# WEST VIRGINIA
# SECRETARY OF STATE
**KEN HECHLER**
# ADMINISTRATIVE LAW DIVISION

Form #3

**Do Not Mark In this Box**

RECEIVED
97 AUG -1 PM 12:08
OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

## NOTICE OF AGENCY APPROVAL OF A PROPOSED RULE AND FILING WITH THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

AGENCY: Insurance Commissioner TITLE NUMBER: 114

CITE AUTHORITY W.Va. Code §§ 33-2-10, 33-25A-4(1)(b) and 33-25A-17a

AMENDMENT TO AN EXISTING RULE: YES___ NO X

IF YES, SERIES NUMBER OF RULE BEING AMENDED: _____

TITLE OF RULE BEING AMENDED: _____

IF NO, SERIES NUMBER OF NEW RULE BEING PROPOSED: Series 53

TITLE OF RULE BEING PROPOSED: Quality Assurance

THE ABOVE PROPOSED LEGISLATIVE RULE HAVING GONE TO A PUBLIC HEARING OR A PUBLIC COMMENT PERIOD IS HEREBY APPROVED BY THE PROMULGATING AGENCY FOR FILING WITH THE SECRETARY OF STATE AND THE LEGISLATIVE RULE MAKING REVIEW COMMITTEE FOR THEIR REVIEW.

B. Reid Shumate

Authorized Signature
General Counsel

§14-80

CECIL H. UNDERWOOD
GOVERNOR

# STATE OF WEST VIRGINIA
# DEPARTMENT OF TAX AND REVENUE

Charleston, West Virginia
P. O. Box 963
Charleston, WV 25324-0963
Ph. (304) 558-0211 - Fax (304) 558-2324

ROBIN C. CAPEHART
SECRETARY

## CONSENT TO PROPOSAL OF RULE

To Whom It May Concern:

Pursuant to West Virginia Code §5F-2-2(a)(12), the undersigned hereby grants consent to the proposal of the following rule proposed by the Insurance Commissioner of the State of West Virginia: Title 114, Series 53, relating to Quality Assurance.

Dated this 25th day of June, 1997.

Robin Capehart
Secretary of Tax and Revenue

Insurance Commissioner
Legislative Rule
Title 114, Series 53

**Quality Assurance**

Title 114, Series 53

**BRIEF SUMMARY OF RULE**

This proposed rule implements the provisions of the Health Maintenance Organization Act, W. Va. Code §§ 33-25A-1 et. seq., which was amended during the 1996 legislative session by House Bill 4511. The rule sets forth the standards for quality assurance programs which must be met by each health maintenance organization as a condition precedent to the issuance of a Certificate of Authority to transact insurance in the State of West Virginia effective May 1, 1998.

Insurance Commissioner
Legislative Rule
Title 114, Series 53

Quality Assurance

Title 114, Series 53

STATEMENT OF CIRCUMSTANCES

During the 1996 legislatiave session, the West Virginia Legislature passed House Bill 4511, which amended the Health Maintenance Organization Act, W. Va. Code §§ 33-25A-1 et. seq. This rule sets forth the standards for quality assurance programs which must be met by each health maintenance organization as a condition precedent to the issuance of a Certificate of Authority to transact insurance in the State of West Virginia effective May 1, 1998.

APPENDIX B

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Quality Assurance
Series 53

Type of Rule: XX Legislative ____Interpretive ____Procedural

Agency: Insurance Commissioner

Address: Post Office Box 50540
2019 Washington Street, East
Charleston, West Virginia 25305-0540

==========

1. Effect of Proposed Rule

| | ANNUAL | | FISCAL YEAR | | |
|---|---|---|---|---|---|
| | Increase | Decrease | Current | Next | Thereafter |
| ESTIMATED TOTAL COST | 243,771 | | | 464,468 | 464,468 |
| PERSONAL SERVICES | 123,680 | | | 197,630 | 197,630 |
| CURRENT EXPENSE | 43,116 | | | 160,637 | 160,637 |
| REPAIRS AND ALTERNATIONS | None | | | None | None |
| EQUIPMENT | 38,900 | | | 38,900 | 38,900 |
| OTHER | 38,075 | | | 67,301 | 67,301 |

2. Explanation of above estimates:

The Consumer Advocacy Division will require additional employees to regulate the quality assurance requirements imposed by this rule and House Bill 4511. These additional employees include: one (1) Office Assistant I, two (2) Nurse 4s, one (1) Health Care Analyst 2 and one (1) Paralegal.

Rule Title: Quality Assurance
Series 53

3. Objectives of these rules:

The objective of this proposed rule is to set forth the standards for quality assurance programs required to be established by health maintenance organizations pursuant to the requirements of H.B. 4511.

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

None, other than those indicated in Question 1.

B. Economic Impact on Political Subdivisions; Specific Industries; Specific groups of Citizens.

Will have economic impact on health maintenance organizations required by H.B. 4511 to undergo a review of quality assurance programs by a nationally recognized accreditation and review organization approved by the Commissioner.

C. Economic Impact on Citizens/Public at Large.

None.

Date: June 26, 1997

Signature of Agency Head or Authorized Representative

B. KEITH HUFFMAN
GENERAL COUNSEL

DATE: August 1, 1997

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM: OFFICE OF THE INSURANCE COMMISSIONER

LEGISLATIVE RULE TITLE: Quality Assurance, Series 53

1. Authorizing statute(s) citation: West Virginia Code §§ 33-2-10, 33-25A-4(1)(b) and 33-25A-17a

2. a. Date filed in State Register with Notice of Hearing:

   June 26, 1997

   b. What other notice, including advertising, did you give of the hearing?

   NONE

   c. Date of hearing(s): The public comment period ended July 28, 1997.

   d. Attach list of persons who appeared at hearing, comments received, amendments, reasons for amendments.

   Attached X

   No comments received __

   e. Date you filed in State Register the agency approved proposed Legislative Rule following public hearing: (be exact)

   August 1, 1997

   f. Name and phone number of agency person to contact for additional information:

   Donna Quesenberry, Associate Counsel
   (304) 558-0401

3. If the statute under which you promulgated the submitted rules requires certain findings and determinations to be made as a condition precedent to their promulgation:

a. Give the date upon which you filed in the State Register a notice of the time and place of a hearing for the taking of evidence and a general description of the issues to be decided.

Not applicable

b. Date of hearing: Not applicable

c. On what date did you file in the State Register the findings and determinations required together with the reasons therefor?

Not applicable

d. Attach findings and determinations and reasons:

Attached: Not applicable

# 114CSR53
# WEST VIRGINIA LEGISLATIVE RULE
# INSURANCE COMMISSION

## SERIES 53
## QUALITY ASSURANCE

Section

RECEIVED
97 AUG -1 PM 12:08
OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

114CSR53
WEST VIRGINIA LEGISLATIVE RULE
INSURANCE COMMISSION

SERIES 53
QUALITY ASSURANCE

**§114-53-1. General.**

1.1. Scope. -- The purpose of this rule is to set forth standards for quality assurance programs established as a component of a health maintenance organization's overall structure.

1.2. Authority. -- W. Va. Code §§ 33-2-10, 33-25A-4(1)(b), and 33-25A-17a.

1.3. Filing Date. --

1.4. Effective Date. --

**§114-53-2. Definitions.**

2.1. "Accountability" means the responsibility of a department or individual for achieving defined goals.

2.2. "Appropriateness" means the extent to which a particular procedure, treatment, test or service is clearly indicated, not excessive, adequate in quantity and provided in the setting best suited to the patient's/member's needs.

2.3. "Commissioner" means the West Virginia Insurance Commissioner.

2.4. "Clinician" means a physician, psychologist or psychiatrist who specializes in clinical studies or practice.

2.5. "Credentialing" means the process by which a health maintenance organization authorizes, contracts with or employs clinicians, who are licensed to practice independently, to provide services to its members.

2.6 "DEA" means Drug Enforcement Administration, the Federal agency that issues licenses to prescribe and dispense scheduled drugs.

2.7. "Delegation" or "delegated" means the formal process by which a health maintenance organization gives a contractor the authority to perform certain functions on its behalf, such as credentialing, utilization review and quality assurance. A health maintenance organization can delegate the authority to perform a function but cannot delegate the responsibility for assuring the function is performed properly.

2.8. "Governing body" means an individual, group or agency with the ultimate authority and responsibility for the overall operation of the organization.

2.9 "Health care services" means any services or goods included in the furnishing to any individual of medical, mental or dental care, or hospitalization, osteopathic services, chiropractic services, pediatric services, home health, health education, or rehabilitation, as well as the furnishing to any person of any and all other services or goods for the purpose of preventing, alleviating, curing or healing human illness or injury.

2.10. "Health maintenance organization" or "HMO" means a public or private organization which provides, or otherwise makes available to enrollees, health care services, including at a minimum basic health care services, which:

a. Receives premiums for the provision of basic health care services to enrollees on a prepaid per capita or prepaid aggregate fixed sum basis, excluding copayments;

b. Primarily provides physicians' services:

1. Directly through physicians who are either employees or partners of the organization;

2. Through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice arrangement; or

3. Through some combination of paragraphs one and two of this subdivision;

c. Assures the availability, accessibility and quality including appropriate utilization of the health care services that it provides or makes available through clearly identifiable focal points of legal and administrative responsibility; and

d. Offers services through an organized delivery system, in which a primary care physician is designated for each subscriber upon enrollment. The primary care physician is responsible for coordinating the health care of the subscriber and is responsible for referring the subscriber to other providers when necessary: Provided, that when dental care is provided by the health maintenance organization the dentist selected by the subscriber from the list provided by the health maintenance organization shall coordinate the covered dental care of the subscriber, as approved by the primary care physician or the health maintenance organization.

2.11. "Medical record" means the record in which clinical information relating to the provision of physical, social and mental health services is recorded and stored.

2.12. "Member," "subscriber" or "enrollee" means an individual who has been voluntarily enrolled in a health maintenance organization, including individuals on whose behalf a contractual arrangement has been entered into with a health maintenance organization to receive health care services.

2.13. "Oversight" means the monitoring and direction of a set of activities by individuals responsible for the execution of the activities resulting in the achievement of desired outcomes.

2.14. "Practice guidelines" or "protocols" means systematically developed statements to assist patient and practitioner decisions about appropriate health care for specific clinical circumstances. Practice guidelines are usually based on such authoritative sources as clinical literature and expert consensus.

2.15. "Provider" means any physician, hospital, or other person or organization which is licensed or otherwise authorized in this state to furnish health care services.

2.16. "Public health related activities" means those activities related but not limited to the prevention of epidemics and the spread of disease in communities; the protection against environmental hazards; the prevention of injuries; the promotion and encouragement of healthy behaviors; and the assurance of accessibility of health services and treatment of specific illnesses for persons in high risk and vulnerable populations.

2.17. "Quality assurance" means an ongoing program designed to objectively and systematically monitor and evaluate the quality and appropriateness of the enrollee's care, pursue opportunities to improve the enrollee's care and to resolve identified problems at the prevailing professional single standard of care.

2.18. "Quality assurance work plan" means an annual plan that describes with timeliness the specific planned quality assurance activities that will be carried out within the quality assurance program.

2.19. "Quality of care" means the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

**§114-53-3. Goals of a Quality Assurance Program.**

3.1. The goals of a health maintenance organization's quality assurance program shall be to:

a. Assure the provision of appropriate medical services delivered to members, while simultaneously addressing the effectiveness of quality of care;

b. Monitor, evaluate and improve the quality of health care;

c. Provide a systematic process that promotes the delivery of medically appropriate care in a timely, effective and efficient manner, while maintaining the quality of health care;

d. Direct members and providers toward the goal of quality, cost effective health care.

3.2. A health maintenance organization's quality assurance program shall include a mechanism for identifying potential utilization management issues and linking them to the HMO's utilization management program.

3.3 A health maintenance organization that has obtained full accreditation or equal status from a nationally recognized accreditation and review organization approved by the commissioner pursuant to W. Va. Code § 33-25A-17a is deemed to be in compliance with this rule.

**§114-53-4. Requirements of a Quality Assurance Program.**

4.1. A health maintenance organization shall develop a quality assurance program which adheres to all applicable state and federal laws, federal regulations and state rules.

4.2. Each application for a certificate of authority or renewal thereof filed with the commissioner pursuant to the Health Maintenance Organization Act, W. Va. Code §§ 33-25A-1 et

seq., shall be accompanied by a description of a health maintenance organization's quality assurance program, which shall include, but not be limited to, the requirements of the quality assurance program set forth in this rule.

a. Pursuant to the requirements of W. Va. Code § 33-25A-3, a health maintenance organization shall file notice with the commissioner prior to any modification of the quality assurance program.

4.3. A health maintenance organization shall have a program for quality assurance which clearly defines the structure, design and responsibilities of both delegated and non-delegated activities.

a. The basic components of the quality assurance program shall include:

1. organizational arrangements and responsibilities for quality management and improvement processes;

2. a documented utilization review program;

3. written policies and procedures for credentialing and Recredentialing physicians and other licensed providers;

4. a written policy addressing members' rights and responsibilities; and

5. the adoption of practice guidelines for the use of preventive health services.

b. Utilization management rules contained in 114CSR51 shall be incorporated herein and made a part hereof.

4.4. If a health maintenance organization delegates any quality assurance activity to contractors, there shall be evidence of oversight and auditing of the contracted activity.

a. The HMO shall maintain a written description of the delegated activities, the contractor's accountability for the activities, the frequency of reporting to the HMO, the process by which the delegation will be evaluated and the remedies available, including revocation of delegation, if the contractor does not fulfill its obligations.

b. The HMO shall maintain evidence of its regular evaluation and approval of the delegated activities by the contractor.

c. The HMO shall be responsible for monitoring the activities of the contractor to which it delegates quality assurance activities and for ensuring that the requirements of this rule are met.

4.5. No health maintenance organization may place restrictions upon any provider or upon any primary care physician which would serve to limit the communication of medical advice or options available to the member, subscriber or enrollee or would act in any way to limit the communication between the provider or physician and his or her patient. An HMO may not prevent any provider from advising an enrollee whether or not a treatment is covered by the plan.

a. No health maintenance organization may provide to any provider or any primary care physician an incentive plan that includes specific payment made directly or indirectly, in any form, to the provider or primary care physician as an inducement to deny, release, limit, or delay specific, medically necessary and appropriate services provided with respect to a specific enrollee or groups of enrollees with similar medical conditions.

4.6. Data or information pertaining to the diagnoses, treatment or health of a member obtained from the member or from

a provider by a health maintenance organization is confidential and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of these rules and as allowed by state law, or upon the express consent of the member, or pursuant to statute or court order for the production of evidence or the discovery thereof or in the event of a claim or litigation between the member and the health maintenance organization where the data or information is pertinent, regardless of whether the information is in the form of paper, preserved on microfilm, or stored in computer retrievable form. If any data or information pertaining to the diagnosis, treatment or health of any enrollee or applicant is disclosed pursuant to the provisions of this subsection, the health maintenance organization making this required disclosure shall not be liable for the disclosure or any subsequent use or misuse of the data.

**§114-53-5. Quality Management & Improvement.**

5.1. Organizational arrangements and responsibilities for quality management and improvement processes shall be clearly defined and assigned to appropriate individuals.

a. There shall be a detailed written description of the program which shall be reviewed annually and updated as necessary.

b. A senior executive shall be responsible for program implementation.

c. A medical director shall have substantial involvement in quality improvement activities, and be employed on a full-time basis no later than the first day of the third year of the health maintenance organization's operation.

d. A committee shall be created to oversee quality improvement and shall include HMO providers as active participants. The committee shall keep contemporaneous written records reflecting all of its actions.

e. The role, structure and function, including frequency of meetings, of the quality improvement committee shall be specified in the program description.

f. Adequate resources including, but not limited to, personnel, analytic capabilities and data resources shall be dedicated to meet program needs.

g. A written quality improvement work plan shall be prepared annually and shall include: the objectives, scope and planned projects or activities for the year; planned monitoring of previously identified issues, including tracking of issues over time; and planned evaluation of the quality improvement program.

5.2. The quality improvement committee shall be accountable to the governing body of a health maintenance organization. The governing body shall consist of the board of directors or a committee of senior management in instances where the board's participation with quality improvement is indirect. There must be documented evidence of a formally designated structure, accountability at the highest levels of the organization and ongoing and/or continuous oversight of quality assurance.

a. The governing body shall formally designate a subcommittee to provide oversight of quality improvement or formally decide to provide such oversight as a committee of the whole.

b. There must be written documentation that the governing body has reviewed and approved the written overall quality improvement program and the annual quality improvement work plan.

c. The governing body or designated committee shall regularly receive written reports from the quality improvement program delineating actions taken and improvements made.

d. All quality assurance information shall be considered in recredentialing, recontracting and/or annual performance evaluations.

5.3. All findings, conclusions, recommendations, actions taken, and results of actions taken as a result of the quality improvement process shall be documented and reported to the appropriate individuals and committees in the health maintenance organization and through established quality improvement standards.

a. Quality improvement activities shall be coordinated with other performance monitoring activities, including but not limited to utilization management, risk management and resolution, monitoring of member complaints and grievances, assessment of member satisfaction and medical records review.

b. Quality improvement shall be linked with other management functions of the health maintenance organization such as network changes, benefits redesign, medical management systems, practice feedback to providers and patient education.

5.4. Requirements to participate in quality improvement activities shall be incorporated into all provider contracts and employment agreements. Contracts shall specify that hospitals and other contractors will allow the health maintenance organization access to members' medical records. Contracts shall also specify that the health maintenance organization allows open provider-patient communication regarding appropriate treatment alternatives and that it does not penalize the provider for discussing medically necessary or appropriate care for the patient.

5.5. The quality improvement program must be ongoing and designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and service provided members and to pursue opportunities for improvements.

a. The scope of the program shall be comprehensive and shall include quality of clinical care and quality of service.

b. Members shall be afforded opportunities to participate in and offer suggestions on quality improvement.

c. A health maintenance organization shall monitor and evaluate clinical issues in institutional and non-institutional settings, primary care and major specialty services including mental health, high volume high-risk services, preventive care services, and the care of acute and chronic conditions. Such monitoring and evaluation shall reflect the population served in terms of age groups, disease categories and special risk status.

5.6. A health maintenance organization shall adopt and use practice guidelines or explicit criteria that are based on reasonable scientific evidence.

a. The guidelines shall be reviewed and updated as needed.

b. The guidelines and any updates shall be communicated in writing to all providers.

5.7. An HMO shall develop and implement mechanisms for:

a. assessing performance against practice guidelines;

b. evaluating member continuity and coordination of care;

c. detecting under and over utilization; and

d. assessing patient outcomes.

5.8. A health maintenance organization shall establish standards for the availability of primary care providers and

access which shall include but not be limited to routine, urgent and emergency care; identification of members with chronic/high-risk illnesses and the appropriate programmatic responses; telephone appointments, advice and member service lines. The availability and access standards shall conform to the minimum requirements set by the commissioner.

5.9. A health maintenance organization shall develop indicators, a data collection system and data analysis capabilities to track quality improvement.

a. Indicators shall be objective, measurable and based on current knowledge and clinical experience and shall be used to monitor and evaluate all aspects of care and services identified.

b. An HMO shall have performance goals and/or a bench marking process for each indicator.

c. Appropriate methods and frequency of data collection shall be used for each indicator.

d. Appropriate clinicians shall be used to evaluate data on the clinical performance of practitioners.

e. Multidisciplinary teams shall be used, where indicated, to analyze and address systems issues.

**§114-53-6. Credentialing & Recredentialing.**

6.1 A health maintenance organization shall ensure that its network has sufficient numbers and types of providers. The HMO shall have a written access plan outlining its strategy for maintaining an adequate network and shall implement mechanisms designed to assure the availability of primary care and specialty practitioners.

6.2 A health maintenance organization shall have written policies and procedures for the credentialing of all providers

that include the original credentialing, recredentialing, recertification and or reappointment of physicians and other licensed independent practitioners who fall under its scope of authority and action.

a. The governing body, or the group or individual to whom the governing body has formally delegated the credentialing function, shall review and approve credentialing policies and procedures.

b. A credentialing committee or other peer review body shall be established to make recommendations regarding credentialing decisions. The committee shall include providers, including but not limited to physicians, as voting members.

6.3 In terms of initial credentialing, an HMO shall obtain and review verification of the following from primary sources:

a. a current valid license to practice;

b. when applicable, clinical privileges in good standing at the hospital designated by the practitioner as the primary admitting facility;

c. a valid DEA certificate, as applicable;

d. graduation from medical school or appropriate graduate school and completion of a residency, specialty training and board certification, as applicable;

e. complete work history;

f. current adequate malpractice insurance according to the HMO's policy;

g. complete professional liability claims history; and

h. any other information deemed necessary by the HMO in determining whether to contract with a prospective provider.

6.4. A prospective provider shall complete an application for membership which includes a statement by the applicant regarding:

a. reasons for any inability to perform the essential functions of the position, with or without accommodation;

b. lack of present illegal drug use and alcohol abuse;

c. history of loss of license and/or felony convictions;

d. history of loss or limitation of privileges or disciplinary activity;

e. any other information deemed necessary by an HMO in determining whether to contract with a prospective provider; and

f. an attestation to the correctness/completeness of the application.

6.5. A health maintenance organization shall request information on the prospective provider from recognized monitoring organizations including: the National Practitioner Data Bank; the appropriate State licensing boards such as the Board of Medicine, Chiropractic Board, Osteopathic Board and/or Dental Board; and any Medicare/Medicaid sanctioning.

6.6. Representatives from the credentialing committee or members of their staff shall make an initial visit to each potential primary care practitioner's office and to the offices of obstetricians/gynecologists and other high-volume specialists resulting in documentation of a structured review of the site and of medical record keeping practices to ensure conformance with the HMO's standards.

6.7. A health maintenance organization shall have written policies and procedures for the initial and ongoing quality assessment of health delivery organizations with which it intends

to contract. The HMO shall confirm that the health delivery organization has been reviewed and approved by a recognized accrediting body and is in good standing with state and federal regulatory bodies. If the health delivery organization has not been approved by a recognized accrediting body, the HMO must develop and implement standards of participation. Health delivery organizations shall include but are not limited to hospitals, home health agencies, behavioral health agencies, nursing homes, skilled nursing facilities and free-standing surgical centers.

a. At least every three years, the health maintenance organization shall confirm that the health delivery organization continues to be in good standing with the state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body.

6.8. In terms of recredentialing, a health maintenance organization shall develop a process for the periodic verification of credentials which shall be implemented at least every two years.

a. At a minimum, recredentialing shall include verification from primary sources of:

1. a valid state license to practice;

2. clinical privileges in good standing at the hospital designated by the practitioner as the primary admitting facility;

3. a valid DEA certificate, as applicable;

4. board certification, as applicable;

5. current, adequate malpractice insurance;

6. professional liability claims history; and

7. any other information deemed necessary by an HMO in determining whether to re-contract with a provider.

b. The recredentialing process shall include a current statement by the applicant regarding reasons for any inability to perform the essential functions of the position, with or without accommodation and lack of present illegal drug use and alcohol abuse.

c. An HMO shall request recredentialing information from the National Practitioner Data Bank; the appropriate State licensing boards such as the Board of Medicine, Chiropractic Board, Osteopathic Board and/or Dental Board; and any Medicare/Medicaid sanctioning.

d. The recredentialing process shall also include a review of data from member complaints and grievances, results of quality reviews, utilization management, member satisfaction surveys, medical record reviews and site visits.

e. The recredentialing process shall include an on-site visit to all primary care providers, obstetricians/ gynecologists and high-volume specialists and shall involve documentation of a structured review of the site and medical record keeping practices to ensure conformance with HMO standards.

f. A health maintenance organization shall have polices and procedures in place for reducing, suspending or terminating practitioner privileges which shall include but is not limited to:

1. a mechanism for reporting to the appropriate authorities serious quality deficiencies resulting in suspension or termination; and

2. an appeal process for and notice thereof to the provider.

**114-53-7. Members' Rights & Responsibilities.**

7.1. An HMO shall demonstrate a commitment to treating members with respect by developing written policies giving them the right to:

a. voice grievances about the HMO or care provided;

b. have information concerning the HMO, its services, the practitioners providing care and members' rights and responsibilities;

c. participate in decision-making regarding health care; and

d. be treated with respect and recognition of their dignity and need for privacy.

7.2. An HMO shall develop a written policy addressing members' responsibilities for cooperating with those providing health care services by giving needed information to professional staff to ensure appropriate care and by following instructions and guidelines given by those providing health care services.

7.3. All policies on members' rights and responsibilities shall be provided in writing in clear and concise terms to all members and participating providers and, at a minimum, shall address the following procedures for, policies concerning or information regarding:

a. how to submit claim for covered services;

b. how to obtain primary and specialty care, behavioral health services and hospital services;

c. after-hours and emergency coverage including the HMO's policy on when to directly access emergency care or use 911 type services;

d. benefits and services included and excluded from membership;

e. obtaining out-of-area coverage;

f. special benefit provisions such, as co-payment, higher deductibles and rejection of claims, that may apply to services outside the system;

g. member charges;

h. notification of termination or change in any benefits, services or delivery site/office;

i. notification of termination of a primary care or specialty provider and the process for selecting a new provider;

j. appealing decisions adversely affecting a member's coverage, benefits or relationship to the HMO;

k. changing practitioners;

l. disenrollment of nongroup subscribers;

m. voicing complaints, grievances and appeals;

n. recommending changes in policies and services;

o. points of access to primary care, specialty care and hospital services;

p. the process by which a managed care organization determines whether or not to include new and emerging technology or treatment as a covered benefit;

q. provider names, qualifications and titles;

r. confidentiality; and

s. member satisfaction surveys that assess patient complaints, requests to change practitioners and/or facilities and disenrollments.

7.4. A health maintenance organization shall have a procedure by which a member, upon diagnosis with a life-threatening, degenerative or disabling condition or disease, either of which requires specialized health care over a prolonged period of time, shall receive a standing referral to a specialist with expertise in that condition or disease who will be responsible for and capable of providing and coordinating the member's specialty care. When a standing referral is made, the HMO shall periodically review the referral for continued necessity.

**§114-53-8. Preventive Health Services.**

8.1. A health maintenance organization shall adopt guidelines for the use of preventive health services which must be based on reasonable medical evidence and the full service population. The guidelines shall be developed or adopted with the participation of the HMO's providers and must include a mechanism for periodic updates.

a. The guidelines and all updates shall be provided in writing to all providers and members.

b. The guidelines shall consist of the following categories:

1. Prenatal and perinatal care;

2. Preventive care for infants up to 24 months;

3. Preventive care for children and adolescents aged two through 19 years old;

4. Preventive care for adults aged 20 through 64 years old; and

5. Preventive care for those aged 65 and older.

c. Each guideline shall describe the prevention or early detection interventions and the recommended frequency and conditions under which the interventions are required. The health maintenance organization shall document the scientific basis or authority upon which it based the preventive health guidelines.

d. Providers from the health maintenance organization who have appropriate knowledge shall be involved in the adoption of the preventive health guidelines.

e. At least annually, an HMO shall monitor, evaluate and take action upon a minimum of two of the following preventive services and take action to improve the use of preventive services as appropriate:

1. Childhood immunizations recognized by the American Academy of Pediatrics or as required by state or federal law;

2. Adult immunizations including influenza vaccine, pneumococcal vaccine, Hepatitis B vaccine, diphtheria and tetanus toxoid, rubella screening for women of childbearing age or any other immunization required by state or federal law;

3. Coronary artery disease risk factor screening and/or counseling for smoking, cholesterol, exercise and hypertension;

4. Breast and cervical cancer screening;

5. Counseling for prevention of motor vehicle injury;

6. Lead toxicity screening;

7. Sexually transmitted disease screening/prevention;

8. Prenatal care;

9. HIV/Aids counseling, screening and education;

10. Prevention of unintended pregnancy;

11. Alcohol and drug abuse screening/prevention; and

12. Any other preventive services deemed appropriate by the commissioner and any other state or federal regulatory authorities.

f. Preventive health service studies shall be enrollee population-based, measuring compliance as it relates to the total at-risk population.

**§114-53-9. Medical Records.**

9.1. A health maintenance organization shall require all of its providers to have an organized medical recordkeeping system. Medical records shall be maintained in a manner that is current, detailed, organized and permits effective patient care and quality review. Records shall also reflect all aspects of patient care including ancillary services.

a. An HMO shall set forth in writing appropriate standards for medical records, the systematic review for conformance and the institution of corrective action when standards are not met. Copies of all standards and goals and any updates shall be provided to all providers.

b. Records shall be available to health care practitioners at each patient visit and to nationally and state recognized reviewing bodies sanctioned by the commissioner.

**§114-53-1. Severability.**

10.1. If any provision of this rule or the application of this rule to any person or circumstances is for any reason held to be invalid, the remainder of the rule and the application of the provisions to other persons or circumstances shall not be affected by the holding.

STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner
Legal Division

CECIL UNDERWOOD
Governor

HANLEY C. CLARK
Insurance Commissioner

August 1, 1997

**HAND DELIVERED**

Ms. Judy Cooper, Director
Administrative Law Division
Office of Secretary of State
State Capitol
Charleston, WV 25305

Dear Ms. Cooper:

Enclosed please find for filing one copy of the following:

(1) Notice of Agency Approval of a Proposed Rule and Filing with the Legislative Rule-Making Review Committee;

(2) Consent of Tax and Revenue Cabinet Secretary to Proposed Rule;

(3) Brief Summary of Rule;

(4) Statement of Circumstances;

(5) Fiscal Note;

(6) Legislative Rule-Making Review Committee Questionnaire; and

(7) The agency approved proposed rule entitled "QUALITY ASSURANCE" (Series 53).

Please contact me if further information is required.

Sincerely,

Donna Quesenberry
Associate Counsel

DQ/ksb

Enclosures

P.O. Box 50540
Charleston, West Virginia 25305-0540

"We are an Equal Opportunity Employer"

**Telephone** (304) 558-0401
**Facsimile** (304) 558-0412

Insurance Commissioner
Title 114, Series 53

Attachment to Question 2(d):

Eleven (11) sets of comments to the proposed rule were received during the comment period, copies of which are attached hereto.

(1) A comment was received from John M. Collins, Chairman of the West Virginia Health Maintenance Organization Association (WVHMOA). The WVHMOA suggests that the word "Assure" in subdivision a of subsection 3.1 be changed to either "Encourage" or "Facilitate" to "better define the role of the HMO." The Commissioner disagrees with this suggestion and points out that it is the role of the HMO, pursuant to West Virginia Code § 33-25A-4(1)(a), to "assure" the provision of medical services.

The WVHMOA suggests that subdivision c of subsection 4.3 which provides that "[g]uidelines concerning public health related activities shall be developed by HMOs to insure the ongoing cooperation and/or collaboration with state and local health agencies" be stricken from the rule. The Commissioner is in agreement with this recommendation, and the appropriate language has been stricken.

In subdivision c of subsection 5.1, the rule requires the HMO to hire a full-time medical director. The WVHMOA suggests that the word "full-time" be stricken because "start-up plans may not require a full-time medical director and may be able to administer an effective quality assurance program with a part-time medical director." The Commissioner is in agreement with this recommendation and amends the language of this subdivision to read as follows:

> c. A medical director will have substantial involvement in the quality improvement activities and be employed on a full-time basis no later than the first day of the third year of the health maintenance organization's operation.

In subdivision d of subsection 5.2, the rule provides that "[a]ll quality assurance information shall be used in recredentialing, recontracting and/or annual performance." The WVHMOA is concerned that some of this information may not be creditable or should not be used, and proposes that the language be changed to require that quality assurance information "shall be considered." The Commissioner is in agreement, and therefore amends the language contained in subdivision d of subsection 5.2 to read as follows:

> d. All quality assurance information shall be ~~used~~ considered in recredentialing, recontracting and/or annual performance evaluations.

The WVHMOA further suggests that the language "telephone appointments, advice be stricken from subsection 5.8. The Commissioner agrees that the provider, not the HMO, is responsible for making a subscriber's appointment with the provider. However, subsection 5.8 requires the HMO to establish "standards" for "telephone appointments, advice," it does not require the HMO to make subscriber appointments. An amendment to this subsection is therefore unnecessary.

The WVHMOA is concerned that section 7.3 seems to require the HMOs to provide a separate document to each member describing members' rights and responsibilities. However, this provision does not specifically require this information to be provided in a separate document. The Commissioner's concern is that this information be provided "in clear and concise terms to all members and participating providers." This information may be incorporated into the Certificate of Coverage as long as it meets all requirements of subsection 7.3. No amendment to the rule is therefore necessary.

Finally, the WVHMOA requests that language be added to the rule providing that an HMO which has obtained approval from a nationally recognized accreditation and review organization pursuant to West Virginia Code § 33-25A-17a, be deemed to be in compliance with this rule. The Commissioner is in agreement and, therefore, adds the following language to section 3:

> 3.3. A health maintenance organization that has obtained full accreditation or equal status from a nationally recognized accreditation and review organization approved by the Commissioner pursuant to West Virginia Code § 33-25A-17a is deemed to be in compliance with this rule.

(2) A comment was received from Amanda Matthiesen, Assistant Legislative Director for the Health Insurance Association of America (HIAA). The HIAA is concerned that the definition of "health maintenance organization" contained in section 114-53-2.9(d) ties dental plans to the HMO rule. The definition of "health maintenance organization" contained in this rule is identical to that contained in West Virginia Code § 33-25A-2(11). This definition does not tie "dental plans" to the rule, but merely applies to those instances when "dental care" is provided by the health maintenance organization.

HIAA is also concerned with the provision contained in section 114-53-4.1 which requires a health maintenance organization to develop a quality assurance program which adheres to all applicable state and federal laws, federal regulations and state rules. Specifically, HIAA is concerned with a state jurisdiction mandating enforcement of federal laws. This provision is already contained in the Utilization Management rule, 114CSR51, as a component of the quality assurance program. The Commissioner is concerned that the HMO meet all regulatory requirements to ensure quality of care, and therefore no amendment to this subsection is made.

HIAA requests that section 114-53-4.2(a), which requires a health maintenance organization to file notice with the Commissioner prior to any modification of the quality assurance program, be amended by inserting the word "material" before the word "modification." The Commissioner disagrees with this suggestion since any modification may have material consequences to the overall quality assurance program as well as a significant impact upon consumers.

HIAA contends that section 114-53-4.3(a) as currently drafted implies that "quality assurance" and "utilization review" are the same. The Commissioner disagrees. The rule clearly states in subsection 4.3 that utilization review is a component of the quality assurance program. This issue has been discussed previously in response to the comments received by the WVHMOA.

HIAA further states that health maintenance organizations should not be subject to public health agency guidelines and principles as required by section 114-53-4.3(c). This issue has been previously discussed, and the language has been stricken from the rule.

HIAA suggests that the last sentence in section 114-53-4.5, which states that "[a]n HMO may not prevent any provider from advising an enrollee whether or not a treatment is covered by the plan" be stricken because "physicians' communications should not bind the HMO to any coverage or promise of coverage." HIAA also requests that the phrase "options available to the member" also be stricken from that subsection. The Commissioner disagrees with these suggestions. The communication between a physician and his patient as to what treatments or options are available to that patient, and whether these options are covered by the HMO, would not bind the HMO to any coverage or promise of coverage. The patient should have some input into what medical treatment to seek with consideration as to the cost of that treatment to the patient.

HIAA has requested clarification on how quality assurance differs from quality management in section 114-53-5. "Quality assurance" is defined in section 114-53-2.16 and is the overall program which includes a component referred to as "quality management." Quality management, as stated in section 114-53-5.1, is the organizational arrangements and responsibilities "within the HMO structure to assure the provision of quality of care to enrollees."

HIAA does not feel that it is necessary to have a medical director, as required by section 114-53-5.1(c), to be employed full time and have substantial involvement in quality improvement activities because as HIAA points out, someone other than the medical director performs utilization review and quality review functions. The issue of a full-time medical director has been discussed previously and an amendment has been made to require a full-time medical director by the third year of operation. This provision, as drafted, does not require the medical director to actually perform those

functions, but instead requires oversight and input into those functions. It is necessary for someone performing this function to have the proper medical training and experience to insure that quality of care objectives are met and improved upon.

HIAA requests that section 114-53-5.1(g), requiring a written quality improvement plan to be prepared annually, be amended to allow for plan information to be considered confidential and proprietary. HIAA does not feel that plan information should be made public for all other plans to review or have access to review. The Commissioner does not feel that this amendment is necessary since there is no requirement that the quality improvement plan be released other than to Commission staff and others performing a review of the quality assurance program.

HIAA does not feel that organizational structure should be regulated as required under section 114-53-5.2. The Commissioner disagrees and feels that for the quality assurance program to be successful and meet the desired objectives that there must be accountability to the governing body of the HMO.

In section 114-53-5.2(d), requiring all quality assurance information to be used in recredentialing, recontracting and/or annual performance evaluation, HIAA suggests the word "appropriate" be substituted for the word "all." That section has already been amended to provide that "all quality assurance information shall be considered in recredentialing . . . . " This amendment should take care of any concerns by HIAA.

In section 114-53-5.3(b), which requires quality improvement to be linked to other management functions of the health maintenance organization such as . . . . benefits redesign, the HIAA requests that the phrase "benefits redesign" be stricken, but offers us no explanation as to why this proposed amendment is requested. The Commissioner feels this language is necessary and therefore does not amend the existing language.

HIAA requests that the language in section 114-53-5.4 be clarified because medical communications between a provider and his/her patient does not bind the health plan to coverage of all treatments discussed. The language which provides for open provider-patient communication regarding appropriate treatment alternatives does not bind the HMO to coverage of all treatments discussed, but merely provides for open communication between the physician and patient as to treatment alternatives. No amendment to this subsection is therefore required.

HIAA requests that the phrases "participate in" be stricken from section 114-53-5.5(b) which provides that members be afforded opportunities to participate in and offer suggestions on quality improvement. HIAA offers no rationale for this suggestion. The Commissioner feels this language is necessary and therefore makes no amendment to this subsection.

With respect to section 114-53-6.3 dealing with recredentialing, HIAA asks whether the State has standard credentialing standards. This rule establishes in subsection 6.3 the credentialing standards for HMO providers.

HIAA is concerned that section 114-53-6.7 requires accreditation of an HMO and points out that accreditation is generally voluntary. Subsection 6.7 does not require accreditation of the HMO, but accreditation of health delivery systems with which it intends to contract. This subsection also makes provisions for those instances in which the health delivery organization has not been approved by an accrediting body. In those instances, the HMO must develop "standards of participation," or standards by which the HMO will participate in or assure the quality of care provided by health delivery systems.

Finally, HIAA points out that some of the requirements contained in section 114-53-7.3, advising members of their rights and responsibilities, may vary by membership and cannot be woven into a general bill of rights. The Commissioner does not view this as problematic since those rights and responsibilities which can vary by membership can be provided as a "supplement" to a general bill of rights. The Commissioner is only concerned that the required information be provided to all members and participating providers in clear and concise terms.

(3) A comment was received from Susan Sobkoviak, Government Relations Associate for the National Association of Social Workers (NASW). NASW is concerned that the term "medical services" as used in section 114-53-3.1 may be too limiting. This is a general term not intended to be limiting. "Medical services" would include, at a minimum, "basic health care services" as that term is defined in West Virginia Code § 33-25A-2, and which the health maintenance organization, by its definition, is required to provide. See section 114-53-2.9.

NASW is also concerned that the term "clinician" is narrowly defined, and requests that other provider groups also be specified. The definition of "clinician" contained in section 114-53-2.4 is the generally accepted medical definition. As that term is used within the rule (section 114-53-5.9), clinicians are required to evaluate data on the clinical performance of the practitioner. As this is a reviewing function, the Commissioner feels it is necessary to have professionals with the extensive training of physicians, psychologists or psychiatrists perform this function. The term "clinician" in no way limits the use of other professionals as providers, as that term is defined in section 114-53-2.14.

NASW is also concerned with the confidentiality of medical records as provided for in section 114-53-4.6. The Commissioner has attempted to include the needed safeguards in the drafting of this language. This subsection specifically states that medical data or information shall not be disclosed "except to the extent that it may be necessary to carry out the purposes of these rules and as allowed by state law." This language should eliminate any concerns by NASW.

In section 114-53-5.2, NASW states that consumers, as well as providers, should be on the governing body of the HMO. The rule states that the governing body is to consist of the board of directors or a committee of senior management. There is no provision which limits the board of directors to providers and West Virginia Code § 33-25A-6 specifically states that the governing body "may include enrollees, providers, or other individuals." Therefore, no amendment to the rule is required.

NASW is concerned that section 114-53-5.3 makes no provision for public access to findings of the quality improvement process. Section 5 of this rule is intended to deal only with the quality improvement committee and the accountability of that committee to upper management of the HMO. This is internal information that will be reviewed by the Commissioner and/or a nationally recognized accreditation and review organization. To release this information to the general public in its raw form may tend to limit the information provided by the HMO. At some future date, the Commissioner may consider releasing general information, or a "report card", regarding HMOs and their efforts to ensure all aspects of quality of care.

In section 114-53-5.5, the NASW is again concerned that the term "clinician" may be too narrowly used. This issue has been addressed previously. The monitoring of clinical issues described in subdivision a of this section is for the quality improvement program.

The NASW questions the source of the practice guidelines provided for in section 114-53-5.6. The term "practice guidelines" is defined in section 115-53-2.13. Any guidelines falling within this definition would meet the requirements of subsection 5.6.

The NASW requests that section 114-53-5.9 calling for multi-disciplinary teams "where indicated to analyze and address systems issues" be expanded upon to provide better guidance. The Commissioner intends the requirement to be drafted in general terms to give the HMOs flexibility. The HMOs will, however, be required to justify the methods used to track quality improvement.

The NASW feels that section 114-53-6.2, requiring the credentialing committee or other peer review committee to include provider doctors as voting members, should be amended to include other types of providers. The Commissioner is in agreement with this suggestion and amends subdivision b of subsection 6.2 to read as follows:

> b. A credentialing committee or other peer review body shall be established to make recommendations regarding credentialing decisions. The committee shall include ~~doctors~~ providers including, but not limited to, physicians as voting members.

As defined by subsection 2.14, provider "means any physician, hospital, or other person or organization which is licensed or otherwise authorized in this state to furnish

health care services." However, "health care services" has not been defined in the rule. To eliminate any potential for misunderstanding, the Commissioner amends section 2 of the rule to include the following definition for "health care services."

> 2.9. "Health care services" means any services or goods included in the furnishing to any individual of medical, mental or dental care, or hospitalization, osteopathic services, chiropractic services, pediatric services, home health, health education, or rehabilitation, as well as the furnishing to any person of any and all other services or goods for the purpose of preventing, alleviating, curing or healing human illness or injury.

NASW is concerned that the language in section 114-53-6.3, subdivision d is too narrow. However, use of the phrase "as applicable" should eliminate this concern, and makes this requirement more general.

Finally, there is a concern that section 114-53-8.3 is not specific enough, and questions "who will be determining what the preventive health guidelines are." Subsection 8.1 specifically states that the guidelines shall be developed by the HMOs "with the participation of the HMO's providers." The reviewing body and the Commissioner will determine upon review of the quality assurance program whether these guidelines are adequate.

(4) A comment was received from Donna Z. Heuneman, Executive Director of the West Virginia Developmental Disabilities Planning Council. The Council is concerned that the definition of "clinician" in section 114-53-2.4 is too narrow. This issue has been discussed previously and the Commissioner does not feel that an amendment to this definition is necessary.

The Council also suggests that the definition of "health maintenance organization" in section 114-53-2.9 be broadened to allow for subcontracting of specialty services other than dental. This issue has been discussed previously and the Commissioner does not feel that an amendment to this subsection is warranted.

In section 114-53-4.3, the Council requests that several additional areas be considered components of the quality assurance program: a written grievance procedure, reasonable time travel/distance from service delivery, and procedures for emergency services. The grievance procedure and availability and accessibility of care have been addressed in the Health Maintenance Organization Act. See West Virginia Code § 33-25A-12 and 33-25A-4, respectively. Procedures for emergency services have been provided for throughout this rule and previous legislative rules. See section 114-53-7.3 and 114CSR50.

The Council requests that section 114-53-4.3, subdivision a, paragraph 5 be amended to add the following language: "including habilitative services for mitigation of

secondary disabilities and to reduce the impact of primary disability." However, the Council offers no reason for the requested amendment. The Commissioner does not feel this additional language is necessary since the term "preventive health services" is broad and would, as necessary, include such habilitative services.

The Council requests that section 114-53-4.5 be amended to include a reference regarding referral to specialists. The Commissioner does not amend this subsection since the general language would include any such communication regarding specialists and specialty care. The Commissioner has, however, amended the rule at subsection 7.4 to provide for a standing referral to specialists.

The Council requests that section 114-53-5.1, subdivision d be amended to include subscribers on the quality improvement committee. The Commissioner does not feel that such an amendment is required. This is an internal committee of the HMO, and the rule does not restrict subscribers from being included.

The Council asks how members will be afforded opportunities to participate in and offer suggestions on quality improvement as required by section 114-53-5.5. The method of member participation is left to the health maintenance organization. The Commissioner and the accreditation and review organization will review the methods to ensure adequate participation. The Commissioner does not amend this provision.

The Council requests the addition of "long-term are services" to the list of issues to be monitored and evaluated in section 114-53-5.3, subdivision c. This subdivision, as currently drafted, requires the monitoring of "acute and chronic conditions." This provision would include "long-term care" and therefore no amendment to this language is required.

The Council requests that the phrase "best practices" be added to section 114-53-5.6, but offers no explanation why this language is necessary. The Commissioner, therefore, does not amend this section.

The Council requests that a new subdivision be added to subsection 5.7, "Assessing patient outcomes." Although no explanation was given, the Commissioner agrees that this language is necessary and is in keeping with the purpose of the rule. This amendment has, therefore, been made to the appropriate subsection.

There is also a concern, in section 114-53-7.1, that there is nothing addressing the availability of alternative formats to meet the needs of people with disabilities. The Commissioner has no objection to an amendment addressing these needs, but the Council has not offered any suggested language. The Commissioner, therefore, does not amend this provision and feels that the requirement in subsection 4.1 requiring the HMO to adhere to "all applicable state and federal laws, federal regulations and state rules" would require adherence to the Americans with Disabilities Act (ADA) and similar state and federal laws.

The Council has suggested that subsection 7.2 be amended to address the issue of a member request for a change in the course of treatment. However, no explanation as to why this amendment is necessary has been given and no suggested language has been provided. The Commissioner does not, therefore, amend this provision.

The Council has suggested that subsections 7.3 and 8.1 be reviewed for compliance with the ADA. As discussed previously, the requirement that the HMOs abide by all applicable state and federal laws should eliminate this concern.

Finally, the Council has suggested that subsection 9.1 be amended to address the member's right to timely access to their own (or minor family member's) medical records. Section 9 deals exclusively with internal record keeping by providers. The right to access to medical records (and confidentiality) is addressed in subsection 4.6.

(5) A comment was received from Elizabeth G. Evans, Ph.D., president-elect of the West Virginia Psychological Association, Inc. The Association feels that the definition of "appropriateness" needs to include who is making the determination. The Commissioner does not feel this amendment is warranted since this is an accepted definition of a nationally recognized accreditation and review organization approved by the Commissioner, and reading the word in context with the rule, it is first the HMO, and then the reviewing body, which will determine the appropriateness of a particular procedure, test, treatment, service, etc.

It is also requested that the term "clinician" in subsection 2.4 be defined more broadly. This issue has been previously discussed and no amendment is made to this definition.

The Association has requested that the term "practice guidelines" be amended to make reference to some objective, nationally recognized source. The Commissioner feels this definition, as drafted, is adequate.

The Association has further requested that the term "provider" be amended to include psychologist. The definition of "provider" is current law contained in West Virginia Code § 33-25A-2. This definition would include a psychologist licensed or otherwise authorized in this state to furnish health care services.

The Association requests that subsection 3.1 be amended to include limits with regard to time or travel to get to a provider. The Commissioner feels this is unnecessary since an HMO is required to demonstrate availability and accessibility of adequate personnel and facilities prior to being licensed. See West Virginia Code § 33-25A-4(1).

The Association requests a 90-day time frame to obtain credentialing and recredentialing. The Commissioner feels this is unnecessary. Should credentialing and

recredentialing take an unreasonable amount of time, this will be noted in review of the quality assurance program. Additionally, the HMO is required under subsection 6.1 to ensure that its network has sufficient numbers and types of providers. This should eliminate any undue delay in the credentialing process.

The Association requests that subsection 3.1 be amended to add, as a goal of the HMO, the provision of a fair and open credentialing process. The Commissioner disagrees and stresses that the goals of an HMO is to provide appropriate quality care to its members in a cost-effective manner.

It is also suggested that subsection 4.5 be amended to prohibit a financial advantage to the provider if the service is not pursued or rendered. The Commissioner is in agreement and adds subdivision a to subsection 4.5 to read as follows:

> c. No health maintenance organization may provide to any provider or any primary care physician an incentive plan that includes specific payment made, directly or indirectly, in any form, to the provider or primary care physician as an inducement to deny, reduce, limit, or delay specific, medically necessary and appropriate services provided with respect to a specific enrollee or groups of enrollees with similar medical conditions.

The Association is concerned that the language contained in subsection 4.6 protects only the HMO and does not adequately protect the patient, but does not explain why it feels the current language is inadequate. It is the Commissioner's position that this subsection, which was drafted to protect patient confidentiality, does so adequately and no amendment to this subsection is needed.

The Association further recommends that a provision be added to section 7 requiring HMOs to provide their quality assurance programs to members at a cost not to exceed $5.00. No rationale for the amendment has been provided. The Commissioner feels that all pertinent information is required to be provided to members under section 7 dealing with members' rights and responsibilities.

The Association feels that section 5 should provide safeguards against financial incentives being used to limit services This issue has been addressed and an amendment has been made to subsection 4.5 to address this prohibition.

It is suggested that subdivision d of subsection 5.1 be amended to include individuals outside the HMO. The rule, as drafted, contains no prohibition against individuals outside the HMO being on the committee.

In subsection 5.2, the Association suggests the addition of "some provision for accountability outside the governing body of the HMO." No explanation as to the need for the amendment has been provided and the Commissioner does not understand why such an amendment is necessary.

The Association requests that a provision be added to subsection 5.2 which requires all notification, review and treatment decisions to be "made by persons who possess the appropriate levels of training and credentialing in this specialty." No explanation is provided as to why this provision is needed. The Commissioner feels that the proper safeguards have been built into the rule as drafted and, therefore, makes no amendment.

In subsection 5.4, the Association is again concerned with client confidentiality. This has already been discussed. Confidentiality is adequately provided for in subsection 4.6. Also in subsection 5.4, an amendment is requested that would require the provider to discuss "and provide" medically necessary or appropriate care. The Commissioner disagrees with the suggestion and is concerned that such language may bind the HMO for coverage of non-covered services. As written, the provision allows the member to be advised of his or her treatment options and any associated costs. Furthermore, any concern with incentive plans should be eliminated with the amendment to subsection 4.5

In subsection 5.5, the Association asks how member input will be accomplished. This issue has been previously dealt with.

The Association requests amendments to subsection 5.6 regarding "ties to sanctioned, ethical professional practice" and considering "the well being of the members before cost." No explanation is given as to why these amendments are considered necessary. The Commissioner feels the appropriate safeguards have been included in the rule as drafted and makes no amendment to this subsection.

The proposed amendment to subsection 5.7 has already been discussed and the rule amended accordingly.

In subsection 5.8, the Association recommends that the standards should address parity between mental and physical health. The Association further asks how high-risk persons will be protected and remain eligible for services. The Commissioner does not feel that the standards need to address parity between mental and physical health since basic health care services provided by HMOs includes at a minimum "short-term mental health services." See West Virginia Code § 33-25A-2(1). Furthermore, renewability of accident and sickness insurance coverage is provided for in West Virginia Code §§ 33-25A-2(d), 33-16-31 and 33-16D-7, all of which are applicable to health maintenance organizations. Therefore, no amendment to this subsection is being made.

The Association requests an amendment to subsection 6.1 ensuring "providers in each area of the state in which it offers services." The Commissioner does not feel this is necessary since availability and accessibility of providers is a requirement for licensure in this State. Additionally, it is not feasible to require certain specialty providers in all areas of the State.

The Association suggests that a standardized application form be developed pursuant to subsection 6.2 so that providers do not have to put the same information into different formats. The Commissioner feels this is outside the realm of the quality assurance rule, and disagrees that the amendment should be made. The Association further asks that the rule provide that credentialing and recredentialing be done within a 90-day period. This issue has been discussed previously, and an amendment is made.

The Association requests an amendment to subsection 7.1 emphasizing members' right ro availability and accessibility of services. As previously stated, this requirement is set forth in statute as a requirement for licensing and, therefore, no amendment is necessary. It is also requested that a provision be made for a member to have the right to receive an appropriate level of care from a provider of the member's choosing. It is a matter of statutory law that the member choose a primary care physician. The PCP is then to refer the member of a specialist as needed. See West Virginia Code § 33-25A-2(17).

The Association has requested language is subsection 7.2 which will protect individuals with special needs from being excluded from services due to their inability to provide information about themselves or follow through with recommended treatment. No explanation or justification has been given for the suggestion and the Commissioner does not understand the need for such language. No amendment to this section is, therefore, being made

It is also requested that language be added so that communications occur in a manner useful for members. While the commissioner has no objection to this suggestion, he feels that the requirement of the HMO to abide by federal and state laws (such as the ADA) should eliminate this concern. No amendment is, therefore, being made.

The Association feels that subdivision j of subsection 7.3 should be amended to provide additional safeguards for the appeals process, such as appeal to the Commissioner. This provision is a matter of statutory law and, therefore, it is unnecessary to reiterate this in the rule. See West Virginia Code § 33-25A-12,

Again, in section 9, the Association stresses the importance of protecting member confidentiality. This issue has been previously addressed and no amendment to this section is deemed necessary.

(6) A comment was received by Nidia Henderson, Government Relations Coordinator for the West Virginia Behavioral Healthcare Providers Association. The Association requests that the definition for "clinician" in subsection 2.4 be broadened. This issue has been previously addressed and no amendment is made.

The Association asks if it is the intent of the Department that the governing body of an HMO be an instate group. The composition of the governing body is determined by West Virginia Code § 33-25A-6. There is no requirement that the body be an instate group.

The Association also expresses concern about the definition of "health maintenance organization" and its referral to dental services. This issue has been discussed and the Commissioner does not feel an amendment is necessary. However, the Commissioner does agree with the comment that "it would be cumbersome and discouraging if a person with a chronic . . . . illness had to seek approval of the HMO's primary care physician every time he or she sought . . . . services." Therefore, the following language is added to section 7:

> 7.4 A health maintenance organization shall have a procedure by which a member, upon diagnosis with a life-threatening, degenerative or disabling condition or disease, either of which requires specialized health care over a prolonged period of time, shall receive a standing referral to a specialist with expertise in that condition or disease who will be responsible for and capable of providing and coordinating the member's specialty care. When a standing referral is made, the HMO shall periodically review the referral for continued necessity.

The Association questions the definition of "member" in subsection 2.11. The Commissioner points out that this is the statutory definition contained in West Virginia Code § 33-25A-2(8) and, therefore, no amendment is warranted.

It is questioned whether the term "practice guidelines" as defined in subsection 2.13 is intentionally vague. This definition was drafted in accordance with the standards of a national accreditation and review organization. The Commissioner intends this term to be broad.

The Association suggests that subdivision c of subsection 3.1 should make reference to reasonable travel distance and waiting times for services. As previously mentioned, availability and accessibility of providers is provided for by statute and is a condition for licensure. Subsection 3.1 already provides for the delivery of care in a timely manner. The Commissioner, therefore, does not feel that an amendment to this subsection is necessary.

The Association suggests that section 4 be amended to provide specific language regarding the provision and payment of emergency medical services. This issue has previously been addressed. Provisions regarding emergency medical services are contained in 114CSR50. No amendment to this rule is, therefore, necessary.

In subsection 4.5, the Association suggests that additional language be added to prohibit the practice of provider reimbursement in relation to service denials. This issue has been discussed previously and the proper amendment has been made.

In subsection 4.6, the Association is concerned regarding the confidentiality of medical records. This issue has been addressed and the Commissioner does not feel any amendment to this subsection is warranted.

The Association suggests that the language in subsection 5.1 should include consumer representative, medical ethicists and other stockholders. This issue has been addressed previously and no amendment is warranted.

The Association again expresses its concern for confidentiality of medical records in relation to the provisions of subsection 5.4. This issue has been addressed and the Commissioner sees no need for any amendment to this subsection.

The Association questions the method in which members are to be notified of opportunities to participate in and offer suggestions on quality improvement. This issue has been addressed previously.

It is requested that "patient outcomes" be added to subsection 5.6. This has been previously suggested and the recommended amendment has been made.

In subsection 7.1, the Association suggests language addressing the needs of persons with disabilities. This issue has been addressed previously and the Commissioner does not feel that an amendment is necessary given required adherence to state and federal laws, such as the ADA.

The Association expresses concern that subsection 7.2 does not address situations where patients are desirous of altering the course of treatment. This issue has been discussed previously and the Commissioner make no amendment to this subsection.

Again, in subsection 9, the Association expresses concern about member confidentiality. This issue has been addressed and no amendment is needed.

(7) A comment was received from Mimmie H. Byrne, President of the West Virginia Chapter of the National Association of Social Workers. Ms. Bryne makes several suggestions without any explanation or rationale as to why these

changes are necessary. Most of these suggestions have been discussed previously and no amendments to the rule were required. The Commissioner has reviewed the remaining suggestions and does not feel any amendments are warranted.

(8) Identical comments were received rom Mimmie Byrne, Pamela Sullivan, Richard M. Goldman of behalf of the West Virginia Coalition of Professional Associations, and Mr. Goldman on behalf of the Licensed Professional Counselors Association. These organizations make suggestions regarding subsections 2.2, 2.4, 2.9, 2.13, 2.14, 2.17, 3.1, 4.3, 4.6, 5.1, 5.2, 5.4, 5.5, 5.6, 5.8, 6.1, 6.2, 7.1, 7.2 and 7.3 which have been previously discussed and the Commissioner does not feel that any amendments to these provisions are necessary.

With regard to subsection 4.5, these organizations are concerned with the prohibition against financial incentives to deny medical services. This issue has been addressed and the proper amendment has been made.

The organizations suggest an amendment to subsection 5.2, but provide no explanation why they feel the proposed language is needed. The Commissioner does not understand the need for this additional language and, therefore, no amendment is being made.

The organizations suggest an amendment to subsection 5.7 which has already been addressed and the appropriate language added.

It is suggested that subdivision d of subsection 6.3 be amended to include the phrase "or appropriate graduate school." The Commissioner is in agreement with this suggestion and amends subdivision d of subsection 6.3 to read as follows:

> d. graduation from medical school <u>or appropriate graduate school</u> and completion of a residency, specialty training and board certification, as applicable.

It is also suggested that subdivision c of subsection 6.8 be amended to specifically include certain boards. The Commissioner does not feel this amendment is necessary since the requirement is not limited to those boards specifically named, "the appropriate State licensing boards **such as**. . . . . " (Emphasis added.)

The organizations also have questions regarding the policies and procedures for reducing, suspending or terminating practitioner privilege. The rule merely requires the HMO to develop and have in place such policies and procedures. The policies and procedures will then be reviewed by the accreditation and review organization and the Commissioner to determine their adequacy.

The organizations also question the provision of grievance procedures in subdivision a, subsection 7.1. This procedure is more fully explained in West Virginia Code § 33-25A-12 and does not need to be reproduced in the rule.

Finally, it is suggested that section 9 be more fully developed, but no suggestions have been made. The Commissioner feels that this section is adequate and makes no amendment at the present time.

COALITION OF PROFESSIONAL ASSOCIATIONS
COPA
OF MENTAL HEALTH PROVIDERS OF WEST VIRGINIA
WV Psychiatric Association
WV Psychological Association
WV Nursing Association
WV Licensed Prof'l Counselors Assoc.
National Association of Social Workers
WV Chapter

MIMMIE BURNS, ASSOC. PROF., WVU BEHAV. MEDICINE, 930 CHESTNUT RIDGE RD., MORGANTOWN, WV 26505 (304) 293-2411

Donna S. Quesenberry, Associate Counsel
Attention: Legal Division
Offices of the Insurance Commissioner
P.O. Box 50540
Charleston, WV 25305-0540

RE: 114CSR53, Legislative Rules on Quality Assurance

Dear Mrs. Quesenberry:

The Steering Committee of the West Virginia Coalition of Professional Associations of Mental Health Care Providers (COPA) commends you and your office for proposing the above-mentioned Legislative Rules on Quality Assurance. We view your effort toward furthering the Rules on Quality Assurance as generally promoting the health and safety of the people of West Virginia and, specifically, as protection of its patients.

The member organizations of COPA , the WV Psychiatric Association, WV Psychological Association, National Association of Social Workers-WV Chapter, WV Psychiatric Association, WV Licensed Professional Counselors Association, and the Appalachian Art Therapy Association), feel that mental health services are as available with the same degree of access and duration as physical health services.

We also feel that it is important that avenues of appeal regarding HMO actions be directed to authorities which exist outside the HMO umbrella. We feel that this is especially necessary when it involves questions about the course of treatment.

We appreciate the opportunity that you offer for providing input regarding this matter. The following comments include many of our concerns, but due to the short preparation time allowed for this letter is not all-inclusive. On a point-by-point basis:

§ 114-53-2 Definitions

2.2 Who sets the standards and determines the "appropriateness"?
2.4 "Clinician" might also include a Licensed Professional Counselor and a Licensed Clinical Social Worker?
2.9 HMO might include mental health services along with health services?
2.9a Also might include mental health services along with health services?
2.9b Might be written "Primarily provides physicians' and other health and mental health care licensed providers services."
2.13 Perhaps could be more specific by citing a national, standard source as basis for establishing the protocols?
2.14 Provider should include Psychologist, Licensed Professional Counselor, and Licensed Clinical Social Worker.
2.17 Designed by whom? Any requirement for non-HMO input?

§ 114-53-3 Goals of a Quality Assurance Program

3.1c Might it also provide for "geographically accessible" care, especially in rural areas?
3.1e As a suggested addition that would provide for a fair, open, and standardized credentialing process.

§ 114-53-4 Requirements of a Quality Assurance Program

4.3a3 A 90 day limit on a standardized credentialing and recredentialing might be established.
4.5 "No HMO may place any restrictions, *financial or otherwise*, upon any provider....(no-gag order)...
4.6 Need stronger protection and delineated sanctions.

§ 114-53-5 Quality Management and Improvement

5.1d The committee might include non-HMO members, such as consumer advocates and professionals who might be able to more objectively monitor quality and ethical issues.
5.2 The quality improvement shall be accountable to the governing body of the HMO *for meeting a given established appropriate standard.*
*5.2e Assure all notification, review and treatment decisions are made by persons who possess the appropriate levels of training and credentialing in their specialty.*
5.4 Must (a) provide for patient confidentiality and (b) call for provider's ability to communicate *and provide* appropriate care.
5.5b Specifically, how will this be accomplished?
5.6 ....criteria that are based on reasonable scientific evidence *and professional ethics.* Sanctions?
*5.6c Guidelines shall prioritize member well-being over cost.*
*5.7e* An HMO shall develop and implement mechanisms for:.....*Patient Outcomes.*
5.8 Standards need to address mental health/physical health parity. It also must protect high-risk persons to remain eligible for services.

§ 114-53-6 Credentialing and Recredentialing

6.1 An HMO shall ensure that its network has sufficient numbers and types of providers *geographically distributed in each area of the state in which it offers services (especially the rural areas).*
6.2 A standardized credentialing and recredentialing form should be developed and utilized.
*6.2c The credentialing/recredentialing process should be limited to 90 days.*
6.3d graduation from medical *or appropriate graduate* school.....
6.5 ....the appropriate State licensing boards such as the Board of Medicine, Chiropractic Board, Osteopathic Board, *Psychology Board, Social Work Board, Board of Examiners in Counseling,* and/or Dental Board;
6.8c ..... Board of Medicine, Chiropractic Board, Osteopathic Board, *Psychology Board, Social Work Board, Board of Examiners in Counseling,* and/or Dental Board;
6.8f Specifically, how is this established and by whom?
6.8f2 Specifically, to whom?

§ 114-53-6 Members' Rights and Responsibilities

7.1 (a) Availability of accessible service (especially in rural areas) and (b) the right to receive an appropriate level of care from a provider of the member's choosing.
7.1a To whom and with what sanctions for the HMO?
7.2 (a) What about protecting members with special needs and their inability to follow-thru?
(b) What about protecting member who do not follow a specialty recommendation?
7.3j Provide additional safeguard for the appeals process, for example, adding....*as well as appealing the HMO decision to the WV Insurance Commissioner or an independent arbitration committee as to which treatment shall be covered.*

§ 114-53-9 Medical Records

This is an area of utmost concern and must be developed significantly.

Confidentiality, access to care for physical and mental health, appropriate mechanism for redress, and an open relationship between provider and patient/client/member highlight many of our concerns. Although there are other concerns that we did not fully have the time to examine and comment on, we hope that you will keep the forum open for both our reported and unreported issues regarding these Legislative Rules.

Sincerely,

Minnie Byrne, National Association of Social Workers
Speaker-Elect, Steering Committee, WV-COPA

COALITION OF PROFESSIONAL ASSOCIATIONS
C O P A
OF MENTAL HEALTH PROVIDERS OF WEST VIRGINIA
WV Psychiatric Association
WV Psychological Association
WV Nursing Association
WV Licensed Profl. Counselors Assoc.
National Association of Social Workers WV Chapter

PAMELA SULLIVAN, M.D., ASSOC. PROF. OF PSYCHIATRY, 930 CHESTNUT RIDGE RD., MORGANTOWN, WV 26505 (304) 293-2411

Donna S. Quesenberry, Associate Counsel
Attention: Legal Division
Offices of the Insurance Commissioner
P.O. Box 50540
Charleston, WV 25305-0540

RE: 114C5R63, Legislative Rules on Quality Assurance

Dear Mrs. Quesenberry:

The Steering Committee of the West Virginia Coalition of Professional Associations of Mental Health Care Providers (COPA) commends you and your office for proposing the above-mentioned Legislative Rules on Quality Assurance. We view your effort toward furthering the Rules on Quality Assurance as generally promoting the health and safety of the people of West Virginia and, specifically, as protection of its patients.

The member organizations of COPA , the WV Psychiatric Association, WV Psychological Association, National Association of Social Workers-WV Chapter, WV Psychiatric Association, WV Licensed Professional Counselors Association, and the Appalachian Art Therapy Association), feel that mental health services are as available with the same degree of access and duration as physical health services.

We also feel that it is important that avenues of appeal regarding HMO actions be directed to authorities which exist outside the HMO umbrella. We feel that this is especially necessary when it involves questions about the course of treatment.

We appreciate the opportunity that you offer for providing input regarding this matter. The following comments include many of our concerns, but due to the short preparation time allowed for this letter is not all-inclusive. On a point-by-point basis:

§ 114-55-2 Definitions

2.2 Who sets the standards and determines the "appropriateness"?
2.4 "Clinician" might also include a Licensed Professional Counselor and a Licensed Clinical Social Worker?
2.9 HMO might include mental health services along with health services?
2.9a Also might include mental health services along with health services?
2.9b Might be written "Primarily provides physicians' and other health and mental health care licensed providers services."
2.13 Perhaps could be more specific by citing a national, standard source as basis for establishing the protocols?
2.14 Provider should include Psychologist, Licensed Professional Counselor, and Licensed Clinical Social Worker.
2.17 Designed by whom? Any requirement for non-HMO input?

§ 114-55-3 Goals of a Quality Assurance Program

3.1c Might it also provide for "geographically accessible" care, especially in rural areas?
3.1e As a suggested addition that would provide for a fair, open, and standardized credentialing process.

§ 114-55-4 Requirements of a Quality Assurance Program

4.5a3 A 90 day limit on a standardized credentialing and recredentialing might be established.
4.5 "No HMO may place any restrictions, *financial or otherwise*, upon any provider....(no-gag order)...
4.6 Need stronger protection and delineated sanctions.

§ 114-58-5 Quality Management and Improvement

5.1d The committee might include non-HMO members, such as consumer advocates and professionals who might be able to more objectively monitor quality and ethical issues.
5.2 The quality improvement shall be accountable to the governing body of the HMO *for meeting a given established appropriate standard.*
*5.2e Ensure all notification, review and treatment decisions are made by persons who possess the appropriate levels of training and credentialing in their specialty.*
5.4 Must (a) provide for patient confidentiality and (b) call for provider's ability to communicate *and provide* appropriate care.
5.6b Specifically, how will this be accomplished?
5.6 ....criteria that are based on reasonable scientific evidence *and professional ethics.* Sanctions?
*5.6c Guidelines shall prioritize member well-being over cost.*
5.7e An HMO shall develop and implement mechanisms for:.....*Patient Outcomes.*
5.8 Standards need to address mental health/physical health parity. It also must protect high-risk persons to remain eligible for services.

§ 114-58-6 Credentialing and Recredentialing

6.1 An HMO shall ensure that its network has sufficient numbers and types of providers *geographically distributed in each area of the state in which it offers services (especially the rural areas).*
6.2 A standardized credentialing and recredentialing form should be developed and utilized.
*6.2c The credentialing/recredentialing process should be limited to 90 days.*
6.8d graduation from medical *or appropriate graduate* school.....
6.8 ....the appropriate State licensing boards such as the Board of Medicine, Chiropractic Board, Osteopathic Board, *Psychology Board, Social Work Board, Board of Examiners in Counseling,* and/or Dental Board;
6.8e ..... Board of Medicine, Chiropractic Board, Osteopathic Board, *Psychology Board, Social Work Board, Board of Examiners in Counseling,* and/or Dental Board;
6.8f Specifically, how is this established and by whom?
6.8f2 Specifically, to whom?

§ 114-58-6 Members' Rights and Responsibilities

7.1 (a) Availability of accessible service (especially in rural areas) and (b) the right to receive an appropriate level of care from a provider of the member's choosing.
7.1a To whom and with what sanctions for the HMO?
7.2 (a) What about protecting members with special needs and their inability to follow-thru?
(b) What about protecting member who do not follow a specialty recommendation?
7.3j Provide additional safeguard for the appeals process, for example, adding....*as well as appealing the HMO decision to the WV Insurance Commissioner or an independent arbitration committee as to which treatment shall be covered.*

§ 114-58-9 Medical Records

This is an area of utmost concern and must be developed significantly.

Confidentiality, access to care for physical and mental health, appropriate mechanism for redress, and an open relationship between provider and patient/client/member highlight many of our concerns. Although there are other concerns that we did not fully have the time to examine and comment on, we hope that you will keep the forum open for both our reported and unreported issues regarding these Legislative Rules.

Sincerely,

Pamela Sullivan, M.D., Steering Committee, COPA
President, West Virginia Psychiatric Association

WEST VIRGINIA LICENSED PROFESSIONAL COUNSELORS ASSOCIATION

Dr. Richard M. Goldman
Immediate Past President
Chair, Government Relations

ONE DOGWOOD LANE ST. GEORGE, WV 26290
(304) 478 - 4842 FAX: 478 - 4906 DRGOLDMAN@AOL.COM

Donna S. Quesenberry, Associate Counsel
Attention: Legal Division
Offices of the Insurance Commissioner
P.O. Box 50540
Charleston, WV 25305-0540

RE: 114CSR53, Legislative Rules on Quality Assurance

Dear Mrs. Quesenberry:

The Board of Directors of the West Virginia Licensed Professional Counselors Association, formerly the WV Mental Health Counselors Association, commends you and your office for proposing the above-mentioned Legislative Rules on Quality Assurance. We view your effort toward furthering the Rules on Quality Assurance as generally promoting the health and safety of the people of West Virginia and, specifically, as protection of its patients.

In accord with our fellow members of WV COPA (The Coalition of Professional Associations of Mental Health Care Providers: WV Psychiatric Association, WV Psychological Association, National Association of Social Workers- WV, WV Psychiatric Association, WV Licensed Professional Counselors Association, and the Appalachian Art Therapy Association), we feel that mental health services are as available with the same degree of access and duration as physical health services.

We also feel that it is important that avenues of appeal regarding HMO actions be to authorities which exist outside the HMO umbrella. We feel that this is especially necessary when it involves questions about the course of treatment.

We appreciate the opportunity that you offer for providing input regarding this matter. The following comments include many of our concerns, but due to the short preparation time allowed for this letter is not all-inclusive. On a point-by-point basis:

§ 114-53-2 Definitions

2.2 Who sets the standards and determines the "appropriateness"?
2.4 "Clinician" might also include a Licensed Professional Counselor and a Licensed Clinical Social Worker?
2.9 HMO might include mental health services along with health services?
2.9a Also might include mental health services along with health services?
2.9b Might be written 'Primarily provides physicians' and other health and mental health care licensed providers services:"
2.13 Perhaps could be more specific by citing a national, standard source as basis for establishing the protocols?
2.14 Provider should include Psychologist, Licensed Professional Counselor, and Licensed Clinical Social Worker.
2.17 Designed by whom? Any requirement for non-HMO input?

§ 114-53-3 Goals of a Quality Assurance Program

3.1c Might it also provide for "geographically accessible" care, especially in rural areas?
3.1e As a suggested addition that would provide for a fair, open, and standardized credentialing process.

§ 114-53-4 Requirements of a Quality Assurance Program

4.3a3 A 90 day limit on a standardized credentialing and recredentialing might be established.
4.5 "No HMO may place any restrictions, *financial or otherwise*, upon any provider....(no-gag order)...
4.6 Need stronger protection and delineated sanctions

§ 114-58-5 Quality Management and Improvement

5.1d The committee might include non-HMO members, such as consumer advocates and professionals who might be able to more objectively monitor quality and ethical issues.
5.2 The quality improvement shall be accountable to the governing body of the HMO *for meeting a given established appropriate standard.*
*5.2e Assure all notification, review and treatment decisions are made by persons who possess the appropriate levels of training and credentialing in their specialty.*
5.4 Must (a) provide for patient confidentiality and (b) call for provider's ability to communicate *and provide* appropriate care.
5.5b Specifically, how will this be accomplished?
5.6 ....criteria that are based on reasonable scientific evidence *and professional ethics.* Sanctions?
*5.6c Guidelines shall prioritize member well-being over cost.*
*5.7e* An HMO shall develop and implement mechanisms for:.....*Patient Outcomes.*
5.8 Standards need to address mental health/physical health parity. It also must protect high-risk persons to remain eligible for services.

§ 114-58-6 Credentialing and Recredentialing

6.1 An HMO shall ensure that its network has sufficient numbers and types of providers *geographically distributed in each area of the state in which it offers services (especially the rural areas).*
6.2 A standardized credentialing and recredentialing form should be developed and utilized.
*6.2c The credentialing/recredentialing process should be limited to 90 days.*
6.3d graduation from medical *or appropriate graduate* school.....
6.5 ....the appropriate State licensing boards such as the Board of Medicine, Chiropractic Board, Osteopathic Board, *Psychology Board, Social Work Board, Board of Examiners in Counseling,* and/or Dental Board;
6.8c ..... Board of Medicine, Chiropractic Board, Osteopathic Board, *Psychology Board, Social Work Board, Board of Examiners in Counseling,* and/or Dental Board;
6.8f Specifically, how is this established and by whom?
6.8f2 Specifically, to whom?

§ 114-58-6 Members' Rights and Responsibilities

7.1 (a) Availability of accessible service (especially in rural areas) and (b) the right to receive an appropriate level of care from a provider of the member's choosing.
7.1a To whom and with what sanctions for the HMO?
7.2 (a) What about protecting members with special needs and their inability to follow-thru?
(b) What about protecting member who do not follow a specialty recommendation?
7.3j Provide additional safeguard for the appeals process, for example, adding....*as well as appealing the HMO decision to the WV Insurance Commissioner or an independent arbitration committee as to which treatment shall be covered.*

§ 114-58-8 Preventive Health Services 8.1e9 Add *Cancer* to HIV Counseling

§ 114-58-9 Medical Records This is an area of utmost concern and must be developed significantly.

Confidentiality, access to care for physical and mental health, appropriate mechanism for redress, and an open relationship between provider and patient/client/member highlight many of our concerns. Although there are other concerns that we did not fully have the time to examine and comment on, we hope that you will keep the forum open for both our reported and unreported issues regarding these Legislative Rules.

Sincerely,

Richard M. Goldman, DDS, MA, LPC, NCC, RTC.
Past-President, Licensed Professional Counselors Association
Chairman, Government Relations Committee

COALITION OF PROFESSIONAL ASSOCIATIONS
COPA
OF MENTAL HEALTH PROVIDERS OF WEST VIRGINIA
WV Psychiatric Association
WV Psychological Association
WV Nursing Association
WV Licensed Prof'l. Counselors Assoc.
National Association of Social Workers
WV Chapter

Dr. Richard M. Goldman, Speaker One Dogwood Lane St. George, WV 26290 (304) 478 - 4842 Fax: 478 - 4906 drgoldman@sol.com

Donna S. Quesenberry, Associate Counsel
Attention: Legal Division
Offices of the Insurance Commissioner
P.O. Box 50540
Charleston, WV 25305-0540

RE: 114CSR53, Legislative Rules on Quality Assurance

Dear Mrs. Quesenberry:

The Steering Committee of the West Virginia Coalition of Professional Associations of Mental Health Care Providers (COPA) commends you and your office for proposing the above-mentioned Legislative Rules on Quality Assurance. We view your effort toward furthering the Rules on Quality Assurance as generally promoting the health and safety of the people of West Virginia and, specifically, as protection of its patients.

The member organizations of COPA , the WV Psychiatric Association, WV Psychological Association, National Association of Social Workers-WV Chapter, WV Psychiatric Association, WV Licensed Professional Counselors Association, and the Appalachian Art Therapy Association), feel that mental health services are as available with the same degree of access and duration as physical health services.

We also feel that it is important that avenues of appeal regarding HMO actions be directed to authorities which exist outside the HMO umbrella. We feel that this is especially necessary when it involves questions about the course of treatment.

We appreciate the opportunity that you offer for providing input regarding this matter. The following comments include many of our concerns, but due to the short preparation time allowed for this letter is not all-inclusive. On a point-by-point basis:

§ 114-53-2 Definitions

2.2 Who sets the standards and determines the "appropriateness"?
2.4 "Clinician" might also include a Licensed Professional Counselor and a Licensed Clinical Social Worker?
2.9 HMO might include mental health services along with health services?
2.9a Also might include mental health services along with health services?
2.9b Might be written "Primarily provides physicians' and other health and mental health care licensed providers services:"
2.13 Perhaps could be more specific by citing a national, standard source as basis for establishing the protocols?
2.14 Provider should include Psychologist, Licensed Professional Counselor, and Licensed Clinical Social Worker.
2.17 Designed by whom? Any requirement for non-HMO input?

§ 114-53-3 Goals of a Quality Assurance Program

3.1c Might it also provide for "geographically accessible" care, especially in rural areas?
3.1e As a suggested addition that would provide for a fair, open, and standardized credentialing process.

§ 114-53-4 Requirements of a Quality Assurance Program

4.3a3 A 90 day limit on a standardized credentialing and recredentialing might be established.
4.5 "No HMO may place any restrictions, *financial or otherwise*, upon any provider....(no-gag order)...
4.6 Need stronger protection and delineated sanctions.

§ 114-58-5 Quality Management and Improvement

5.1d The committee might include non-HMO members, such as consumer advocates and professionals who might be able to more objectively monitor quality and ethical issues.
5.2 The quality improvement shall be accountable to the governing body of the HMO *for meeting a given established appropriate standard.*
*5.2e Assure all notification, review and treatment decisions are made by persons who possess the appropriate levels of training and credentialing in their specialty.*
5.4 Must (a) provide for patient confidentiality and (b) call for provider's ability to communicate *and provide* appropriate care.
5.5b Specifically, how will this be accomplished?
5.6 ....criteria that are based on reasonable scientific evidence *and professional ethics.* Sanctions?
*5.6c Guidelines shall prioritize member well-being over cost.*
*5.7e* An HMO shall develop and implement mechanisms for:.....*Patient Outcomes.*
5.8 Standards need to address mental health/physical health parity. It also must protect high-risk persons to remain eligible for services.

§ 114-58-6 Credentialing and Recredentialing

6.1 An HMO shall ensure that its network has sufficient numbers and types of providers *geographically distributed in each area of the state in which it offers services (especially the rural areas).*
6.2 A standardized credentialing and recredentialing form should be developed and utilized.
*6.2c The credentialing/recredentialing process should be limited to 90 days.*
6.3d graduation from medical *or appropriate graduate* school.....
6.5 ....the appropriate State licensing boards such as the Board of Medicine, Chiropractic Board, Osteopathic Board, *Psychology Board, Social Work Board, Board of Examiners in Counseling,* and/or Dental Board;
6.8c ..... Board of Medicine, Chiropractic Board, Osteopathic Board, *Psychology Board, Social Work Board, Board of Examiners in Counseling,* and/or Dental Board;
6.8f Specifically, how is this established and by whom?
6.8f2 Specifically, to whom?

§ 114-58-6 Members' Rights and Responsibilities

7.1 (a) Availability of accessible service (especially in rural areas) and (b) the right to receive an appropriate level of care from a provider of the member's choosing.
7.1a To whom and with what sanctions for the HMO?
7.2 (a) What about protecting members with special needs and their inability to follow-thru?
(b) What about protecting member who do not follow a specialty recommendation?
7.3j Provide additional safeguard for the appeals process, for example, adding....*as well as appealing the HMO decision to the WV Insurance Commissioner or an independent arbitration committee as to which treatment shall be covered.*

§ 114-58-9 Medical Records

This is an area of utmost concern and must be developed significantly.

Confidentiality, access to care for physical and mental health, appropriate mechanism for redress, and an open relationship between provider and patient/client/member highlight many of our concerns. Although there are other concerns that we did not fully have the time to examine and comment on, we hope that you will keep the forum open for both our reported and unreported issues regarding these Legislative Rules.

Sincerely,

Richard M. Goldman, DDS, MA, LPC, NCC, RTC.
Speaker, Steering Committee, COPA

cc: Minnie Byrne, President, WV National Association of Social Workers
Dr. Pam Sullivan, President, WV Psychiatric Association
Dr. Betsy Evans, President-Elect, WV Psychological Association
Ann Haynes, President, WV Psychiatric Nurses Association

West Virginia Behavioral Healthcare Providers
ASSOCIATION



July 24, 1997

Donna S. Quesenberry, Associate Counsel
Legal Division
Office of the Insurance Commissioner
P.O. Box 50540
Charleston, WV 25305-0540

Dear Ms. Quesenberry:

Please accept the following as comments on the proposed rules in the Series 53, relating to Quality Assurance standards with Health Maintenance Organizations. We thank you in advance for your consideration.

First, we'd like to commend your office for proposing such rules, as they will help to set a standard at a crucial period in the health care delivery system as the expansion of HMO's continues, both relative to private and public sector patients. While West Virginia has been slow compared to other states in this regard, the trend still indicates that the growth will continue, particularly as more Medicaid patients are enrolled.

Given the fact that HMOs are now predominately for profit organizations, and that they have a strong incentive to control costs, without proper oversight and controls, many consumers could suffer from the denial of medically necessary services.

With that said, let me offer these specific comments:

1) In the Definition section, 114-53-2, 2.4, we are concerned that the definition of clinician is too narrowly defined excluding such practitioners as physician assistants, nurses, chiropractors, podiatrists, acupuncturists (who are now licensed in the state), social workers, drug and alcohol abuse counselors, occupational therapists, physical therapists, etc. We would suggest language that is in conformity with the states' policies and practice (Medicaid, PEIA, etc.) recognizing other legitimate provider groups. To do otherwise could preclude many recipients of HMO services, particularly persons with disabilities, from receiving medically necessary services.

2) 2.8, Governing Body, is it the intent of your department that this be an instate group?

8 Capitol Street, Suite 600 Charleston, West Virginia 25301 304•343•0728

3) 2.9, d, we have concerns that this language practically precludes the ability of a HMO from subcontracting for specialty services other than dental. It would be cumbersome and discouraging if a person with chronic mental illness had to seek the approval of the HMO's primary care physician every time he or she sought mental health services. As you may know, there are thousands of West Virginians who depend on the routine care behavioral health providers deliver which enable them to live successfully in the community.

4) 2.11, we question if the term "voluntarily enrolled" is intentional in light of developments in Congress?

5) 2.13, do you mean to leave practice guidelines vague or refer to nationally recognized standards? For example, a reliable and objective source can be found in the U.S. Agency for Health Care Policy and Research.

6) Section 114-53-3, 3.1c, should not reference be made to reasonable travel distances and waiting times for services?

7) Section 114-53-4, Requirements of a Quality Assurance Program, we believe this should have very specific language relative to the provision and payment of emergency medical services.

8) 4.5, we strongly support this language, but would suggest that in addition to this "no gag rule", that additional language would be adopted prohibiting the practice of provider reimbursement in any way being related to service denials.

9) 4.6 regarding the confidentiality of medical records, we suggest that this language further delineate that in matters involving disclosure of records, that only those portions of the record be released pursuant to law, and not the entire medical record.

10) Section 114-53-5, 5.1, d, should not this committee include consumer representatives, medical ethicists, and other stakeholders?

11) 5.4, again we have concerns relative to the confidentiality of medical records. Health care contractors should not be required to release a patients medical records in total, only the relevant sections. The last sentence of 5.4 should also address policies regarding provider ability to treat appropriately, as well as addressing the issue of freely giving advise.

12) 5.5 b, how are members to be notified of such opportunities and through what forums may they have input?

13) 5.6, it would be appropriate to add a section relevant to patient outcomes.

14) 7.1, absent here is language addressing the needs of persons with disabilities.

TDD services must be available, information on audio tape, braille, etc. A thorough review of this section in relation to compliance with the Americans with Disabilities Act would be helpful. Furthermore, it would be appropriate to ensure compliance with other civil rights statutes in this section.

15)7.2 This language is troubling in that it does not address situations where patients are desirous of altering the course of their treatment.

16)7.3, again this entire section should be reviewed to comply with the ADA.

17) Section 114-53-9, Medical Records, we reiterate extreme caution here in relation to only those relevant records being released pursuant to state and federal laws. We further urge, in concert with the recent debate in Washington and pronouncements from President Clinton, that discrimination based upon genetic testing be prohibited.

Ms. Quesenberry, these comments are far from exhaustive but we hope will provide some assistance to you and the Department as you proceed on this very important project.

Sincerely yours,

Nidia

Nidia Henderson
Government Relations Coordinator

HIAA
Health Insurance Association of America



July 23, 1997

Ms. Donna S. Quesenberry
Associate Counsel, Legal Division
Department of Insurance
Post Office Box 50540
Charleston, West Virginia 25305-0540

RE Proposed Regulations Title 114, Series 53
Quality Assurance

Dear Ms. Quesenberry:

On behalf of the Health Insurance Association of America (HIAA), I appreciate the opportunity to provide comments on the above-referenced proposed regulations. The HIAA is a leading national trade association representing more than 200 health insurance companies nationwide. Together, HIAA member companies provide high-quality health services for the nation.

**Section 114-53-2.9 (d) Definitions/ Health Maintenance Organization**
Among other things, ties dental plans to health maintenance organization regulations. HIAA believes that dental plans are separate products and subject to separate regulations. It should also be noted, that some dental plans are fee for service add-ons.

**Section 114-53-4.1 Quality Assurance Program/Federal Requirements**
HIAA has concerns with this section which requires a health maintenance organization to develop a quality assurance program which adheres to all applicable state and federal laws, federal regulations and state rules. Specifically, HIAA has concerns with state jurisdiction over mandating enforcement of federal laws.

**Section 114-53-4.2 (a) Quality Assurance Program/Filing Requirements**
Requires a health maintenance organization to file notice with the commissioner prior to any modification of the quality assurance program. HIAA respectfully requests that the Department insert the word "material" before the word modification. By inserting the word "material" it would eliminate unnecessary and burdensome filings.

**Section 114-53-4.3 (a) Quality Assurance Program/Components**
The language as currently drafted, implies that "quality assurance" and "utilization review" are the same. HIAA believes that these sections should be redrafted, so that the two terms are not interchanged.

**Section 114-53-4.3 (c) Quality Assurance Programs/Public Health Agencies**
Provides that guidelines concerning public health related activities shall be developed by HMO's to ensure the ongoing cooperation and/or collaboration with state and local health agencies. HIAA does not believe that HMOs are public health agencies, and therefore, should not be subject to public health agency guidelines and principals.

**Section 114-53-4.5 Quality Assurance/Communication**
This section states that: "an HMO may not prevent any provider from advising an enrollee whether or not a treatment is covered by the plan." HIAA believes that coverage is an Administrative issue, not a medical issue and physicians' communications should not bind the HMO to any coverage or promise of coverage. HIAA respectfully suggests that the Department strike this sentence from this section. In addition, HIAA respectfully requests that the Department strike the phrase "options available to the member."

**Section 114-53-5 Quality Management & Improvement**
HIAA respectfully requests clarification on how quality assurance differs from quality management.

**Section 114-53-5.1 (c) Quality Management & Improvement/Medical Director**
Provides that a medical director shall be employed full-time and will have substantial involvement in quality improvement activities. HIAA does not feel that this section is necessary. Frequently, someone other than the medical director performs utilization review and quality review functions.

**Section 114-53-5.1 (g) Quality Management & Improvement/Work Plan**
Provides that a written quality improvement work plan be prepared annually and shall include: the objectives, scope and planned projects or activities for the year; planned monitoring of previously identified issues, including tracking of issues over time; and planned evaluation of the quality improvement program. HIAA does not feel that plan information should be made public for all other plans to review or have access to review. Therefore, HIAA respectfully requests that these requirements be amended to allow for plan information to be considered confidential and proprietary.

**Section 114-53-5.2 Quality Management & Improvement/Organizational Structures**
HIAA has concerns with this section which provides that the quality improvement committee shall be accountable to the governing body of a health maintenance organization. Specifically, HIAA does not feel that organization structures should be regulate.

**Section 114-53-5.2 (d) Quality Management & Improvement/Information**
Provides that all quality assurance information shall be used in recredentialing, recontracting and/or annual performance evaluations. HIAA respectfully suggests that the Department strike the work "all" and substitute "appropriate."

**Section 114-53-5.3 (b) Quality Management & Improvement/Management Functions**
Requires quality improvement to be linked with other management functions of the health maintenance organization such as network changes, benefits redesign, medical management systems, practice feedback to providers and patient education. HIAA respectfully suggests that the Department strike the phrase "benefits redesign."

**Section 114-53-5.4 Quality Management & Improvement/Provider-Patient Communication**
Among other things, requires contracts to specify that the HMO allow open provider-patient communication regarding appropriate treatment alternatives and that it does not penalize the provider for discussing medically necessary or appropriate care for the patient. HIAA respectfully requests that this sentence be clarified. The medical communications between a provider and his/her patient does not bend the Health Plan to coverage of all treatments discussed.

**Section 114-53-5.5 (b) Quality Management & Improvement/Member Participation**
Provides that members shall be afforded opportunities to participate in and offer suggestions on quality improvement. HIAA respectfully suggests that the Department strike the phrase "participate in."

**Section 114-53-6.3 Credentialing & Recredentialing/Deemer Rule**
Provides that in terms of initial credentialing, an HMO shall obtain and review verification of the sources specified. HIAA respectfully requests clarification on deemer rule when plan is credentialed by an outside accredited credentialing agency. Does the State of West Virginia have standard credentialing standards?

**Section 114-53-6.7 Credentialing & Recredentialing/Accrediting**
Requires among other things, that an HMO shall confirm that the health delivery organization has been reviewed and approved by a recognized accrediting body and is in good standing with state and federal regulatory bodies. Generally, accreditation by an HMO is voluntary. Also, HIAA respectfully requests that the Department clarify what is meant by the phrase "standards of participation."

**Section 114-53-7.3 (f) (g) (h) Members' Rights & Responsibilities/Bill of Rights**
Provides among other things, that all policies on members' rights and responsibilities shall be provided in writing in clear and concise terms to all members and participating providers and, at a minimum, shall address the following procedures for, polices concerning or information regarding: (f) special benefit provisions such, as co-payment, higher deductibles and rejection of claims, that may apply to service outside the system; (g) member charges; and (h) notification of termination or change in any benefits, services or delivery site/offices. HIAA respectfully suggests that the benefit provisions outline under subsection "f," "g," and "h" cannot be specifically woven into a general bill of rights because they can vary by membership category.

Thank you again for the opportunity to offer these comments.

With kindest regards, I am

Sincerely,

Amanda Matthiesen

Amanda Matthiesen
Assistant Legislative Director

cc: Randy Cox
Julie Garner
Ron Souders
Susan VanGelder

j:\doc\stat\akm\states\wv\series53\7-21.doc

July 25, 1997



Donna S. Quesenberry, Associate Counsel
Attention: Legal Division
Offices of the Insurance Commissioner
P. O. Box 50140
Charleston, WV 25305-0540

**RE: Title 114, Series 53, Quality Assurance**

Dear Ms. Quesenberry:

On behalf of the West Virginia Health Maintenance Organization Association ("WVHMOA"), I am submitting the comments below on the above-referenced proposed rule. The WVHMOA is a West Virginia association consisting of the following health maintenance organizations: Advantage Health, Carelink, Coventry, Health Plan, Optimum Choice and Prime One. The WVHMOA has limited comments regarding this proposed regulation.

In Section 3.1.a on page 4, the WVHMOA requests that the word "Assure" be changed to either "Encourage" or "Facilitate" to better define the role of the HMO.

In Subsection 4.3.c on page 6, the regulations provide that: "Guidelines concerning public health related activities shall be developed by HMO's to insure the ongoing cooperation and/or collaboration with state and local health agencies." While the regulations generally track the NCQA standards, this requirement is not contained in the NCQA standards. The Association has concerns about this requirement because it neither understands what this language requires an HMO to do, nor how it will be applicable to HMO's in the private sector, nor why it is necessary. Further, HMO's are not public health agencies. Accordingly, the WVHMOA asks that this provision be stricken from the regulations.

In Section 5.1.c on page 8, the regulations require that an HMO hire a full-time Medical Director. Start-up plans may not require a full time medical director and may be able to administer an effective quality assurance program with a part-time Medical Director. Accordingly, we suggest that the words "full time" be stricken.

In Section 5.2.d on page 9, the regulation provides that "All quality assurance information shall be used. . ." A concern this creates is that some of this information may not be creditable or should not be used. We would propose that this language be changed to the following: "All quality assurance information shall be considered. . ."

In Subsection 5.8 on page 11, the regulations require that "a health maintenance organization shall establish telephone appointments, advice and member service lines." Generally, the provider rather than the HMO will be responsible for making a subscriber's appointment with the provider. Likewise, the provider and not the HMO will provide advice to subscribers. Accordingly, the WVHMOA would ask that the language "telephone appointments, advice" be stricken from this subsection.

In Section 7.3 on page 17, the regulations seem to require that the HMO's provide a separate document to each member to include this information. Presently, this information may be incorporated into the Certificate of Coverage which is distributed to each member. By allowing the HMO's to incorporate this information into one document, it will be administratively easier, less costly, and will accomplish the same goals.

The regulations set forth comprehensive standards for quality assurance for HMO's. Further, W. Va. Code § 33-25A-17A(c) provides, in pertinent part:

> As a condition to doing business in this state, each health maintenance organization which has been in existence for at least three years shall apply for and submit to an accreditation examination to be performed by a nationally recognized accreditation review organization approved by the Commissioner. The accreditation review organization must be experienced in health maintenance organization activities and the appraisal of medical practice and quality assurance in a health maintenance organization setting. . .

Accordingly, an HMO must submit, among other things, its quality assurance program for review by a nationally recognized accreditation review organization after it has been in existence for at least three years. The regulations do not provide that if an HMO has obtained approval from a nationally recognized accreditation and review organization that the WVHMOA's quality assurance program is deemed to be in compliance with these regulations. We would request that the regulations provide that if an HMO has obtained approval from such an organization that its quality assurance program is deemed to be in compliance with these regulations.

If you have any questions, please do not hesitate to contact me at (304) 340-6947.

Sincerely,

WEST Virginia HEALTH MAINTENANCE
ORGANIZATION ASSOCIATION

By: John M. Collins, Chairman

5154

NASW
National Association of Social Workers
Charleston, West Virginia
TEL. (304) 345-NASW (6279)
FAX (304) 343-3295
E-MAIL: NASWWV@aol.com
WEST VIRGINIA CHAPTER

July 28, 1997

Donna S. Quesenberry, Associate Counsel
ATTN: Legal Division
Offices of the Insurance Commissioner
PO Box 50540
Charleston, WV 25305-0540

Dear Ms. Quesenberry:

Pursuant to the Legislative Rules on Quality Assurance, my concerns are as follows:

114-53-2
- 2.4 Add clinical social worker
- 2.9.b strike physician; add health, mental health and sometimes child welfare
- 2.9.b.1 strike physician, add provider
- 2.9.b.2. strike physician; add provider

114-53-3
- 1.a. strike medical; add health

114-53-5
- 1.d. A committee... include HMO providers *and consumers* as active participants
- Add h. The portion of the health care premiums spent on direct care shall be determined and made available to the Commissioner

114-53-6
- 6.2.b strike doctors; add clinicians. Also add: The training of the committee shall be similar to the training of those being credentialed.
- 6.3.d. after board certification add "or completion of a professional training program in preparation for independent clinical licensure."
- 6.3.i.Add: Credentialing applications shall be approved by the Commissioner.
- 6.4.b strike illegal drug use and alcohol abuse; add alcohol or drug dependency
- 6.8 Add: This verification of credentials should be in standard format approved by the Commissioner.
- 6.8.b. strike illegal drug use and alcohol abuse; add alcohol and drug dependency.

114-53-7
- 1.a. Add: Information about grievances to the Insurance Commissioner shall be provided.
- 3.j. Add : Appeal to an external body shall be provided.

I would like it noted that I have commented on these Rules. Thank you for reviewing my comments.

Sincerely,

Mimmie H. Byrne, President
WV Chapter
National Association of Social Workers

*West Virginia*
*Developmental Disabilities*
*Planning Council*

July 25, 1997

Donna S. Quesenberry, Assoc. Counsel
ATTN: Legal Division
Offices of the Insurance Commissioner
P.O. Box 50540
Charleston, WV 25305-0540

Dear Ms. Quesenberry:

Thank you for the opportunity to comment on the proposed standards for Series 53, Quality Assurances for health maintenance organizations.

The Developmental Disabilities Planning Council is aware of the growth in enrollment in health maintenance organizations in West Virginia. This means, of course, that more individuals with developmental and other disabilities are receiving their health care coverage through managed care entities. We commend the Insurance Commission on drafting standards for quality assurance. We would like to request your consideration of the following specific comments:

1. §114-53-2, 2.4: We are concerned that this definition may be too narrow. Other practitioners such as occupational and physical therapists, chiropractors, podiatrists, nurses, physician assistants, etc. should be included as well. We would like you to consider language which conforms to the state's policies and practice of recognizing other legitimate provider groups.

2. §114-53-2, 2.9.d: You may wish to broaden the category of subcontracting for specialty services other than dental. It could prove burdensome to some individuals with disabilities to seek the approval of their PCP each time they sought speciality care; i.e. mental health services, neurological services in the management of seizures or other chronic conditions.

3. §114-53-4, 4.3a: Please add several areas which should be considered as components of the quality assurance program: a written grievance procedure which is timely and effective for members; address the issue of reasonable travel time/distance from service delivery; and written policies and procedures for emergency services.

4. §114-53-4, 4.3.a.5: Please add "including habilitative services for mitigation of secondary disabilities and to reduce the impact of primary disability."

5. §114-53-4, 4.5: We strongly support this section, but would request that you add a component addressing the need to refer to specialists as on option that also may not be restricted. This is especially critical for individuals with developmental disabilities.

*110 Stockton Street, Charleston, WV 25312-2521*
*(304) 558-0416 (VOICE) ♦ (304) 558-2376 (TTD) ♦ (304) 558-0941 (FAX)*

6. §114-53-5, 5.1.d: We strongly encourage you to include subscribers on this committee, including at least one person with a disability.

7. §114-53-5, 5.5.b: How will members be afforded these opportunities to participate in and offer suggestions on quality improvement? This should be defined.

8. §114-53-5,5.5.c: We would ask you to consider the addition of "long-term care services" to the list of issues to be monitored and evaluated.

9. §114-53-5, 5.6: Please add "and best practices" after "reasonable scientific evidence" at the end of the first paragraph.

10. §114-53-5, 5.7: Please add "D. Assessing patient outcomes."

11. §114-53-7, 7.1: There is nothing in this section addressing the needs of people with disabilities: the availability of alternative formats, or TDD access. This section should be reviewed for compliance with the ADA and other appropriate state and federal regulations. We also suggest you consider the addition of a Patient Advocate in this section (similar to that provided through the Medicaid Managed Care program).

12. §114-53-7, 7.2: We feel you should also address the issue of a member request for a change in the course of treatment here.

13. §114-53-7, 7.3 and §114-53-8, 8.1.a also need to be reviewed for compliance with the Americans with Disabilities Act.

14. §114-53-9, 9.1.a: This section should also address the member's right to timely access to their own (or minor family member's) medical records.

Once again, thank you for the opportunity to comment on these crucial standards. We would appreciate it if you could send us a copy of the final version.

Sincerely,

Donna Z. Heuneman
Executive Director

# West Virginia Psychological Association, Inc.

POST OFFICE BOX 643 • SCOTT DEPOT, WEST VIRGINIA 25560 • (304) 757-0458 • FAX (304) 757-7675


July 24, 1997



Donna S. Quesenberry, Associate Counsel
ATTN: Legal Division
Offices of the Insurance Commissioner
P.O. Box 50540
Charleston, WV 25305-0540

RE: **114CSR53**, Legislative Rules on Quality Assurance

Dear Ms. Quesenberry:

The executive committee of the West Virginia Psychological Association would like to commend your office for proposing the above referenced quality assurance rules. We believe it is in the best interest of the citizens of West Virginia to assure the quality of health services, and applaud your efforts to seek ways to contain costs while not allowing financial incentives to be the sole determining factor in health care availability.

We believe it is also important to ensure that mental health services are available with the same ease of access and duration as physical health services, and to provide a method of appealing to an authority outside of the HMO itself when there is a question about the necessity of certain treatments.

Thank you for providing an opportunity to provide feedback regarding the proposed rules. Your consideration is appreciated and, although the following comments are far from exhaustive, we hope they will be useful.

114-53-2 Definitions

**2.2** "Appropriateness" -- the definition needs to include who is making the determination.
**2.4** "Clinician" -- definition may be too narrow to adequately serve some populations
**2.13** "Practice guidelines" -- The definition seems broad and vague. Perhaps it could reference some objective, nationally recognized source.
**2.14** "Provider" -- should include psychologist

114-53-3 Goals of a Quality Assurance Program

**3.1c.** This provision should include reasonable limits with regard to travel and/or time it takes to get to the service provider. For example, adding "and assuring members shall not have to travel over 40 minutes to receive basic health care services."

Consider adding 3.1 e : Provide for a fair and open credentialing process

114-53-4 Requirements of a Quality Assurance Program

**4.3 a 3** The length of time required to obtain credentialing and recredentialing should be included. A 90 day time-frame would be reasonable.

**4.5** We strongly support the inclusion of this "no-gag" clause, and would like to see it strengthened so that there is no financial advantage to the provider if service is not pursued, nor disadvantage if the service is rendered.

**4.6** The last several lines address protecting the HMO, but what about patient confidentiality? Additional language protecting confidentiality seems warranted.

Consider adding 4.7 --Quality Assurance Programs shall be provided to any member or provider who requests one for a cost not to exceed $5.00.

114-53-5 Quality Management & Improvement

This section should provide safeguards against financial incentives being used to limit availability and/or provision of services.

**5.1d** This committee should include some individual(s) outside of the HMO such as a consumer advocate or professionals who are responsibler for monitoring ethical practice.

**5.2** There should be some provision for accountability outside of the governing body of the HMO.

Consider adding 5.2 e -- Assure all notification, review and treatment decisions are made by persons who possess the appropriate levels of training and credentialing in their specialty.

**5.4** Here again there is no provision made to protect client confidentiality. Also, with regard to provider-patient communication, the provider should be able to discuss AND PROVIDE medically necessary or appropriate care.

**5.5b** It is good to allow members to have input. How will that be accomplished?

**5.6** This must be more specific with clear ties to sanctioned, ethical professional practice.

Consider adding 5.6 c -- All guidelines shall consider the well being of the members before cost.

Consider adding 5.7 d -- Patient outcomes.

**5.8** The HMO established standards should address parity between mental and physical health. If high-risk persons are clearly identified, how will they be protected and remain eligible for services?

114-53-6 Credentialing & Recredentialing

**6.1** HMO shall ensure ... providers in each area of the state in which it offers services. This is crucial since in the recent past some organizations have required individuals to travel hours in order to obtain covered services.

**6.2** A standardized application form should be developed so that providers do not waste hours of time putting the same information into a different format.

Consider adding 6.2 c --Credentialing and recredentialing shall be done within 90 days from receipt of application.

114-53-7 Members' Rights & Responsibilities

**7.1** Add language emphasizing members' right to availability and accessability to services. Also the right to receive an appropriate level of care from a provider of the member's choosing.

**7.2** Add language which protects individuals with special needs from being excluded from services due to their inability to provide information about themselves or follow through with recommended treatments. Also, will members be excluded from all areas of service if they fail to follow a recommendation in a specialty area?

**7.3** Add language so that these communications occur in a manner useful to members, for example using audio or visual recordings.

**7.3j** Provide additional safeguard for the appeals process, for example, adding ... as well as appealing the HMO decision to the WV insurance commissioner as to which treatment would be covered.

114-53-9 Medical Records

We would like to emphasize the importance of protecting members' confidentiality. Some thought should be given to how QA information can be obtained without compromising confidentiality, especially as it relates to sensitive areas such as mental health.

Ms. Quesenberry, thank you again for your consideration and the opportunity to share our comments. Although not exhaustive, we hope you will find them helpful as you continue this significant project.

Sincerely,

Elizabeth G. Evans, Ph.D.

Elizabeth G. Evans, Ph.D.
President-elect, WVPA

NASW
National Association of Social Workers

1608 Virginia Street, East
Charleston, West Virginia 25311
TEL. (304) 345-NASW (6279)
FAX (304) 343-3295
E-MAIL: NASWWV@aol.com

WEST VIRGINIA CHAPTER



July 24, 1997

Donna S. Quenenberry, Associate Counsel
Legal Division
Office of the Insurance Commissioner
PO Box 50540
Charleston, WV 25305-0540

Dear Mr. Quesenberry:

Thank you for giving us the opportunity to comment on the proposed rules in the Series 53, relating to Quality Assurance standards with Health Maintenance Organizations. We feel it is very important for rules to be established as HMO's continue to grow and expand in West Virginia and commend your office for proposing such rules. Due to limited time, we were only able to make a cursory review. Thank you for considering these comments.

An over-all concern of ours is that HMO's have strong incentives to control costs. We are in agreement that health care costs need to be controlled, but are concerned that without safeguards in place, consumers could be denied necessary services. Some specific areas of concern include:

114-53-1 (a) As written, HMO's are confined to "medical services". Depending on the definition of "medical services", this may be too limiting. i.e. mental health counseling, drug and alcohol treatment etc.

114-53-2, 2.4. We are concerned that the definition of "clinician" is very narrowly defined. We suggest other provider groups that have been recognized in other state policies also be specified here: physical therapists, social workers, drug and alcohol counselors, physician assistants, etc.

114-53-4.4.5. We strongly support this "anti-gag rule" provision.

114-53-4.4.6. The issue of confidentiality concerns us. The way this proposed rule reads, the health care provider would have to disclose the patient's entire medical record, not just the relevant portions.

114-53-5.2 We feel it is essential to establish a subcommittee to oversee quality improvement. We would like to see consumers as well as providers on the governing body.

114-53-5.3. Documentation is required about findings of the quality improvement process. However there are no provisions for public access to this documentation. Perhaps there could be a rule that these documents are to be filed with the office of the insurance commissioner on January 1 of each year; or they could be filed as they are written.

114-53-5.5 (c) Mental health is listed as a major specialty service. Again we reiterate that other types of "clinicians" need to be specifically mentioned in the definition of clinician as mentioned previously. This section seems to require the HMO keep statistics. We are unclear as to what end these statistics are to be kept or if they are to be reported to anyone, other than for quality improvement.

114-53-5.6. What is the source for the practice guidelines? Are you referring to nationally recognized standards? We feel this is a very important stipulation but it is not specified where the guidelines are coming from.

114-53-5.9 (e) This section calls for the use of multidisciplinary teams "where indicated to analyze and address systems issues". This statement is quite vague and needs to be expanded upon to provide better guidance.

114-53-6.2 (b) This section states the "credentialling committee or other peer review body...shall include provider doctors as voting members." We feel this should be changed to include other types of providers. Perhaps a minimum ration of committee membership could be established. This raises the question as to who is credentialling whom. We suggest that the credential committee have voting members who are equally prepared in education and training to the providers they are considering for credentialling.

114-53-6.3 Again this narrow language concerns us for providers in other disciplines: "graduation from medical school and completion of a residency, specialty training and board certification..."

114-53-7. This is a very good beginning for a client bill of rights and gives us something to build on.

114-53-8. Preventive Health Services. While we are pleased to see a section devoted to preventive health we would also like to see more specificity in this area. Who will be determining what the preventive health guidelines are? Many other states have developed standards with a very heavy emphases on preventive health services to keep consumers healthy and out of the hospital, thus reducing health care costs. It may be beneficial for West Virginia to review theses standards.

Again, we thank your office for proposing these rules and appreciate the opportunity to comment. We hope this will be of benefit to you. If given the opportunity, we would like to further comment at a later date.

We hope we can be of assistance to you.

Sincerely,

Susan Sobkoviak
Government Relations Associate