Democratic Caucus Chairman

11TH DISTRICT
MICHAEL A. O'PAKE, Esq.
SENATE BOX 203011
HARRISBURG, PA 17120-3011
TELEPHONE: (717) 787-8925
FAX: (717) 772-0578

ROCKLAND PROFESSIONAL CENTER
1940 NORTH 13TH STREET, STE. 232
READING, PA 19604
TELEPHONE: (610) 929-2151
FAX: (610) 378-4438
E-MAIL: opake@dem.pasen.gov

REPLY TO:
Harrisburg

Senate of Pennsylvania

COMMITTEES

JUDICIARY, MINORITY CHAIRMAN
AGRICULTURE AND RURAL AFFAIRS
APPROPRIATIONS
BANKING AND INSURANCE
RULES AND EXECUTIVE NOMINATIONS
URBAN AFFAIRS AND HOUSING

PENNSYLVANIA COMMISSION ON CRIME AND DELINQUENCY
PENNSYLVANIA HIGHER EDUCATION ASSISTANCE AGENCY
BEN FRANKLIN/IRC PARTNERSHIP BOARD
JOINT STATE GOVERNMENT COMMISSION

February 16, 2000

ORIGINAL: 2079/BUSH
COPIES: McGinley
Harris
Jewett
Markham
Smith
Wilmarth
Sandusky
Wyatte, Notebook

Honorable John R. McGinley, Chairman
PA Independent Regulatory Review Commission
14th Floor, Harristown 2
Harrisburg, PA 17120

Dear Chairman McGinley:

We are writing to express the following concerns regarding the regulations under review by the IRRC today in connection with Act 68 of 1998. We respectfully request that the IRRC request that changes be made to these proposed regulations to address these concerns.

The proposed regulations fail to ensure access to care.

- They Limit the Act's requirement that plans must provide "direct access to OB/GYNs by permitting an enrollee to select a health care provider participating in the plan to obtain maternity and gynecological care ... without prior authorization," by prohibiting plans from requiring prior authorization for any OB/GYN services considered "routine" but allowing prior authorization for any "non-routine" procedures. §9.682
- No standards for less frequently used specialists. No standards for providers who are not hospitals, PCPs or specialists (such as drug stores, home health agencies or durable medical equipment providers). §§9.679, 9.681
- Fails to require HMOs to provide access to a provider within 24 hours for urgent care. §9.651
- Allows plans to make only part of their network of providers available to enrollees, upon disclosure to potential enrollees. Does not require disclosure to current enrollees, and not set minimum standards for disclosure, such as inclusion of language in provider directory and/or marketing and enrollment materials. §9.654
- Permits networks without a single provider for a covered service as long as the service is otherwise arranged for-giving enrollees no choice in the matter. §9.654
- Permits limited networks for those within a "reasonable travel distance" without defining that standard. §9.654(b)(4)
- Allows an HMO to restrict access by limiting some enrollees (the working poor? those who are higher risk?) to a potentially inadequate network. §9.654

The Proposed Regulations fail to ensure quality of care.

- Allows the Department of Health to waive requirements for out-of-state HMOs. §9.636(c)

- Health plans are required to have a quality assurance process but no specific standards or outcome measurements are mentioned. As long as the plans have a process and follow that process, Dept. of Health won't look behind it to see if the process actually results in quality care. This section does not really set out quality assurance STANDARDS at all. §9.674
- Deadline for first external review for Quality Assurance pushed back from 12 months after HMO begins operation under current regs (§9.93(a)) to 18 months. §9.655 Furthermore, external review is done by a firm hired and paid by the plan with plan determining the scope of review no requirement of corrective action, etc. if external review finds problems. §9.655
- No public access to external review. §9.655(e)
- Next external review not required for 3 years even if serious problems. §9.655(a)
- No standards of scope of review required by the external reviews and no requirement that compliance with Act 68, HMO Act and accompanying regulations be reviewed. §9.655
- Reduces the scope of external reviews by no longer requiring a review of a statistically significant sample of medical records that is required under current regs (§9.93(c)(5)) §9.655.
- No requirement that Dept. of Health regulators ever step foot in a plan-permits Dept. of Health to rely exclusively on external reviewers hired and paid for by the plan to do any external reviews. §9.632(e)
- Does not provide for the development of a uniform member satisfaction survey which would enable "report cards", as recommended by Dept. of Health workgroup.
- Fails to establish QA standards that include a system to identify special, chronic and acute needs quickly, a mechanism for inform providers and enrollees of updates and changes, and maximum appointment waiting times. §9.674

The proposed regs undermine the fundamental fairness of the grievance & appeal process

The following are consumer protections that were required of HMOs by Dept. of Health for the past 9 years (as set forth in the Department's policy memo of 9/1/91 entitled "HMO grievance systems operational standards for fundamental fairness") which are missing and presumably lost in the Department's proposed regulations. The proposed grievance regulations are at §9.701 et.seq..

- Fails to require plans to accept an oral grievance from an enrollee and reduce it to writing.
- No longer requires that first level complaint and grievance decisions contain: a description of the reviewer's understanding of the member's dispute; clear terms and in sufficient detail for the member to respond further; references to the evidence and documentation used as a basis of decision; a statement that the decision is binding unless the person appeals.
- Fails to require plans to identify the identity, position and credentials of the individual(s) who make its decisions despite the enrollees right to have a decision rendered by a properly credentialed person.
- Does not require plans to make available to the enrollee all documentation relating to the issue in dispute.
- Allows plans to send notification of decisions to either the enrollee or provider, contrary to Act 68, which requires notification to both.
- No longer requires that members be given at least 15 days advance written notice of the second level complaint/grievance committee hearing and their right to appear, be given a description of the Committee's procedures to prepare, and be re-advised that they can be assisted by an uninvolved HMO staff person if they need help preparing.

- No longer requires that the second level review committee (for complaints and grievances) be made up of at least 1/3 HMO members, and that the consumer attending be told which of the of theCommittee is staff and which members.
- Does not require plans to make available for questioning, at the second level review, those persons who made the determination in dispute.
- Does not require the entire second level review hearing to be transcribed by the HMO and fails to guarantee the enrollee the right to record/transcribe the proceeding.
- Does not prohibit the second level review committee from basing a decision against an enrollee on a reason not specifically raised in the first level review decision.
- No longer requires that an HMO staff person knowledgeable about the grievance/complaint be present at the second level review to present the HMO's view of why the denial should be upheld, and that the staff person may be questioned by the member and by the Committee.
- No longer requires that the second level grievance/complaint committee base their decision solely on materials and testimony presented at the hearing.
- Does not require the second level complaint/grievance decision to articulate a detailed basis, including reference to the standard used and the evidence considered.

Thank you very much for your careful consideration of these concerns which we believe reflect the best interests of Pennsylvania's HMO plan members. We hope for your positive response

Sincerely,

Jay Costa

Jay Costa, Jr.
Senator- 43rd District

Mike O'Pake

Michael A. O'Pake
Senator--11th District

CC: Robert C. Nyce, E. D.

MAO'P:TWG