Health Policy Commission (HPC) Internal Patient Appeals Policy Requirement

Frequently Asked Questions

Q1 Can the Risk Bearing Provider Organization (RBPO)/Accountable Care Organization (ACO) require an appeal to be written?

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

Q2: Who can file an appeal?

A: Patients with commercial insurance who have selected or who are otherwise attributed to a primary care provider (PCP) participating in the RBPO/ACO may file appeals. The Lahey Clinical Performance Network (LCPN) contracts within this category include Blue Cross Blue Shield of Massachusetts (BCBSMA), Harvard Pilgrim Health Care (HPHC), Tufts Health Plan (THP), and Cigna.

Q3: Does this process apply to Medicare or MassHealth patients? What about patients who have Medicare Advantage?

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

Q4: 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, skilled-nursing facility (SNF) and home health services that the patients receive or seek to receive.

Q5: 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.

Q6: 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.

Q7: 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.

Q8: 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.

Q9: 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.

Q10: Can practices put the Patient Notification on their own letterhead? Or should it be on Lahey Health System (LHS) letterhead?
While the regulations don't govern this, given that this is an LCPN-wide appeals process the notice shouldn't go on individual practice letterhead. If the independent practices are reluctant to post/provide a notification on LHS letterhead then we would recommend LCPN letterhead.

Q11: What if the patient was already seen by the out-of-network (OON) specialist and then requests a referral which the PCP does not approve (i.e. a retrospective referral request); could the patient appeal this?
Yes, the ACO/RBPO appeals process applies to denials of referrals generally and we are not aware of any limitation that would prevent a patient from using the process to appeal a retrospective referral request that was denied.

Q12: Does the notification need to be posted only PCP offices, or specialist sites too?
The regulations require that notifications be "available in all locations where Patients regularly seek care". That language alone doesn't answer your question (and arguably could include specialists' offices), but we looked back at the interim guidance in which HPC stated "[a]t a minimum, the RBPO shall make such notice available in writing at all locations where patients regularly seek care, *such as primary care physicians' offices*". (emphasis added). Given that HPC mentioned PCP offices and did not mention specialist sites when indicating what "locations where patients regularly seek care" means, it should not be necessary to post the notice at all specialist sites.

Q13: Does the notification need to be in every exam room, or just in the waiting room?
The waiting room should be sufficient as the regulations don't indicate that the notice needs to be posted more than once at "locations where Patients regularly seek care".