMR 11.09 are included in the written resolution letter.

Q14: Must the RBPO/ACO include OPP's external review request form with all written resolution letters, or only letters where the referral, treatment or service is denied?

A: The RBPO/ACO must include a paper copy of the request form issued by OPP with all written resolution letters.

Reporting

Q15: When is reporting due to OPP?

A: The next RBPO/ACO appeals report is due to OPP by April 1, 2019 for the period of January 1, 2018 through December 31, 2018. Reports for each subsequent year are due to OPP by April 1st. The quarterly reporting under the Interim Guidance is no longer required.

Q16: Will OPP release an updated template for annual reporting?

A: Yes. OPP will release an updated reporting template in early January 2019. The reporting template will be substantially similar to the previous reporting template.

Q17: 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.

Q18: Should the RBPO/ACO report on issues that are resolved at the point of care or service?

A: No. If patient issues are resolved at the point of care or 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 or service or raises an issue after care delivery, via a phone call to the appeals contact for example, that should be reported as an RBPO/ACO appeal.

Q19: 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.

Q20: 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 exemptions to disclosure may apply.

Q21: What are the recordkeeping requirements of these appeals?

A: RBPOs/ACOs are required to establish a system for maintaining records of each appeal and must retain the records for seven years.

External Review

Q22: How will the RBPO/ACO be notified that a patient has requested an external review?

A: OPP will notify the RBPO/ACO via secure email of external review requests that have been deemed eligible. OPP will notify the RBPO/ACO via secure email on the same day that the external review is assigned to an external review agency. OPP will email the patient appeals contact listed on the last quarterly report submitted by the RBPO/ACO, unless the RBPO/ACO has since identified a different contact person.

Q23: How should the RBPO/ACO send medical and treatment records to the external review agency?

A: The RBPO/ACO may send medical records to the external review agency via a method that is convenient for the RBPO/ACO and meets the RBPO/ACO's confidentiality and security standards. The external review agencies accept medical records via mail, fax, or secure email. The RBPO/ACO must send medical and treatment records relevant to the review to the external review agency within three business days of receipt of notifcation from OPP for standard appeals and within one business day of receipt of notification from OPP for expedited appeals.

Q24: What is the standard of review that the external review agency will use?

A: The external review agency will determine whether the requested referral, treatment or service that is the subject of the review is likely to produce a more clinically beneficial outcome for the patient than the referral, treatment or service recommended by the RBPO/ACO. The external review agency will consider the following factors in making this determination: the patient's clinical history; the availability within the RBPO/ACO of a health care professional with appropriate training and experience to meet the particular health care needs of the patient, including timely access; generally accepted principles of professional medical practice; the efficacy of the requested treatment or service based on scientific evidence, professional standards, and expert opinion; and other factors the external review agency considers relevant to the patient's ability to access the requested referral, treatment, or service.

Q25: How will the RBPO/ACO be notified of the external review agency's decision?

A: The external review agency will provide a final copy of the decision to the RBPO/ACO via mail or fax.

Q26: How will the RBPO/ACO be billed for each external review?

A: Upon completion of the external review, the external review agency will bill the involved RBPO/ ACO directly. The fees for a standard review range from $465-$575, depending on the external review agency. The fees for an expedited review range from $525-$750, depending on the external review agency.