ORIGINAL: 2079

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Senate of Pennsylvania

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March 27, 2001

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REVIEW COMMISSION
SECRETARY

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

Dear Mr. McGinley:

Please be advised that on March 27, 2001, the Senate Public Health and Welfare Committee met and by unanimous vote **approved** the Department of Health's revised final form managed care regulation, #10-160.

Sincerely,

Harold F. Mowery, Chairman
Senate Public Health & Welfare Committee

Sincerely,

Vincent J. Hughes, Minority Chairman
Senate Public Health & Welfare Committee

HFM/kk
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cc: Robert E. Nyce

Original: 2079

MANAGED CARE REGULATIONS
Tolling Memo Changes

§9.675 Delegation of Medical Management Contracts

In order to clarify the intent of Act 68, the Health and Human Services Committee would recommend deleting the following sentences from §9.675(a) "However, the Department may at a later date require the plan to correct any deficiencies identified by the Department. A plan shall submit medical management contracts entered into or renewed prior to the effective date of the regulations for review and approval, but approval before use will not be required for these contracts."

The Committee does not intend the regulations to disrupt on-going business relationships with medical management organizations and health care providers that are based on contracts already approved by the Department. These contracts are always available to the Department as necessary to conduct investigations of complaints. These recommendations reflect the concerns of the Committee and the changes as above are based on the consensus of the committee.

§9.722 Plan and Health Care Provider Contracts

The Committee would recommend deleting the following sentence from §9.722(a) "A plan shall submit provider contracts entered into or renewed prior to the effective date of the regulations for review and approval, but approval before use will not be required for these contracts." The Committee also would recommend deleting the following from the last sentence in §9.722(a) "...however, the plan (Department) may at a later date require the plan to correct any deficiencies identified by the Department."

The Committee does not intend the regulations to disrupt on-going business relationships with medical management organizations and health care providers that are based on contracts already approved by the Department. These contracts are always available to the Department as necessary to conduct investigations of complaints. These recommendations reflect the concerns of the Committee and the changes as above are based on the consensus of the Committee.

§9.741 Applicability and §9.742 CRFs

The Committee would recommend deleting section §9.741(c) and §9.742(c) . The Committee is concerned that these sections could be construed to mean that all Licensed Insurers are required to comply with the Act. The Committee believes that the intention of Act 68 and appropriate

interpretation was to require only Licensed Insurers who do utilization review for enrollees of a managed care plan to comply with the utilization review requirements of the Act.

§9.601 Definition

The Committee would recommend deleting the definition of Licensed Insurer as it is defined by the Insurance Department in its regulations and is no longer necessary in light of the changes discussed above.

§9.705 Internal Grievance Process

The Committee would recommend adding the following language at the end of §9.705(c)(2)(III)(I.), "The Committee shall not base its decision upon any document obtained on behalf of the plan which sets out medical policies, standards or opinions or specifies opinions supporting the decision of the plan unless the plan has made available, in person or by telephone, an individual, of the plan's choice, who is familiar with the policies, standards or opinions set out in the document and has sufficient knowledge regarding the basis of the policies, standards or opinions to answer questions from the review committee or the enrollee."

This language further defines the use of materials and documents presented at the review.

The Committee would recommend changing the language in §9.705(c)(3)(v) from "For the purposes of this section, a primary care provider does not qualify as a licensed physician, or an approved licensed psychologist, in a same or similar specialty, unless the service in question was provided by a primary care provider." To "For the purposes of this section, if a specialist is requesting the health care service in dispute, the reviewing physician or psychologist must be a specialist in the same or similar specialty."

The language clears up any ambiguity regarding the credentials of the reviewing physician or psychologist.

§9.673 Plan Provision of Prescription Drug Benefits to Enrollees

The Committee would recommend deleting the following language from §9.673(d) "...regarding the coverage of or amount of the coverage for one drug versus another," as a dispute solely concerning the dollar amount of coverage would more accurately be a complaint and not a grievance.

§9.679 Access Requirements In Service Areas

The Committee would recommend deleting the word "potential" in §9.679(c) and replacing it with the word "probable" as the Department should only be concerned with receiving notice of a "probable" loss of any general acute care hospital and any primary care provider, whether an individual practice or a group practice, with 2000 or more assigned enrollees.

Coordination of Implementation Of The Regulations with the Insurance Department

The Committee would recommend that the Department add to the Preamble that the DOH will work with the Insurance Department pursuant to the Administrative Procedures at 71 P.S. §181. The Department should also state in this section of the Preamble that Act 68 does not permit enforcement by both agencies for the same violation and restate the specific provision of Act 68 which states that "In no event shall the (health) department and the Insurance Department impose a penalty for the same violation".

§9.681(a)(3) Health Care Providers

The Committee would recommend deleting the requirement in this section of the regulation which requires a CRNP to list the name, address and telephone number of the physician with whom the CRNP has a collaborative relationship.