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REVIEW COMMISSION

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

RE: Regulation #10-160 (IRRC #2079)

Dear Mr. Nyce:

The passage of Act 68 was a major achievement of the 1997/1998 Legislative Session. Upon reviewing the above-referenced regulation and listening to public comment and staff analysis, I have some concerns about the Health Department's proposed regulations.

The Department of Health is entrusted with administering the act in the public interest. In keeping with that commitment, I recommend the department review and revise the following provisions in accordance with the General Assembly's legislative intent.

1) *The following definitions conflict with Act 68 or the Insurance Department's proposed regulation*:

- The definition of *enrollee* should be broadened to include parents of minor enrollees or legal representatives of enrollees.
- The definition of *primary care provider* should include the credentials of providers classified as a primary care provider.
- The definition of *gatekeeper* should preclude anyone other than the primary care provider.
- The definition of *grievance* should affirm that any claim concerning medical necessity is designated as a grievance.
- The definition of *integrated delivery system* should be consistent with the Insurance Department's definition.
- The definition of *managed care plan* should be revised to conform with the Insurance Department's definition.
- The definition of *service area* conflicts with the definition in Act 68.
- The definition of *utilization review* should be limited to utilization review entities.

2) *Section 9.603 Technical Advisories* should authorize purchaser, provider and public access to information contained in the advisory.

3) *Section 9.604 Plan Reporting Requirements* should expand reporting requirements to include HEDIS data collection elements and retain financial penalties for plans failing to file timely reports.

4) *Section 9.604 Department Investigations* should authorize the department to access financial records as they relate to quality of care issues.

5) *Section 9.674* should provide more specific guidance for the evaluation of quality assurance to ensure satisfactory levels of care.

6) *Section 9.675 The Delegation of Medical Management* should be revised to require contractors to report to the plan on a monthly basis and require random sampling to ensure adequate oversight.

7) *Section 9.676 Enrollee Rights and Responsibilities* should more fully address the needs of non-English speaking enrollees.

8) *Section 9.677 Medical Necessity* should revert to the original definition of medical necessity proposed under the earlier draft to ensure a level of standardization.

9) *Section 9.678 Primary Care Providers* should be revised to clarify that certain enrollees are entitled to have a specialist as their primary care provider.

10) *Section 9.682 Direct Access for Obstetrical and Gynecological Care* should be revised to eliminate provisions that serve to deny access to services authorized as directly accessible under Act 68.

11) *Section 9.702 Complaints and Grievances* should be revised to grant enrollee access to records and other information necessary to adequately prepare for appeal. Grievances should also be subject to an expedited review when necessary.

12) *Section 9.704 Internal Complaint Procedure* should be revised to require the plan to notify the enrollee of the plan's receipt of a complaint or grievance to assist in monitoring compliance with the Act. The enrollee should have access to the plan's files and records as they relate to the enrollee's complaint. Since a plan has 30 days to review and investigate a complaint, the plan should be required to issue a decision within a specific deadline or the complaint should be resolved in the enrollee's favor.

13) *Section 9.742 Certified Utilization Review Entities (CREs)* should be revised to preclude insurance companies from conducting utilization review for another insurance company or the parent or subsidiary of the insurance company without first obtaining certification to eliminate conflicts of interest.

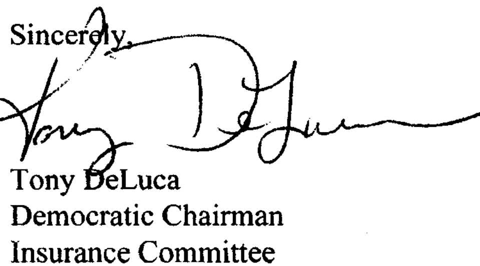
14) *Section 9.743 Content of an Application for Certification as a Utilization Review Entity* should be revised to identify conflicts of interest with more specificity to ensure an impartial review consistent with the standards under Section 9.744.

15) *Section 9.747 Department Review and Approval of Certification Request* should authorize department access to books, records, staff, facilities and other information necessary to monitor compliance. The general requirement that CREs be accredited should not be used as a substitute for department oversight.

16) *Section 9.761 Provider Credentialing* requires plans to establish and maintain provider credentialing systems. Consequently, the department should be granted enforcement authority to ensure plan compliance with the plan's credentialing system.

I am available to meet with you or your staff to discuss these issues in greater detail. As always, I look forward to working with you.

Sincerely,



Tony DeLuca
Democratic Chairman
Insurance Committee

TD:dwm