HMO - referral

NICHOLAS A. MICOZZIE, MEMBER
ROOM 45, EAST WING
HOUSE BOX 202020
HARRISBURG, PENNSYLVANIA 17120-2020
PHONE: (717) 783-8808
FAX: (717) 783-0688

6 S. SPRINGFIELD ROAD
CLIFTON HEIGHTS, PENNSYLVANIA 19018
PHONE: (610) 259-2820
FAX: (610) 259-7019

House of Representatives
COMMONWEALTH OF PENNSYLVANIA
HARRISBURG

COMMITTEES

INSURANCE COMMITEE, CHAIRMAN
HEALH & HUMAN SERVICES

99 APR -2 AM 8:38

FORTHCOMING
Nyce
Sandusky
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Jewett
Smith

Insurance

Act 68 Implementation

Wednesday, March 24, 1999

10:00 a.m.

Room 140, Main Capitol, Harrisburg, PA

Original: 2046
~~Bush~~
cc; Harris
Jewett
Markham
Smith
Sandusky
Legal

Opening Remarks
The Honorable Nicholas Micozzie

10:15 a.m. **I.Steven Udvarhelyi, M.D.**
Senior VP Chief Medical Officer
Independence Blue Cross

Gary M. Owens, M.D.
VP Patient Care Management
Independence Blue Cross

Michael A. Green
Senior VP Processing Services
Independence Blue Cross

Mary Ellen McMillen
VP Legislative Policy
Independence Blue Cross

10:45 a.m. **Samuel Marshall**
President-Elect
Insurance Federation Pennsylvania

11:05 a.m. **John C. Hickey, Esq.**
Vice President, Legal and Government Programs
Keystone Health Plan Central

11:25 a.m. **Kimberly J. Kockler**
Executive Director
Managed Care Association of Pennsylvania

Independence
Blue Cross

Pennsylvania House of Representatives

Insurance Committee

Public Hearing on the Implementation of Act 68, 1998

Presented by:

I. Steven Udvarhelyi, M.D.
Senior Vice President and Chief Medical Officer

Gary M. Owens, M.D.
Vice President Patient Care Management

Michael A. Green
Senior Vice President Processing Services

Mary Ellen McMillen
Vice President, Legislative Policy

March 24, 1999

Good morning Chairman Micozzie, distinguished members of the House Insurance Committee, committee staff, ladies and gentleman. My name is Dr. Steven Udvarhelyi and I am here today in my capacity as Senior Vice President and Chief Medical Officer for Independence Blue Cross (IBC). I am also a Board Certified Internist, a member of the Board of Directors of the National Committee on Quality Assurance, and have previously served on the Faculty of Harvard Medical School. I am pleased to present testimony on behalf of IBC regarding the implementation of Act 68 of 1998, the Quality Health Care Accountability and Protection Act. I am accompanied today by Dr. Gary Owens, Vice President, Patient Care Management, Mr. Michael Green, Senior Vice President, Processing Services, and Ms. Mary Ellen McMillen, Vice President, Legislative Policy.

I want to take this opportunity to commend you Chairman Micozzie, Representative Vance and the other members of your committee for all of your work in developing this law which establishes rules that protect the rights of our members and our network providers.

Independence Blue Cross serves approximately 2.7 million subscribers and members in Southeastern Pennsylvania. Our company offers a full range of health insurance products: traditional, fee-for-service indemnity plans in conjunction with Pennsylvania Blue Shield; Personal Choice, a PPO; Blue Choice, a PPO; Keystone Health Plan East, our commercial HMO; Keystone 65, our Medicare HMO; Personal Choice 65, our Medicare PPO; and Security 65 our Medicare Supplemental coverage. We also contract with the state to provide HMO coverage for

CHIP eligible children in our region, and in partnership with Mercy Health Plan we offer Medical Assistance HMOs, Keystone/Mercy Health Plan and AmeriHealth/Mercy Health Plan.

Over 730,000 members are enrolled in Keystone Health Plan East (KHPE). IBC has a member-focused utilization review process that is designed to ensure that our subscribers and members receive high quality care in an appropriate, effective and timely manner. Given that leading medical journals in the United States have reported that as much as 30% - 40% of selected medical services are either medically inappropriate or unnecessary, we view this review process as essential to our quality improvement efforts on behalf of our members.

Each year, KHPE reviews more than 85,000 hospital stays, accounting for 516,000 hospital days. Additionally, our precertification process reviews more than 80,000 requests annually for outpatient procedures, durable medical equipment and home health care. We approve more than 90% of all requests on initial review. At all levels within our Patient Care Management Department, utilization review decisions are made by appropriate certified health care professionals. Consistent with the requirements of Act 68, only licensed physicians issue payment denial decisions. My department has twenty-four (24) Medical Directors on staff, all of whom are physicians with specialties including: Internal Medicine, Rheumatology, Anesthesiology, Emergency Medicine, Family Practice, Urology, Obstetrics & Gynecology, General Surgery, Infectious Disease and Pediatrics. These physicians review cases daily, and are assisted by over 200 external physician consultants in active clinical practice representing all medical specialties, these consultants are used for difficult cases and for specialties not

represented on my medical staff. All Medical Directors and consultants are board certified or board eligible by one of the American Boards for Medical Specialties.

IBC uses the Optimed clinical appropriateness software as a tool to guide our reviewers in assessing medical necessity and medical appropriateness. This sophisticated software has been in place at IBC since 1993 and has undergone six major revisions and numerous minor revisions since implementation, reflecting changes in medical practice. Optimed software is developed and maintained by Optimed Medical Systems, using the input of more than 300 medical experts nationwide. It is extensively referenced and each year the criteria are reviewed and approved by IBC's Patient Care Management Committee, a group that includes practicing physicians in Southeastern Pennsylvania. These criteria reflect the latest advances in medical knowledge.

This tool is used as a guide for our review nurses to approve payment for care. When the reviewer receives an indication that the care may not be medically appropriate, the case is referred to a medical director for review. When the case is sent to a medical director, the physician may approve the case, contact the attending physician, or issue a non-certification based on a thorough review of available medical information. If a denial of coverage is issued, the treating physician is offered a chance to appeal the denial immediately, and speak with an IBC medical director to discuss the case.

The Optimed system is proprietary, and is licensed by IBC from Optimed Medical Systems, the owner of the software. Any physician or hospital system may purchase the criteria

in a software version to use on a personal computer. IBC has, when requested, reviewed individual pathways with hospitals and physicians, and forwarded copies of pertinent sections of the criteria to providers.

When IBC approves an inpatient stay, an initial approval is given for the number of days that correspond to the amount of time many patients require hospitalization for a given procedure or condition. Contrary to anecdotal stories, IBC does not mandate that the initial approval is all that will be approved, nor does IBC expect that all patients will require hospitalization for the period of time covered by the initial approval. IBC has nurse reviewers on-site at over 75% of the acute care hospitals we contract with in Southeastern Pennsylvania. Based on their clinical review of the patients' history and progress, and review by our medical directors, almost 50% of patients with the ten most common reasons for hospitalization have extensions approved beyond the initial approval.

IBC also reviews procedures and other medical services to determine the appropriate location for them to be rendered. There are many services that are medically necessary and appropriate, but they can be safely provided in an outpatient setting. In such cases, IBC would approve payment for the service, but not for an inpatient stay. Similarly, IBC has contracted with most of the acute care hospitals for multiple levels of care, with varying reimbursement rates dependent on the intensity of services provided. In addition to contracted rates for acute levels of care, contracted rates are in effect for sub-acute levels of care, and for skilled nursing levels of care. The facilities have contracted for these rates with the knowledge that the different rates reflect the varying needs of patients. During the review process, IBC will approve payment

at a rate that reflects the level of care and service intensity needed by the patient, and at a rate that is contractually agreed to by IBC and the hospital.

When it is necessary for IBC to deny payment for a service, denial letters are sent to the member, the facility and the provider stating the reason, a brief clinical rationale, and a statement of how to initiate an appeal of the determination. Additional detail regarding the clinical rationale is provided upon request. Typically, such requests constitute appeals of denials and are handled in compliance with the provisions of Act 68.

I want to emphasize that IBC has the best interests of its members at heart. Numerous disease management programs have permitted the identification of members with, or at risk of developing, chronic diseases. Through these disease management programs, IBC has been able to assist its members in staying healthy and improving their level of function with chronic diseases. In fact, it has been able to demonstrate that quality of care and quality of life can be improved while reducing health care costs, which is really the goal of managed care. The asthma disease management program has resulted in a 26 % improvement in asthma severity, a 32% reduction in symptoms, a 13 % reduction in days away from work or school, a 32 % reduction in emergency room use, a 28% reduction in hospitalizations, and a 25% improvement in patients understanding of their disease. Similarly, for congestive heart failure patients, IBC assisted its members in increasing the use of appropriate medications by 10 % and improving fluid management, which resulted in a 50% reduction in repeat hospitalizations and an improvement in members' functional status and quality of life scores. In the area of diabetes, IBC has started a comprehensive disease management program aimed at improving control of diabetes in its members, and decreasing complications. Early results show that important screening studies,

such as annual eye exams to prevent the eye complications of diabetes, have improved substantially as a result of this effort.

IBC does understand the need to have its utilization review processes independently reviewed to ensure that they are fair, impartial, and consistent with industry standards. That is why IBC's utilization and review procedures have been reviewed and fully accredited by the American Accreditation Health Care Commission (AAHC/URAC) and our HMO, Keystone Health Plan East has received full three-year accreditation from the National Committee for Quality Assurance (NCQA). As you may know, NCQA is the leading external review organization used by the Department of Health to assist in their oversight of HMOs in the state. Beyond this external review, IBC intends to fully comply with all of the provisions of Act 68 and we are working with the Departments of Health and Insurance on the development of regulations of the Act.

To comply with the provisions of Act 68, IBC created a project implementation team with representatives from multiple departments in our company to determine what changes were necessary to ensure that we are in full compliance with the act. With the exception of the prompt payment requirement, IBC is required to implement the act only for policies that are issued or renewed after the January 1, 1999 effective date. However, we decided to begin steps to implement the Act for all of our managed care plans on January 1, 1999.

In addition, even prior to the enactment of Act 68, IBC had implemented changes that are consistent with certain aspects of the Act. Specifically, IBC had:

- Provided direct access to maternity and gynecological services for Keystone members;
- Implemented a payment policy for emergency services that not only pays for the service based on prudent layperson standards, but pays hospitals and physicians a triage fee equal to an office visit payment for non-emergencies. This virtually eliminates denial of payment for emergency services for IBC members.
- For certain patients with chronic illness, IBC had already allowed the designation of a specialist as the primary physician.

To further comply with the Act, IBC has implemented a process whereby a member with a life-threatening, degenerative, or disabling condition can, working with their primary care physician, request and obtain a standing referral to a specialist or designate a specialist as the primary physician. This process can be initiated with a single phone call from the member.

For claims processing, our goal prior to Act 68 was to process all clean claims in less than 30 days, better than the 45 day requirement. In fact we have done better than this. In 1998, we processed over 11 million claims in Pennsylvania with an average turnaround time of 10 days. We have dramatically increased our claims processing staff, and invested heavily in training programs and new technology. In an effort to further expedite claims, we have deployed staff on-site to various hospital billing offices to aid in the submission process.

It is important to understand that the definition of a clean claim is one that has no billing improprieties and accurately reflects the service provided. There are disputed claims and billing errors that take longer to resolve, which become the anecdotal examples of "payment delays."

However, these are the exceptions and the vast majority of claims are processed quickly and accurately.

With the expansion of hospital networks and hospital mergers, we see the consolidation of accounting and billing departments, and reductions in staff, which lead to poor billing quality and accounts receivable increases. In some cases, hospitals have claim error rates as high as 15-20%. Many of the erroneous claims are simply resubmitted in their original incorrect form. Claims that are corrected, are sometimes not submitted for weeks after the billing office was notified of the error. This in turn causes the hospitals' accounts receivables to climb. Many providers also send bills to our members before their claims are resolved, confusing our members. On the other hand, many providers bill accurately, and claims are processed rapidly. IBC wants to pay what is owed, and has worked closely with many providers to help them fix these problems as in the end all parties benefit from the reduction of reworking claims multiple times.

IBC also makes every effort to ensure that only appropriate claims are paid, and that there is the detection of the practices of upcoding and unbundling, duplicate claims, and in some cases fraud. As I am sure you are aware, upcoding is the practice whereby a provider bills for a higher level of service than was actually required to treat the patient, and unbundling is the practice of billing separately for services that legitimately should be considered one service. Healthcare is expensive, and IBC is doing everything possible to make sure that its members and your constituents only pay for appropriate services received. It is a mission and fiduciary responsibility that we take seriously.

We understand that at earlier hearings on Act 68, testimony was presented that stated the Independence Blue Cross definition of "medical necessity" is confidential. This is not true. That definition is printed in every IBC member handbook, every customer policy and every provider contract. It is:

> Medically Necessary (Medical Necessity) – the requirement that Covered Services or medical supplies are needed, in the opinion of; (a) the Primary Care Physician or the Referred Specialist consistent with KHPE policies, coverage requirements and utilization guidelines; and (b) in order to diagnose and/or treat a Member's illness or injury and:
>
> A. are provided in accordance with accepted standards of American medical practice;
>
> B. are essential to improve the Member's net health outcome and may be as beneficial as any established alternatives;
>
> B. are as cost-effective as any established alternative; and
>
> C. are not solely for the Member's convenience, or the convenience of the Member's family or health care Provider.

At earlier hearings questions have also been raised about how a health plan determines that a treatment or procedure is "experimental or investigative." Again, all of our member literature includes a definition of "experimental or investigative services." To assist in our determinations of what constitutes experimental and investigational services, IBC draws on the expertise of the Blue Cross Blue Shield Association's

Technology Evaluation Center (TEC). TEC produces "state-of-the-art" technology assessments, and is one of a handful of centers in the United States designated as an Evidence Based Practice Center by the Agency for Health Care Policy and Research of the federal government. The research performed by the TEC is a cornerstone of our technology assessment process; a rigorous, fact-based assessment process that helps us provide coverage for new technologies and treatments once published medical information supports that they are safe and effective.

In further developing the regulations to clarify the activities required to comply with Act 68, IBC would urge the Committee to recommend the following :

- Independent review entities, as defined by the Act, should be held to the same standards of performance and professional conduct as IBC and other managed care organizations when reviewing appeals. In addition, these entities should not be allowed to direct IBC to pay benefits for services that are excluded from the benefit contracts, or to pay providers at rates or terms that are inconsistent with any contracts in force between IBC and the provider.
- Our members should not be threatened with dunning notices from collection agencies for improper balances and claims that have not yet been resolved. The elderly are especially scared by the collection agency tactics and end up paying for claims that carriers have already paid, or that were denied with the member held harmless under the provider contract with IBC.
- Eliminate collection agencies until 90 days have passed and the provider has proven that they have accurately billed appropriate services and that the member is liable. Allow the member 60 days to pay before the collection process begins.

- Ensure that non-network providers are not permitted to balance bill our members during the continuity of care period for new members and members whose providers have been terminated from the network.
- Permit an extension of timeframes in the internal grievance process when it is in the member's best interest. This is the current practice for Medicare HMOs.
- Require providers to supply managed care organizations with all necessary medical records and other information needed to make utilization review decisions and to review appeals and grievances.

I thank you for the opportunity to testify before you today, and again commend the members of the Committee for the work that you have done. I would be pleased to answer any questions you may have.

THE INSURANCE FEDERATION OF PENNSYLVANIA, INC.

Public Testimony

prepared for

FORTHCOMING
Nyce _____
Sandusky _____
Gelnett _____
Jewett _____
Smith _____

HOUSE INSURANCE COMMITTEE

on

Act 68

March 24, 1999

The Insurance Federation of Pennsylvania, Inc.
1600 Market Street, Suite 1520
Philadelphia, PA 19103
215-665-0500

GOOD MORNING, AND THANK YOU FOR THE OPPORTUNITY TO BE HERE. I AM SAM MARSHALL, PRESIDENT-ELECT OF THE INSURANCE FEDERATION. WE ARE A NON-PROFIT TRADE ASSOCIATION REPRESENTING ALL LINES OF INSURANCE. AMONG ARE MEMBERS ARE A NUMBER OF THE FOR-PROFIT HEALTH INSURERS IN PENNSYLVANIA, INCLUDING BOTH THE MANAGED CARE PLANS COVERED UNDER ALL OF THE ACT AND OTHER TYPES OF HEALTH INSURERS COVERED UNDER ITS PROMPT PAYMENT PROVISIONS.

IT SEEMS TO ME THERE ARE REALLY TWO QUESTIONS THAT SHOULD CONCERN THIS COMMITTEE: FIRST, HOW ARE THE REFORMS OF ACT 68 WORKING; AND SECOND, WHAT MORE NEEDS TO BE DONE? HERE ARE SOME THOUGHTS IN BOTH AREAS.

1. HOW IS ACT 68 IS WORKING?

IT IS TOO SOON TO TELL FOR SURE, BUT THE EARLY SIGNS ARE ENCOURAGING.

FIRST, THE ACT HAS TAKEN EFFECT WITHOUT A HEALTH INSURANCE EQUIVALENT OF A Y2K DISASTER: ALTHOUGH THE INSURANCE AND HEALTH DEPARTMENTS HAVE NOT PROPOSED REGULATIONS ON THE ACT, THEY HAVE SHARED STATEMENTS OF POLICY, AND THEY HAVE OPENED LINES OF COMMUNICATION WITH ALL PARTIES TO MAKE SURE

POLICIES AND PRACTICES WERE CHANGED AS OF JANUARY 1, WITHOUT INSURANCE COVERAGE BEING DROPPED OR UNAVAILABLE.

SECOND, BECAUSE OF THE DETAIL IN THE ACT'S PROVISIONS, IT SEEMS THAT MOST OF THE CONCERNS ARE WITH HYPOTHETICALS RATHER THAN ACTUAL PROBLEMS - AT LEAST ON SUCH QUESTIONS AS THE DIFFERENCE BETWEEN COMPLAINTS AND GRIEVANCES, EXPEDITED EXTERNAL REVIEWS, CONSUMER DISCLOSURE AND CONTINUITY OF CARE.

THAT'S NOT TO SAY THAT THOSE HYPOTHETICALS WILL NOT OCCUR OR DON'T NEED TO BE ADDRESSED. THAT'S ALSO NOT TO SAY THE FIRST FEW MONTHS HAVE NOT BEEN A LEARNING PROCESS FOR ALL PARTIES - CONSUMERS, PROVIDERS AND MANAGED CARE PLANS. THEY HAVE, AND WE ARE STILL LEARNING AND ADJUSTING. BUT AT LEAST AT THIS STAGE, IT APPEARS THAT ALL PARTIES ARE COMING TO A COMMON UNDERSTANDING OF THE ACT'S MAJOR PROVISIONS.

BUT THE ULTIMATE QUESTION IS NOT WHETHER THE REFORMS OF ACT 68 ARE UNDERSTOOD AND BEING IMPLEMENTED. IT IS, I THINK, WHETHER THOSE REFORMS ANSWER THE CONCERNS OF THE CONSUMERS AND EMPLOYERS WHO DEPEND ON MANAGED CARE FOR THEIR HEALTH CARE, AND THE CONCERNS OF PROVIDERS WHO PRACTICE IN MANAGED CARE PLANS.

AGAIN, IT IS TOO SOON TO TELL FOR SURE - BUT AGAIN, THE EARLY SIGNS ARE ENCOURAGING.

WHEN THE CALL TO REFORM MANAGED CARE BEGAN, WE HEARD MANY CONCERNS. LOOKING BACK AT THE TESTIMONY IN SENATE AND HOUSE HEARINGS, THEY CENTERED AROUND UNFAIR OR OBTUSE REVIEW SYSTEMS, WHETHER FOR PROVIDER OR CONSUMER PROBLEMS; INADEQUATE DISCLOSURES TO CONSUMERS; THE NEED FOR CONTINUITY OF CARE FOR ENROLLEES; THE NEED FOR STANDING REFERRALS AND DIRECT ACCESS; THE NEED FOR PROMPT PAYMENT OF CLAIMS; AND THE NEED FOR FAIR CREDENTIALING PROCEDURES.

WE WILL OBVIOUSLY LEARN MORE OVER THE NEXT FEW YEARS AS TO HOW WELL THE REFORMS OF ACT 68 HAVE ANSWERED THESE CONCERNS. BUT SO FAR, IT IS CLEAR THAT THE QUESTION IS NOT WHETHER IT HAS ADDRESSED THEM - IT HAS.

SOME COMPLAINTS ABOUT HOW WELL IT HAS ADDRESSED THOSE CONCERNS HAVE BEEN RAISED IN EARLIER HEARINGS, AND I WOULD LIKE TO ADDRESS THEM.

FIRST IS THE COMPLAINT THAT, DESPITE THE ACT'S 45 DAY PROMPT PAYMENT RULE, INSURERS TAKE TOO LONG TO PAY BILLS. I HAVE HEARD SOME PROVIDERS CLAIM THAT INSURERS INTENTIONALLY DELAY

PAYMENTS BECAUSE OF THE INVESTMENT INCOME THEY GET WHILE HOLDING THE MONEY.

I LOVE CONSPIRACY THEORIES AS MUCH AS THE NEXT PERSON, BUT THIS ONE IS GROUNDLESS. NO CLAIM MANAGER GETS REWARDED FOR HAVING THE MOST OPEN FILES, AND WHATEVER INTEREST AN INSURER MIGHT GET BY HOLDING A BILL FOR A FEW WEEKS WOULD BE MORE THAN OFFSET BY ITS OWN ADMINISTRATIVE COSTS AND THE 10% INTEREST PENALTY IN THE ACT. AT LEAST WITH OUR MEMBERS, THE GOAL IS FOR A QUICK TURN-AROUND.

I SUSPECT THE REAL CULPRIT IS THAT INSURERS AND PROVIDERS DON'T ALWAYS AGREE ON THE AMOUNT OF DOCUMENTATION NEEDED TO SUPPORT A BILL. I DOUBT THERE CAN BE A LEGISLATIVE OR REGULATORY FIX TO THIS; PENNSYLVANIA ENACTED A UNIFORM CLAIM FORM ACT EARLIER THIS DECADE, AND IT APPARENTLY HASN'T SOLVED EVERY PROBLEM. MY GUESS IS THAT THIS IS SOMETHING THAT NEEDS GREATER UNDERSTANDING ON BOTH THE PROVIDER AND PAYER SIDES, AND THAT THIS CAN ONLY COME FROM DIALOGUE - NOT DISPUTES - BETWEEN THOSE GROUPS.

A SECOND COMPLAINT IS THAT A PROVIDER - GENERALLY A HOSPITAL - PROVIDES ONE LEVEL OF CARE FOR A PATIENT, AND THE INSURER'S REVIEW DETERMINES THAT A DIFFERENT LEVEL OF CARE

WAS APPROPRIATE. SOME HOSPITALS MAY CALL THIS "DOWNCODING;" I WOULD CALL IT PROPER CODING.

THERE ARE NO EASY ANSWERS TO THIS ONE, AND IT IS A PROBLEM IN ALL HEALTH CARE REIMBURSEMENT, NOT JUST MANAGED CARE: A PROVIDER MAY PROVIDE CARE THAT IS ULTIMATELY DETERMINED TO BE EXCESSIVE OR UNNECESSARY. I DON'T THINK THE ANSWER IS TO PAY HIM FOR DOING SO - THE ANSWER IS TO PAY HIM FOR PROVIDING THE RIGHT AMOUNT OF CARE, AND TO PUT IN PLACE A SYSTEM THAT LEADS TO A FAIR DETERMINATION OF THIS AS SOON AS POSSIBLE.

YES, THERE ARE TIMES WHEN THE PROVIDER WILL HAVE TO MAKE A JUDGMENT CALL, TIMES WHEN HE WILL TAKE ON SOME RISK BECAUSE HE WON'T HAVE THE CHANCE TO GET PRIOR AUTHORIZATION. I DOUBT YOU CAN LEGISLATE OR REGULATE THAT OUT OF EXISTENCE - BUT AS WITH PROMPT PAYMENT ISSUES, KEEPING AN OPEN DIALOGUE BETWEEN PAYERS AND PROVIDERS SHOULD MINIMIZE THIS.

A THIRD COMPLAINT IS THAT THE ACT'S DISTINCTIONS BETWEEN COMPLAINTS AND GRIEVANCES ARE TOO VAGUE, AND THAT A CONSUMER PROBLEM MIGHT BE INCORRECTLY PUT INTO ONE OR THE OTHER CATEGORY. BEFORE SAYING THIS IS AN AREA WHERE ACT 68 DOES NOT WORK, I THINK WE OUGHT TO SEE HOW IT PLAYS OUT IN THE

REAL WORLD. THIS IS AN AREA WHERE THE HYPOTHETICALS ARE INFINITE, BUT REAL WORLD EXAMPLES - AT LEAST IN THESE EARLY DAYS OF ACT 68 - ARE NOT THERE.

2. WHAT MORE NEEDS TO BE DONE?

FIRST AND FOREMOST, I THINK THE LEGISLATURE SHOULD BE MINDFUL OF WHATEVER REGULATIONS THE INSURANCE AND HEALTH DEPARTMENTS WILL PROPOSE LATER THIS YEAR.

THERE IS ALWAYS THE TEMPTATION TO USE A REGULATION NOT SO MUCH TO CLARIFY OR BETTER IMPLEMENT A STATUTE, BUT TO CHANGE OR EXPAND IT. THAT TEMPTATION APPLIES NOT JUST TO REGULATORS, BUT TO INTERESTED PARTIES - INCLUDING OUR INDUSTRY - AND TO LEGISLATORS. THAT'S A HARD TEMPTATION TO RESIST - BUT I THINK THE THOUGHT, THE EFFORT AND THE DETAIL OF ACT 68 MAKE IT ESPECIALLY IMPORTANT TO RESIST IT HERE.

SECOND, I THINK EVERYBODY SHOULD TAKE SOME TIME TO SEE JUST HOW ACT 68 WORKS IN ACHIEVING ITS OBJECTIVE OF IMPROVING THE QUALITY OF MANAGED CARE WITHOUT RAISING - TOO MUCH - ITS COST. LET'S SEE HOW THE REAL WORLD MARKET RESPONDS BEFORE EMBARKING ON A SECOND WAVE OF REFORMS.

FORTHCOMING
Nyce _____
Sandusky _____
Gelnett _____
Jewett _____
Snith _____

TESTIMONY

Before the

PENNSYLVANIA HOUSE OF REPRESENTATIVES
INSURANCE COMMITTEE

Rep. Nicholas A. Micozzie, Chairman

At the

PUBLIC HEARING

On the

IMPLEMENTATION OF THE ACT 68 OF 1998 QUALITY HEALTH CARE ACCOUNTABILITY AND PROTECTION PROVISIONS

Presented by

John C. Hickey, Esq.
Vice President, Legal and Government Programs
Keystone Health Plan Central

March 24, 1999

Good morning, Chairman Micozzie, distinguished members of the Committee, Committee staff and other members of the legislature and public who are in attendance here today. My name is John Hickey and I am the Vice President of Legal and Government Programs for Keystone Health Plan Central, a health maintenance organization which is jointly owned by Capital Blue Cross and Pennsylvania Blue Shield, a Highmark company. Keystone Health Plan Central provides coverage to residents in 19 counties in Central Pennsylvania and Lehigh Valley. I am pleased to be here today to present testimony regarding some of the issues and challenges associated with the implementation of the managed care provisions of Act 68.

Keystone Health Plan Central has been fully engaged in ensuring that we meet the requirements of Act 68 since it was signed into law last June. Within weeks of its passage, we had formed a task force to review and assess the Act and to determine what changes were necessary to our day-to-day operations in order to comply with its provisions. Since that time we have continued to review the Act and the statements of policy issued by the Departments of Health and Insurance in October. We attended those departments' joint meeting in December and have attended subsequent meetings in order to gain a better understanding of how they were interpreting the Act and its requirements.

We believe that compliance with Act 68 is in the interest of our membership as well as our company, in that the Act's goal is to improve the quality and accountability of health care services provided in the Commonwealth. We commend Chairman Micozzie, Representative Vance and all of the members of the Committee for their leadership in passing this law.

Fortunately, many of the provisions of the Act were in line with how we at Keystone Health Plan Central already did business. Where changes were necessary, we believe that we have successfully implemented those changes to meet the Act's requirements. Nonetheless, the changes we have made and the processes we have in place today are not without certain risks going forward, including exposure to litigation and regulatory sanctions based upon how certain provisions of the Act might be interpreted differently. Therefore, we eagerly anticipate the release of final regulations to clarify certain aspects of the Act and its related statements of policy. We welcome this Committee's expertise and participation in this rule making process.

Many of the Act's provisions, such as those detailing consumers' rights under the complaint and grievance processes, and those regarding access to information were built upon standards which were already maintained by many managed care plans. Likewise, that portion of the Act which requires coverage for emergency services both in and out of network was also reflective of industry practice. Prohibitions against provider "gag" clauses and financial disincentives to care were also not problematic, as Keystone's contracts did not contain such language. In fact, in many cases, implementation of Act 68 has required only minor adjustments to our standard operating procedures in order to come into compliance.

Other provisions of the Act have been more problematic to implement. I would like to take a few minutes today to highlight a few of those areas which have provided greater difficulty for us and which we believe will benefit from clarification through the rule making process.

One example is the Act's provision regarding continuity of care where there is an "ongoing course of treatment," and the procedures and systems modifications required to allow for this provision, particularly during a transitional period as a new member joins the plan. In the past, plans had generally allowed for continuity of care only in certain cases, such as maternity, post-operative services and certain other serious medical conditions. We believe that this area of the Act is one in which regulatory clarification will assist managed care plans in consistently applying its provisions so as to meet the intent of the law, while continuing to allow for quality assurance and other member protections. By way of example, we have struggled with the simple question of whether the phrase "ongoing course of treatment" is intended to include cases such as an out of network pediatrician who has initiated a course of immunizations to a child. Or, rather, was the Act meant to apply only in cases where members are in the process of receiving care and treatment for more serious conditions, in which the quality of their care may be adversely affected by a change in providers.

Another provision which has raised several questions during our implementation efforts pertains to the requirement that the Plan adopt and maintain procedures by which an enrollee with a life-threatening, degenerative or disabling disease or condition shall be permitted to receive a "standing referral" to a specialist with clinical expertise in treating that disease or condition. While the Act specifies that such standing referrals shall be available only pursuant to an approved treatment plan and in compliance with the plan's established standards, it does not otherwise describe timeframes or limitations which may be applicable to such a referral. Keystone Health Plan Central has had in place for some time a policy which would allow for standing referrals of up to 90 days. These referrals

can be renewed after consultation with the member's primary care physician ("PCP"), so as to assure continued clinical need and to ensure PCP oversight and continuity of care. The Act appears to allow plans to continue such quality oversight activities. We would recommend that during the regulatory rule making process, clarification be provided regarding the plan's ability to monitor the appropriateness and quality of care during standing referrals, particularly through review and recertification. It is also necessary to clarify that, to the extent a standing referral or the related designation of a specialist as coordinator of a member's care is made under the Act, the specialist designated will be required to otherwise comply with network limitations and other terms and conditions of the Plan.

On a related note, we would request that the regulations provide additional language regarding what constitutes the "same terms and conditions" as that phrase is used in the continuity of care section of the Act. In order to avoid future conflict with the provider community, particularly those providers who are not under contract with the plan, the regulations should set forth what constitute material terms and conditions, which providers must accept in order to avail themselves with the continuity of care provisions of the Act.

You have already heard, at other hearings, of the need for additional clarification regarding the distinction between complaints and grievances as defined in the Act. I would reiterate today that such a need exists. We also seek clarification in the regulations regarding the time frames for appeals and any penalties attached thereto. More specifically, we believe that the time frames associated with the review of initial grievances or complaints should begin only after plans have received all medical and

other records reasonably necessary to review the appeal. Such a requirement will benefit not only the plans, but enrollees also, as plans will be better equipped to make fully informed decisions regarding the proposed course of treatment. The necessity for relief in the area of measuring these time frames stems from the fact that many providers, particularly out-of-network, out-of-state facilities, routinely take far more than thirty (30) days to respond to our requests for medical records. Additionally, we suggest that further elaboration regarding the expedited internal grievance process should be provided to address such issues as next steps after an unfavorable decision regarding whether a request meets the criteria to be considered an expedited grievance.

I said earlier that our company is exposed to certain risks until clarifying regulations are finalized. An example of this type of exposure is in the area of provider credentialing as described in the Act. The Act states that individuals providing information to plans during the credentialing process shall have the protections set forth in the Peer Review Protection Act. However, Act 68 fails to extend the protections of the Peer Review Protection Act to the managed care plan itself, even though the plan is required to establish and maintain a credentialing process to enroll qualified health care providers and to create an adequate provider network. Our credentialing process necessarily involves the participation of peer reviewers, who sit on our credentialing committees and provide us with valuable, independent input regarding those individuals who seek to be credentialed or recredentialed as participating providers in our network. We must be able to assure our peer reviewers and committee members that their participation in and, more importantly, their statements made in the course of their participation in the credentialing process, are protected from future disclosure under the

Peer Review Protection Act. The immunity provided by the Peer Review Protection Act is necessary to ensure that peer reviewers, including those serving on managed care credentialing committees, are free to provide relevant, candid input without fear of reprisal. Such input is vitally important to maintaining a high level of quality in plans' provider networks.

This is particularly true in this era of increasing litigation involving managed care plans. The direct costs as well as the time and resources consumed in defending suits brought against managed care plans provide a real and challenging burden for the plans in terms of administrative expense. While plans are increasingly being exposed to liability which parallels that of hospitals, we are not afforded the same protections. Your intervention in this area would serve to protect consumers by assuring that rigorous credentialing is done pursuant to the Act and also by reducing the administrative expenses which plans endure in defending unnecessary litigation and administrative proceedings.

Act 68 has also increased our administrative burden through its requirements that we track and report complaints and grievances separately and report them both to the Insurance Department and the Department of Health. This same data is already being tracked and reported in to the NCQA. To the extent that the Act's requirements do not align with the NCQA's, they cause a duplication of effort a necessity for additional databases and, therefore, increased expense for the same function. Therefore, we would urge that future regulations and legislation consider the use of nationally accepted standards of accrediting bodies as the accepted standard for managed care plans within the Commonwealth. While this appears to be the intent of certain provisions of Act 68, it

was not clearly codified as such. A significant advantage of tying regulatory compliance to these nationally recognized standards is that they adjust on a yearly basis, thereby "raising the bar" without requiring additional legislation or regulations. We would make the same recommendation in the context of the current discussion of consumer "report cards." Given that plans are already making significant efforts in reporting HEDIS measures to certifying organizations and large employer groups, such reporting should be enough to satisfy a reasonable standard for health plan report cards. Again, this would assist plans in operating more efficiently by reducing redundant efforts and, thereby, administrative costs.

We believe that these comments on administrative expenses are particularly relevant at this time. The media has widely reported that managed care plans are increasing their premium rates and that employer groups are concerned with rising insurance costs. Each new mandate that adds additional benefit requirements or otherwise increases the administrative costs associated with delivering existing benefits should be evaluated as to whether the value added exceeds the cost of the mandate. As you review the benefits of Act 68 and any new legislation being considered, we urge you to consider this litmus test of whether the added value exceeds implementation costs. We believe that this will support our mutual goals of providing quality health care coverage and access to providers while maintaining the affordability of our plans for Pennsylvania consumers.

In closing, I would like to thank the Committee for allowing Keystone Health Plan Central to comment on implementation issues regarding Act 68. We wholeheartedly support your efforts to ensure quality protections for citizens of the Commonwealth.

Once again, thank you for this opportunity. I would be happy to entertain any questions you may have.

MANAGED CARE ASSOCIATION OF PENNSYLVANIA

240 North Third Street, Suite 203
P.O. Box 12108
Harrisburg, PA 17108-2108
(717) 238-2600
Fax (717) 238-2656

FORTHCOMING
Nyce _____
Sandusky _____
Gelnett _____
Smith _____
Jewett _____

PUBLIC TESTIMONY
ACT 68, 1998 IMPLEMENTATION

SUBMITTED TO:

Insurance Committee
Pennsylvania House of Representatives
The Honorable Nicholas A. Micozzie, Chairman

SUBMITTED BY:

Kimberly J. Kockler
Executive Director

March 24, 1999
Harrisburg, Pennsylvania

Chairman Micozzie and members of the House Insurance Committee:

My name is Kimberly Kockler and I am the Executive Director of the Managed Care Association of Pennsylvania (MCAP). The Association currently represents 13 Commonwealth HMOs. Our member plans enroll approximately 1.5 million Pennsylvanians in commercial, Medicare and Medicaid health plans. I am pleased to have the opportunity to speak to the Committee today about the implementation of Act 68, 1998, specifically the managed care provisions collectively known as the "Quality Health Care Accountability and Protection Act."

Background

Act 68 implementation and compliance have been top priorities for our member health plans since the law was signed by the Governor last June. Act 68 impacts many different aspects of managed care plan operations, including marketing, member services, quality assurance, utilization review, credentialing and claims processing, to name a few. The breadth of the law has required managed care plans to form implementation teams and to expend significant time and resources in order to comply with the new Act.

Immediately following passage of Act 68, MCAP formed an internal workgroup of member plan representatives. The workgroup's immediate objective was to provide the Departments of Health and Insurance with initial feedback prior to the publication of the Act 68 Statements of Policy. The workgroup met throughout the summer and submitted to the Departments a series of detailed letters outlining not only our concerns but also our recommendations in regard to Act 68 implementation and regulations.

For your reference, attached to my testimony is a copy of a letter which MCAP forwarded to the Departments in response to the publication of the Act 68 Statements of Policy in October, 1998. The Association was generally pleased with the Statements of Policy which addressed a number of issues raised by our internal workgroup. In addition, we have appreciated the willingness of the Health and Insurance Departments to listen to our concerns about how Act 68 will impact the day-to-day operations of managed care plans which, in turn, impacts enrolled members and providers. While certainly not always in agreement with our proposed solutions, both Departments have been open to stakeholder input.

Outstanding Issues

As indicated previously, the Association was generally pleased with the Act 68 Statements of Policy which were intended for use as guiding principles until the promulgation of final regulations. As we anticipate those regulations, however, the Association remains concerned about the practical application of a number of Act 68 provisions. Some examples include:

- ✓ In terms of continuity of care, what specifically is meant when an out-of-network provider is required to comply with a managed care plan's "terms and conditions" when treating enrolled members? Will this include the managed care plan's utilization review, quality of care, referral and reimbursement standards, for example?

- ✓ How or will an "ongoing course of treatment" be defined? Will this apply to any course of treatment for any medical condition or be restricted to only pregnancy or serious, chronic conditions?

- ✓ When a woman goes directly to the ob/gyn, what specific follow-up services will be permitted without a referral from the managed care plan?

- ✓ Will utilization-based provider incentives (such as those which reward providers for achieving certain levels of immunizations or mammography screenings) be prohibited by the financial incentives restrictions in the Act?

- ✓ Will the prudent layperson standard for emergencies lead to an increase in the inappropriate use of the emergency room by managed care plan members?

- ✓ In order to address continuity and quality of care concerns, will there be a specific timeframe in which managed care plans must be notified that a member has been treated in an emergency facility, particularly when additional follow-up care is necessary?

- ✓ Will there be ongoing monitoring to ensure that Act 68 requirements are integrated with the contractual requirements of the State's mandatory managed care program for Medical Assistance recipients (HealthChoices)?

MCAP Educational Efforts

One of the Association's major objectives has been to provide information and education about managed health care to legislators, regulators, the media and the public. As such, we have recently been asked by a number of groups and organizations to speak or make presentations about Act 68 and the implications for consumers, providers, purchasers and health plans. MCAP views such requests as opportunities to provide some much needed education as to how managed care does and does not work and to dispel many of the myths about managed health care.

MCAP has also begun to host educational sessions for legislative staff on the topic of addressing constituent issues with managed care plans, focusing specifically on the new provisions within Act 68. The Association was asked to conduct a session for House Democratic district office staff as part of the new members' orientation session. We also recently conducted a session for Senate staff and intend to schedule similar presentations for House staff.

Conclusion

Finally, Mr. Chairman, we would like to thank you, Representative Vance and the members of the Committee as well as the staff members who worked to ensure that Act 68 achieved a balance between the interests of consumers, providers, purchasers and health plans. While the ultimate impacts of Act 68 will not be realized until regulations are finalized and we have had some experience under the new law, the Association and its member plans appreciate the ongoing opportunity to relay our concerns to you and the members of this Committee.

MANAGED CARE ASSOCIATION OF PENNSYLVANIA

240 North Third Street, Suite 203
P.O. Box 12108
Harrisburg, PA 17108-2108
(717) 238-2600
Fax (717) 238-2656

email: info@managedcarepa.org
website: www.managedcarepa.org

November 23, 1998

Mr. Thomas Chepel
Acting Director
Bureau of Managed Care
Department of Health
1030 Health & Welfare Building
Harrisburg, PA 17108

Mr. Geoffrey Dunaway
Director
Bureau of Accident & Health
Insurance Department
1311 Strawberry Square
Harrisburg, PA 17120

Dear Tom and Geoff:

On behalf of the Managed Care Association of Pennsylvania (MCAP), I would like to thank you for the inclusion of a number of the Association's recommendations in the Act 68, 1998 Statements of Policy. Providing specific examples of complaints and grievances, stating that balance billing by providers is prohibited and establishing a process for eliminating conflicts of interest in the external grievance process are but a few examples of areas where the Statements reflect MCAP's concerns and suggested changes. It was gratifying to the members of MCAP's internal Act 68 workgroup that the Departments recognized several of the industry's concerns and supported our suggestions.

As intended by the Departments, our member plans are reviewing the Statements for use as an internal guide prior to the promulgation of regulations. To that end, the Association would like to reiterate the following major remaining concerns for your consideration during development of Act 68 regulations. I would note that issues not previously raised by MCAP are identified in boldface type throughout the document.

1) Continuity of Care

As you know, continuity of care requirements present the greatest concern as health plans will be forced to reimburse health services provided by a wide variety of non-network, non-credentialed providers. The Association makes the following recommendations:

- Continuity of care requirements should apply only to primary care physicians and ob/gyns. The State of Maryland has implemented continuity of care as part of its health insurance law, however, the law applies only to primary care physicians.
- "Terms and conditions" should be specifically defined to require that non-network providers comply with the managed care plan's utilization review, quality of care, referral, balance billing and reimbursement standards.
- "Ongoing course of treatment" should also be defined and, in addition to pregnancy, should apply only to chronic, ongoing conditions.

- There should be a specific notification requirement regarding new enrollees who wish to continue with a provider not in the network. Providers should have to contact the managed care plan in this event.
- Managed care plans should be permitted to alert consumers to the fact that they may be billed directly by their non-network provider and/or for any services which the provider refers them to. Consumers should also be advised that such providers may not be credentialed by the managed care plan.
- Oftentimes, managed care plan enrollees select a group practice (as opposed to an individual physician) as their primary care provider. Within that practice, the enrollee typically does designate one physician as their PCP; however, for operational purposes (billing, utilization review, etc.), the managed care plan designates one provider code for the entire practice and not for each individual physician within the practice. With that in mind, what will the managed care plan's responsibility be in terms of notifying enrollees when one provider from a group practice is terminated (specifically if the terminated provider is not the enrollee's primary care provider)?

2) Financial Incentives/Gag Clauses

The Association remains concerned about the potential for elimination of utilization-based incentive systems and increasing litigation. Our recommendations are as follows:

- The Department should specifically state what is prohibited in terms of financial incentives and specifically note that utilization-based incentives are not prohibited.
- Managed care plans should be required to instruct providers that their respective incentives cannot be used to deny medically necessary care, interfere with the care management or disease prevention or exacerbate a current medical condition.
- Providers should be required to inform patients that the treatment or services they are proposing or suggesting MAY NOT be covered by the managed care plan.

3) Emergency Services

In addition to the concern that the "prudent layperson" standard will encourage consumer's inappropriate use of emergency room services, the Association would note the lack of a specific timeframe for notifying a managed care plan that a member has presented for an emergency medical condition and received treatment. Recommendations include:

- That the emergency room provider or facility be required to notify the managed care plan within 24 hours that a member has presented, treatment rendered and, if applicable, the member's condition.
- That there be a penalty for noncompliance with the notification provision. Specifically, it is recommended that, if the managed care plan is not notified within 24 hours, then 50 percent of the emergency room claim will not be paid.
- MCAP would suggest that any such requirements be communicated to the emergency provider community via a Health/Insurance Department bulletin.

4) Confidentiality

MCAP's only concern is protection of a managed care plan's existing confidentiality practices which protect patient confidentiality while facilitating critical operations such as utilization review and claims adjudication. Further, patient medical records are and should be maintained by a physician's office and physician -- not managed care plans. Physicians should remain responsible for providing consumer access to such information. In terms of clarification, the Association would ask:

- How should managed care plans handle "second hand" requests for patient medical records (these would be full or partial records received during the normal course of claims/medical management review from PCPs, specialists or facilities; examples would be claims forms with diagnosis and treatment codes or summaries of telephone calls with plan staff and providers where treatment plans, codes, etc. are discussed). What is the plan's liability in releasing such information?

5) Utilization Review

The certification/licensing requirements for all utilization review entities (UREs) remain a concern. MCAP has indicated in previous communications with the Departments that third party UREs which are under the direct supervision of an HMO not be required to be certified. Such licensure may prove burdensome or undesirable to delegated entities and thus increase health care costs. In addition, the National Committee for Quality Assurance (NCQA) currently reviews such arrangements.

A specific example of such an arrangement would be when a managed care plan has a contract with a provider group of any type or with a facility that accepts risk in some fashion. The group may credential physicians, contract with providers, provide for utilization review and some quality oversight or pay claims, for example.

MCAP would strongly urge that such arrangements not be subject to licensure. Further, it is MCAP's recommendation that only UREs acting independently be required to have certification and that compliance with NCQA standards be sufficient for purposes of UREs under the direct supervision of an HMO.

Other utilization review recommendations include:

- Electronic transmissions such as facsimile and e-mail communications qualify as notification (in writing) of utilization review decisions.
- Utilization review decisions be deemed as having been communicated when such information leaves the managed care plan.

6) Complaints

- As acknowledged by the DOH at the November 12, 1998 informational meeting, there is no specific timeframe in which a consumer must file a complaint. It is

our understanding that a limited number of managed care plans currently institute such timeframes either contractually or informally. MCAP strongly suggests inclusion of a specific timeframe (perhaps 60 days) as a way of protecting consumers. In essence, if a consumer does not act within a certain timeframe, the consumer will lose the ultimate ability to file the case in court (if necessary) as there is currently a two-year statue of limitations on such civil actions. This same concern exists within the Act 68 internal grievance process (as noted below).

As stated earlier, the inclusion of specific examples of what constitutes a consumer complaint is useful. The Association remains supportive, however, of the development of a specific system for referring consumer complaints either to the Insurance or Health Department. Our recommendation would be:

- That the Departments of Health and Insurance develop a specific process used to determine which Department will receive which types of consumer complaints and that such a process is shared with managed care plans in order to more effectively serve enrollees and guide them through the complaint process.
- MCAP would also support consumer education efforts regarding the complaint and grievance processes. Development of a consumer brochure and use of electronic media are two examples of educational efforts the Association supports and looks forward to working with the Departments to accomplish. MCAP would respectfully request that such a brochure be released first in draft form in order to permit managed care plans to review/make suggestions.

7) Internal Grievance

- In the event that a managed care plan member receives an unsatisfactory decision under the expedited internal grievance process, does the process end at that point?
- Once again, MCAP would strongly recommend that there be a specific timeframe (60 days) during which a consumer must initiate the internal grievance process.

8) Prompt Payment

The Association would advocate that the following be added during the promulgation of regulations:

- Payment of clean claims will occur only when appropriate premium payments have been received from purchasers.

9) Enforcement

The Association remains concerned about potential Departmental investigations of health plans based upon enrollee or provider allegations. MCAP recommends the following:

- That managed care plans be assured some form of due process to respond to complaints which may potentially trigger an investigation under Act 68.

10) Penalties and Sanctions

In enforcing the penalties and sanctions provisions of the Act, MCAP supports the following:

- As some violations of the Act would certainly have more serious implications than others and the penalties and sanctions vary widely, that there be some assessment of integrating or matching specific violations with specific sanctions.
- That assessment of penalties and sanctions not be based on isolated instances and that a pattern of managed care plan abuses be required prior to punitive measures.

11) Integration with the Medical Assistance/HealthChoices Program

As the State's Medical Assistance (MA) population is enrolled in managed care, MCAP remains concerned about the apparent lack of inclusion of the Department of Public Welfare in Act 68 discussions. There are a number of instances (complaints/grievances, utilization review standards, prompt payment) where Act 68 requirements and MA/HealthChoices requirements differ. MCAP strongly recommends the following:

- Coordination between the Departments of Health, Insurance and Public Welfare on Act 68 implementation to include development of a specific crosswalk between the Act and the MA/HealthChoices program. Development of specific instructions for plans participating in MA/HealthChoices would also be useful. Particularly important will be a clear, concise description of consumer complaint/grievance/appeal rights which are notably different in the commercial market and the State's MA program.

As always, the Managed Care Association appreciates the opportunity to provide our comments/feedback. MCAP looks forward to continuing to work cooperatively with the Departments as the regulatory process ensues.

Sincerely,

Kimberly J. Kockler
Executive Director

cc: Molly Raphael
Gregory S. Martino

PATRICIA H. VANCE, MEMBER
HOUSE POST OFFICE BOX 202020
MAIN CAPITOL BUILDING
HARRISBURG, PENNSYLVANIA 17120-2020
PHONE: (717) 787-5935
FAX: (717) 787-0860

DISTRICT OFFICE:
3806 MARKET STREET
CAMP HILL, PENNSYLVANIA 17011-4327
PHONE: (717) 975-1985
FAX: (717) 975-2247
1-800-287-4045

House of Representatives
COMMONWEALTH OF PENNSYLVANIA
HARRISBURG

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September 16, 1999

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Robert E. Nyce, Executive Director
Independent Regulatory Review Commission
14th Floor, Harristown 2
333 Market Street
Harrisburg, PA 17101

Dear Robert:

Your agency is presently reviewing the regulations prepared by the Insurance Department regarding Act 68.

During the prolonged discussions of this proposed legislation, it was always the legislative intent to have the patient authorize the physician to pursue a claim with the patient's insurer of a medical denial. The whole purpose of the legislation was to bring back and include the patient (consumer) in health care. To allow a provider to proceed without the patient's consent would be to negate the process.

Clarification is needed regarding direct access to Ob/Gyn providers without a referral and when prior authorizations and pre-approvals for treatment are needed from that provider. It was the legislative intent to have prior approvals needed for those tests, etc. that go beyond normal routine, but certainly not for standard tests such as a Pap smear.

Lastly, it is hoped that the regulations from the Departments of Insurance and Health will be viewed together since they both impact the same statute.

Thank you for the opportunity to express my opinions on this subject.

Sincerely,

PATRICIA H. VANCE
Representative, 87th Legislative District

NICHOLAS A. MICOZZIE, MEMBER

6 S SPRINGFIELD ROAD
CLIFTON HEIGHTS, PENNSYLVANIA 19018
PHONE: (610) 259-2820
FAX: (610) 259-7019

ROOM 45, EAST WING
HOUSE BOX 202020
HARRISBURG, PENNSYLVANIA 17120-2020
PHONE: (717) 783-8808
FAX: (717) 783-0688

House of Representatives
COMMONWEALTH OF PENNSYLVANIA
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INSURANCE COMMITEE, CHAIRMAN
HEALTH & HUMAN SERVICES

February 10, 2000

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Robert E. Nyce, Executive Director
Independent Regulatory Review Commission
14th Floor, Harristown 2
333 Market Street
Harrisburg, PA 17101

Dear Mr. Nyce:

Please find enclosed comments on how the regulations for Act 68 can be improved from Ronald J. Butler. I am forwarding his comments for your review.

If you have any questions, please feel free to contact me.

Sincerely,

Nicholas A. Micozzie, Chairman
House Insurance Committee

NAM/se

Enclosure

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HEALTH SYSTEM

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Laurel Health System
15 Meade Street
Wellsboro, Pennsylvania 16901-1813

January 17, 2000

The Honorable Matthew E. Baker
House of Representatives of Pennsylvania
P.O. Box 202020
Harrisburg, PA 17120-2020

Forwarded with Rep. Miccozzie's 2/10/00 letter

Dear Representative Baker:

I am sending this letter to inform you of the importance and the impact of Act 68, The Quality Health Care Accountability and Protection Act, enacted January 1, 1999, on our hospitals and health systems.

Act 68 has proven, thus far, to be an effective starting point in creating accountability in managed care organizations and has taken strides in improving health insurance practices. There are, however, some needed modifications to the Act to ensure a high quality of care to our patients. They are as follows:

1. The Department of Health has defined emergency services differently from the Insurance Department; they need to be similar. In reference to inpatient services, skilled nursing services need to be defined on their own and not included as inpatient time.

2. The section on co-payments and co-insurance is too vague and needs to be clarified to ensure patient access to care.

3. Insurance regulations do not coincide with the definition of emergency services. This definition needs to include evaluation, stabilization and treatment.

4. The definition of medical necessity needs to be similar at all Departments to ensure access to care, and a process of periodic evaluation for determining such medical necessity is needed.

-continued-

5. The term "access" needs to be clarified, as it implies the use of motor vehicles but does not address inaccessible or unaffordable transport.

6. The Department of Health has differentiated between routine and non-routine obstetric and gynecologic care, while the Act has not. This also needs to be similar to avoid conflict in the future.

7. The Department of Health and the Insurance Department differ on continuity of care. It is important that these also be similar.

8. There is a lack of clarity in regard to grievance issues. Denial letters have lacked, in the past, a clinical rationale; and at times, services which were pre-approved have been denied once submitted for billing.

9. In regard to internal complaints, the consumer needs additional time to file such complaints. Thirty days is recommended.

10. The dispute resolution needs to be simplified, such as not requiring written consent from the patient to allow the provider to seek a resolution in procedural errors and administrative denials.

11. It should be required that any changes to contract terms be mutually agreed upon and communicated to providers with thirty days notice.

12. The regulations need to include how monitoring of all those involved will take place to ensure compliance with state laws and regulations.

It is imperative that these issues be addressed and the needed corrections be made to the regulations of Act 68 so that the Laurel Health System, and hospitals and health systems across the state, may continue to provide the best possible care to our communities.

Thank you for your consideration.

Sincerely,

Ron

Ronald J. Butler
President and CEO

NICHOLAS A. MICOZZIE, MEMBER

6 S. SPRINGFIELD ROAD
CLIFTON HEIGHTS, PENNSYLVANIA 19018
PHONE (610) 259-2820
FAX (610) 259-7019

ROOM 45, EAST WING
HOUSE BOX 202020
HARRISBURG, PENNSYLVANIA 17120-2020
PHONE (717) 783-8808
FAX (717) 783-0688

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INSURANCE COMMITTEE, CHAIRMAN
HEALTH & HUMAN SERVICES

February 10, 2000

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Ronald J. Butler, President & CEO
Laurel Health System
15 Meade Street
Wellsboro, PA 16901-1813

Dear Mr. Butler:

Recently I received a copy of your recommendations for the Act 68 regulations from Representative Matthew Baker. I want to thank you for the time and effort you spent reviewing the regulations and making suggestions on how they can be improved. Your perspective as a professional in the health care field is imperative as we in the legislature examine these proposed regulations.

I have taken the opportunity to forward your letter to the Independent Regulatory Review Commission so they may properly consider your comments in their review of the regulations. I have enclosed a booklet for your information regarding the regulatory process in Pennsylvania.

As you may be aware, the Department of Health's regulations are still in the proposed stage. The public comment period for their regulations closed on January 18th. The Insurance Department has submitted their final form regulations and the public comment period closed on February 3rd. Although I was not able to submit your comments prior to the deadline for the Health regulations, they were timely for the Insurance regulations. Please note in the booklet that you will have a second opportunity to comment on the Department of Health's regulations during the final form phase of the review.

Again, thank you for sharing your insight on these important regulations and if you have any further questions or concerns, please contact me or Representative Baker.

Sincerely,

Nicholas A. Micozzie

Nicholas A. Micozzie, Chairman
House Insurance Committee

cc: The Honorable Matthew Baker

PHYLLIS MUNDY, MEMBER
PARK BUILDING
SUITE 113
400 THIRD AVENUE
KINGSTON, PENNSYLVANIA 18704
PHONE: (570) 283-9822
(570) 655-3375

MAIN CAPITOL BUILDING
HOUSE BOX 202020
HARRISBURG, PENNSYLVANIA 17120-2020
PHONE: (717) 783-1614

House of Representatives
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HARRISBURG

CHAIR,
NORTHEAST DEMOCRATIC DELEGATION

COMMITTEES
APPROPRIATIONS
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SUBCOMMITTEE ON EDUCATION
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February 14, 2000

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Mr. Robert E. Nyce
Executive Director
Independent Regulatory Review Commission
333 Market Street, 14th Floor
Harrisburg, PA 17120

Re: Final-Form Rulemaking Comments
IRRC Regulation #11-195 (#2046)
Insurance Department
Quality Health Care Accountability and Protection

Dear Mr. Nyce:

Please except these comments regarding the above stated final-form rulemaking for consideration at IRRC's February 17, 2000 Public Meeting. My overwhelming concern is that the proposed rules fail to address a crucial managed care consumer protection and accountability safeguard by neglecting to define what constitutes "medical necessity."

A uniform definition of medical necessity is a key ingredient to building consumer protection in dealing with managed care organizations. Section 154.17 (Complaints) establishes a grievance process that "includes review of the *medical necessity* and appropriateness of services otherwise covered by the managed care plan." However, Section 154.2 (relating to definitions) fails to define what constitutes a medically necessary treatment or procedure. Absent a uniform definition of medical necessity, every managed care organization will continue to impose upon policyholders their own arbitrary definition of what "medically necessary" means and have the ability to deny patients needed health services under the parameters established by that definition.

In order to address this issue, the Department should utilize the HealthChoices definition of "medical necessity" for all managed care plans. As you know, HealthChoices is Pennsylvania's managed care program for Medical Assistance recipients. A similar definition passed the House overwhelmingly on two occasions during the last legislative session and continues to be a legislative priority of mine. The definition is as follows:

Medical Necessity – clinical definitions to establish a service or benefit which will or is reasonably expected to: (1) prevent the onset of an illness, condition or disability; (2) reduce or ameliorate the physical, mental, behavioral or developmental effects of an illness, condition or disability; or (3) assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities appropriate for individuals of the same age.

By incorporating this language, the Department would be providing a definition of medical necessity that is already in use and widely accepted. This simple and straightforward regulatory change would help to legitimate the grievance process and greatly strengthen health care accountability and protection provisions for consumers under Act 68.

Thank you for your consideration of this proposed regulatory change.

Sincerely,

Phyllis Mundy

Phyllis Mundy
State Representative
120th District

PM/rcb