Pennsylvania
Psychiatric Society

The Pennsylvania
District Branch of the
American Psychiatric Association

August 30, 1999

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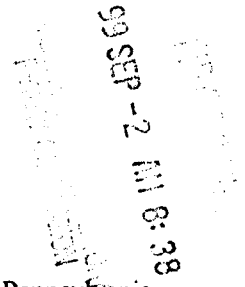
Peter J. Salvatore, Regulatory Coordinator
Department of Insurance
1326 Strawberry Square
Harrisburg, PA 17120



Dear Mr. Salvatore:

I am writing on behalf of President Lee C. Miller, MD, of the Pennsylvania Psychiatric Society, in regard to the Department of Insurance's proposed regulations for Act 68, as published in the *Pennsylvania Bulletin* July 31, 1999.

Although as physicians we are interested in numerous aspects of the legislation and regulations, our primary concern as psychiatric physicians is ensuring that the regulations clarify the Act's scope in relation to managed mental health services. Such services are often "carved out" of a health plan, either internally or by subcontract, and are subjected to separate and sometimes different managed care protocols than those related to the bulk of services covered by the health care plan.

A problem arises in that the Act clearly covers mental health care, but it was drafted with the usual, non-mental health management protocols in mind. We believe that an important function of the regulations is to make explicit the Act's relationship and applicability to managed mental health services which are "carved out," usually but not necessarily by subcontract. The object is to prevent the unintended exemption of managed mental health services by plans (and perhaps courts) through either simple confusion or a strict interpretation of regulatory language predicated on physical health protocols.

Happily, the proposed regulations represent a great improvement over earlier, non-published versions, demonstrating the Department's sensitivity to the issue. Nevertheless, the proposed regulations need further work in order to eliminate the danger of unintended consequences. Under the proposed rules, determining whether a particular plan is subject to the Act involves a very convoluted process. It first requires examination of § 154.1 (Applicability and Purpose), subsection (c). The next step is examination of the definition of "managed care plan," in § 154.2 (Definitions). That definition references "gatekeeper," whose definition references and requires an analysis of "primary care provider." "Primary care provider" in turn relies on the definition of "health care provider."

Discussion and suggested solutions

§ 154.1 Applicability and purpose

This section, in (c), represents a considerable improvement over earlier drafts in that it explicitly establishes applicability to entities which subcontract with managed care organizations.

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(1) Nevertheless, the construction of the sentence in (c) makes unclear whether the qualifying phrase "which issues subscriber contracts covering enrollees" refers to the managed care plan or the subcontractor. Subcontracting mental (behavioral) health organizations generally do not issue subscriber contracts. They provide services on behalf of managed care plans which issue subscriber contracts. Although this appears to be a technical matter, correcting the problem is essential if the ostensible purpose of subsection (c) is to be achieved.

Solution: We suggest simply removing the phrase completely, as it doesn't seem to add any element not covered elsewhere.

(2) Second, the current wording in (c) fails to address another concern we expressed in earlier communications: managed mental health care delivered through subcontract to a plan which, except for the subcontracted portion, does not meet the definition of managed care plan.

The current regulation would appear to exempt those managed care services which are provided under a subcontract with fee-for-service or similar plans. This is of critical importance to mental health treatment, since some primarily fee-for-service plans subcontract with behavioral health organizations to tightly manage the mental health benefit. In most cases the subcontractors are the very same organizations, applying the same managed care techniques, which are covered under the regulations if the behavioral health organization is subcontracted to a "managed care plan" rather than a fee-for-service plan. The distinction, of course, is irrelevant to the subscriber who happens to encounter a mental health problem.

Solution: We suggest adding a subsection (e) to clarify that when an otherwise-exempt plan separately manages or subcontracts the management of certain conditions or types of conditions, the regulations will apply to that portion of the health care plan which functions as a managed care plan.

§ 154.2 Definitions

The definition of "managed care plan" is, of course central to the scope of the Act. The definition is even more critical if the Department agrees that the "carved out" portion of an otherwise exempt plan - or a free-standing behavioral health care plan - is covered when the carved-out portion meets the definition of "managed care plan," as we have suggested.

"Managed Care Plan" - On its own, the definition seems reasonable. However, it references the use of a "gatekeeper," so the definition of "gatekeeper" becomes critical.

"Gatekeeper" – This definition is very helpful in that it recognizes a plan, or its agent, as gatekeepers in addition to the more common understanding of a gatekeeper as a primary care physician serving as the source of basic care and referrals. Decisions about basic care and referrals for patients seeking mental health services are often made by someone other than the Primary Care Provider making those decisions for the patient's other health care needs.

However, since the definition of "gatekeeper" references "primary care providers," and plans and agents serving as primary care providers, it is necessary to examine the definition of "primary care provider" to make sure that what these behavioral health plans and agents actually do is consistent with the definition of "primary care provider."

"Primary Care Provider" - The definition of "primary care provider" is a "health care provider" who performs specific, listed activities. Plans and agents of the plan operating carved-out behavioral

health delivery systems are unlikely to meet the definition of "health care provider," a term restricted to facilities and individuals licensed to provide health care services. Health care plans are not so licensed, nor, necessarily, are their agents. This may not be problematic, since the gatekeeper definition covers plans and agents "serving as" the primary care provider. A common-sense reading would indicate that the plan or its agents would not need to meet the definition of "health care provider" in order to "serve" as the primary care provider for gatekeeping purposes.

We recommend and request, however, that the regulations clarify this point.

Second, and potentially more problematic, the functions used to define "primary care provider" are idiosyncratic to systems of care which seek to centralize responsibility or oversight of all of a patient's health care needs in one provider. When mental health care is carved out of that system and treated separately by a plan or subcontracted agent "acting as" the primary care provider, certain responsibilities associated with primary care providers are either absent or exist in a different form. For example, a behavioral health organization is not responsible for continuity of care in the manner of primary care providers who oversee all aspects of a patient's health, because the behavioral health organization only deals with one aspect of the patient's health. As another example, referrals are handled in a variety of ways.

Solution: Since the listed functions defining "primary care provider" are not exactly accurate as a description of the basic primary care function as it is performed in "carved out" behavioral health plans, we recommend that the regulations clarify that plans and their agents are deemed to be "serving as" the primary care provider when they perform any of the listed or similar functions under the "primary care provider" definition. An alternative solution would be a statement to the effect that plans and agents "serving as the primary care provider" need not strictly meet the definition of "primary care provider" in order to be considered gatekeepers.

§ 154.11 Managed care plan requirements

Subsections (b) (1) and (2) allow managed care plans to establish time restrictions on approved treatment plans which include standing referrals, and requirements that treatment plans be periodically reviewed and re-approved by the plan. These practices are already common in the utilization management of behavioral health care. Unfortunately, the time restrictions and frequency of reviews are sometimes so excessive and burdensome that they discourage requests for treatment which would meet medical necessity criteria.

The regulation should be amended to include a reasonableness standard consistent with the standard of practice of the medical community.

§ 154.15 Continuity of Care

Subsection (g) (6) allows managed care plans to require nonparticipating or terminating providers to give "copies of the enrollee's medical records to the plan or the enrollee's participating primary care provider, or both, prior to the conclusion of the ongoing course of previously authorized treatment."

This subsection omits any requirement for patient permission. Although the Act itself requires managed care plans to adhere to all applicable laws and professional ethical standards regarding the confidentiality of records, this regulation, read out of context, will likely be used to improperly compel production of actual records without the informed, signed consent of the patient and other requirements

of federal and state law. Further, the plan's need to have a copy of the entire record, as opposed to the primary care provider's need, is questionable and problematic for many mental health patients.

We recommend that subsection (g) (6) be amended to include the patient's consent and adherence to all applicable laws, regulations, and professional ethical standards, as required by the Act We also recommend that the requirement be restricted to the primary care physician or, in the case of specialty care, to the specialist who will be providing services to the enrollee - not to the plan itself.

§ 154.18 Prompt payment

Subsection (a) requires insurers and plans to pay clean claims within 45 days of receipt of the clean claim. The regulations should describe some method for determining or assuming the date of receipt.

We recommend that subsection (a) be amended to allow the use of either three business days past the mailing date; or the date of receipt as indicated on the return-receipt from a certified mailing.

Subsection (e) requires providers to contact insurers to inquire about unpaid claims before filing a complaint with the Department. Although it is reasonable to require some good faith effort to resolve the matter prior to filing a complaint, it is not reasonable to place the entire burden on the provider. The provider, after all, is the one to whom something is owed.

We recommend that the regulations be amended to require insurers to notify providers of all deficiencies in their claims within ten working days of receipt. The regulation should specify that all deficiencies should be revealed at the same time, to avoid the all-too-frequent situation where a provider finds out a claim is deficient, fixes the problem, resubmits the bill, receives no payment, inquires again, and is told of another problem.

In support of our ten-day notification recommendation, we would point out that the "threat" of having to pay interest on unpaid clean claims is unlikely to help the private practitioner who sees many patients in the office and files a large number of small claims. Few of those claims are likely to reach the $2 interest threshold (a $100 claim paid one month late, at 10%, will incur less than $1 in interest), but in the aggregate the physician may be owed thousands of dollars.

In closing, we want to thank the Department again for the sensitivity it has shown to the particular issues which we raised in the past, and to express our hope that our comments here will be useful in further refining the regulatory language to accomplish the stated purpose of the Act.

Sincerely yours,

Gwen Lehman

Gwen Yackee Lehman
Executive Director

cc: Lee C. Miller, MD
John Jewett, IRRC
The Honorable Nicholas Micozzie
Gregory Martino, DOI

gyl/govt/68DOIregs

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Office of Special Issues

August 3,1999

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Peter J. Salvatore
Regulatory Coordinator
Department of Insurance
1326 Strawberry Square
Harrisburg, Pa. 17120

Re: Act 68 Proposed Rulemaking

Dear Mr. Salvatore:

Thank you for the opportunity to comment on the Department of Insurance proposed regulations related to the implementation of Act 68 of 1998. We appreciate the department's willingness to continue to consider the views of various stakeholders as the process moves forward.

As you may know, the Eastern Paralyzed Veterans Association (EPVA) is dedicated to enhancing the lives of veterans with a spinal cord injury or disease by assuring quality health care, promoting research, and advocating for civil rights and independence. EPVA has played a major role in the legislative and regulatory process related to managed care in Pennsylvania.

Section 154.2 Definitions

Enrollee – this term should include a parent, designee or legal representative.

Gatekeeper – As stated in our April 5 comments, Act 68 does not include a definition of gatekeeper. While it may be necessary for the department to clarify the issue via regulation, the definition should also be reflective of passive gatekeepers where the enrollee has to receive referrals to specialists, etc. This is especially important for people with disabilities seeking access to specialty care in a passive gatekeeper system. The grievance and complaint rights under Act 68 should be afforded to *all* gatekeeper systems. Without mention of passive gatekeepers in the definition plans may be confused and as a result people with disabilities could be denied their rights to access specialty care, as well as complaint and grievance rights.

Managed Care - The definition continues to exclude passive gatekeeper. As stated above this could lead to a denial of the right to access specialty care and complaint and grievance rights. The department's definition would most likely exclude people from the protections of the act that the General Assembly did not intend to exclude.

Section 154.11 Managed Care Plan Requirements

Obviously, the most important aspect of Act 68 for people with disabilities was the provision of Act 68 related to access to specialty care. The department, in its proposed regulations, has chosen to expand upon the provision of the act related to plan procedures for accessing specialty care. While this is consistent with the act, we would recommend that the department require the plan to

disclose those procedures and any limitations. For instance, Section 514.11 (b) (1), (2), and (3) should be disclosed to enrollees consistent with the acts required disclosure provisions. Because people with disabilities have not traditionally fit into managed health care, we recommend that the department monitor the development of this process closely and that the department continue to discuss this matter with appropriate stakeholders.

Section 154.17 Complaints

We note that the reference to grievances has been taken out of this section and that the department has clarified the difference between a complaint and a grievance related to access to specialty care. Because the legislative intent of Act 68 clearly intended to increase access to specialty care for people with disabilities, the department should make it clear via regulation that it will monitor this process closely to ensure the intent of the act is met and that unnecessary denials are not made.

The regulations should also reflect that access to specialty care, as set up in the Act, is a clinical process and therefore that issues related to denials, not based on self-referrals, are presumptively grievances. This would allow for self- referrals to continue to be deemed complaints while other issues related to clinical matters are grievances. We are also hopeful that the Department of Insurance statement will be consistent with the Department of Health Statement of Policy and final regulations in this regard.

Finally, we recommend that the department, along with the Department of Health, retain existing protections in the Department of Health 1991 Operational Guidelines and that the departments work together to guarantee consistency in both sets of regulations.

Thank you again for your attention to this matter. We are hopeful the department will consider our suggestions when drafting final regulations. Should you have any questions or comments concerning this matter, feel free to contact me directly at 215-381-3037.

Sincerely,

Hugh O. Allen
Senior Legislative Liaison

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT
OFFICE OF SPECIAL PROJECTS
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August 5, 1999

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Mr. Robert Nyce
Executive Director
Independent Regulatory Review Comm.
333 Market Street
Harrisburg, PA 17120

Re: Insurance Department
Proposed Regulation No.
11-195, Quality Health Care
Accountability and Protection

Dear Mr. Nyce:

Pursuant to Section 5(c) of the Regulatory Review Act, the Department is required to submit all comments on proposed regulations received during the public comment period to the Independent Regulatory Review Commission and the Legislative Standing Committees within 5 days.

Attached is a list of commentators that have submitted comment on the above-mentioned regulation and the respective comment that was received.

If you have any questions regarding this matter, please contact me at (717) 787-4429.

Sincerely yours,

Peter J. Salvatore

Peter J. Salvatore
Regulatory Coordinator

11-195c1.doc

Comments on the regulation listed below have been received from the following:

Reg #	*Regulation Title*
11-195	*Quality Health Care Accountability and Protection*

Mr. Hugh O. Allen — *Senior Legislative Liaison*
Eastern Paralyzed Veterans Association
P.O. Box 42938
Philadelphia, PA 19101-2938

Date Received *8/5/1999*

Date sent to Committes and IRRC 8/5/1999

The Reading Hospital and Medical Center

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November 1, 1999

John R. McGinley, Jr.
Chairman, Independent Regulatory Review Commission
14th Floor, Harristown 2
333 Market Street
Harrisburg, PA 17101

Dear Mr. McGinley:

This letter is to discuss several issues which I feel are important to the effective implementation of Act 68. As a healthcare provider, I am excited that the administration has supported this act and am optimistic that this will enhance patient care throughout the state. I understand that the Insurance Department has published proposed regulations pursuant to Act 68 and would like to comment on some of these regulations.

Currently, I am Acting Director in the Department of Emergency Medicine at the Reading Hospital and Medical Center in West Reading, Pennsylvania. Annually, we treat approximately 70,000 people in our Emergency Care Unit. As you know, the utilization of Emergency services is growing as the reimbursement for these services is waning.

I would like to stress the Insurance Department's requirements for access of enrollees to emergency services. It is important that insurers and managed care plans accept responsibility for all reasonably necessary costs for patients needing emergency service, including emergency transportation and services necessary to provide a medical screening exam for the patient. It is essential that these services include any interventions necessary to diagnose, stabilize and treat the patient.

Insurers and managed care plans must also incorporate the prudent layperson definition of emergency service into all plan policies, consumer literature and marketing materials. It is by this definition that many of our patients feel they are justified in receiving emergency services. It is unfortunate that insurance carriers do not provide for these services as they abide by an alternative definition of "emergency".

Mailing Address: PO Box 16052 • Reading, PA 19612-6052
Located at: Sixth Avenue and Spruce Street • West Reading, Pennsylvania
Telephone: 610-988-8000

Currently, we receive many inquiries from patients whose emergency evaluations and treatment were denied payment by their insurance company. In most cases, we feel that our care was appropriate and have difficulty understanding the insurance company's refusal. We provide the level of care to our patients which we would like to receive ourselves if the condition warranted. I am sure that you can appreciate our philosophy.

Once again, I am encouraged by the Insurance Department regarding Act 68 regulations, and am writing to give my support to the points stated above.

Please contact me if you have any questions or comments.

Sincerely,

C Barbera

Charles F. Barbera, M.D., F.A.C.E.P.
Acting Director, Emergency Care Unit
The Reading Hospital and Medical Center

cc: Scott R. Wolfe, TRHMC
Carolyn F. Scanlan, HAP

UNIVERSITY OF
PENNSYLVANIA
HEALTH SYSTEM

Robert D. Martin, Ph.D.
Chief Operating Officer

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October 8, 1999

Re: Act 68

To Whom It May Concern:

The University of Pennsylvania Health System ("UPHS") believes that our strength stems from our Mission Statement; Creating the Future of Medicine through education, research and the delivery of extraordinary care. We can somewhat manage education by continuing to recruit and retain outstanding faculty for the School of Medicine, and to some degree manage research through the quality of our faculty, students and Curriculum 2000™. Proof of that is the unprecedented growth in NIH funding alone that UPHS has experienced in recent years. However, the delivery of extraordinary care becomes increasingly difficult when plagued with delays in payment and/or unreasonable denials in combination with losing money on patient care. Therefore, Act 68 is of utmost importance to us in helping us carry out our mission. We fully support the comments provided by The Hospital & Healthsystem Association of Pennsylvania ("HAP") as a means of improving accountability of health insurers.

The Insurance Department should be congratulated for the improvements already made to the proposed regulation. These include, but are not limited to:

1. Reducing the administrative burden for notification to plans of emergency services in cases where the individual is not admitted;

2. Recognizing that prompt pay provisions apply to all health insurers;

3. Permitting providers to file complaints regarding prompt payment problems; and

4. Clarifying that interest will accrue for both the contested and non-contested portions of a claim as it relates to prompt payment.

More importantly, we specifically would like to call your attention to 3 areas of suggested improvement to Act 68 which were outlined by HAP in a letter to the Insurance Departments which we feel are imperative.

3400 Spruce Street • Philadelphia, PA 19104-4283 • 215-662-2203 • FAX: 215-662-7625

1. Clarifying the requirements for access and payment of **emergency services** by:

    - Requiring insurers and managed care plans to pay all reasonably necessary costs for patients needing emergency service, including emergency transportation, services reasonably necessary to screen the patient, and services reasonably necessary to diagnose, stabilize and treat the patient; and

    - Requiring insurers and managed care plans to incorporate the "prudent layperson definition" of emergency service in all plan policies, consumer literature and marketing materials, and provider contracts.

2. Clarifying the requirements for **continuity of care** to enable patients to have their health needs met appropriately.

3. Clarifying the requirements of **prompt payment** by:

    - Requiring insurers and managed care plans to notify providers that a claim is being contested or denied and the reasons for contesting or denying the claim;

    - Requiring insurers and managed care plans to provide contracting providers with requirements regarding claims submission and the types of data and information required by the insurer or managed care plan; and

    - Requiring insurers and managed care plans to pay uncontested portions of clean claims within 45 days.

We at the University of Pennsylvania Health System are grateful for all your efforts to support the Insurance Department in requiring health insurers and managed care plans to demonstrate compliance with Act 68 as well as encourage your support in the modification of these regulations.

Sincerely,

Robert D. Martin, Ph.D.
Chief Operating Officer

CROZER-KEYSTONE
HEALTH SYSTEM

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Joan K. Richards
President
Crozer-Keystone Hospitals

October 8, 1999

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Mr. John R. McGinley, Jr., Chairman
Independent Regulatory Review Commission
Harristown 2, 14th Floor
333 Market Street
Harrisburg, PA 17101

Re: Proposed Insurance Department
Act 68 Regulations

Dear Chairman McGinley:

With many of Pennsylvania's hospitals and healthcare systems losing money on patient care, we no longer have the ability to sustain inordinate payment delays or unreasonable denials without affecting the quality of care of our patients.

The Insurance Department should be commended for making improvements to the proposed Act 68 regulations; however, there are further changes needed. It is imperative that those improvements urged by the Hospital Association of Pennsylvania be addressed. These include clarifying the requirements for access and payment of emergency services by requiring insurers and managed care plans to pay all reasonably necessary costs for patients needing emergency service, including emergency transportation, services reasonably necessary for screening of the patient, and services reasonably necessary to diagnose, stabilize and treat the patient. In addition, insurers and managed care plans must be required to incorporate the *"prudent lay-person definition"* of emergency service in all plan policies, consumer literature and marketing materials, as well as all provider contracts. Of equal importance is the need to clarify the requirements for *"continuity of care"*, enabling patients to have their health needs met appropriately, and *"prompt payment"*. Insurers and managed care plans must be required to notify providers that a claim is being contested or denied and the reasons for such, as well as payment of uncontested portions of clean claims within a 45 day period. It should also be mandatory that insurers and managed care plans provide contracted providers with the requirements regarding claims submission and the types of data and information required for speedy processing.

Continued...

We in the healthcare industry are most appreciative of our legislature's efforts to support the Insurance Department in requiring health insurers and managed care plans to demonstrate compliance with Act 68, but strongly urge inclusion of those items listed above to ensure the quality and continuity of care demanded by those we serve.

I thank you in advance for your assistance.

Respectfully,

Joan K. Richards

Joan K. Richards
President
CROZER-KEYSTONE HOSPITALS

LP

GUTHRIE *Robert Packer Hospital*

October 7, 1999

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Mr. John R. McGinley, Jr.
Chairman, Independent Regulatory Review Commission
14th Floor, Harristown 2
333 Market Street
Harrisburg, PA 17101

Dear Mr. McGinley:

As you are well aware, the majority of the hospitals and health systems in the State of Pennsylvania are losing money on patient care. While we have been very active at attempting to initiate cost reducing measures, we have no ability to affect inordinate payment delays or unreasonable denials for care once the patient has reached our facilities. Together with HAP, we believe that effective implementation of Act 68 will benefit patients by fostering greater coordination and cooperation among health plans and health care providers.

Specifically, it is imperative that the improvements urged by HAP be addressed. As an example, HAP has asked for clarifying the requirements for prompt payment by requiring insurers and managed care plans to pay uncontested portions of clean claims within 45 days. As of September 21, 1999 the dollar value of payments that are in excess of 45 days late for Robert Packer Hospital was $1,427,487. This amount is for the expected payments, not the charges, and only includes the managed care accounts with our hospital. The above amount represents about 6% of our total accounts receivable. Prompt payment by the health plans would help us manage our AR to a lower level.

We are most appreciative of the administration's and the legislature's effort to support the insurance department in requiring health insurers in managed care plans to demonstrate compliance with Act 68. As we here at Robert Packer Hospital struggle to address the impacts of the balanced budget amendment, it would comfort us to know that clean claims will be paid in a timely fashion in a manner similar to our own payment policies for bills sent to us. We heartily support the comments provided by the Hospital and Healthsystem Association of Pennsylvania as a means of improving accountability for all health insurers.

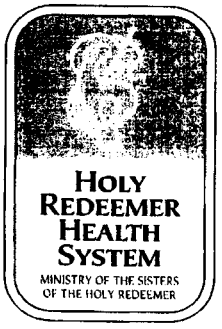
Sincerely,

William F. Vanaskie
President

WFV:dfl

Robert Packer Hospital
Guthrie Square
Sayre, Pennsylvania 18840
570-888-6666

A member of the Guthrie Healthcare System



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September 28, 1999

John R. McGinley, Jr.
Chairman
Independent Regulatory Review Commission
14th Floor, Harristown 2
333 Market Street
Harrisburg, PA 17101

Dear Mr. McGinley:

I am writing to request your assistance in assuring that some additional improvements are made in the proposed Act 68 Insurance Department Regulations. While I am appreciative of the changes made to date by the Insurance Department, additional changes are necessary to help health care providers such as Holy Redeemer deal with the increasing number of denied days, reduction in level of care days, as well as outpatient denials that have become the norm in the Philadelphia market. The cost associated with the aforementioned issues totaled more than $4 million in FY 1999 for Holy Redeemer. It has become a hardship for us to continue to maintain our high standards of care while dealing with payment delays and unreasonable denials.

Therefore, I urge you to take the necessary steps to incorporate the following in the regulations:

First, require insurers and managed care plans to pay all reasonably necessary costs for patients needing emergency service, including emergency transportation, services reasonably necessary to screen the patient, and services reasonably necessary to diagnose, stabilize and treat the patient.

Second, require insurers and managed care plans to incorporate the "prudent layperson definition"

Drueding Center/
Project Rainbow

Holy Redeemer
Foundation

Holy Redeemer
Hospital and
Medical Center

Holy Redeemer
Physician and
Ambulatory Services

Holy Redeemer
Managed Care
Organization

Holy Redeemer
Visiting Nurse
Agency-NJ

Holy Redeemer,
Nazareth and
St. Mary Home
Health Services

The
Lafayette-Redeemer

St. Joseph's Manor

Redeemer Village

Redeemer-Nazareth
Medical Supply
Company

of emergency service in all plan policies, consumer literature and marketing materials, and provider contracts.

Third, clarify the requirements for continuity of care to enable patients to have their health needs met appropriately.

Fourth, require insurers and managed care plans to notify providers that a claim is being contested or denied and the reasons for contesting or denying the claim.

Fifth, require insurers and managed care plans to provide contracting providers with requirements regarding claims submission and the types of data and information required by the insurer or managed care plan.

Sixth, require insurers and managed care plans to pay uncontested portions of clean claims within 45 days.

Thank you your continuing support of initiatives that benefit the well being of the people of the Commonwealth and its health care providers.

I would be happy to discuss the difficulties we have had with these issues and other provider shortcomings at any time. Thank you for your support.

Sincerely,

Michael B. Laign
President/CEO

/dt
cc: Denise Collins
Sandra Santello
Michele Urofsky

Shamokin Area Community Hospital

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September 21, 1999

John R. McGinley, Jr.
Chairman, Independent Regulatory Review Comm.
14th Floor, Harristown 2
333 Market Street
Harrisburg, PA 17101

Dear Mr. McGinley,

Currently, more than two-thirds of Pennsylvania's hospitals and health systems are in a grave situation-losing money on patient care, with the maintenance of the quality of care they are able to provide being challenged. The practice of insurers not paying claims promptly or not adequately covering claims for care provided in emergency rooms continues to adversely affect the financial state of health care facilities.

We strongly believe that effective implementation of Act 68 can only benefit patients by encouraging greater cooperation between health plans and care providers. The positive changes that have already been made to the proposed regulations are a key aspect of the success of this legislation. It is crucial, however, that the proposed modifications submitted to the Insurance Department by the Hospital Association of Pennsylvania be given serious consideration in the final form of Act 68. These improvements include:

- Clarifying the requirements for access and payment of emergency services.
- Clarifying the requirements for continuity of care to enable patients to have their health needs met appropriately, and
- Clarifying the requirements of prompt payment.

These clarifications to the existing proposed regulations will not only protect the patient, but will contribute to the providers' ability to submit "cleaner claims," reducing contested claims and streamlining the process in the long term.

Hospitals and health systems continue to be appreciative of the administration's and legislature's efforts to support the Insurance Department in requiring health insurers and managed care plans to demonstrate compliance with Act 68.

Sincerely,

John P. Wiercinski
President and Chief Executive Officer

PENNSYLVANIA HEALTH LAW PROJECT

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801 ARCH STREET, SUITE 610A
PHILADELPHIA, PA 19107
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September 10, 1999

VIA FACSIMILIE AND US MAIL

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Markham
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Legal

John Jewitt
Mary Lou Harris
Christopher L. Markham
Fiona E. Willmarth
James M. Smith
Independent Regulatory Review Commission
14th Floor Harristown II
333 Market Street
Harrisburg, PA 17101

Dear Colleagues:

I write on behalf of our clients, the Consumer Health Coalition and the Armstrong County Low-Income Rights Organization to thank you for meeting with us, the Pennsylvania Health Law Project, on September 1, 1999 to discuss the proposed regulations of the Department of Insurance.

During our meeting, we discussed the disclosure to enrollees section of the regulations and our concern that the regulations fail to sufficiently spell out the disclosures that plans must make to enrollees. I understand the regulatory policy of not restating entire sections of legislation where such can be incorporated by reference. I have, therefore, reviewed §2136(a) of the Act to assess which items need additional clarification in the regulations. I reaffirm our prior comments on this section. It is especially important that the regulations clarify the requirement that materials be "easily understandable to the layperson" to ensure that plans accommodate individuals with disabilities and individuals with limited English proficiency.

Upon review of §2136(a) of the Act, our concern is that the Act imposes broad, amorphous requirements upon plans that, although they are positive requirements, may be so broadly stated that plans may vary in their interpretations of these requirements. For example, §2136(a)(8) requires disclosure of a summary of the complaint and grievance process. What precisely comprises a "summary" is left to the plans to decide. Consumers will only be fully informed of their rights to appeal if the plans are uniformly required to make full disclosure of the information regarding the complaint and grievance process, as that process is spelled out in

the regulations. The regulations cannot incorporate by reference the Act unless the incorporated provisions of the Act are viewed as incorporating the relevant regulations.

Another example would be the OBGYN and Emergency Services provisions. Although §2136(a)(1) and (2) could be construed as requiring plans to disclose the features of the direct access to OBGYN services and the features of the Emergency Services provisions that are spelled out in the regulations, they do not, in fact, require such disclosure. Such disclosure is necessary if consumers are to be fully informed of their health care options. Thus, the Act's requiring plans to disclose "a description of ... benefits" is too ambiguous. It does not require plans to disclose all benefits, etc. The regulations must make clear that plans are required to disclose all benefits, length of coverage, all exclusions, etc. including those laid out in the rest of the Act and the regulations.

§2136(a)(5) requires plans to disclose to enrollees the plans' methods for addressing the needs of non-English speaking enrollees. This allows too much room for variation among the plans. The regulations must give plans guidance on how to address the needs of non-English speaking enrollees. The Act's broad requirement that plans disclose their methods does not prevent the Department from prescribing a method. The Department must provide minimal requirements to plans and the plans must meet these requirements in creating their methods for addressing the needs of non-English speaking enrollees. Once the plans have incorporated the department's requirements into their method, the plans must disclose their method to enrollees.

Additionally, in §154.16(h), the regulations restate §2136(a)(9) of the Act but also misstate it. In this section, the regulations require plans to employ a definition of emergency services "consistent with the act" even though the Act requires plans to employ a definition of emergency services "as set forth in the Act". We are concerned that the regulations not take away the Act's consumer protections. Requiring one set definition for emergency services prevents variation among plans. Additionally, if this provision is not to be incorporated by reference but to be spelled out due to its importance, it must be spelled out correctly.

As we also discussed last week, I am concerned that the regulations do not set forth specific timeframes for mandatory disclosures and specific mechanisms and timeframes for non-mandatory disclosures. For example, it is not clear how an enrollee might access information in an expedited fashion if an urgent need for such information should arise. It is not clear how soon after a request for non-mandatory disclosures, such information must be provided.

Once again, I thank you for meeting with us last week and for your attention to this letter. Please feel free to contact me in the Philadelphia office or David Gates at our Harrisburg office if you have any additional questions about our comments.

Sincerely,

Ann S. Torregrossa, Esq.
Director

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FAX TRANSMITTAL

DATE: 9/10/99

NUMBER OF PAGES INCLUDING COVER SHEET: 3

TO: IRRC Analysts	FROM: Ann Torreglossa
TELEPHONE:	TELEPHONE: (215) 625-3663
FAX: (717) 783-2664	FAX: (215) 625-3879

COMMENTS:

From: Mcareofpa@aol.com
Date: Tue, 7 Sep 1999 11:59:09 EDT
Subject: Proposed Rulemaking 11-195
To: psalvato@ins.state.pa.us
X-Mailer: AOL 4.0 for Windows 95 sub 22

Dear Mr. Salvatore: Although the comment period on proposed rulemaking 11-195 (Quality Health Care Accountability & Protection Act) has expired, I was hoping you would accept the following comment as an addendum to the Managed Care Association of Pennsylvania's (MCAP's) previously submitted comments:

Continuity of Care - Section 154.15 (f)

Subsection (f) states that "Health services provided under the continuity of care requirements shall be covered by the managed care plan under the same terms and conditions as applicable for participating providers." MCAP understands and appreciates the Insurance Department's intent to minimize the impact on managed care plans with this language. However, the Association is concerned that nonparticipating providers may interpret this language to mean that they may demand the fees paid to participating providers which, in some cases, may actually be higher than what nonparticpating providers are paid. This will particularly be an issue in Medical Assistance where managed care plans are focused on building and maintaining strong and diverse provider networks and therefore may pay participating providers at higher rates than nonparticpating providers. Higher rates are intended as an incentive to keep providers in the network.
The Association asks that the phrase be reworded to state "Health care services provided under the continuity of care requirements shall be covered according ot the terms and conditions established by the managed care plan."

Thank you for your consideration.

Kimberly J. Kockler
Executive Director
Managed Care Association of Pennsylvania
717/238-2600

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT
OFFICE OF SPECIAL PROJECTS
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September 9, 1999

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Mr. Robert Nyce
Executive Director
Independent Regulatory Review Comm.
333 Market Street
Harrisburg, PA 17120

Re: Insurance Department Proposed Regulation No. 11-195, Quality Health Care Accountability and Protection

Dear Mr. Nyce:

Pursuant to Section 5(c) of the Regulatory Review Act, the Department is required to submit all comments on proposed regulations received during the public comment period to the Independent Regulatory Review Commission and the Legislative Standing Committees within 5 days.

The attached e-mail printout from Kimberly J. Kockler, Executive Director of the Managed Care Association of Pennsylvania, was received after the 30-day public comment period. The Department, in its review, will consider the comment; however, the Department would like it noted that this comment was late.

If you have any questions regarding this matter, please contact me at (717) 787-4429.

Sincerely yours,

Peter J. Salvatore

Peter J. Salvatore
Regulatory Coordinator

11-195c3.doc

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99 SEP -1 AM 11:24

INSURANCE COMMITTEE
Insurance Department Regulations on Act 68

Tuesday, August 24, 1999
10:30 a.m.
Room 60, East Wing
Main Capitol Building, Harrisburg, PA

Opening Remarks
The Honorable Nicholas A. Micozzie

10:45 a.m. **Gregg Martino, Deputy Commissioner**
Pennsylvania Insurance Department

11:05 a.m. **Andrew B. Wigglesworth, President**
Delaware Valley Healthcare Council of HAP

11:25 a.m. **Don McCoy, Director, Policy & Regulatory Affairs**
Pennsylvania Medical Society

11:45 a.m. **Samuel R. Marshall, President**
Insurance Federation Pennsylvania

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Pennsylvania Department of Health
Managed Care

(717)787-5193

Additional Consumer Rights Issues

(Note: some of these questions may appear elsewhere in the questions and answers relating to Act 68 implementation. Because of expressed consumer concerns over the specific issues regarding complaints and grievance, the Department has addressed these questions and answers in greater detail.)

Q. Act 68 and the Department of Health's Statement of Policy appear to have resulted in a decrease in consumer rights in certain critical areas relating to consumer complaints and grievances, when compared with HMO standards previously in effect in these areas. For example, HMOs are not required to provide consumers with essential information about their decisions and the decision making process. Is this correct?

A. HMOs and managed care plans are in fact required to provide consumers with descriptions of the appropriate complaint and grievance processes and appeal rights under Act 68. These descriptions will be found in amendments or revisions to enrollee subscriber contracts, being reviewed and approved by the Insurance Department, and likewise may appear in other forms of enrollee literature, including, for example, member handbooks, marketing materials, etc. The Departments have toll-free numbers for consumers to call with questions; HMO and managed care member services are available to answer questions; and the Departments are working on distribution of a consumer education pamphlet, a copy of which is already posted on this Web Site (See New Managed Care Brochure). Experience of all parties – consumers, providers, managed care plans, state agencies– will be utilized to help determine how specific Act 68 regulations will need to be in addressing these and similar issues.

Q. Why is there not "adequate" consumer representation on the complaint and grievance committees, especially when contrasted with prior requirements that 1/3rd of the membership be HMO plan enrollees?

A. Since the HMO Act is non-specific on the details of a consumer grievance system, when the Department published the 1983 HMO regulations, it did in fact establish a standard that 1/3rd of the membership of a grievance committee be HMO enrollees. Act 68 of 1998 however is much more specific and detailed in nature, including composition of the new complaint and grievance committees established thereunder. This composition includes, for the 2nd level complaint review committee, 3 or more individuals who did not participate in the initial review, at least one third of whom shall not be employed by the managed care plan. For the 2nd level grievance review committee, one or more persons selected by the managed care plan who did not previously participate in the decision to deny payment for the health care service, with a requirement that the review include a licensed physician or, where appropriate, an approved licensed psychologist in the same or similar specialty that typically manages or consults on the health care service. The Department believed, given the level of specificity in the Act, that it would be inappropriate in a statement of policy to attempt to go beyond apparent legislative intent to include consumer representation on these committees. The Department is willing to reconsider the issue during its development of formal regulations on Act 68, and to hear pros and cons on the issue, including whether it can, in fact, through regulation, go beyond the specificity of the Act, to require consumer representation on these committees.

Q. Why did the Statement of Policy not include a clear statement, previously made by the Department of Health, that requires impartiality of the members of the complaint and grievance committee?

A. The Department of Health's August 1991 document, "HMO Grievance systems: Operational Standards for Fundamental Fairness for HMO Members", which did not have the force of law or regulation and which was not formally published even as a statement of policy, but was rather

made available to plans to represent guidance on the attributes of a grievance system which the Department could find to be fundamentally fair and acceptable under the HMO Act, does contain the guideline that, "(Second level grievance review) Committee members must have the ability to be fair and impartial." The Department continues to have a reasonable expectation, as do managed care plan enrollees, that the new complaint and grievance committee members under Act 68 will be impartial in their consideration of enrollee and/or provider appeals. It is the intent of the Department to include a specific standard to this effect in its proposed Act 68 implementation regulations. It is likewise the expectation of the Department that managed care plans, in implementing the new Act 68 complaint and grievance procedures, will utilize the general guidance provided in the cited "Operational Standards", where it is not inconsistent with Act 68 or the Department's statement of policy, to develop, operate and maintain fundamentally fair complaint and grievance systems for enrollees and providers filing grievances with the written consent of enrollees.

Another issue addressed in the "Operational Standards" but not in Act 68 or the statement of policy relates to disclosure to consumers about decisions made by the managed care plan and its committees at each step of the appeals process. The "Operational Standards" go into great detail providing guidance on fundamentally fair procedures, including information that should be provided to consumers in order to assist them in understanding the process, the basis for decisions at each appeal level, and rights to appeal to the next level.

These "Operational Standards", to the extent they were not preempted by Act 68, are to be read as consistent with the implementation of Act 68 and remain in effect.

Once again, the Department's expectation is that each managed care plan will maintain its new Act 68 complaint and grievance procedures in a manner so as to provide enrollees with a fundamentally fair dispute resolution process, consistent with the general guidance provided in the "Operational Standards." The Department will determine the extent to which the guidelines contained in the "Operational Standards" should be incorporated into Act 68 implementing regulations, including, for example, any necessary clarification of "burden of proof" issues, another concern raised by consumers.

Generally, it is the Department's belief that since 1991, given the monitoring by the Department, its hearing of grievance appeals, and its in-depth review of grievance case files, HMOs have operated a fundamentally fair consumer grievance system, with adequate consumer safeguards, and that HMOs and managed care plans will continue to do so under the revised provisions of Act 68. Failure to provide fundamentally fair procedures in accordance with the Act will be monitored and corrective action required.

Q. Won't consumers suffer because of the failure to have an expedited process for medically pressing denials?

A. Act 68 only specifies a procedure for an expedited internal review by a managed care plan. It is silent on what the next step should be if the consumer and/or provider is dissatisfied with the decision and wants to appeal further. The statement of policy does not go beyond Act 68, but the Department has urged plans to provide specific details regarding this process to consumers and providers. Most plans submitting compliance materials have indicated that the next logical step in the process is to proceed directly to the internal 2nd level grievance committee; in other words, the internal 48 hour expedited grievance appeal takes the place of the 1st level grievance committee review and decision, thereby cutting the review process by 30 or more days. Again, based on actual implementation experience and input from all parties, the Department intends to address this issue in its draft Act 68 implementation regulations, andsooner, if necessary.

Q. Why are consumers not permitted to file oral grievance requests, as they where under the old grievance system?

A. The language of Act 68, Section 2161(a), uses the phrase, "...shall be able to file a written grievance regarding the denial of payment for a health care service." (Emphasis added.)

Q. Why are providers not required to explain to consumers, when obtaining their written consent to file a grievance, that by doing so consumers lose their right to appeal directly?

A. Act 68 does not provide specific details concerning the form or content of an acceptable written

consent. The Department has received expressions of concern from all parties, including health plans, providers and consumers with regard to written consent. Based upon actual implementation experience, the Department, if necessary or desirable, will address this issue in its draft Act 68 implementation regulations. Pending the regulations, the Department expects that providers, at the time a managed care plan enrollee presents for treatment, may obtain written consent to file a grievance for the limited purposes of obtaining reimbursement. The Department likewise expects that providers will clearly disclose to the managed care plan enrollee that by signing the consent the enrollee gives up his or her ability to file a grievance directly, for the limited purpose of obtaining reimbursement for the provider.

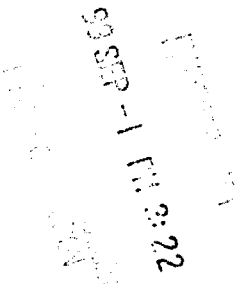
Last modified on 01/22/99

PA Health Law Project

20 N. Market Sq., 3rd flr., Harrisburg, PA 17101

Phone: (717) 236-6310 Fax: (717) 236-6311

Date : 09/01/1999 **Subject : DoH policy statement**



To: John Jewett

Company : IRRC

From : David Gates **Pages : 4**

Message:

Here's the policy statement DoH posted on their web site that their policy statement from 1991 regarding appeal & grievance rights remains in effect.

MANAGED CARE ASSOCIATION OF PENNSYLVANIA

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

September 1, 1999

Christopher L. Markham
Regulatory Analyst
Independent Regulatory Review Commission
333 Market Street, 14th Floor
Harrisburg, PA 17101

Fiona E. Wilmarth
Regulatory Analyst
Independent Regulatory Review Commission
333 Market Street, 14th Floor
Harrisburg, PA 17101

Dear Mr. Markham and Ms. Wilmarth:

On behalf of the members of the Managed Care Association of Pennsylvania (MCAP), I would like to thank you for meeting with me recently to discuss the Insurance Department's proposed rulemaking pursuant to Act 68, 1998, the Quality Health Care Accountability and Protection Act. The Association currently represents 14 Commonwealth managed care plans (list enclosed) which enroll over 1.5 million Pennsylvanians in various commercial as well as Medicare and Medicaid health plans.

I hope that you found our listing of priority issues useful and will consider our concerns during promulgation of final regulations. As promised during the meeting, I am enclosing a letter which summarizes the results of a 1998 informal survey of our members regarding prompt claims payment. The letter and survey were requested by the Senate Public Health and Welfare Committee. As you will see, the average turnaround time on a clean claim was estimated at 15 days and an estimated 15 percent of claims received are deemed "unclean."

I hope this information is useful in your analysis and that you will not hesitate to contact me directly with any questions you may have. Thank you again for the opportunity to discuss our concerns.

Sincerely,

Kimberly J. Kockler

Kimberly J. Kockler
Executive Director

enclosures

cc: Kathy McCormac
Melanie Brown

MANAGED CARE ASSOCIATION OF PENNSYLVANIA

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Corporate Members

Alliance Health Network
Gateway Health Plan
HealthAmerica Pennsylvania, Inc.
Healthcare Management Alternatives, Inc.
HealthCentral, Inc.
HealthGuard
Health Partners
Horizon Healthcare of Pennsylvania, Inc.
Oak Tree Health Plan
Penn State Geisinger Health Plan
QualMed Plans for Health, Inc.
UPMC Health Plan, Inc.

Associate Members

One Health Plan of Pennsylvania
Pennsylvania Healthmate, Inc.

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mcareofpa@aol.com

January 21, 1998

Mr. Scott Johnson
Executive Director
Senate Public Health and Welfare Committee
Room 169 Main Capitol
Harrisburg, PA 17120

VIA FACSIMILE - Hard copy to follow by mail

Dear Scott:

Thank you for contacting me regarding the issue of timely payment of provider claims. Pursuant to your inquiry, we conducted an informal poll of our member HMOs and asked specifically for the following information:

- Average turnaround time to process a clean claim.
- Percentage of claims received which are **not** clean claims.
- Examples of circumstances which delay claims payment.

As you may know, MCAP represents the interests of 12 of the State's HMOs which enroll well over one million Pennsylvanians. The following information, therefore, is representative of our member health plans and not the State's HMO market in its entirety.

1) ***Average turnaround time to process a clean claim.***

The vast majority of our plans reported a 30-day turnaround time on clean claims. The plan with the lowest turnaround time reported 10 days and the highest reported 35.

2) ***Percentage of claims received which are not clean claims.***

On the average, our plans report that 15 percent of the claims they receive are not clean claims. The highest reported percentage of unclean claims was 20 percent and the lowest was 6 percent.

3) *Examples of circumstances which delay claims payment.*

By far, the most common reason for claims payment delays is incorrect or missing information on the claim form, for example improper coding. Absence of a referral or prior authorization, the need for utilization management review, membership and/or eligibility clarification difficulties, emergency services medical review, provider status, and receipt of the necessary medical records are among the various other reasons why claim payments may be delayed. The nature of the claim may also be a factor. For example, processing a claim for a complicated transplant case may take significantly more time than processing an office visit claim.

It is fair to say, based upon all of the aforementioned factors which may affect timely payment of claims, that our members have concerns about legislating or mandating specific deadlines for claims payment. Perhaps this issue might be better addressed by a more informal effort whereby plans and providers worked cooperatively to decrease the number of instances of unclean claims.

As always, I appreciate the opportunities you provide for us to respond to Senator Mowery's concerns. I hope this information is useful. I would be glad to discuss this issue in further detail and, if necessary, arrange a meeting with some of our members and yourself or the Senator.

Sincerely,

Kimberly J. Kockler

Kimberly J. Kockler
Executive Director

Garner, Kim

From: David Gates [dg931@ibm.net]
Sent: Wednesday, September 01, 1999 3:38 PM
To: IRRC
Subject: For John Jewitt

John: Attached is a self viewing file containing the August 1991 appeal & grievance policy memo from DoH. You should be able to read & print this document by simply saving the file to your hard drive then double clicking on it from Windows Explorer or a directory window.

--
David Gates
PA Health Law Project
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PENNSYLVANIA DEPARTMENT OF HEALTH

HEALTH MAINTENANCE ORGANIZATION GRIEVANCE SYSTEMS OPERATIONAL STANDARDS FOR FUNDAMENTAL FAIRNESS FOR HEALTH MAINTENANCE ORGANIZATION MEMBERS

I. INTRODUCTION

The Pennsylvania Department of Health (hereinafter referred to as the Department) has developed Health Maintenance Organization (HMO) Grievance System Operational Standards and is distributing this explanation of its expectations in order to:

- Assist HMOs in the Commonwealth to comply with provisions of the HMO Act and Department of Health Regulations (28 PA Code Chapter 9);
- Help ensure that the HMO member receives a fundamentally fair process for resolving grievances;
- Maximize the use by a member of internal HMO grievance systems and procedures before involving regulatory agencies;
- Maximize thorough investigation and documentation of substantive issues regarding a member grievance by HMOs themselves, so as to ensure creation of adequate records upon which appeals to the Department by an HMO member may be judged;
- Minimize the potential for the Department overturning HMO second level Grievance Review Committee (as specified in 9.73(s)) decisions based on failure to follow proper administrative procedures, and/or to provide adequate fundamentally fair grievance resolution;
- Develop and promote uniformity in the reporting of grievances to enhance the potential for tracking trends and comparative analysis of grievance resolution and member satisfaction not only by the Department but by purchasers and consumers of HMO services; and
- Ensure prompt expedited review by both the HMO and the Department of grievances alleging HMO denial of urgently needed care.

Each licensed HMO is to submit, not later than the date specified in the covering letter accompanying this document, for Department review and approval, member grievance resolution procedures complying with the provisions of the HMO Act and regulations and Department expectations regarding compliance set forth herein.

II. BACKGROUND

During the course of the external quality review process, Department staff identified many deficiencies in the methods by which HMOs define, process and resolve disputes with their members. The Department identified the need for improvement and standardization of grievance procedures in quality improvement plans of many HMOs.

Comments on the regulation listed below have been received from the following:

Reg #	*Regulation Title*
11-195	*Quality Health Care Accountability and Protection*

Ms. Mary Etezady *President*
The League of Women Voters
226 Forster Street
Harrisburg PA 17102-3220

Phone: (717) 234-1576 X00000 *EMail:*

Date Received *8/30/1999*

Date sent to Committes and IRRC 8/30/1999

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THE LEAGUE
OF WOMEN VOTERS
PENNSYLVANIA

August 30, 1999

Peter J. Salvatore, Regulatory Coordinator
1326 Strawberry Square
Harrisburg, PA 17120

Dear Mr. Salvatore,

The League of Women Voters of Pennsylvania appreciates this opportunity to comment on proposed rules for Act 68, The Quality Health Care Accountability and Protection Law.

Our comments on Act 68 rules address two distinct issues. The first pertains to consumers and managed care plans excluded by Act 68 from basic consumer protections. Today millions of Pennsylvanians receive health services from plans that are not in the proposed definition of a managed care plan — "a health plan that uses a gatekeeper to manage the utilization of health care services." Under Act 68, consumers in preferred provider organizations and traditional indemnity plans will lack the protections available to those in "gatekeeper" plans. **The League of Women Voters of Pennsylvania recommends additional regulations and/or legislation to extend the basic protections of Act 68 to all consumers in all insurance plans under the jurisdiction of the Commonwealth.**

Secondly, we believe the Act should provide consumers with balanced, fair and effective mechanisms that will resolve differences that might arise with their health plans, providers or the institutions that serve them. The proposed rules of Act 68 establish a rigorous system of internal review and an independent system of external review, both essential to a fair appeals process. However, it does this by bifurcating disputes into complaints and grievances, and by delineating definitions and processes under each. The complicated processes defined by the Act will be incomprehensible to most consumers and providers. Thus, the right of consumers to resolve real differences with their managed care plans is questionable, due to the complexity inherent in Act 68 and proposed rules. **The League of Women Voters of Pennsylvania recommends that the appeals processes of Act 68 be simplified to assure that consumers can easily understand and make use of the mechanisms available to resolve disputes that might arise with their plans.**

The Quality Health Care Accountability and Protection Law extends essential rights to consumers in the Commonwealth. By extending these protections to consumers insured by all types of health care plans under its jurisdiction and by simplifying the appeals process of the Act. Pennsylvania will truly have enacted a Patients' Bill of Rights.

Sincerely,

Mary Etezady, President

226 FORSTER STREET • HARRISBURG, PA 17102-3220 • (717) 234-1576

COMMONWEALTH OF PENNSYLVANIA
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99 SEP -1 AM 9:42

August 30, 1999

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Mr. Robert Nyce
Executive Director
Independent Regulatory Review Comm.
333 Market Street
Harrisburg, PA 17120

Re: Insurance Department
Proposed Regulation No.
11-195, Quality Health Care
Accountability and Protection

Dear Mr. Nyce:

Pursuant to Section 5(c) of the Regulatory Review Act, the Department is required to submit all comments on proposed regulations received during the public comment period to the Independent Regulatory Review Commission and the Legislative Standing Committees within 5 days.

Attached is a list of commentators that have submitted comment on the above-mentioned regulation and the respective comment that was received.

If you have any questions regarding this matter, please contact me at (717) 787-4429.

Sincerely yours,

Peter J. Salvatore
Regulatory Coordinator

11-195c

Comments on the regulation listed below have been received from the following:

Reg #	*Regulation Title*
11-195	*Quality Health Care Accountability and Protection*

Ms. Paula A. Bussard *Senior Vice President*
The Hospital & Healthsystem Association of Pennsylva
4750 Lindle Road
Harrisburg PA 17105-8600

Phone: (717) 561-5344 X00000 *EMail:*

Date Received *8/30/1999*

Date sent to Committes and IRRC 8/30/1999

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HAP

THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

August 30, 1999

Mr. Peter J. Salvatore
Regulatory Coordinator
Pennsylvania Insurance Department
1326 Strawberry Square
Harrisburg, PA 17120

Dear Mr. Salvatore:

The Hospital & Healthsystem Association of Pennsylvania (HAP), on behalf of its members (more than 225 acute and specialty hospitals and health systems in the Commonwealth) and the patients they serve, appreciates the opportunity to comment on the Insurance Department's proposed regulations to implement the Quality Health Care Accountability and Protection provisions of Act 68.

Hospitals and health systems supported the enactment of Act 68 as a first step in assuring improved managed care accountability for Pennsylvania citizens. We believe that effective implementation of Act 68 will foster greater coordination and cooperation among health plans and health providers, which will benefit patients.

We applaud the Department's efforts for proposing regulations which will provide for managed care accountability that will improve health insurance practices. We believe this is vitally important to Pennsylvania hospitals and health systems, as they strive to provide appropriate and necessary health care to patients, and to serve their communities.

In reviewing the proposed regulations we want to commend the Department for incorporating numerous changes into the proposed regulations which HAP commented on in the pre-draft release of the proposed regulations. These changes include:

- ❒ the Department defining "licensed insurer" to ensure applicability of the prompt pay provisions of the act to *all* health insurers as the legislation intended, including HMOs and both gatekeeper and non-gatekeeper PPOs;

- ❒ the regulations now ensure that no limitation in allowing direct access to obstetrics and gynecologic care is imposed. HAP believes that the act intended direct access by women for both wellness and sickness obstetrics and gynecological care, and supports the regulations as proposed;

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- ❒ the clarification of the process for filing complaints by insureds to make the process more consumer-friendly;

- ❒ the proposed regulations also recognize that a claim can serve as the required notification for emergency services when a patient is not subsequently admitted to the hospital. Requiring telephone notification in these cases would be an unnecessary administrative burden;

- ❒ elimination of the provision that would have allowed insurers to not pay for covered health care services in the event that a premium had not been paid on behalf of the insured individual. HAP contended that this provision was beyond the scope of the act;

- ❒ establishing a process for providers to file complaints with the Insurance Department regarding prompt payment problems with insurers; and

- ❒ establishing that interest will accrue for both the contested and non-contested portions of a claim as it relates to the prompt payment provisions. HAP had objected to insurers potentially splitting claims for purposes of avoiding interest payments.

The attached detailed comments are respectfully submitted to the Department for consideration in drafting the final form regulations. In general, the comments relate to provisions that are not sufficiently clear or need to be addressed to ensure that managed care plans and licensed insurers have policies and procedures in place to comply with provisions of the act. These include:

- ❒ payment and access to emergency services;
- ❒ continuity of care;
- ❒ complaints; and
- ❒ prompt payment.

HAP

Again, I appreciate the opportunity to comment on these proposed regulations. HAP is committed to improving accountability to patients receiving care under managed care, and strongly encourages the Department to provide regulations which require plans to demonstrate their compliance with this act in an effective manner. Feel free to contact me at (717) 561-5344 if you need clarification on our comments.

Sincerely,

Paula A. Bussard

PAULA A. BUSSARD
Senior Vice President
Policy and Regulatory Services

Attachment

c: Greg Martino, Deputy Insurance Commissioner
Geoffrey Dunaway, Director, Bureau of Accident and Health Insurance
Robert M. Zimmerman, Jr., Secretary, Department of Health
M. Diane Koken, Insurance Commissioner
Melia Belonus, Senior Policy Analyst, Governor's Policy Office
Howard A. Burde, Deputy General Counsel, Office of General Counsel
Lori Gerhard, Acting Deputy Secretary for Quality Assurance, DOH
Stacey Mitchell, Director, Bureau of Managed Care, DOH

HAP

THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

The Hospital & Healthsystem Association of Pennsylvania Comments on Insurance Department Act 68 Proposed Regulations

In reviewing the Insurance Department's proposed regulations, HAP has identified several areas where we believe additional clarification is necessary to assure Pennsylvanians that managed care plans and licensed insurers are accountable under the provisions of the Quality Health Care Accountability and Protection Act.

§ 154.14 Emergency Services

Act 68 states that individuals may seek emergency care after the sudden onset of a medical condition that meets a "prudent layperson" definition of emergency, and that, subsequently, emergency care providers should be paid all reasonably necessary costs associated with the treatment of an emergency. Even though Act 112 of 1996 included similar provisions, consumers and emergency care providers continued to experience problems with managed care plans using various means to require prior authorization and to deny payment retrospectively for what individual patients perceived to be an emergency. In order to prevent problems from continuing in this area, the Department's regulations must be made clear so that consumers trust that emergency care is there when they perceive that need, and that providers receive appropriate reimbursement.

❶ Act 68 states that "the managed care plan shall pay all reasonably necessary costs associated with the emergency services provided during the period of the emergency." Because regulations interpret an act or operationalize an act, HAP recommends that the following additional language should be added to § 154.14 to provide clarification on the meaning of reasonably necessary costs:

(b) Plans are required to pay all reasonably necessary costs for patients meeting the prudent layperson definition for emergency services, to include: emergency transportation, services reasonably necessary to screen the patient, services reasonably necessary to diagnose, stabilize, and treat the patient.

❷ The Department should require insurers and managed care plans to incorporate the "prudent layperson definition" found in this act in all plan policies, consumer literature and marketing materials, and provider contracts. This would include how the plan determines or operationalizes "reasonably necessary costs."

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❸ Act 68 also states that "the emergency health care provider shall notify the enrollee's managed health care plan of the provision of emergency services and the condition of the enrollee." The regulations require notification to the plan within 48 hours if the patient is admitted. This is appropriate in the predominant number of cases.

However, there are occasionally cases where circumstances make it difficult to determine the individual's insurer or managed care plan within 48 hours. This could include circumstances in which a severely injured person or individual with a psychiatric emergency is unable to identify themselves or their insurer. HAP recommends that the regulation include language as follows:

An exception to this requirement will be made where the medical condition of the patient precludes the provider from accurately determining the identity of the enrollee's insurer or managed care plan within 48 hours of the admission.

§ 154.15 Continuity of Care

Act 68 states, "Any health care service provided under this section shall be covered by the managed care plan under the same terms and conditions as applicable for participating health care providers." These provisions are designed to enable chronically-ill individuals to continue with their health care provider during a transition to managed care, or in the event their provider's contract with a managed care plan is terminated.

The proposed regulations implementing the continuity of care provisions of the act, as drafted, state in (g) that, "Managed care plans may require nonparticipating or terminating providers to agree to terms that include:

(4) Agreeing to make referrals for specialty care, diagnostic testing and related services to the enrollee's current managed care plan's participating providers.

(5) Agreeing that nonemergency inpatient care will be provided at one of the enrollee's current managed care participating hospitals or facilities."

HAP believes that these provisions essentially defeat the purpose of the continuity of care. For example, a patient with a chronic medical condition could choose to continue with their nonparticipating physician, who practices in another state at a nonparticipating facility. If the physician orders an MRI and other diagnostic tests during a visit, the individual would not be able to receive those tests on the same day at the same geographic location of the physician. Further, if the physician determines that surgery

may be needed, the individual might not be able to have the physician perform the procedure because the hospital is nonparticipating.

While the "spirit" of these provisions is laudable, the actuality is that the application of (g)(4) and (5) conflicts with the continuity of care provisions. As such, HAP recommends that (g)(4) and (5) be deleted or modified to recognize "to the extent possible and consistent with the delivery of appropriate care to the patient...." The regulation should not impose requirements which could be medically inappropriate or cause the patient not to be able to avail himself or herself of continuity of care. The regulations should ensure that the continuity of care requirements are based on the needs of the patient.

§ 154.17 Complaints

Act 68 defines a complaint as "dispute or objection regarding a participating health care provider or the coverage, operations or management policies of a managed care plan..."

HAP recommends the regulations identify that complaints could also include problems relating to claims submissions requirements that may be unduly burdensome, not related to the plan's ability to adjudicate the claim, or an unreasonable definition of a clean claim.

§ 154.18 Prompt Payment

Act 68 requires timely payment and interest penalties if claims are not paid on a timely basis. For far too long managed care plans and licensed health insurers have not paid claims as promptly as they should, and this has adversely affected the financial state of the health care system. With more than two-thirds of Pennsylvania's hospitals and health systems losing money on patient care, there is no ability to sustain inordinate payment delays without such delays affecting the quality of care. The regulations in § 154.18 implement the provisions of the act and provide definitions and meaning to the provisions of the act. However, HAP feels that further clarifications are needed to comply with the intent of the act.

- The act defines a clean claim as "a claim for payment for a health care service which has no defect or impropriety. A defect or impropriety shall include lack of required substantiating documentation or a particular circumstance requiring special treatment which prevents timely payment from being made on the claim. The term shall not include a claim from a health care provider who is under investigation for fraud or abuse regarding that claim."

The proposed regulations define clean claim the same as the law. Since regulations are designed to implement the law, it is reasonable for the regulations to provide further clarity regarding the definition. In particular, a provision should be added which states:

A defect or impropriety in a claim shall not include: (1) the absence of information that has no reasonable relationship to the managed care plan's or licensed insurer's ability to adjudicate the claim; (2) the absence of information attributable to the licensed insurer or managed care plan; (3) that the claim is subject to the licensed insurer's or managed care plan's coordination of benefit policies; or (4) that the claim is subject to the licensed insurer's or managed care plan's retrospective utilization review process.

❷ Section (b) defines how it will be determined that a claim has been paid. This is an interpretation of the law provided in regulation. It is similarly reasonable for the Department to interpret the law to require licensed insurers and managed care plans to notify providers and the enrollee of claim status, including why the insurer does not believe it is obligated to pay the claim or portion thereof and the reason for the dispute. This notification is particularly important since claims may be lost by the insurer during processing and absent notification, how the enrollee or provider will know this. In the absence of notification, the provider or enrollee will not know there is a good faith dispute or that there has been an error in the submission of the claim, and therefore, will not be in a position to respond to the problem and receive timely payment. A section should be added on claim adjudication that states:

Within 45 days, the licensed insurer or managed care plan will pay the clean claim, the uncontested portion of the claim, and/or notify the provider that the claim or portion of the claim is contested or denied, and the reasons for contesting or denying payment thereof.

❸ Subsection (d) specifically recognizes "uncontested" and "contested" portions of the claim. HAP believes that "uncontested" and "contested" portions of the claim also should be specifically stated in subsection (a) as follows:

" Licensed insurers and managed care plans shall pay clean claims or the uncontested portions of clean claims... within 45 days...."

❹ Subsection (f) establishes a process by which health care providers may file complaints. HAP recommends that this subsection be amended to allow providers

to submit complaints regarding prompt payment in batches. The purpose for this is twofold: (1) the Insurance Department will appreciate not having individual complaints filed on each provider in each instance; and (2) by allowing batch submission the provider will be able to present a "pattern of behavior" by a managed care plan or licensed insurer.

❺ HAP also believes that regulations should require licensed insurers and managed care plans to provide contracting providers with the requirements regarding claims submission and the types of data and information reasonably required by licensed insurers or managed care plans to determine whether a submitted claim is clean. This will: a) help providers by ensuring that they are submitting "clean claims"; and b) close the loop with regard to insurers possibly defining claims submitted as having a defect, when in fact the provider was unaware of the need to include said information.

❻ HAP applauds the Department for conducting an extensive data call (July 23, 1999 Data Call Regarding Payment of Claims to Providers). Through Act 68, the Department is granted enforcement power. Therefore, the Department should include in regulations that it will conduct periodic evaluations to determine licensed insurer and managed care plan compliance with prompt pay provisions.

❼ Finally, HAP believes the act clearly intends all clean claims to be paid promptly, regardless of whether the provider has a contract with a managed care plan and/or licensed insurer. Therefore, § 154.18 also should include a provision that prompt payment clearly applies to all "clean claims", including those submitted by out-of-network or nonparticipating providers.

HAP
8/30/99

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT
OFFICE OF SPECIAL PROJECTS
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August 30, 1999

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Mr. Robert Nyce
Executive Director
Independent Regulatory Review Comm.
333 Market Street
Harrisburg, PA 17120

Re: Insurance Department
Proposed Regulation No.
11-195, Quality Health Care
Accountability and Protection

Dear Mr. Nyce:

Pursuant to Section 5(c) of the Regulatory Review Act, the Department is required to submit all comments on proposed regulations received during the public comment period to the Independent Regulatory Review Commission and the Legislative Standing Committees within 5 days.

Attached is a list of commentators that have submitted comment on the above-mentioned regulation and the respective comment that was received.

If you have any questions regarding this matter, please contact me at (717) 787-4429.

Sincerely yours,

Peter J. Salvatore

Peter J. Salvatore
Regulatory Coordinator

11-195c

THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

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August 30, 1999

Mr. Peter J. Salvatore
Regulatory Coordinator
Pennsylvania Insurance Department
1326 Strawberry Square
Harrisburg, PA 17120

Dear Mr. Salvatore:

The Hospital & Healthsystem Association of Pennsylvania (HAP), on behalf of its members (more than 225 acute and specialty hospitals and health systems in the Commonwealth) and the patients they serve, appreciates the opportunity to comment on the Insurance Department's proposed regulations to implement the Quality Health Care Accountability and Protection provisions of Act 68.

Hospitals and health systems supported the enactment of Act 68 as a first step in assuring improved managed care accountability for Pennsylvania citizens. We believe that effective implementation of Act 68 will foster greater coordination and cooperation among health plans and health providers, which will benefit patients.

We applaud the Department's efforts for proposing regulations which will provide for managed care accountability that will improve health insurance practices. We believe this is vitally important to Pennsylvania hospitals and health systems, as they strive to provide appropriate and necessary health care to patients, and to serve their communities.

In reviewing the proposed regulations we want to commend the Department for incorporating numerous changes into the proposed regulations which HAP commented on in the pre-draft release of the proposed regulations. These changes include:

- the Department defining "licensed insurer" to ensure applicability of the prompt pay provisions of the act to *all* health insurers as the legislation intended, including HMOs and both gatekeeper and non-gatekeeper PPOs;

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Senior Vice President
Policy and Regulatory Services

Attachment

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HAP
8/30/99

Comments on the regulation listed below have been received from the following:

Reg #	*Regulation Title*
11-195	*Quality Health Care Accountability and Protection*

Dr. Christine M. Stabler *President*
Pennsylvania Academy of Family Physicians
5201 Jonestown Road, Suite 200
Harrisburg PA 17112-

Phone: (717) 564-5365 X00000 *EMail:*

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