



NAMI Southwestern Pennsylvania

formerly the Alliance for the Mentally Ill of Southwestern Pennsylvania

January 14, 2000

Stacy Mitchell, Director
Bureau of Managed Care
PA Dept. of Health
P.O. Box 90
Harrisburg, PA 17108-0090

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2000 JAN 21 PM 12:28
INDEPENDENT REGULATORY
REVIEW COMMISSION

Reference: Proposed Regulations to Implement Act 68

Dear Ms. Mitchell,

In response to the call for public comments on the referenced regulations, our first reaction is one of extreme disappointment in that the proposed regulations appear to be a step backwards from the present safeguards and protections. Further, from discussions we have had with Senator Murphy and his staff, they do not embody the spirit or intent of the legislation which we have heard from them. There appear to be many issues needing strengthening and reconsideration and we will address some of the more significant ones.

A. CRITERIA FOR GRANTING A NEW HMO CERTIFICATE OF AUTHORITY

1. No requirement to use generally accepted medical standards for utilization review.
2. No standards for quality assurance.

B. INADEQUATE NETWORK DEFINITION

1. No access standards such as distance, travel time, specialties, etc.

C. NO REQUIREMENT FOR DOH OVERSIGHT

1. Permits external review by entities hired and paid by HMO.

D. LACK OF CLARITY ABOUT PCP TRAINING AND NETWORK AND SPECIALISTS ACTING AS PCP.

E. DRUG FORMULARY DISCLOSURE

1. While the regulations require a plan to disclose existence of a restrictive formulary to members, it is not required to make the disclosure to prospective members. This enables the HMO to withhold vital decision making information from prospects and should be an unacceptable practice.

F. DISCLOSURE OF MEMBER RIGHTS AND RESPONSIBILITIES

1. Does not require plans to inform members of their rights to get current and complete information from their physician about their diagnosis, treatment and prognosis.
2. Does not require the plans to regularly tell members about rights under the complaint/grievance system and/or how to file a complaint/grievance.

G. HEALTH CARE PROVIDER CONTRACTS

1. Does not place any limits on conflict of interest between the provider and the patient/member.
2. Permits sizable financial incentives to providers to limit care.
3. No objective standard to determine if the financial incentive compensates the provider for providing less than medically necessary and appropriate care.
4. No requirement that the HMO provide a reason for non-renewal or sanction of a provider.

H. THERE IS NO REQUIREMENT FOR AN EXPEDITED COMPLAINT REVIEW

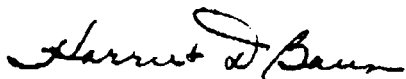
1. Does not spell out specifics of procedures to assure independent input to complaint resolution.
2. Allows plans to send notifications of complaint decisions to either the member or the provider which is contrary to language in Act 68 which requires both.

I. RELATIONSHIP TO INSURANCE DEPARTMENT

1. We understand that the Insurance Department prepared regulations which have been withdrawn. We further understand that there are conflicts between these Health Dept. proposed regulations and the Insurance Dept. withdrawn regulations. How are these differences being resolved? The Legislative Budget and Finance Committee Report "Commonwealth Efforts to Assure Quality of Care in the Changing Health Care Environment" dated June 1999 identified this type of ambiguity and conflict as a problem which needs to be addressed. We are disappointed that the writers of these proposed regulations apparently have not dealt with the departmental differences.

In summary, we do not support the regulations as written and, in view of the number and seriousness of objections, we recommend an extensive rewrite and second submission for public comment. Thank you for the opportunity to comment.

Yours truly,



Harriet Baum, Executive Director

cc: Senator Tim Murphy

**NAMI Southwestern Pennsylvania***(formerly the Alliance for the Mentally II of Southwestern Pennsylvania)*

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Pittsburgh, PA 15237-3415
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F A X**To:** Stacy Mitchell**From:** Harriet Baum**Fax:** 717/705-0947**Pages:** 3 (including cover sheet)**Phone:****Date:** 1/14/00**Re:** Proposed Regulations to
Implement Act 68**CC:****Remarks:**



**Lutheran
Advocacy
Ministry in Pennsylvania**

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INDEPENDENT REGULATORY
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Kathleen S. Daugherty, Director
Craig S. Staller, Associate Director

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Internet: lamp@paonline.com • Luther Link: LAM PA • Web Site: http://www.lamp.org

A MINISTRY OF:

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Evangelical Lutheran
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Northeastern
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Southeastern
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and the
Pennsylvania
Lutheran Agency
Network (PLAN)

January 14, 2000

Ms. Stacy Mitchell, Director
Bureau of Managed Care
Pennsylvania Department of Health
PO Box 90
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Originally rec'd 1/12/00 12:35 p.m.

Dear Ms. Mitchell:

I write, as the director of the Lutheran Advocacy Ministry in Pennsylvania (LAMPa), to comment on the proposed regulations intended to implement Act 68 of 1998, the Managed Care Accountability Act.

LAMPa, a state public policy office the Evangelical Lutheran Church in America, represents seven bishops, over 1,300 congregations, and more than 933,000 congregation members. The 1999-2000 Public Policy Agenda of LAMPa stresses that all Pennsylvanians deserve access to quality physical and behavioral health care services. We advocate for public policies that assure that managed health care systems provide comprehensive benefits.

Our comments on the Act 68 regulations center generally on the assuring of quality physical and behavioral health care for members of health maintenance organizations (HMO):

- There are no standards in the proposed regulations for ownership of an HMO in Pennsylvania. Owners and operators of HMOs do not have to demonstrate prior experience in health care management. The regulations do not establish a minimum credentialing standard for education, training, experience, record keeping, equipment, and facility. The PA Department of Health fails to require the review of a practitioner's substance abuse history, board certification, and malpractice history.
- The PA Department of Health has very limited HMO plan oversight. There is no external review for the first 18 months of operation. After the initial 18 months, a firm hired and paid by the plan conducts the review, with the plan

determining the scope of the review. Should the external review find problems, there is no requirement of corrective action on the part of the HMO. There is no public access to the external review report and no further review is needed for three years if there are serious problems.

- Health plans are required to have a quality assurance process but no specific standards or outcome measurements are mentioned. The proposed regulations presume that having a quality assurance process in place results in quality care. The HMO is not required to take corrective action.
- The regulations do not require the HMO to provide a consumer satisfaction survey to its customers.

In summary, I encourage the PA Department of Health, in revising these proposed regulations, to insert language that emphasizes quality and best medical practices in the ownership and operation of an HMO in the Commonwealth. In order to advance better health for all Pennsylvanians, HMO plans need to use generally accepted medical standards for utilization reviews. There is no emphasis on best medical practices or basic recognized national standards.

I look forward to the next draft of proposed regulations intended to implement Act 68 of 1998, the Managed Care Accountability Act.

Sincerely,

A handwritten signature in black ink, appearing to read "Kathleen Daugherty", written in a cursive style.

Kathleen Daugherty
Director

xc: PLAN Steering Committee
The Hon. Timothy F. Murphy

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2000 JAN 25 AM 8:45

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January 14, 2000

Ms. Stacy Mitchell
Director
Bureau of Managed Care
Pennsylvania Department of Health
PO Box 90
Harrisburg, PA 17108-0090

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Dear Ms. Mitchell:

As a health care provider it is our responsibility to provide each patient served the highest quality of care. That means providing the most up to date and appropriate medical interventions for their condition at the appropriate point in their recovery and for the appropriate length of time. In today's environment of managed care this is only possible if health insurance plans and health care providers work together in the best interest of the patient. We need to focus our efforts on managing patient care rather than managing insurance costs possibly at the expense of quality patient care.

Hospitals and health systems believe that the Department of Health Regulations for Act 68 is an important first step to providing managed care accountability. We support the establishment of plan reporting requirements to help ensure effective oversight and establishing consistency in the definition of medical necessity by health plans.

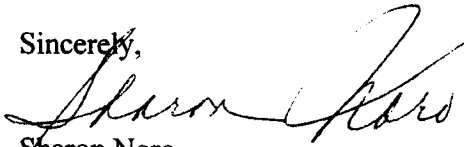
However there are several points in the Department of Health's regulations that need revision. The following points are essential in ensuring improvements in health insurance practices:

- Strengthening the utilization review standards to ensure that:
 1. plans provide a clinical rationale in denial letters;
 2. there are ongoing standards for utilization review for licensed insurers and managed care plans;
 3. there is effective monitoring and enforcement by the Department of Health of utilization review practices; and
 4. licensed insurers and managed care plans are held accountable for prospective and concurrent utilization review decisions.
- Ensuring that providers may advocate for their patients and may obtain written consent to do so at the time of treatment

As a major health care provider in Pennsylvania, we are concerned about the ability to sustain quality health care services in today's environment without these important changes in the proposed regulations. When a patient purchases health insurance they are under the belief that their medical needs will be covered and that qualified medical personnel will make decisions on their treatment. We need to assure that cost management does not override sound medical management. I would appreciate your support of the Department of Health in requiring health insurers and managed care plans to demonstrate appropriate and effective compliance with Act 68.

Thank you for your consideration and support of this important regulation.

Sincerely,

A handwritten signature in cursive script, appearing to read "Sharon Noro".

Sharon Noro
Administrator/CEO

8001162

Mr. & Mrs. H. S. Rockwood III
218 Hays Road
Pittsburgh, PA 15241
724-941-4167
fax 724-941-3979
e-mail <rockwood@usaor.net>

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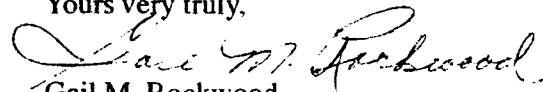
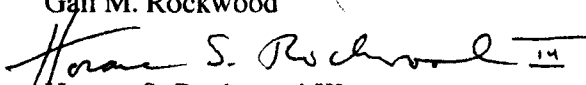
January 14, 2000

Stacy Mitchell, Director
Bureau of Managed Care
Pennsylvania Department of Health
PO Box 90
Harrisburg, PA 17108-0090

Dear Ms. Mitchell:

We have enclosed our comments on the promulgation process of and the product cited as Annex A, TITLE 28. HEALTH AND SAFETY, PART 1. GENERAL HEALTH, CHAPTER 9. MANAGED CARE ORGANIZATIONS (29Pa.B.6422-6441).

Yours very truly,


Gail M. Rockwood

Horace S. Rockwood III

Copy to:

IRRC
Senator Tim Murphy
Representative John Maher

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Director of Case Management/UR
Crozer Chester Medical Center
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January 14, 2000

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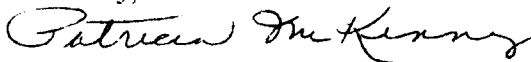
Ms Stacy Mitchell:

After reviewing proposed regulations under Act 68, I have concerns in the following areas:

- Use of utilization review criteria as the sole tool in decision making
- Retrospective denial of days previously approved
- Barriers that impede providers acting on behalf of the patient e.g. written consents

Although having health insurance coverage improves access, it does not guarantee good care. Emphasizing cost reduction rather than quality improvement may be dangerous if it reduces access to effective services. This is a pivotal time in American healthcare. There is an urgent need to improve health care quality. If regulations are implemented appropriately, this act will establish managed care accountability and improve health insurance practices in PA.

Sincerely,



Patricia McKinney

0001162

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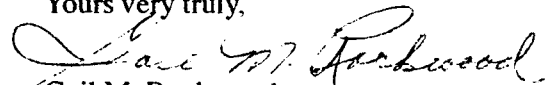
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Stacy Mitchell, Director
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Yours very truly,


Gail M. Rockwood


Horace S. Rockwood III

Copy to:

IRRC
Senator Tim Murphy
Representative John Maher

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City of Pittsburgh Emergency Medical Services

Accounts Receivable
Public Safety Building
100 Grant Street Room 601
Pittsburgh PA 15219
(412) 255-2360 Fax (412) 393-0130
January 14, 2000

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Dear Ms. Mitchell:

As a 911 emergency response ambulance service there is an issue that we would like addressed under PA Act 68 that went into effect January 1, 1999.

Is it possible to stipulate that the providers of ambulance services are paid directly for services rendered. This direct payment to the provider should be made to both participating and non-participating providers.

Industry wide 911 ambulance services are often non-participating providers. As a result insurance payments are sometimes made directly to the patient. Direct payment to the provider of the service will be more convenient to the patient and to the provider of services. This is a very important issue for us.

Thanks for your consideration of this matter.

Sincerely,

Linda Gale Krause



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JAN. 14. 2000 10:22AM

DPW MANAGED CARE PROGRAMS:TR

412 NO. 57682 P. 1/02



City of Pittsburgh Emergency Medical Services

Accounts Receivable
Public Safety Building
100 Grant Street Room 601
Pittsburgh PA 15219
Phone (412) 255-2260 Fax (412) 393-0138



0001097

To: Ms Stacy Mitchell

From: Linda Gale Krause

Director of Bureau of Managed Care

Fax: 717-772-8328

Pages: 2

Phone:

Date: 01/14/00

Re: Regulations for Pa Act 68

CC: Representative Jane Orie

☐ Urgent

☐ For Review

☐ Please Comment

☐ Please Reply

☐ Please Recycle

In the regulations for Pa Act 68 please stipulate that payment of ambulance services are made directly to the ambulance company whether it is a participating or non-participating provider as in the letter that is being faxed.

058/121



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Armstrong County Memorial Hospital
One Nolte Drive • Kittanning, PA 16201 • (724) 543-8500

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Ms. Stacy Mitchell Bureau of Managed Care Director
Pennsylvania Department of Health
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Dear Ms. Stacy Mitchell:

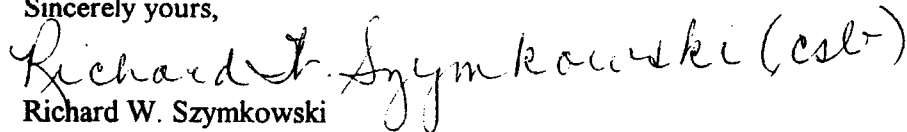
I am writing to you on behalf of Armstrong County Memorial Hospital to express our concerns regarding the proposed regulations implementing Act 68.

We believe that the Department of Health should be commended for including requirements in the regulations which establish a method for reporting information to the public regarding plan practices. We are impressed with the regulations requiring all definitions of medical necessity to be consistent across all material and literature published by a plan and that the regulations provide for a mechanism to correct routine procedural errors and denials between the plan and the provider without the need of enrollee consent.

We feel it is also imperative that the Department of Health regulations be improved by clarifying standards for insuring that enrollees receive the same benefit level for either emergency services provided by non-participating providers or for services for which there are no participating health care providers capable of performing the needed service. We feel that establishing payment standards would interfere in the contracting process between the health plans and the health care providers. The plans and the providers should have the latitude to negotiate fair payment rates. The Department of Health standards regarding emergency services and direct access to obstetrics and gynecological care are consistent with the insurance department regulations. These regulations should insure that providers may advocate for their patients and may obtain the written consent to do so at the time of treatment. We also feel that strengthening of utilization review standards should be established to ensure that plans provide a clinical rational in denial letters. There should be standards for utilization review of licensed insurers and managed care plans that there is an effective monitoring and enforcement by the Department of Health of utilization review practices. Licensed insurers and managed care plans should be held accountable for prospective and concurrent utilization review decisions.

We appreciate the efforts of the Commonwealth of Pennsylvania which has resulted in legislation such as Act 68 protecting the quality of care and the rights of patients and providers to receive fair payment for the provision of care to our citizens.

Sincerely yours,


Richard W. Szymkowski
VP Finance/CFO

RWS/csb

cc: Jack Hoard
Liz White



A subsidiary of Uniontown Health Resources, Inc.

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2000 JAN 25 AM 8:45

500 W. Berkeley Street

Uniontown, PA

PA 15401-3336
REGULATORY
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Telephone (412) 430-5204

Gary Macioce

Vice President, Operations

Fax (412) 430-3342

January 13, 2000

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Harrisburg, PA 17108-0090

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Dear Ms. Mitchell:

I am writing to comment on the regulations that are being proposed by the Pennsylvania Department of Health regarding Act 68. I have also provided these comments to the Hospital Association of Pennsylvania.

The "prudent layperson" component of the Act is designed to require payment for all reasonably necessary services provided in an emergency. It is our recommendation that the regulations be developed in sufficient detail to allow for consistent application by providers and payers. First, the prudent layperson should be defined by a limited set of signs and symptoms that could reasonably precipitate a visit to the Emergency Department. The signs and symptoms could be limited to those that occur most commonly that may, or may not, be an emergency. For example, dizziness.

Second, the regulations should allow for services to be rendered to these patients in the Emergency Department without pre-authorization by the primary care physician. This is a very important issue for physicians since the authorization is usually unnecessary given the suspicious nature of the patient's signs and symptoms, which logically require intervention. Accordingly, providing authorization is an unnecessary task for the primary care physician. Pre-authorization is equally burdensome for the hospital and interferes with the efficient delivery of care in the Emergency Department.

Finally, the regulations should require all insurers to pay for services provided in an Emergency Department to patients with these defined signs and symptoms, and without authorization by the primary care physician. Hospitals should not be required to follow different guidelines and definitions issued by different insurers in order to receive reimbursement, and should be assured of payment even if the patient's final diagnosis was not an emergency condition.

Ms. Stacy Mitchell
Pennsylvania Department of Health
January 13, 2000
Page 2

This matter has been of particular concern to Uniontown Hospital and members of the medical staff. It is hoped that the final regulations will make the "prudent layperson" provision an effective solution to problems experienced by providers.

Please contact me at (724) 430-5204 if I can be of further assistance.

Sincerely,



Gary Macioce
Vice President, Operations

c: Paula Bussard, Senior Vice President, Policy & Regulatory Services, Hospital
Association of Pennsylvania

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January 13, 2000

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Re: Managed Care Organizations Proposed Rulemaking

Dear Ms. Mitchell:

This letter is in response to your Department's request for public comments with regard to the proposed rulemaking for managed care organizations, published in the December 18, 1999 Pennsylvania Bulletin. We appreciate the opportunity to provide comments about this important document. For your information, the Regional Nursing Centers Consortium (RNCC) was founded in 1996 and is an association of community-based nurse-managed health centers that serve more than 35,000 clients in Pennsylvania. These nursing centers are currently credentialed with HMOs and provide quality health care services to thousands of rural and urban families in Pennsylvania.

Since 1998, nurses and nursing centers in Pennsylvania have worked hard to ensure that the definition of primary care in Act 68 included advanced practice registered nurses and nurse practitioners. We are now writing to express our appreciation that the managed care proposed rulemaking includes similar language. However, we do have one concern with *Section 9.678. Primary Care Providers* and the second sentence of this section, outlining that "*the Department has a similar requirement in 9.75 (c) of the HMO regulations that an HMO must make a primary care physician who is to supervise and coordinate the health care of the subscriber.*"

As an organization representing community-based nurse-managed health centers, where nurse practitioners currently practice independently as primary care providers in collaboration with physicians, we have some concern that this paragraph will have a negative impact upon the ability of our centers to function independently. As it reads now, HMOs must have physicians on board that supervise and coordinate the care of a subscriber, and a nurse practitioner cannot see his/her patient independently as the practice is now. Therefore, we would like to see this language clarified since physician supervision is not consistent with current practice.

Stacy Mitchell
Director
Bureau of Managed Care
January 13, 2000
Page 2


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Also, we believe the Pennsylvania Health Law Project has outlined detailed recommendations with regard to the managed care proposed rulemaking, which we strongly support. We hope you will take their recommendations into consideration as well.

Again, we appreciate the opportunity to provide comments about this important proposed rulemaking. Please feel free to call me if you have any questions for need any additional information. I can be reached at (215) 951-0330 ext. 147.

Thank you.

Sincerely,


Tine Hansen-Turton
Executive Director

Cc: Nancy Rothman, Chair

0001159

**National Alliance for The Mentally Ill of Pennsylvania
Bucks County Chapter
P.O. BOX 355, Warrington Pa. 18976-0355
215-946-1152**

NAMI Bucks County's Voice on Mental Illness

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2000 FEB -4 AM 8:45

Subject: Comments on: Proposed Regulations to Implement Act 68 of 1998, the Managed Care Accountability Act (P.L. 464, No. 68), (40. P.S. §§ 991.2001-991.2361).

The National Alliance for The Mentally Ill of Pennsylvania, Bucks County Chapter endorses the following comments generated by the PHLP. In particular those comments dealing with "Complaints, Standing referrals, OB/GYN Services & Timing". Disabled persons suffering from severe and persistent mental illness require special safeguards to protect them as they transition through the recovery process. Some of these safeguards are removed in your proposed regulations. We strongly request that you continue to safeguard this ill population, who did not make themselves ill, do not want to be ill but non-the-less suffer from no fault brain disorders.

PHLP COMMENTS:

One major area of concern involves timing. The regulations needed to implement Act 68 are the joint responsibility of DOI and the Department of Health (DOH); each is responsible for specific aspects of the Act. Rather than acting in concert, however, the Departments are working under different timelines, and the proposed regulations of the Department of Health have not yet been published. As a result, the public has been put in the difficult and somewhat absurd position of being asked to comment on one major part of the regulations, without knowledge of the content or scope of the other part. PHLP's clients, as well as other community groups, argue that consumers must be given an opportunity to comment when both sets of proposed regulations are available so that consumers can see the whole picture and better identify any existing gaps or inconsistencies in the proposals.

Other major issues of concern regarding DOI's proposed regulations involve the following:

Complaints

the regulations contain a "bare bones" complaint process instead of a fully-elaborated process that consumers can comprehend. the regulations fail to incorporate important consumer protections currently in place, which means that those protections are likely to be lost. Among the consumer protections which would be lost are (1) notices, from plans to consumers, made at each step of the appeals process, that describe the processes and timeframes involved; (2) that the consumers be entitled to attend their second-level reviews and present their cases; (3) standards that guarantee that the committee deciding complaints remains unbiased; (4) accommodation for consumers when scheduling second-level reviews, and allowance for postponements when needed by the consumer; and (5) detailed explanations of decisions from health plans responding to complaints, that describe the facts and the evidence considered.

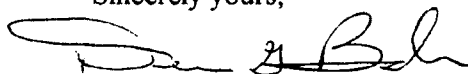
Standing Referrals

The DOI proposes to regulate standing referrals. These matters should be governed by the Department of Health since they typically involve issues of medical necessity, which are more clearly within the scope of the Department of Health. The proposed regulations are inadequate and fail to assure compliance with Act 68 in many of the following ways: failing to set criteria describing when plans should grant standing referral requests; failing to set timeframes for plans to decide on requests; and failing to require disclosure to consumers and providers of the criteria for approving standing referrals.

OB/GYN Services

Act 68 guarantees consumers direct access to all services within an OB/GYN's scope of practice. The DOI's proposed regulations impermissibly limit this guarantee of direct access by requiring consumers to seek prior authorization for some of these services. This section of the Act should not be governed by DOI but rather by the Department of Health, which has the expertise to determine whether particular services are outside of an OB/GYN's scope of practice.

Sincerely yours;



Dennie G. Baker, BOD NAMI of Bucks County

Copy:

SENATOR STUART GREENLEAF, 12th district

HEALTHSOUTH

Rehabilitation Hospital of Altoona

January 13, 2000

Ms. Stacy Mitchell
Director, Bureau of Managed Care
Pennsylvania Department of Health
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Dear Ms. Mitchell:

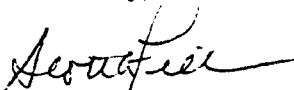
We at HEALTHSOUTH Rehabilitation Hospital of Altoona are very encouraged by the Department of Health's efforts towards holding health insurers and managed care plans accountable for appropriate and effective compliance with Act 68.

While we are in agreement with most of the Department of Health's proposed regulations, we feel it is imperative that changes be made to the following aspects:

- Clarifying standards for ensuring that enrollees receive the same benefit level for either emergency services provided by non-participating providers or services for which there are no participating health care providers capable of performing the needed service. These standards should not dictate provider payments in these situations. The way these provisions are described in the preamble goes beyond the scope of both the HMO and Act 68. Establishing payment standards would interfere in the contracting processes between health plans and health care providers by, in effect, establishing *default payment rates*, thus removing any incentive to negotiate fair payment rates.
- Ensuring that Department of Health Standards regarding emergency services, continuity of care, and direct access to obstetric and gynecologic care are consistent with the Insurance Department's regulations.
- Ensuring that providers may advocate for their patients and may obtain written consent to do so at the time of treatment.
- Strengthening the utilization review standards to ensure that:
 1. Plans provide a clinical rationale in denial letters;
 2. there are ongoing standards for utilization review for licensed insurers and managed care plans;
 3. there is effective monitoring and enforcement by the Department of Health of utilization review practices; and
 4. licensed insurers and managed care plans are held accountable for prospective and concurrent utilization review decisions.

Your consideration to these regulation changes are greatly appreciated. Should you have any questions, please do not hesitate to contact me at (814) 941-3205.

Sincerely,



Scott A. Filler
Chief Executive Officer

See
B772
1/18/00



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Country Club Road
Monongahela, PA 15063-1095
724-258-1000

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January 13, 2000

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Originally rec'd 1/21/00 12:34 p.m.

The Honorable Robert J. Zimmerman, Jr.
Secretary of Health
Department of Health
Room 802
Health and Welfare Building
Harrisburg, PA 17120

Dear Honorable Zimmerman:

The following are the comments submitted on behalf of Monongahela Valley Hospital in response to the development of Department of Health Regulations for Act 68:

Role of the Health Care Provider in the Grievance Process

While acknowledging that Act 68 requires a health care provider to obtain the written consent of the enrollee to appeal a decision concerning the medical necessity and appropriateness of a health care service, there are times when this requirement unfairly creates burdens for the providers.

In the Pennsylvania Bulletin, Vol. 29, No. 51, December 18, 1999, page 6423, a grievance is defined and circumstances when a grievance may be filed are outlined. All of the listed circumstances and the definition address when health care services are "**requested**" which implies a prospective decision making process.

Frequently decisions related to medical necessity are made by health plans on a retrospective basis, ie, after the service has been provided. These retrospective denials or changes in approved level of service are made despite prospective and/or concurrent approval by the health plan. When this occurs, the service has already been provided and oftentimes the patient has been discharged.

Agreements between health care providers (hospitals) and health plans frequently contain a hold harmless clause that prohibits the provider from billing the patient for "medically unnecessary" services. Services denied on a retrospective basis are then considered medically unnecessary. Since the patient is often discharged and the patient will not be held financially responsible for the bill, the patient is not motivated to sign a consent form to allow the provider to appeal the health plan's decision to receive the reimbursement dollars rightly owed.



This set of circumstances, which frequently occurs, places an unfair burden on providers to participate in the due process of the outlined appeal mechanism. Without the patient's consent, the provider is not permitted to even initiate the process.

Three (3) actions or revision could correct this problem:

1. Prohibit health plans from retrospectively denying services that were prospectively or concurrently approved unless the provider was derelict in providing information to the health plan which was needed to make an appropriate decision.
2. Allow providers to obtain the patient's consent to participate in the grievance process when treatment is initiated.
3. Remove the requirement for the enrollee's consent on retrospective denials.

Act 68 was not intended to create friction between enrollees and providers of health care services. The health plans' practice of retrospectively denying health care services without explicitly communicating the reason for the denial and the requirement to obtain the enrollee's consent to appeal this action creates friction and undue burdens on the providers. I hope, therefore, that you consider the comments outlined in this letter.

I would also like to communicate Monongahela Valley Hospital's support of the comments being submitted by the Hospital & Healthsystems Association of Pennsylvania.

Very truly yours,

A handwritten signature in cursive script that reads "Donna Ramusivich".

Donna L. Ramusivich
Vice President,
Professional Services & Quality

DLR:sv

cc: Hospital & Healthsystems of Pennsylvania
Ms. Stacy Mitchell, Director, Bureau of Managed Care
The Honorable Harold F. Mowery
The Honorable Vincent J. Hughes
The Honorable Dennis M. O'Brien
The Honorable Frank L. Oliver

8501151

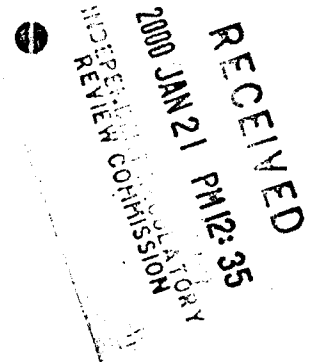
The Pennsylvania Radiological Society

January 12, 2000

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Ms. Stacy Mitchell, Director
Bureau of Managed Care
Pennsylvania Department of Health
911 Health and Welfare Building
Harrisburg, Pennsylvania 17108

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Dear Ms. Mitchell:

On behalf of the Pennsylvania Radiological Society, I would like to personally thank you for your efforts on the proposed regulations on managed care. We know it took a lot of time and hard work by you and your staff to address the concerns of all of the interested parties. We have reviewed the regulations as well as the comments being submitted by the Pennsylvania Medical Society. We have sent the Pennsylvania Medical Society a letter of concurrence with their comments.

Again, we appreciate your thoughtful consideration of the Pennsylvania Radiological Society issues with respect to managed care. We look forward to building our relationship with the Department and your Bureau as we continue to strive to deliver quality health care to our patients in Pennsylvania.

Sincerely,

Harvey L. Nisenbaum, M.D., FACR
President, Pennsylvania Radiological Society
PO Box 75
Landisville, PA 17538

Pennsylvania Radiological Society, A Chapter of the American College of Radiology

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January 12, 2000

Ms. Stacy Mitchell, Director
Bureau of Managed Care
Department of Health
PO Box 90
Harrisburg, PA 17108-0090

RE: Department of Health Proposed Rulemaking – Managed Care Organizations –
Pennsylvania Bulletin, Vol. 29, No. 51, December 18, 1999

Dear Ms. Mitchell:

As Chair of the Pennsylvania Section of the American College of Obstetricians and Gynecologists (PA ACOG), an organization representing over 1,800 obstetricians and gynecologists, I reviewed the Department of Health's proposed regulations of Act 68. It is evident that the Department incorporated many of the suggestions made by the stakeholders. The following comment is provided to improve health care and access to health care for the women we both serve.

9.682(b). Direct access for obstetrical and gynecological care

Act 68 did not include the phrase "*routine part of obstetrical and gynecological care*." The addition of these words severely limits when a woman can seek direct access to gynecologic services. Most plans already allow women to directly access their ob-gyn for annual exams (which are considered "routine").

Gynecologic "problems" are *not* "routine." The intent of the law was to allow women to seek gynecologic services for gynecologic problems (e.g., excessive vaginal bleeding, suspected sexually transmitted disease, severe cramping, etc.). The addition of the phrase "routine" appears to be an attempt by the insurance industry to only provide "routine annual exams" - which already exists.

PA ACOG recognizes that the intent of the law was not to include direct access for gynecologic subspecialty care (e.g., reproductive endocrinology, oncologic gynecology, and maternal and fetal medicine). We recommend that the department consider language that states these subspecialty services are the only restrictions for direct access to gynecologic care.

We strongly urge the Department of Health to uphold the original language in the statute when referencing direct access to obstetrical and gynecologic services. The wording in Act 68 encompasses the true intent of the benefits women should receive in Pennsylvania. The proposed draft language imposes too many restrictions for women and their health care providers that if incorporated, will not move health care for women forward, but instead remain status quo.

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HARRISBURG, PA 17105-8820
888-PA OBGYN (726-2496)
717-558-7841 FAX

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EXECUTIVE DIRECTOR
KRISTI WASSON

Thank you for allowing PA ACOG to comment on the draft regulations of Act 68. I hope you will carefully consider our comments as we hope to optimize the benefits for our patients.

Please feel free to contact me if you have any questions regarding the aforementioned comments. I can be reached at 610-378-6827. You may also contact Jan Reisinger, PA ACOG Executive Director at 888-726-2496 if you have questions about our comments.

Best regards,

A handwritten signature in black ink, appearing to read "P. A. Schwartz", with a stylized flourish at the end.

Peter A. Schwartz, MD
Chairman
PA Section of ACOG

cc: Don McCoy, Pennsylvania Medical Society

[Paacog/legislation/directaccess/regcomments-doh2](#)

0001150

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WRITER'S DIRECT DIAL:
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robinson@hh-law.com

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Stacey Mitchell
Director, Bureau of Managed Care
Pennsylvania Department of Health
P.O. Box 90
Harrisburg, PA 17108-0090

Dear Director Mitchell:

We are writing on behalf of Phar-Mor, LLC regarding the recent decision by the UPMC Health Plan to designate Giant Eagle as its exclusive provider of prescription drug services in most areas. We are concerned that this arrangement will reduce the availability and accessibility of quality care for enrollees of the UPMC Health Plan.

Phar-Mor was formerly one of several providers of prescription drug services under the UPMC Health Plan. When UPMC Health Plan announced its decision to make Giant Eagle its exclusive provider of prescription drug services, Phar-Mor received complaints from UPMC Health Plan enrollees that the decision was going to greatly reduce the availability of prescription drug services in their area.

Mindful of the steps that the Pennsylvania General Assembly has taken to assure that enrollees of managed care plans have access to health services, we are writing to request that the Department exercise its statutory authority to ensure that the UPMC Health Plan is continuing to provide adequate and accessible prescription drug services to its enrollees. In 1998, the General Assembly passed Act 68 that requires managed care plans to "assure availability and accessibility of adequate health care providers." The Act includes pharmacists in its definition of health care providers.

In December of 1999, the Department published proposed rules to implement the provisions on quality healthcare and accountability in Act 68. These proposed rules would replace the existing regulations on managed care organizations and provide more detail on what a plan must do if it is going to provide health services like prescription benefits. The proposed rules state that if an HMO is going to provide prescription drug services they must operate a network of providers "sufficient to provide reasonable access to and availability of" the contracted service.

Houston
Harbaugh

January 12, 2000

Page 2

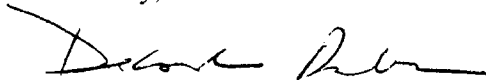
The proposed rules also state that a plan "shall demonstrate at all times that it has an adequate number and range of health care providers." These proposed rules demonstrate the Department's thinking on implementation of Act 68 and would impose a duty on managed care plans to demonstrate that they are providing sufficient access to their health services.

Section 2181 of Act 68 also imposes a duty on the Department of Health to ensure compliance with the provisions of the statute. We would like to know what steps the UPMC Health Plan has taken to demonstrate to the Department that it is in compliance with access and availability requirements of Act 68. We have learned that the UPMC Health Plan has not submitted any documents to the Department in connection with its decision to designate Giant Eagle as its primary provider of prescription drug services. If the UPMC Health Plan has not submitted any documents to demonstrate that it is in compliance with the statute, we would also like to know what the Department is doing to ensure that this arrangement is in compliance with Act 68.

Phar-Mor has received complaints from pharmacy customers and UPMC Health Plan enrollees expressing concern that the switch to Giant Eagle as the exclusive provider of prescription drug services in most areas under the UPMC Plan is going to greatly reduce their access to, and the availability of, prescription drug services in their area. These complaints demonstrate that the UPMC Health Plan may not be in compliance with the with the quality health care and accountability requirements set forth by the Pennsylvania General Assembly in Act 68. Based on these complaints, we are requesting that the Department of Health initiate an investigation of the UPMC Health Plan/Giant Eagle contract pursuant to its statutory authority under 40 P.S. § 991.2181(d) and that they be enjoined from proceeding with this arrangement before you have completed this investigation.

We would be happy to answer any questions you may have about this letter. Please feel free to contact me at the above address or phone number.

Sincerely,



Deborah J. Robinson

cc: Michael Malkin, Esq.



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Wednesday, January 12, 2000

Stacy Mitchell, Director
Bureau of Managed Care
Pennsylvania Department of Health
P.O. Box 90
Harrisburg, PA 17108

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Dear Ms. Mitchell:

I am taking this opportunity to share my wife's experiences and my nephew's attitude with regard to the Department of Health's review of the new proposed Act 68 regulations. I understand that these are the regulations that will govern HMOs - both commercial and Medicaid.

The purpose of sharing these experiences is to urge the Department of Health to require all health insurance companies to cover the cost of sign language interpreters for the deaf and hard of hearing citizens of the Pennsylvania Commonwealth.

Every delay in resolving this issue puts every deaf and hard of hearing person at risk for loss of life or irreparable damage to their health. And the games that medical providers play to get around the ADA regulations scares me greatly.

For example, I contacted my wife's insurance company, Personal Choice, to see if they would cover the cost of her interpreter for her visit to a specialist. After being passed around among several people and finally with the supervisor, I was advised that they were not authorized to cover interpreter costs and that it was up to the specialist. After explaining that I knew the ADA law, was aware that the interpreter cost would not cover the insurance reimbursement from the insurance company, and that it was a matter of time before they'd be hit with a tremendous law suit, we hung up on pleasant terms. My wife's doctor did arrange for an interpreter after I reminded him of the ADA requirements. After the visit with the interpreter present, the specialist said that he has done all he could for her and that he was making specific recommendations that she see a different specialist, a back specialist. He will send her primary physician a report with his recommendations and that the primary physician will manage her care. My wife and I can't help but wonder whether this is the specialist's way of avoiding future interpreter costs. My wife has arthritis and you know that arthritis is an ongoing medical problem with no cure that requires regular medical attention for management. Currently she is taking Celebrex which gives you an idea of the seriousness of her problem. This was despite the fact that I made it clear to the specialist that we were not going to ask for an interpreter for every visit, but only when after a certain period of time, when my wife felt the need for a deep discussion of her medical problem and management. Now her primary physician, who, because he has a deaf son and signs well, is going to manage her care. But we can't help but wonder about the quality of her arthritic management under the care of a primary physician as opposed to being in regular touch with a rheumatologist.

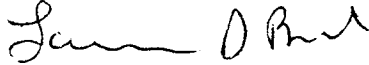
Compared to the seriousness of many other deaf and hard of hearing people, my wife's problem may seem minor. But how long must we put up with this? Even my nephew, who is a doctor and with whom I am close, objects strenuously to being held responsible

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for interpreter costs. He signs adequately, but doesn't want his sign language skills advertised because it takes longer for him to communicate with a deaf patient than with a hearing patient. If this is how my nephew feels, it leaves me with little doubt about how doctors with whom the deaf population do not have a relationship must feel about this whole issue.

The reason I share this experience is that I feel that until the insurance industry assumes responsibility for ensuring equal access to the deaf and hard of hearing population, this group will be at risk. I look to you to provide leadership in requiring that the insurance companies assume the interpreter costs

Sincerely yours,

A handwritten signature in black ink, appearing to read "Lawrence J. Brick". The signature is fluid and cursive, with a large initial "L" and a distinct "B" at the end.

Lawrence J. Brick
Chairperson, PSAD Medical Access Committee

cc: Rachel Mann, Attorney
Steve Gold, Attorney
Louise Montoya, Medical Access Committee
Gil Ott, Director of Liberty Resources
Steve Florio, President PSAD
Carolyn Brick, wife of Lawrence J. Brick

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January 12, 2000 2000 JAN 20 AM 10:11

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Ms. Stacy Mitchell
Director
Bureau of Managed Care
PA Department of Health
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Harrisburg, PA 17108-0090

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Re: Proposed Regulations To Implement Act 68

Dear Ms. Mitchell;

I am writing this letter to you on behalf of the Consumer Health Coalition (CHC) and its participating member organizations in order to express our concerns with respect to the proposed regulations to implement Act 68 as published by your office in the December 18, 1999 edition of the Pennsylvania Bulletin.

Among the many points on which we would offer formal comment, we feel constrained to stress the following issues which are of a particular concern to us:

1. Medical Necessity:

- The regulations eliminate language from your first draft which require that plans adopt a definition of "medical necessity" which is not unduly restrictive and which does not rely solely on the interpretation of the plan.
- They fail to require Managed Care plans to consider information by the plan participant, his family, primary care practitioner, other providers and agencies that have evaluated the individual when determining the "medical necessity" of a given service.

2. Health Care Provider Contracts:

- Our concerns in this area are too numerous to fully amplify within the body of this letter, however, our paramount concern involves the failure of the regulations to place any limit on the conflict of interest which can be found to exist between health care providers and their patients, and instead to permit huge financial incentives which plans afford to providers who limit the care which they provide to their patients. In other words, if physicians are beholden to insurance companies, who incentivize their practices if they limit the care which they provide to patients, the physician then has a financial incentive to treat a patient in a way which is inconsistent with the patient's needs, wants, and, quite possibly, the canons of professional responsibility. The mere appearance of impropriety necessarily creates a conflict of interest between physician and patient.

Act 68 DOH Letter

Page 2

January 12, 2000

3. Complaint and Grievance Process

We are extremely concerned about the consumer "take-aways" apparent in this section. The Fundamental Fairness Guidelines for HMOs previously issued by the Department and currently in place have many excellent consumer protections that are inexplicably not contained in these proposed regulations. We understand that unless these protections are incorporated, they will be lost. Among the many protections we are concerned about are:

- The regulations no longer require that plan members be given at least 15 days advanced written notice of the second level complaint/grievance committee hearing, among other things.
- Likewise, the regulations do not require plans to make available to the consumer all documentation relating to the consumer's dispute
- The regulations no longer detail a fair, uniform for how complaint and grievance hearings are conducted across plans.

PLEASE NOTE: The remainder of our concerns in this area, while very specific, can generally be summarized as follows: the regulations, as currently drafted, eliminate far too many of the protections which were provided for previously!

4. Disclosure of Consumer Rights:

- The proposed regulations no longer require plans to advise members of their right: to get current, complete information from their physician regarding diagnosis and treatment; to emergency services; to receive technical communications which are written in "plain language"; and to request and receive the credentials of any "hands-on" health care provider. Simply stated, it is CHC's position that lack of knowledge of a right negates a person's potential exercise of the right, which effectively works to eliminate the right itself.

5. Subcontracted Services:

- We find it particularly disturbing that the regulations appear to permit plans to subcontract-out almost all plan functions to unlicensed entities who are not subject to these regulations.

Our other concerns with the proposed regulations involve their failure to define what an adequate network is, their failure to limit co-payments, their failure to require a minimum of PCP's based on plan membership, their failure to proscribe the restriction of network providers to potential enrollees, their limitation of direct access to OB-GYN's via the requirement of prior authorization for any non-routine procedures, their limitation on access to emergency services, their failure to provide for expedited review of complaints, and, finally, their lack of coordination with Insurance Department regulations.

In summary, we urge you not to go forward with these regulations as written. Instead, we urge that the regulations be substantially redrafted in light of these concerns and the

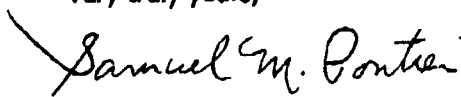
Act 68 DOH Letter

Page 3

January 12, 2000

others raised on our behalf by the Pennsylvania Health Law Project. Should you have any questions or comments with respect to the contents of this letter, or should you merely wish to discuss this matter, please do not hesitate to contact me.

Very truly yours,

A handwritten signature in cursive script that reads "Samuel M. Pontier". The signature is written in dark ink and is positioned above the printed name and title.

Samuel M. Pontier
Executive Director
Consumer Health Coalition

0001096

CONSUMER HEALTH COALITION

Fax TransmissionDate: 1-13-00

To:

STACY MITCHELL

Address:

Telephone Number:

Fax Number:

(717) 705-0947

Verification Number:

From:

Sam Pontier

Address:

Consumer Health CoalitionCentre City Tower, Suite 2390650 Smithfield StreetPittsburgh, PA 15222

Telephone No:

(412) 456-1877

Fax Number:

(412) 232-6240

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MESSAGE:

formal comment on ACT 68 regs.



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January 12, 2000

Mr. Steve Horner
Pa. Department of Health
P.O. Box 90
Harrisburg, Pa. 17120

Dear Mr. Horner:

As part of First Priority Health's on going evaluation of Pa. Department of Health Regulations and Act 68, a question has arisen regarding Section 2121 (d) of Act 68. It is stated in the Act that a "managed care plan shall submit a report to the department regarding its credentialing process at least every 2 years or as may otherwise be required by the department".

To ensure that we are providing you with the required information, to remain in compliance with Act 68, we are requesting clarification as to the amount and type of information required for us to submit. Our demonstration of compliance could range from simply being NCQA accredited to providing you with updates on the number of practitioners credentialed, recertified and terminated for quality reasons every two years.

For your information, First Priority Health has been and continues to be accredited by NCQA since 1992.

Please forward your guidance to this question to me at the following address:

Edward P. Syron FACHE, FNAHQ
Senior Director Quality Management
First Priority Health
70 North Main Street
Wilkes-Barre, Pa. 18711

Thank you for your time and attention to this matter. If you have any questions please contact me directly at 570-831-3719.

Sincerely,

Edward P. Syron FACHE, FNAHQ
Senior Director Quality Management
First Priority Health

cc: Carmella Sebastian, MD
Gloria Blondina

0001080

PENNSYLVANIA OPTOMETRIC ASSOCIATION

218 NORTH STREET · PO BOX 3312 · HARRISBURG, PA 17105
PHONE (717) 233-6455 · FAX (717) 233-6833
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Stacy Mitchell, Director
Bureau of Managed Care
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RE: Proposed Managed Care Regulations

Dear Ms. Mitchell,

On May 27, 1999, the Pennsylvania Optometric Association responded to your request for comments on the draft managed care regulations. We have compared the draft and the proposed regulations as published, and submit the following comments for your consideration.

Section 9.604 - Plan Reporting Requirements

Nowhere in this section are plans required to provide information as to outcomes. We realize this is an area of great debate in pending legislation, but we still believe that it remains a crucial set of data that consumers need in choosing their health care plan. Are patients getting the care they need with as little inconvenience as possible, and are they able to make informed decisions that lead to quality care in the system? We commend the Department on the changes you propose in data collection, as we believe the more information that is available to the public, the better the system will be.

Section 9.676 - Enrollee Rights

Providers, and employers, should be provided with the same access to the information supplied under this section to enrollees, and all should be made public so that prospective plan participants can make informed decisions as to whether to participate. Also, we believe that terms of the provider contract must be enforceable for the duration of the enrollment period, so that no changes can be made by a plan that would cause a participant to want to leave, without the ability to do so.

Section 9.674 - Quality Assurance Standards

In the summary of the regulations the Department recognizes its obligation to set standards by which plans can monitor themselves for effectiveness. One of the ways this can be accomplished

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is to have a quality assurance panel that has a broad array of health care providers of all disciplines, not just physicians. The regulations should be changed in subsection (b)(3) to read... “that includes plan participating **health care providers**...”

Section 9.679 – Access Requirements in service areas

As we commented on the draft regulations, Subsection (e) should be further defined. The “20/20 or 30/30” rule appears to provide adequate access, but if it applies only to geography, and not availability of actual services, it does not fully meet the need. In other words, if, for instance, there is an ophthalmological office within 30 miles of a rural community that is open only a couple of days a month, then the access requirement should not be considered met. Our members are frequently shut out of plans because the plan says it has met the access requirements by having an ophthalmologist in the area, or that the plan does not cover routine eye exams or glasses. As the Department is well aware, optometrists provide far more medically related eye care services than those covered in the “vision plans.” In fact, most primary eye care in medically underserved areas is provided by optometrists. Other arbitrary standards, like hospital affiliation, should not be allowed as reasons for keeping a provider off of a panel. Today more and more health care services are provided outside a hospital setting, especially in the area of eye care.

Section 9.684 – Continuity of Care

POA appreciates the Department’s change in this section to remove a requirement that non-participating providers accept the plan’s reimbursement as “payment in full.” However, the requirement that the plans cover health care services “under the same terms and conditions as applicable for services provided by participating providers” could lead plans to attempt to require such an agreement. Although we recognize that this is a direct reference to the language in Act 68, the regulations should affirmatively prohibit that requirement, so that only the services and the plans reimbursement for those services will be negotiated with the plan, not the fees that can be negotiated separately with the patient.

Section 9.677 – Requirements of Definitions of Medical Necessity

The plan’s definition should be included in the application for authority documents, so it can be reviewed by the Department prior to approval. We believe that the Department should develop a standard definition of medical necessity, and include in regulations.

Subchapter I: Enrollee and Provider Complaints and Grievance System

Although we acknowledge the unfortunate legal requirement that review of denials be made by physicians, we believe that it remains within the purview of the Department, and is good health policy, that reviewers at least consult with members of the same profession as the provider who

performed the service being reviewed to determine whether it falls within the standard of care for that profession. Perhaps members of the professional association, the state licensing board, or faculty of a relevant accredited professional school located within the Commonwealth could be utilized for this purpose. It is not a stretch to say that medical doctors do not always share the same view of appropriate care as non-MD providers for certain services. In fact, even among physicians there are often disagreements among specialties as to necessity of certain procedures. The law recognizes that this is particularly true in behavioral health, as psychologists are included "when appropriate." This points up the need for more than one viewpoint in reviewing a denial.

We hope that this list of suggestions has been helpful. We remain available as a willing and able resource to the Department as you move forward with these important regulations.

Sincerely,

PENNSYLVANIA OPTOMETRIC ASSOCIATION

Charles J. Stuckey, Jr., O.D.
Executive Director

cc: Dr. Robert Muscalus, Physician General



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Dear Ms. Mitchell:

I am writing regarding PA Act 68 which took effect January 1, 1999. I would like to address the issue of payment to non-participating providers with medical insurance companies and request a review of certain procedures.

The City of Pittsburgh EMS is a 911 emergency response ambulance service. As a emergency ambulance service we have an ethical and moral responsibility to respond to 911 calls and to transport patients to a hospital. We are a non-participating provider with numerous insurance companies. And it is my understanding that most ambulance companies are non-participating providers with medical insurance companies.

Denial of ambulance transport bills has been prevalent among the HMO's covered under PA Act 68. We respond to emergency calls and transport to a hospital regardless of whether the patients transport is later determined by the HMO's not to have been a medical emergency. An example is when we are called for a patient experiencing chest pain when it is later determined the patient had heartburn or an elderly patient experiencing dizziness when the HMO's determine this patient should have taken a cab. When we are denied payment for such an ambulance transport what recourse do we have? How can the regulations address payment for an emergency 911 system for services performed whether or not it is ultimately found to be an emergency?

The City of Pittsburgh EMS system is in a unique situation since City laws prohibit from directing billing a city resident for such service. If the HMO's deny payment the bill is uncollectable. If the patient is a non-resident the bill is submitted to them. However if the non-resident is covered by PA medical welfare or by a DPW HMO we are prohibited from billing the patient directly and another bill is uncollectable. Therefore, in the above examples, regardless if the patient is a resident or non-resident, we do not get paid for our emergency services. Even if the ambulance transport is not deemed a medical emergency

shouldn't we be compensated for our services? What recourse is there for a non-participating provider?

Another issue is that according to PA Act 68 we must receive the patients' permission to contest denial of a claim. We will have very little contact time with the patient and sometimes never see them again. It is impractical and unreasonable to think they will respond to our inquiries.

Is it possible the regulations could consider acceptance of 911 ambulance transport and/or treatment as a binding unwritten contract in order that an ambulance service can appeal denials automatically?

Who has the final determination in which complaints are considered an emergency? Is dizziness, severe stomach aches, severe headaches, nausea (which can be a sign of heart attack in women) considered an emergency?

Can the regulations require that as a 911 response, ambulance service be paid for all ambulance trips by virtue of a 911 response?

Sincerely,

A handwritten signature in cursive script, appearing to read "Linda Noszka".

Linda Noszka
Supervisor