
THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL
No. 20

Session of
1991

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RUDY, MARCH 11, 1991

SENATOR PETERSON, PUBLIC HEALTH AND WELFARE, IN SENATE, AS
AMENDED, JUNE 9, 1992

AN ACT

1 ~~Providing a comprehensive plan for health care for the indigent, <—~~
2 ~~for operation of medical assistance, for primary health care~~
3 ~~programs, for access to health care, for health insurance~~
4 ~~reform and for studies on health care; further providing for~~
5 ~~State funds and for powers and duties of administrative~~
6 ~~agencies; imposing penalties; and making repeals.~~
7 PROVIDING A COMPREHENSIVE PLAN FOR HEALTH CARE FOR CHILDREN, FOR <—
8 OPERATION OF MEDICAL ASSISTANCE, FOR PRIMARY HEALTH CARE
9 PROGRAMS, FOR ACCESS TO HEALTH CARE, AND FOR STUDIES ON
10 HEALTH CARE; ESTABLISHING THE BUREAU OF RURAL AND INNER-CITY
11 HEALTH CARE SERVICES; FURTHER PROVIDING FOR STATE FUNDS AND
12 FOR POWERS AND DUTIES OF ADMINISTRATIVE AGENCIES; IMPOSING
13 PENALTIES; MAKING APPROPRIATIONS; AND MAKING REPEALS.

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12 SECTION 3105. EFFECTIVE DATE.

13 The General Assembly of the Commonwealth of Pennsylvania
14 hereby enacts as follows:

15 ~~CHAPTER 1~~

<—

16 ~~GENERAL PROVISIONS~~

17 ~~Section 101. Short title.~~

18 ~~This act shall be known and may be cited as the Health Care~~
19 ~~Partnership Act.~~

20 ~~Section 102. Legislative findings and intent.~~

21 ~~(a) Declaration. The General Assembly finds and declares~~
22 ~~that:~~

23 ~~(1) All citizens of this Commonwealth have a right to~~
24 ~~access to affordable and reasonably priced health care and to~~
25 ~~nondiscriminatory treatment by health insurers and providers.~~

26 ~~(2) The uninsured health care population of this~~
27 ~~Commonwealth is over one million persons, and many thousands~~
28 ~~more lack adequate insurance coverage. Approximately two~~
29 ~~thirds of the uninsured are employed or dependents of~~
30 ~~employed persons.~~

~~(3) Over one third of the uninsured health care population are children. Uninsured children are of particular concern because of their need for ongoing preventative and primary care. Measures not taken to care for such children now will result in higher human and financial costs later. Access to timely and appropriate primary care is particularly serious for women who receive late or no prenatal care which increases the risk of low birth weights and infant mortality.~~

~~(4) The uninsured and underinsured lack access to timely and appropriate primary and preventative care. As a result, they often delay or forego health care, with the resulting increased risk of developing more severe conditions, which are more expensive to treat. This tendency of the medically indigent to delay care and to seek ambulatory care in hospital based settings also causes inefficiencies in the health care system.~~

~~(5) Health markets have been distorted through cost shifts for the uncompensated health care costs of uninsured citizens of this Commonwealth which has caused decreased competitive capacity on the part of those health care providers who serve the poor, and increased costs of other health care payors.~~

~~(6) Not for profit hospitals which have been granted a tax free status by the State vary greatly in the amount of charitable uncompensated health care they provide and on average provide less than the national average. There has been no uniform definition to determine the amount of charity care provided by these health care institutions.~~

~~(7) Although the proper implementation by hospitals of spend down provisions under medical assistance should result~~

1 ~~in the provision of the vast majority of all hospital care~~
2 ~~for the uninsured through the medical assistance program,~~
3 ~~hospitals vary widely in their willingness to allow patients~~
4 ~~to incur expenses so they can qualify for medical assistance.~~

5 ~~(8) The professional health service plan corporation and~~
6 ~~the hospital plan corporations which are granted an exemption~~
7 ~~from the premium tax have varied greatly in the amount of~~
8 ~~health services they provide to low income citizens of this~~
9 ~~Commonwealth and the manner in which they have targeted their~~
10 ~~subsidies.~~

11 ~~(9) Many health maintenance organizations have been~~
12 ~~unwilling to reach an agreement with the Department of Public~~
13 ~~Welfare, to enroll as subscribers, individuals participating~~
14 ~~in or eligible for medical assistance.~~

15 ~~(10) No one sector can absorb the cost of providing~~
16 ~~health care to all citizens of this Commonwealth who cannot~~
17 ~~afford health care on their own. The cost is too large for~~
18 ~~the public sector alone to bear and instead requires the~~
19 ~~establishment of a public/private partnership to share the~~
20 ~~costs in a manner economically feasible for all interests.~~
21 ~~The magnitude of this need also requires that it be done on a~~
22 ~~time phased, cost managed and planned basis.~~

23 ~~(b) Intent. It is the intent of the General Assembly and~~
24 ~~the purpose of this act that:~~

25 ~~(1) Eligible citizens of this Commonwealth have access~~
26 ~~to cost effective, comprehensive health coverage when they~~
27 ~~are unable to afford coverage or obtain it through their~~
28 ~~employment.~~

29 ~~(2) Care be provided in appropriate settings by~~
30 ~~efficient providers, consistent with high quality care and at~~

~~an appropriate stage, soon enough to avert the need for
overly expensive treatment.~~

~~(3) Equity be assured among health providers and payors
by providing a mechanism for providers, employers, the public
sector and patients to share in financing indigent health
care.~~

~~Section 103. Definitions.~~

~~The following words and phrases when used in this act shall
have the meanings given to them in this section unless the
context clearly indicates otherwise:~~

~~"Bad debt." The difference between the patient pay amount
due and the patient pay revenue received.~~

~~"Child." A person under 18 years of age.~~

~~"Council." The Health Care Cost Containment Council.~~

~~"Department." The Department of Public Welfare of the
Commonwealth.~~

~~"Disproportionate share hospital." Each hospital, including
distinct parts, providing a certain number or percentage of
inpatient services paid through the medical assistance program,
as defined in regulations of the Department of Public Welfare
and the Federally approved Medical Assistance State Plan.~~

~~"EPSDT." Early and periodic screening, diagnosis and
treatment.~~

~~"Group." Any group for which a health insurance policy is
written in the Commonwealth of Pennsylvania.~~

~~"Health maintenance organization" or "HMO." An entity
organized and regulated under the act of December 29, 1972
(P.L.1701, No.364), known as the Health Maintenance Organization
Act.~~

~~"Health service corporation." A professional health service~~

~~corporation as defined in 40 Pa.C.S. (relating to insurance).~~

~~"Hill-Burton program."—The hospital survey and construction program provided in the Hill-Burton Act (60 Stat. 1040, 42 U.S.C. § 291 et seq.).~~

~~"Hospital."—An institution having an organized medical staff which is engaged primarily in providing to inpatients, by or under the supervision of physicians, diagnostic and therapeutic services for the care of injured, disabled, pregnant, diseased or sick or mentally ill persons. The term includes facilities for the diagnosis and treatment of disorders within the scope of specific medical specialties, including facilities which provide care and treatment exclusively for the mentally ill and drug or alcohol inpatient detoxification or rehabilitative care. The term does not include inpatient nonhospital activity as described in 28 Pa. Code § 701.1 (relating to general definitions), publicly owned inpatient facilities or skilled or intermediate care nursing facilities. The term also does not include a facility which is operated by a religious organization for the purpose of providing health care services exclusively to clergymen or other persons in a religious profession who are members of a religious denomination or a facility providing treatment solely on the basis of prayer or spiritual means.~~

~~"Hospital plan corporation."—A hospital plan corporation as defined in 40 Pa.C.S. (relating to insurance).~~

~~"Insurer."—An entity subject to the act of May 17, 1921 (P.L. 682, No. 284), known as The Insurance Company Law of 1921.~~

~~"MAAC."—The Medical Assistance Advisory Committee.~~

~~"Managed care organization."—A health maintenance organization organized and regulated under the act of December 29, 1972 (P.L. 1701, No. 364), known as the Health Maintenance~~

~~Organization Act; a risk assuming preferred provider organization or exclusive provider organization, organized and regulated under the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921; or a preferred provider with a health management/"gatekeeper" role for primary care physicians organized and regulated as a health services corporation under 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).~~

~~"Medical assistance." The State program of medical assistance established under the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.~~

~~"Medicaid." The Federal medical assistance program established under Title XIX of the Social Security Act (Public Law 74-271, 42 U.S.C. § 301 et seq.).~~

~~"Medically indigent." Families and individuals who lack sufficient income or financial resources through insurance or other means to pay for necessary health care services.~~

~~"MIC." The Federal Maternal, Infant and Child Care program.~~

~~"Preexisting condition." A disease or physical condition for which medical advice of treatment has been received within 90 days immediately prior to the effective date of coverage.~~

~~"Specialty and supplemental health services." Services not included as primary health services, such as hospital care, home health services, rehabilitative services, mental health services, drug and alcohol services and ambulatory surgical services.~~

~~"Spend down." The qualifying procedure for the Pennsylvania Medical Assistance Program set forth in 55 Pa. Code, Ch. 181 (relating to income provisions for categorically needy nonmoney payment (NMP-MA) and medically needy only (MNO-MA) medical~~

1 ~~assistance (MA)).~~

2 ~~"Subgroup." An employer covered under a contract issued to a~~
3 ~~multiple employer trust or to an association.~~

4 ~~"Title XIX." Title XIX of the Social Security Act (Public~~
5 ~~Law 74-271, 42 U.S.C. § 301 et seq.).~~

6 ~~"Waiting period." A period of time after the effective date~~
7 ~~of enrollment during which a health insurance plan excludes~~
8 ~~coverage for the diagnosis or treatment of one or more medical~~
9 ~~conditions.~~

10 ~~"WIC." The Federal Women, Infants and Children program.~~

11 ~~CHAPTER 5~~

12 ~~MEDICAL ASSISTANCE PROGRAM~~

13 ~~Section 501. Hospital responsibilities under medical assistance~~
14 ~~program.~~

15 ~~(a) Necessary care. Each licensed acute care hospital shall~~
16 ~~not deny necessary and timely health care due to a person's~~
17 ~~inability to pay in advance from current income or resources for~~
18 ~~all or part of that care.~~

19 ~~(b) Installment agreements. Hospitals shall enter into~~
20 ~~reasonable installment agreements to cover the spend down cost~~
21 ~~of the care necessary for the person to qualify for medical~~
22 ~~assistance coverage or insurance. Within six months of the~~
23 ~~effective date of this act, the department shall issue~~
24 ~~guidelines to ensure uniformity of this provision and compliance~~
25 ~~with Federal and State requirements.~~

26 ~~(c) Prohibitions. It is unlawful for any hospital licensed~~
27 ~~by the Commonwealth:~~

28 ~~(1) to require, as a condition of admission or~~
29 ~~treatment, assurance from the patient or any other person~~
30 ~~that the patient is not eligible for or will not apply for~~

1 ~~medical assistance;~~

2 ~~(2) to deny or delay admission or treatment of a person~~
3 ~~because of his current or possible future status as a medical~~
4 ~~assistance recipient;~~

5 ~~(3) to transfer a patient to another health care~~
6 ~~provider because of his current or possible status as a~~
7 ~~medical assistance recipient;~~

8 ~~(4) to discharge a patient from care because of his~~
9 ~~current or possible future status as a medical assistance~~
10 ~~recipient; or~~

11 ~~(5) to discourage any person who would be eligible for~~
12 ~~the medical assistance program from applying or seeking~~
13 ~~needed health care or needed admission to a health care~~
14 ~~facility because of his inability to pay for that care.~~

15 ~~(d) Application for medical assistance. Each hospital shall~~
16 ~~provide to each prospective uninsured or underinsured patient,~~
17 ~~assistance in completing an application for medical assistance,~~
18 ~~within one business day of the prospective patient's first~~
19 ~~request to be admitted to the hospital.~~

20 ~~(e) Access to all services. Each hospital shall ensure that~~
21 ~~all medical assistance recipients have full access to all~~
22 ~~available services, physician specialists and any department of~~
23 ~~the facility. Each hospital shall establish a physician referral~~
24 ~~service to assist medical assistance recipients with referrals~~
25 ~~to primary care and specialist physicians on an equitable,~~
26 ~~rotating basis.~~

27 ~~Section 502. Medical assistance outreach.~~

28 ~~(a) Content of program. The department shall establish and~~
29 ~~administer an outreach program to enroll people who are eligible~~
30 ~~for medical assistance but have not enrolled. This shall~~

1 include:

2 ~~(1) Providing for on-site applications at all~~
3 ~~disproportionate share hospitals and Federal qualified health~~
4 ~~centers.~~

5 ~~(2) Developing a program of public service announcements~~
6 ~~to be aired on television and radio on a regular Statewide~~
7 ~~basis, advising citizens of:~~

8 ~~(i) expanded medical assistance eligibility for~~
9 ~~pregnant women, infants, the elderly, the disabled,~~
10 ~~persons with acquired immune deficiency syndrome (AIDS);~~

11 ~~(ii) general eligibility requirements, spend down,~~
12 ~~expedited issuance of medical assistance cards, and how~~
13 ~~and where to apply; and~~

14 ~~(iii) availability of primary and specialty care~~
15 ~~physicians who accept medical assistance.~~

16 ~~(3) Providing to medical assistance recipients periodic~~
17 ~~notification of primary and specialty care physician~~
18 ~~availability, procedure to access physicians, complaint~~
19 ~~procedures and consumer rights.~~

20 ~~(4) Developing pamphlets and informational services for~~
21 ~~medical assistance providers to help providers inform~~
22 ~~patients about medical assistance options and eligibility.~~

23 ~~(5) Providing the General Assembly and the public an~~
24 ~~annual report for each fiscal year, detailing the outreach~~
25 ~~and enrollment efforts taken by each county assistance~~
26 ~~office, and reporting by county on the number of citizens~~
27 ~~enrolled in the medical assistance program and the projected~~
28 ~~medical assistance eligible population of each county.~~

29 ~~(b) Applications for medical assistance and children's~~
30 ~~health care plan.~~

~~(1) Persons taking applications for medical assistance, including persons at sites other than county assistance offices, shall offer to take an application for coverage under the Children's Health Care Plan, as established under Chapter 7, for any child. Persons taking applications for the Children's Health Care Plan shall promptly forward the applications to the entity designated by the health service corporation and hospital plan corporations to administer the plan.~~

~~(2) The department shall supply an application form for enrollment in the Children's Health Care Plan under Chapter 7 with any notice of termination from medical assistance where a child under 19 years of age is among the persons being terminated.~~

~~Section 503.— Pennsylvania Children's Medical Assistance
program.~~

~~(a) Coverage.—~~

~~(1) The department shall amend its medical assistance regulations to provide all medically necessary health care, diagnostic services, rehabilitative services and treatment for which Federal financial participation is available, to all children enrolled under this section.~~

~~(2) Health care services shall be provided in sufficient amount, duration and scope, required for each enrolled child's medical condition.~~

~~(b) Enrollment.—~~

~~(1) Every child shall be immediately enrolled in the EPSDT program upon authorization for medical assistance. Any parent wishing not to participate in the EPSDT program must sign a form detailing the health care benefits that are being~~

1 waived.

2 ~~(2) At time of authorization, or shortly thereafter, for~~
3 ~~medical assistance for any child, or the addition of a new~~
4 ~~child, the department or its designee shall assist the parent~~
5 ~~in making an appointment for the child for a EPSDT screen~~
6 ~~with the physician of the parent's choice.~~

7 ~~(3) Periodically, the department or its designee shall~~
8 ~~determine whether the children are current in their screens~~
9 ~~and if they are in need of assistance in arranging health,~~
10 ~~dental, mental health or other treatment. Assistance shall be~~
11 ~~provided the parent by the department or its designee, if~~
12 ~~needed, in arranging for such care, screen or transportation~~
13 ~~therefor.~~

14 ~~(c) Audit. The department shall annually conduct a~~
15 ~~performance analysis of the EPSDT program, including the~~
16 ~~following:~~

17 ~~(1) The outreach efforts as schools, day care~~
18 ~~facilities, hospitals, etc., to enroll children in the~~
19 ~~medical assistance and EPSDT program.~~

20 ~~(2) Of those children enrolled in medical assistance,~~
21 ~~the percentage of children current in their screens and for~~
22 ~~whom needed treatment and services have been obtained.~~

23 ~~(3) Coordination of MIC, WIC, EPSDT, mental health, drug~~
24 ~~and alcohol, State and county health centers and other~~
25 ~~services in the county available to children on medical~~
26 ~~assistance.~~

27 ~~(d) Noncompliance. If the EPSDT program is found to be in~~
28 ~~noncompliance with the provisions of this section or has failed~~
29 ~~to take sufficient outreach efforts to enroll any county's~~
30 ~~eligible children under this section, the department shall~~

~~immediately file a corrective action plan. The department shall do quarterly compliance reviews of the EPSDT program until it has corrected the identified performance deficiencies.~~

~~(e) Publicity. The department shall develop and widely utilize a media campaign for use on television, radio and local newspapers, advising Pennsylvania's citizens of the availability of health care for low income children under this section.~~

~~(f) Report to General Assembly. The department shall provide a written annual report to the General Assembly detailing on a county by county basis the findings of the performance audits set forth in this section and evaluating the media campaign used by the department to inform citizens about the availability of health coverage for low income children under this section.~~

~~(g) Advisory committee. The MAAC shall, on a quarterly basis, review county assistance and departmental implementation of this section and to advise the department on changes in policy needed to maximize the availability of timely and cost-effective health care to Pennsylvania's low income children who depend on medical assistance for their health care. In its review, the MAAC shall seek the advice from the Consumer Subcommittee of the MAAC; the Pennsylvania Chapter of the American Academy of Pediatricians; the Pennsylvania Academy of Family Physicians; the Developmental Disability Planning Council and other interested groups.~~

~~CHAPTER 7~~

~~PRIMARY HEALTH CARE PROGRAMS~~

~~Section 701. Children's health care.~~

~~(a) The Children's Health Fund Authority. The Children's Health Fund Authority is established as an agency of the~~

1 ~~Commonwealth, exercising public powers, including all powers~~
2 ~~necessary or appropriate to carry out and effectuate the~~
3 ~~purposes and provisions of this section.~~

4 ~~(1) The Children's Health Fund Authority shall consist~~
5 ~~of 17 voting members, composed of and appointed in accordance~~
6 ~~with the following:~~

7 ~~(i) The Secretary of Health.~~

8 ~~(ii) The Secretary of Public Welfare.~~

9 ~~(iii) The Insurance Commissioner.~~

10 ~~(iv) One representative from the Pennsylvania~~
11 ~~Chapter of the American Academy of Pediatrics, appointed~~
12 ~~by the Governor from a list of three qualified persons~~
13 ~~recommended by the Academy.~~

14 ~~(v) One representative from the Pennsylvania Academy~~
15 ~~of Family Physicians, appointed by the Governor from a~~
16 ~~list of three qualified persons recommended by the~~
17 ~~Academy.~~

18 ~~(vi) A representative from the Developmental~~
19 ~~Disability Council, appointed by the Governor from a list~~
20 ~~of three qualified persons recommended by the council.~~

21 ~~(vii) A representative appointed by the Child Health~~
22 ~~Subcommittee of the Medical Assistance Advisory~~
23 ~~Committee.~~

24 ~~(viii) One representative appointed by the Maternal~~
25 ~~and Infant Advisory Council.~~

26 ~~(ix) A parent of a child who receives primary health~~
27 ~~care funded by the authority, appointed by the Governor~~
28 ~~from a list of parent applicants.~~

29 ~~(x) The Majority Chairman and the Minority Chairman~~
30 ~~of the Appropriations Committee of the Senate and the~~

Majority Chairman and the Minority Chairman of the
Appropriations Committee of the House of Representatives

~~(xi) The Majority Chairman and the Minority Chairman
of the Public Health and Welfare Committee of the Senate
and the Majority Chairman and the Minority Chairman of
the Health and Welfare Committee of the House of
Representatives.~~

~~(2) All initial appointments to the authority shall be
made by within 60 days of the effective date of this act, and
the authority shall commence operations immediately
thereafter. If any specified organization should cease to
exist or fail to make a recommendation within 90 days of a
request to do so, the authority shall specify a new
equivalent organization to fulfill the responsibilities of
this section.~~

~~(3) The members of the authority shall annually elect,
by a majority vote of the members, a chairperson and vice
chairperson from among the members of the authority.~~

~~(4) The authority may appoint staff necessary to carry
out its functions.~~

~~(5) Nine members shall constitute a quorum for the
transacting of any business. Any act by a majority of the
members present at any meeting at which there is a quorum
shall be deemed to be that of the authority.~~

~~(6) All meetings of the authority shall be advertised
pursuant to the act of July 3, 1986 (P.L.388, No.84), known
as the Sunshine Act, unless otherwise provided in this
section. The authority shall meet at least quarterly and may
provide for special meetings as it deems necessary. Meeting
dates shall be set by a majority vote of members of the~~

~~authority or by call of the chairperson upon seven days' notice to all members. The authority shall publish a schedule of its meetings in the Pennsylvania Bulletin and at least four newspapers of general circulation in this Commonwealth. Notice shall be published at least once in each calendar quarter and shall list a schedule of meetings of the authority to be held in the subsequent calendar quarter. Notice shall specify the date, time and place of the meeting and shall state that the authority's meetings are open to the general public. All action taken by the authority shall be taken in open public session and shall not be taken except upon a majority vote of the members present at a meeting at which a quorum is present.~~

~~(7) The authority shall adopt regulations not inconsistent with this section.~~

~~(8) The members of the authority shall not receive a salary or per diem allowance for serving as members of the authority but shall be reimbursed for actual and necessary expenses incurred in the performance of their duties.~~

~~(9) Terms of authority members shall be as follows:~~

~~(i) The terms of the Secretary of Health and the Secretary of Public Welfare and Insurance Commissioner shall be concurrent with their holding of public office. The terms of legislative members shall be concurrent with the legislative session in which they became members. The six appointed authority members shall serve for a term of three years and shall continue to serve thereafter until their successors are appointed.~~

~~(ii) An appointed member shall not be eligible to serve more than two full consecutive terms of three~~

1 ~~years. Vacancies on the authority shall be filled in the~~
2 ~~same manner in which they were designated within 60 days~~
3 ~~of the vacancy.~~

4 ~~(iii) A member may be removed for just cause by the~~
5 ~~appointing authority or by a vote of at least nine~~
6 ~~members of the authority.~~

7 ~~(b) Distribution of funds. The authority shall provide for~~
8 ~~the expanded access to primary health care for eligible children~~
9 ~~through the distribution of the Children's Health Fund for~~
10 ~~health care for indigent children as established by section 1296~~
11 ~~of the act of March 4, 1971 (P.L.6, No.2), known as the Tax~~
12 ~~Reform Code of 1971.~~

13 ~~(1) No less than 80% of the funds from the Children's~~
14 ~~Health Fund shall be used to fund those primary health care~~
15 ~~programs defined in subsection (d) and established under 40~~
16 ~~Pa.C.S. Chs. 61 (relating to hospital plan corporations) and~~
17 ~~63 (relating to professional health services plan~~
18 ~~corporations).~~

19 ~~(i) Except as provided in subparagraph (ii), no more~~
20 ~~than 15% of the amount stated in this paragraph shall be~~
21 ~~used for administration expenses, including outreach, in~~
22 ~~providing those primary health care programs defined in~~
23 ~~subsection (c).~~

24 ~~(ii) If a hospital service corporation or a health~~
25 ~~service corporation presents documented evidence that~~
26 ~~administrative expenses are in excess of the maximum set~~
27 ~~forth in subparagraph (i), the Insurance Commissioner~~
28 ~~shall advise the authority to make an additional~~
29 ~~allotment of funds for administrative expenses to the~~
30 ~~extent the Insurance Commissioner finds such expenses~~

1 ~~reasonable and necessary.~~

2 ~~(2) The authority may grant start up funds pursuant to~~
3 ~~this subsection for any qualifying corporation needing such~~
4 ~~funds to establish a foundation eligible to receive grants~~
5 ~~from the authority.~~

6 ~~(3) All grants made pursuant to this subsection shall be~~
7 ~~on an equitable basis based on the number of enrolled~~
8 ~~eligible children or eligible children anticipated to be~~
9 ~~enrolled. The authority shall use its best efforts to provide~~
10 ~~grants that ensure that eligible children have access to~~
11 ~~basic primary health care services to be provided under this~~
12 ~~section on an equitable Statewide basis.~~

13 ~~(c) Limitations.—~~

14 ~~(1) No more than 1% of the funds from the Children's~~
15 ~~Health Fund may be used for expenses of members of the~~
16 ~~authority and for administration.~~

17 ~~(2) No more than 20% of the funds from the Children's~~
18 ~~Health Fund may be used for demonstration projects to link~~
19 ~~primary health care services with dental, hearing and vision~~
20 ~~care for eligible children. All grants made pursuant to this~~
21 ~~subsection shall be to any organization or corporation~~
22 ~~providing primary health services or willing to provide~~
23 ~~primary health services in accordance with subsection (c) for~~
24 ~~eligible children.~~

25 ~~(d) Grant criteria. The Children's Health Fund Authority~~
26 ~~shall annually accept applications for grants to be made~~
27 ~~pursuant to this section by the authority pursuant to the~~
28 ~~following:~~

29 ~~(1) To the fullest extent practicable, grants shall be~~
30 ~~made to applicants that contract with providers to provide~~

~~primary care services for enrollees on a basis best calculated to manage costs of the program, including, but not limited to, purchasing health care services on a capitated basis, using managed health care techniques and, where appropriate, other cost management methods. The authority shall require grantees to use appropriate cost management methods so that the Children's Health Fund can be used to provide the basic primary benefit services to the maximum number of eligible children. This shall include contracting with qualified, cost effective providers, including hospital outpatient departments, HMOs, clinics, group practices and individual practitioners.~~

~~(2) To the fullest extent practicable, the authority shall ensure that eligible children have access to primary health care provided by the Children's Health Fund that has adequate primary care physicians and that provides adequate freedom of choice of physicians within a reasonable and convenient travel distance.~~

~~(3) To the fullest extent practicable, the authority shall ensure that any grantee who determines that a child is not eligible because the child is eligible for medical assistance provide in writing to the family of the child the telephone number of the county assistance office of the department where the family can call to apply for medical assistance.~~

~~(c) Eligible primary health care coverage for funding. All grantees funded shall include the following minimum benefit package for eligible children:~~

~~(1) Preventive care, which shall include well child care visits in accordance with the schedule established by the~~

~~American Academy of Pediatrics and the services related to those visits, including, but not limited to, immunizations, well child care, health education, tuberculosis testing and developmental screening in accordance with routine schedule of well child visits. Care shall also include a comprehensive physical examination, including x rays if necessary, for any child exhibiting symptoms of possible child abuse.~~

~~(2) Diagnosis and treatment of illness or injury, including all services related to the diagnosis and treatment of sickness and injury and other conditions provided on an ambulatory basis, such as wound dressing and casting to immobilize fractures.~~

~~(3) Injections and medications provided at the time of the office visit or therapy, outpatient surgery performed in the office or freestanding ambulatory service center, including anesthesia provided in conjunction with such service, and emergency medical service.~~

~~(4) Emergency accident and emergency medical care.~~

~~(5) Availability of 24 hour a day, 7 day a week access to the services in this subsection.~~

~~(f) Waiver. The authority may grant a waiver of the minimum benefit package of subsection (c) upon demonstration by the applicant that they are providing primary health care services for eligible children that meet the purpose and intent of this section.~~

~~(g) Inpatient hospital care. To ensure that inpatient hospital care is provided to eligible children, all primary care physicians providing primary care services to eligible children under this chapter shall make the necessary arrangements through the spend down provisions of medical assistance for admission to~~

~~the hospital and for the necessary specialty care for a child needing such care and shall continue to care for the child as a medical assistance provider in the hospital as appropriate.~~

~~(h) Eligibility for enrollment in programs receiving funding through the Children's Health Fund Authority.—~~

~~(1) Any organization or corporation receiving funds from the Children's Health Fund Authority shall enroll any child who meets all of the following:~~

~~(i) Is under 19 years of age.~~

~~(ii) Is a resident of this Commonwealth and of a county served by the organization or corporation.~~

~~(iii) Is not eligible for nor covered by a health insurance plan, a self insurance plan or the medical assistance program.~~

~~(iv) Is qualified under subsection (i).~~

~~(2) Coverage shall not be denied on the basis of a preexisting condition.~~

~~(3) The authority may permit enrollment by children with health insurance coverage for inpatient hospital care, but little or no coverage for the primary health care services funded by the authority if, after the first year of operation, there appears to be sufficient revenue to do so.~~

~~(i) Free care. The provision of primary health services for eligible children shall be free to all children whose family income is less than or up to 150% of the Federal poverty level and shall be available on a sliding fee basis to children whose family income is more than 150% but less than or up to 200% of the Federal poverty level. The sliding scale fee shall not exceed \$25 per child per year and \$100 per family per year. Those families with income higher than 200% of the Federal~~

~~1 Poverty level may purchase coverage for their children at cost.~~
~~2 There shall be no copayments or deductibles of any kind for~~
~~3 uninsured children whose family income is less than 100% of the~~
~~4 Federal poverty level; and, in no case, may the copayments or~~
~~5 deductibles exceed 0.1% of the family income.~~

~~6 (j) Annual report. The authority shall provide the General~~
~~7 Assembly and the public with an annual report for each fiscal~~
~~8 year, outlining primary health services funded for the year,~~
~~9 detailing the outreach and enrollment efforts by each grantee~~
~~10 and reporting by county the number of children for whom primary~~
~~11 care is funded by the authority and the projected eligible~~
~~12 children.~~

~~13 (k) Role of the health service corporation and hospital plan~~
~~14 corporations. By January 1, 1993, each health service~~
~~15 corporation and hospital plan corporation doing business in this~~
~~16 Commonwealth shall file a letter of intent with the authority to~~
~~17 apply for funds from the authority in the area serviced by the~~
~~18 corporation. Each health service corporation and hospital plan~~
~~19 corporation shall provide insurance identification cards to~~
~~20 those eligible children covered under programs receiving grants~~
~~21 from the authority. The card shall not specifically identify the~~
~~22 holder as low income.~~

~~23 (l) Rate filing request information. The Insurance~~
~~24 Commissioner shall make a copy and forward to the authority all~~
~~25 relevant information and data filed by each health service~~
~~26 corporation and hospital plan corporation doing business in this~~
~~27 Commonwealth as part of any rate filing request for programs~~
~~28 receiving grants under this section by the corporation.~~

~~29 (m) Dedicated funding. The Children's Health Fund for~~
~~30 health care for indigent children, as established by section~~

~~1296 of the Tax Reform Code of 1971 shall be dedicated exclusively for distribution by the Children's Health Fund Authority pursuant to this section.~~

~~Section 702. Uninsured workers and adults.~~

~~(a) Development. The health service corporation and the hospital plan corporations shall concurrently develop a primary health care insurance plan for adults, equivalent to the Children's Primary Health Care Plan set forth in section 701 for purchase at cost by January 1, 1993. The plan for adults shall make affordable primary health care available to individual Commonwealth residents whose income exceeds medical assistance eligibility guidelines but who are without sufficient means to purchase other health care insurance to cover the costs of health care.~~

~~(b) Rates. The Insurance Commissioner shall review the rates for the Primary Health Care Plan for adults and shall ensure that the premium covers all appropriate costs, reserves and administrative costs of the health service corporation and the hospital plan corporations.~~

~~(c) Cost data. The health service corporation and the hospital plan corporations shall keep detailed actuarial data on the costs of the adult plan.~~

~~(d) Premiums. The health service corporation and the hospital plan corporations shall establish a premium structure for enrollment effective January 1, 1993, which shall be adjusted to reflect the incomes of persons seeking to become enrollees in the program and shall be structured so that individuals whose incomes are insufficient to pay the full premium can participate in the program.~~

~~(e) Expiration of section. If prior to January 1, 1993, the~~

~~Insurance Commissioner approves an adult health care plan by the health service corporation and the hospital plan corporations that meets the intent and purposes of the primary health care plan for adults, the commissioner shall publish a notice of this approval in the Pennsylvania Bulletin. This section shall expire upon the date of publication of that notice.~~

~~Section 703. Outreach and quality assurance.~~

~~(a) Public information. The health service corporation and the hospital plan corporations shall actively publicize both the children's and adults' primary care health plans and shall solicit the assistance of the Commonwealth, health care providers and others in bringing the program to the attention of prospective enrollees.~~

~~(b) Enrollment information. Commencing January 1, 1993, and on an annual basis, all employers who do not provide health care insurance shall provide their employees with enrollment information concerning the Primary Health Care Plan for Adults.~~

~~CHAPTER 11~~

~~ACCESS TO HEALTH CARE~~

~~Section 1101. Managed care organizations.~~

~~(a) Fair share of medical assistance subscribers. Within six months of the effective date of this act, each managed care organization shall enter into an agreement with the department to enroll as subscribers individuals who are eligible to receive medical assistance benefits. A managed care organization that receives its certificate of authority after the effective date of this act shall enter into an agreement with the department under this section before the end of the managed care organization's second year of operation in this Commonwealth. All managed care organizations shall agree to accept as~~

1 ~~enrollees a fair share of medical assistance recipients. A "fair~~
2 ~~share" of medical assistance subscribers for purposes of this~~
3 ~~section shall be defined as the same ratio of medical assistance~~
4 ~~recipients to general population in the managed care~~
5 ~~organization's service area as enrolled medical assistance~~
6 ~~subscribers to the total managed care organization enrollment or~~
7 ~~25%, whichever is less. Within three years of the effective date~~
8 ~~of the contract between the department and the managed care~~
9 ~~organization, the managed care organization shall have enrolled~~
10 ~~or have attempted to enroll its fair share of medical assistance~~
11 ~~subscribers.~~

12 ~~(b) County percentages. The department shall publish~~
13 ~~annually in the Pennsylvania Bulletin notice of the county~~
14 ~~percentage of medical assistance recipients for each county and~~
15 ~~shall assist managed care organizations in determining the~~
16 ~~number of medical assistance subscribers necessary to constitute~~
17 ~~its fair share.~~

18 ~~(c) Separate systems. Unless authorized by the department,~~
19 ~~after consultation with the Medical Assistance Advisory~~
20 ~~Committee, a managed care organization shall not establish~~
21 ~~separate systems of care for its medical assistance subscribers.~~
22 ~~This subsection shall not preclude entities operating as medical~~
23 ~~assistance subcontractors to a health maintenance organization~~
24 ~~prior to July 1, 1991, from maintaining their current contracts~~
25 ~~or entering into new contracts with health maintenance~~
26 ~~organizations. These entities must still comply with all~~
27 ~~applicable provisions for quality assurance contained in this~~
28 ~~act.~~

29 ~~(d) Waiver of requirements. The department may grant a~~
30 ~~waiver of the requirements of this section if it finds that the~~

~~managed care organization has made and continues to make a good faith effort to obtain a fair share of medical assistance subscribers, but is unable to reach or maintain that percentage. The department may also grant a waiver of the requirements of this section upon demonstration by the managed care organization that this section would result in insolvency of the managed care organization.~~

~~Section 1102. Enforcement.~~

~~(a) Civil penalty.~~

~~(1) Any health maintenance organization that violates the provisions of this chapter shall be subject to a civil penalty equal to 2% of the annual premiums of the HMO or the HMO's average rate per member multiplied by the number of individuals that the HMO has failed to enroll under the fair share provisions of this chapter, whichever is greater. This penalty shall be deposited in the General Fund for augmentation of the medical assistance appropriation. The penalty shall be levied by the department, annually, when it concludes that the HMO did not make a good faith effort to enroll the minimum number of medical assistance subscribers required by this chapter.~~

~~(2) Any HMO found to have violated the provisions of this chapter shall have the right to appeal such a determination to the Secretary of Public Welfare in the manner provided in Title 2 of the Pennsylvania Consolidated Statutes (relating to administrative law and procedure).~~

~~(b) Civil action. Any individual alleging discrimination under this chapter may file a civil cause of action in a court of competent jurisdiction against a health maintenance organization or group insurers alleged to be in violation of~~

~~this chapter. If the health maintenance organization or group insurers is found to have violated this chapter the court may assess attorney fees, cost and penalties against the health maintenance organization or group insurers in addition to any monetary compensation to the plaintiff. A judgment against a health maintenance organization or group insurers shall be referred by the court to the appropriate professional licensing authority or regulatory agency.~~

~~CHAPTER 13~~

~~HEALTH INSURANCE REFORMS~~

~~Section 1301. Continuity on replacement of a group contract or policy.~~

~~(a) Contracts and policies subject to this section.~~

~~Notwithstanding any other provision of law, this section applies to all group health insurance contracts, except group long term care policies, issued by any insurer, nonprofit hospital plan or professional health service corporation and to contracts for the provision or management of health care issued by a managed care organization.~~

~~(b) Persons protected by this section. Any person who had been covered under a replaced contract or policy for at least 90 days before discontinuance or termination of the replaced contract shall be entitled to the protections of this section. Protected individuals include the dependent of an employee where the employee and the dependent had been covered under the replaced contract or policy. Persons covered for less than 90 days before discontinuance or termination of the replaced contract shall be entitled to the protections of this section; however, a preexisting condition exclusion period or waiting period may be imposed if it is not longer than 90 days and if~~

~~the preexisting condition exclusion period or waiting period of the replacement contract or policy is not imposed for a period exceeding the period of time that would be remaining on such exclusion period or waiting period of the replaced policy were it still in effect.~~

~~(c) Protections. No insurer, nonprofit hospital plan, professional health service corporation or managed care organization may do any of the following:~~

~~(1) Request or require a person protected by this section to provide or otherwise seek to obtain evidence of health or genetic status or history as a condition of enrolling the person in a replacement contract or policy subject to this section.~~

~~(2) Decline to enroll any person protected by this section in a replacement contract or policy subject to this section based on health or genetic status or history if the person is otherwise eligible to be enrolled.~~

~~(3) Impose a preexisting condition exclusion period or waiting period upon a person protected by this section for any condition except to the extent that there is a preexisting condition exclusion period or waiting period from the replaced contract or policy that remains unexpired. In this event, the preexisting condition exclusion period or waiting period of the replacement contract or policy may be imposed for a period not to exceed the period of time that would be remaining on the exclusion period or waiting period of the replaced policy were it still in effect.~~

~~(d) Determination of waiting period. If a determination of the existence of a preexisting condition exclusion period or waiting period under the replaced contract or policy is required~~

1 ~~for the insurer, nonprofit hospital plan, professional health~~
2 ~~service corporation or managed care organization issuing or~~
3 ~~entering into a replacement contract or policy to comply with~~
4 ~~this section, the issuer of the replaced contract or policy~~
5 ~~shall, at the request of the issuer of the replacement contract~~
6 ~~or policy, furnish a statement as to the existence and terms of~~
7 ~~any preexisting condition exclusion period or waiting period~~
8 ~~under the replaced contract or policy. If an exclusion period or~~
9 ~~a waiting period exists under the replaced contract or policy,~~
10 ~~the issuer of the replacement contract or policy shall calculate~~
11 ~~the amount of time remaining on the period based on the terms of~~
12 ~~the replaced contract or policy.~~

13 ~~(c) Limited liability after discontinuance. The insurer,~~
14 ~~nonprofit hospital plan, professional health service corporation~~
15 ~~or managed care organization that issued the replaced contract~~
16 ~~or policy is liable after discontinuance of that contract or~~
17 ~~policy only to the extent of its accrued liabilities and~~
18 ~~extensions of benefits.~~

19 ~~(f) Duplication. Nothing in this section shall be construed~~
20 ~~as requiring any employer or any insurer, nonprofit hospital~~
21 ~~plan, professional health service corporation or managed care~~
22 ~~organization issuing or entering into a replacement contract or~~
23 ~~policy to provide the same or similar type of extent of coverage~~
24 ~~as the replaced contract or policy. Nothing in this section~~
25 ~~shall require an employer to provide any health insurance to~~
26 ~~employees.~~

27 ~~Section 1302. Continuity of coverage for individual who changes~~
28 ~~groups.~~

29 ~~(a) Contracts and policies subject to this section. This~~
30 ~~section applies to all contracts and policies set forth in~~

1 ~~section 1301(a).~~

2 ~~(b) Persons protected by this section. The protections of~~
3 ~~this section apply to any person who seeks coverage under or~~
4 ~~enrollment in a group contract or policy issued by any insurer,~~
5 ~~nonprofit hospital plan, professional health service corporation~~
6 ~~or managed care organization if all of the following apply:~~

7 ~~(1) The person was covered under an individual or group~~
8 ~~contract or policy issued by any insurer, nonprofit hospital~~
9 ~~plan, professional health service corporation or managed care~~
10 ~~organization or was covered under a governmental health~~
11 ~~financing program such as medical assistance, Medicare or any~~
12 ~~program established by this act.~~

13 ~~(2) The coverage under the prior contract, policy or~~
14 ~~governmental program terminated with three months before the~~
15 ~~person enrolled or was eligible to enroll in the succeeding~~
16 ~~contract or policy. A period of ineligibility for any health~~
17 ~~plan imposed by terms of employment may not be considered in~~
18 ~~determining whether the coverage ended within three months of~~
19 ~~the date the person enrolled or was eligible to enroll.~~

20 ~~(c) Protections. Any insurer, nonprofit hospital plan,~~
21 ~~professional health service corporation or managed care~~
22 ~~organization may not do any of the following:~~

23 ~~(1) Request or require a person protected by this~~
24 ~~section to provide or otherwise seek to obtain evidence of~~
25 ~~health or genetic status or history as a condition of~~
26 ~~enrolling the person in a contract or policy subject to this~~
27 ~~section.~~

28 ~~(2) Decline to enroll any person protected by this~~
29 ~~section in a contract or policy subject to this section based~~
30 ~~on health or genetic status or history if the person is~~

1 ~~otherwise eligible to be enrolled.~~

2 ~~(3) Impose a preexisting condition exclusion period or~~
3 ~~waiting period upon a person protected by this section for~~
4 ~~any condition except to the extent that there is a~~
5 ~~preexisting condition exclusion period or waiting period from~~
6 ~~the prior contract or policy that remains unexpired. In this~~
7 ~~event, the preexisting condition exclusion period or waiting~~
8 ~~period of the replacement contract or policy may be imposed~~
9 ~~for a period not to exceed the period of time that would be~~
10 ~~remaining on the exclusion period or waiting period of the~~
11 ~~prior policy were it still in effect.~~

12 ~~(d) Determination of waiting period. If a determination of~~
13 ~~the existence of a preexisting condition exclusion period or~~
14 ~~waiting period under the prior contract or policy is required~~
15 ~~for the insurer, nonprofit hospital plan, professional health~~
16 ~~service corporation or managed care organization issuing or~~
17 ~~entering into a succeeding contract or policy to comply with~~
18 ~~this section, the issuer of the prior contract or policy shall,~~
19 ~~at the request of the issuer of the succeeding contract or~~
20 ~~policy, furnish a statement as to the existence and terms of any~~
21 ~~preexisting condition exclusion period or waiting period under~~
22 ~~the prior contract or policy. If an exclusion period or a~~
23 ~~waiting period exists under the replaced contract or policy, the~~
24 ~~issuer of the subsequent contract or policy shall calculate the~~
25 ~~amount of time remaining on the period based on the terms of the~~
26 ~~prior contract or policy.~~

27 ~~(e) Duplication. Nothing in this section shall be construed~~
28 ~~as requiring any employer or any insurer, nonprofit hospital~~
29 ~~plan, professional health service corporation or managed care~~
30 ~~organization issuing or entering into a succeeding contract or~~

~~policy to provide the same or similar type or extent of coverage as the prior contract or policy. Nothing in this section shall require an employer to provide any health insurance to employees.~~

~~Section 1303. Extension of benefits for disabled persons.~~

~~(a) Policies subject to this section. This section applies to all group health insurance policies, except group long term care policies or group long term disability policies, or group policies providing coverage only for dental expense issued by insurers, professional health service corporations, nonprofit hospital plans or health maintenance organizations doing business in this Commonwealth.~~

~~(b) Requirement. Every group policy subject to this section must provide a reasonable extension of benefits for a person, including a dependent child covered under the policy, who is totally disabled on the date the group policy is discontinued, or on the date coverage for a subgroup in the policy is discontinued. A person may not be charged during the period of extension. An extension of benefits provision is reasonable if it provides benefits for covered expenses directly relating to the condition causing total disability for at least six months following the effective date of discontinuance.~~

~~(c) Description of benefits extension. The extension of benefits provision must be described in all policies and group certificates. The benefits payable during any period of extension are subject to the regular benefit limits under the policy.~~

~~(d) Liability after discontinuance. After discontinuance of a policy, the insurer, professional health service corporation, nonprofit hospital plan corporation or health maintenance~~

1 ~~organization remains liable only to the extent of its accrued~~
2 ~~liabilities and extensions of benefits. The liability of the~~
3 ~~insurer or health maintenance organization is the same whether~~
4 ~~the group policyholder or other entity secures replacement~~
5 ~~coverage from any insurer, professional health service~~
6 ~~corporation, nonprofit hospital plan corporation or health~~
7 ~~maintenance organization, self insures or foregoes the provision~~
8 ~~of coverage.~~

9 ~~(c) Definition of term. The Secretary of Health shall in~~
10 ~~the manner provided by law, promulgate a regulation defining~~
11 ~~"total disability" for purposes of this section. The definition~~
12 ~~must identify persons who are unable, as a result of disability,~~
13 ~~to obtain comparable alternative coverage through comparable~~
14 ~~employment or otherwise. The regulations promulgated under this~~
15 ~~subsection shall not be subject to the act of June 25, 1982~~
16 ~~(P.L.633, No.181), known as the Regulatory Review Act.~~
17 ~~Section 1304. Preexisting conditions.~~

18 ~~(a) Disease or condition specific condition exclusion~~
19 ~~limited. Notwithstanding any other provision of law, it shall~~
20 ~~be unlawful for any insurer, nonprofit hospital plan,~~
21 ~~professional health service corporation or managed care~~
22 ~~organization to exclude, limit or reduce coverage or benefits in~~
23 ~~a group contract or policy beyond the waiting periods permitted~~
24 ~~under this act for a specifically named or described preexisting~~
25 ~~disease, condition or genetic predisposition on the basis of its~~
26 ~~preexistence.~~

27 ~~(b) Mandated offer to all group members. When offering a~~
28 ~~contract or policy to a group, any insurer, professional health~~
29 ~~service corporation, nonprofit hospital plan corporation or~~
30 ~~managed care organization shall also offer coverage of all~~

~~members of the group who reside within the service area of the insurers' corporation or organization. This requirement may be met by offering coverage on an individual basis for some group members. Nothing in this section shall be construed as requiring any employer to accept any such offer.~~

~~(c) Limitation on preexisting condition waiting periods.— Notwithstanding any other provision of law, it shall be unlawful for any insurer, nonprofit hospital plan, professional health service corporation or managed care organization to include in a group contract or policy a preexisting condition exclusion period or waiting period which is longer than six months.~~

~~(d) Preexisting condition waiting periods for individual policies.— Any insurer, nonprofit hospital plan, professional health service corporation, or managed care organization that offers individual or nongroup contracts or policies shall also offer policies to individuals and nongroup subscribers that do not contain a preexisting condition exclusion period or waiting period which is longer than six months.~~

~~CHAPTER 15~~

~~STUDIES AND HEARINGS ON HEALTH CARE~~

~~Section 1501.— Hospital uncompensated charity care study.~~

~~(a) Charity care data.— The Health Care Cost Containment Council shall collect each year commencing with the calendar year beginning January 1, 1993, the following charity care data from all acute care hospitals licensed in this Commonwealth:~~

~~(1) Catastrophic inpatient and outpatient costs which are defined as the allowable audited costs of services provided to persons above 150% of the poverty level, with an unpaid personal liability greater than annual family income, less an amount equivalent to 150% of the Federal poverty~~

1 level. Such amount must be net, following reasonable
2 collection procedures, consistently applied, and may not
3 include any costs or services for which reimbursement could
4 have been secured from the medical assistance or Medicare
5 program or other third party payor, nor any costs or services
6 rendered by a hospital in fulfillment of any charity care
7 obligation funding from foundations or Federal or State
8 sources including funding under the Hill Burton program.

9 (2) ~~Medical assistance which is defined as the inpatient~~
10 ~~and outpatient patient pay amount for medical assistance~~
11 ~~recipients which has been unable to be collected following~~
12 ~~reasonable collection procedures, consistently applied.~~

13 (3) ~~Underinsured inpatient charity care which is defined~~
14 ~~as the allowable audited cost of services provided to~~
15 ~~underinsured persons below 150% of the Federal poverty level,~~
16 ~~following reasonable collection procedures, consistently~~
17 ~~applied. Such amount may not include payment for goods or~~
18 ~~services which could have been reimbursed under the medical~~
19 ~~assistance or Medicare program or other third party payor,~~
20 ~~nor any costs or services rendered by a hospital in~~
21 ~~fulfillment of any charity care obligation funding from~~
22 ~~foundations or Federal or State sources including funding~~
23 ~~under the Hill Burton program.~~

24 (4) ~~Uninsured inpatient charity care which is defined as~~
25 ~~the allowable audited cost of services provided to persons~~
26 ~~without public or private insurance coverage, with income~~
27 ~~below 150% of the poverty level, following reasonable~~
28 ~~collection procedures, consistently applied. Such amount may~~
29 ~~not include payment for goods or services which could have~~
30 ~~been reimbursed under the medical assistance or Medicare~~

~~program or other third party payor, nor any costs or services rendered by a hospital in fulfillment of any charity care obligation funding from foundations or Federal or State sources including funding under the Hill Burton program.~~

~~(5) Additional data that the council believes is necessary in determining charity care provided by acute care hospitals.~~

~~(b) Recommendations to General Assembly. Commencing March 1, 1994, and every March 1 thereafter, the council shall submit recommendations to the Governor and the General Assembly as to whether a source of funding is required for uncompensated charity care provided by acute care hospitals in this Commonwealth. These recommendations shall be based on data collection for uncompensated charity care as defined in this section for the preceding calendar year.~~

~~(c) Annual hearings of the General Assembly. The Health and Welfare Committee of the House of Representatives and the Public Health and Welfare Committee of the Senate shall hold annual joint public hearings in each region to review the council's recommendations for the level of funding required for charity care.~~

~~Section 1502. Medical assistance reimbursement.~~

~~(a) Joint hearings. The Health and Welfare Committee of the House of Representatives and the Public Health and Welfare Committee of the Senate shall hold joint public hearings in each region of this Commonwealth to review the adequacy of payments to providers under the medical assistance program.~~

~~(b) Joint Select Committee on Medical Assistance Reimbursement Procedures. The President pro tempore of the Senate and the Speaker of the House of Representatives shall~~

~~1 appoint members to a Joint Select Committee to study the~~
~~2 feasibility of implementing material improvements in the~~
~~3 processing of claims for medical assistance reimbursements to~~
~~4 providers, and in the use of Pennsylvania Medical Assistance by~~
~~5 its low income citizens. The study shall include, but not be~~
~~6 limited to, the following:~~

~~7 (1) The cost effectiveness of contracting the entire~~
~~8 medical assistance reimbursement process to a fiscal~~
~~9 intermediary, such as Blue Cross/Blue Shield.~~

~~10 (2) Explanation sections in all claim forms so that they~~
~~11 contain a clear description in English of the applicable~~
~~12 codes and messages in order that providers and recipient's~~
~~13 can respond to or complete the form.~~

~~14 (3) Additional staffing of the 800 telephone number so~~
~~15 that providers and beneficiaries can verify eligibility to~~
~~16 receive benefits, inquire as to applicable eligibility~~
~~17 requirements and coverage restrictions, and receive a~~
~~18 verification number as to preclude denial for reasons~~
~~19 inconsistent with the information received by telephone.~~

~~20 (4) Development of a special training for providers,~~
~~21 identifying those parts of the claim forms with the greatest~~
~~22 incidence of error and explaining how to avoid such errors.~~

~~23 (5) Submission of claims by providers on floppy disks,~~
~~24 tape to tape billing or telecommunications.~~

~~25 (6) Development of computer software that will~~
~~26 automatically identify errors by validity edit which verifies~~
~~27 that the data entered into any field or claim line on a claim~~
~~28 is appropriate for that field or claim line.~~

~~29 (7) Rewriting the provider handbook and reorganizing~~
~~30 provider bulletins on a regular basis to make these documents~~

~~more understandable and usable.~~

~~(c) Reports. Each committee shall issue a report by
December 31, 1992, and the General Assembly shall enact
legislation, if necessary, to adjust medical assistance provider
reimbursement to comply with Federal requirements and to
implement changes in medical assistance reimbursement
procedures.~~

~~Section 1503. Cost of mandated health benefits.~~

~~(a) Content of study. The Health Care Cost Containment
Council, through its Mandated Benefits Review Panel, is directed
to study the costs and effectiveness of existing mandated health
benefits to businesses. For each of the existing mandated health
benefits, the review panel shall determine the financial impact
and health care effectiveness of the existing benefit, including
at least:~~

~~(1) The number of persons utilizing the existing
benefit.~~

~~(2) The extent to which elimination of the existing
benefit as a mandated health benefit would result in
inadequate health care for the population of this
Commonwealth.~~

~~(3) The cost effectiveness of the existing benefit in
reducing further more costly medical procedures.~~

~~(4) The impact of the existing benefit on the total cost
of health care within this Commonwealth.~~

~~(5) The impact of the existing benefit on health
insurance costs of health care purchasers.~~

~~(6) The impact of the existing benefit on administrative
expenses of health care insurers.~~

~~(7) The extent to which elimination of the existing~~

~~benefit as a mandated health benefit would result in increased medical assistance expenditures and charity care.~~

~~(8) The extent to which elimination of the existing benefit as a mandated health benefit could be paid for by the person receiving the existing benefit.~~

~~(9) The impact of the existing benefit on the ability of small businesses to purchase health insurance for their employees and on the ability of self-employed persons to purchase health insurance.~~

~~(b) Findings and recommendations. The review panel shall issue a report to the council by June 30, 1993, outlining their findings on the costs and effectiveness of the existing mandated health benefits. After review of the panel's report, the council shall submit a final report to the Governor and the General Assembly by December 31, 1993, outlining their findings on the costs and effectiveness of the existing mandated health benefits and recommendations as to whether any or all existing mandated health benefits should be eliminated.~~

~~Section 1504. Physician acceptance of medical assistance patients.~~

~~The council shall, for all providers within this Commonwealth and within the appropriate regions and subregions within this Commonwealth, prepare and issue quarterly reports that provide information on the number of physicians, by specialty, on the staff of each hospital or ambulatory service facility and the number and names of those physicians, by specialty, on the staff that accept medical assistance patients.~~

~~Section 1505. Subsidies provided by health service corporation and hospital plan corporations.~~

~~The health service corporation and hospital plan corporations~~

~~presently are exempt from paying the 2% premium tax. In lieu of this exemption, and as part of their obligation to serve low-income subscribers, the health service corporation and hospital plan corporations shall submit annually, commencing on January 31, 1993, to the Department of Health and the Department of Insurance data documenting their subsidies to health care purchasers that they provide in lieu of their exemption from the 2% premium tax. In submitting this data, the health service corporation and hospital plan corporations shall indicate which subsidies are based on the income of the health care purchaser or beneficiary.~~

~~CHAPTER 31~~

~~MISCELLANEOUS PROVISIONS~~

~~Section 3101. Mandated coverage.~~

~~(a) Health care providers. All insurance companies writing group accident and sickness insurance in this Commonwealth shall by January 1, 1993, offer in every area in which they write such insurance, a policy or policies meeting all State mandated coverage. In selecting the health care providers, the insurance companies shall utilize the data produced by the council and other relevant data to design the insurance products.~~

~~(b) Approval. All such policies shall be approved by the Insurance Department to assure that the policies provide for adequate urgent and emergency care from other health providers, should that be needed and to ensure sufficient numbers and types of health care providers.~~

~~Section 3102. Group accident and sickness insurance.~~

~~In addition to the provisions of section 621.2(a)(3) of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, group accident and sickness insurance shall~~

~~1 also include insurance under policies issued to the trustees of
2 a fund established by any two or more employers or by an insurer
3 licensed in this Commonwealth.~~

~~4 Section 3103. Severability.~~

~~5 The provisions of this act are severable. If any provision of
6 this act or its application to any person or circumstance is
7 held invalid, the invalidity shall not affect other provisions
8 or applications of this act which can be given effect without
9 the invalid provision or application.~~

~~10 Section 3104. Repeals.~~

~~11 All acts and parts of acts are repealed insofar as they are
12 inconsistent with this act.~~

~~13 Section 3105. Expiration.~~

~~14 This act shall expire December 31, 1999, unless reenacted by
15 the General Assembly.~~

~~16 Section 3106. Effective date.~~

~~17 This act shall take effect September 1, 1992, or immediately,
18 whichever is later.~~

19 CHAPTER 1

<—

20 GENERAL PROVISIONS

21 SECTION 101. SHORT TITLE.

22 THIS ACT SHALL BE KNOWN AND MAY BE CITED AS THE HEALTH CARE
23 PARTNERSHIP ACT.

24 SECTION 102. LEGISLATIVE FINDINGS AND INTENT.

25 (A) DECLARATION.--THE GENERAL ASSEMBLY FINDS AND DECLARES
26 THAT:

27 (1) ALL CITIZENS OF THIS COMMONWEALTH HAVE A RIGHT TO
28 ACCESS TO AFFORDABLE AND REASONABLY PRICED HEALTH CARE AND TO
29 NONDISCRIMINATORY TREATMENT BY HEALTH INSURERS AND PROVIDERS.

30 (2) THE UNINSURED HEALTH CARE POPULATION OF THIS

1 COMMONWEALTH IS OVER ONE MILLION PERSONS, AND MANY THOUSANDS
2 MORE LACK ADEQUATE INSURANCE COVERAGE. APPROXIMATELY TWO-
3 THIRDS OF THE UNINSURED ARE EMPLOYED OR DEPENDENTS OF
4 EMPLOYED PERSONS.

5 (3) OVER ONE-THIRD OF THE UNINSURED HEALTH CARE
6 POPULATION ARE CHILDREN. UNINSURED CHILDREN ARE OF PARTICULAR
7 CONCERN BECAUSE OF THEIR NEED FOR ONGOING PREVENTATIVE AND
8 PRIMARY CARE. MEASURES NOT TAKEN TO CARE FOR SUCH CHILDREN
9 NOW WILL RESULT IN HIGHER HUMAN AND FINANCIAL COSTS LATER.
10 ACCESS TO TIMELY AND APPROPRIATE PRIMARY CARE IS PARTICULARLY
11 SERIOUS FOR WOMEN WHO RECEIVE LATE OR NO PRENATAL CARE WHICH
12 INCREASES THE RISK OF LOW BIRTH WEIGHTS AND INFANT MORTALITY.

13 (4) THE UNINSURED AND UNDERINSURED LACK ACCESS TO TIMELY
14 AND APPROPRIATE PRIMARY AND PREVENTATIVE CARE. AS A RESULT,
15 THEY OFTEN DELAY OR FOREGO HEALTH CARE, WITH THE RESULTING
16 INCREASED RISK OF DEVELOPING MORE SEVERE CONDITIONS, WHICH
17 ARE MORE EXPENSIVE TO TREAT. THIS TENDENCY OF THE MEDICALLY
18 INDIGENT TO DELAY CARE AND TO SEEK AMBULATORY CARE IN
19 HOSPITAL-BASED SETTINGS ALSO CAUSES INEFFICIENCIES IN THE
20 HEALTH CARE SYSTEM.

21 (5) HEALTH MARKETS HAVE BEEN DISTORTED THROUGH COST
22 SHIFTS FOR THE UNCOMPENSATED HEALTH CARE COSTS OF UNINSURED
23 CITIZENS OF THIS COMMONWEALTH WHICH HAS CAUSED DECREASED
24 COMPETITIVE CAPACITY ON THE PART OF THOSE HEALTH CARE
25 PROVIDERS WHO SERVE THE POOR, AND INCREASED COSTS OF OTHER
26 HEALTH CARE PAYORS.

27 (6) NOT-FOR-PROFIT HOSPITALS WHICH HAVE BEEN GRANTED A
28 TAX-FREE STATUS BY THE STATE VARY IN THE AMOUNT OF CHARITABLE
29 UNCOMPENSATED HEALTH CARE THEY PROVIDE.

30 (7) ALTHOUGH THE PROPER IMPLEMENTATION BY HOSPITALS OF

1 SPEND-DOWN PROVISIONS UNDER MEDICAL ASSISTANCE SHOULD RESULT
2 IN THE PROVISION OF THE MAJORITY OF ALL HOSPITAL CARE FOR THE
3 UNINSURED THROUGH THE MEDICAL ASSISTANCE PROGRAM, HOSPITALS
4 VARY WIDELY IN THEIR ABILITY TO ALLOW PATIENTS TO INCUR
5 EXPENSES SO THEY CAN QUALIFY FOR MEDICAL ASSISTANCE.

6 (8) MANY CITIZENS IN RURAL AND INNER-CITY AREAS OF THIS
7 COMMONWEALTH DO NOT HAVE REASONABLE ACCESS TO PRIMARY HEALTH
8 CARE DUE IN PART TO INSUFFICIENT NUMBERS OF PRIMARY HEALTH
9 CARE PROVIDERS.

10 (9) NO ONE SECTOR CAN ABSORB THE COST OF PROVIDING
11 HEALTH CARE TO ALL CITIZENS OF THIS COMMONWEALTH WHO CANNOT
12 AFFORD HEALTH CARE ON THEIR OWN. THE COST IS TOO LARGE FOR
13 THE PUBLIC SECTOR ALONE TO BEAR AND INSTEAD REQUIRES THE
14 ESTABLISHMENT OF A PUBLIC/PRIVATE PARTNERSHIP TO SHARE THE
15 COSTS IN A MANNER ECONOMICALLY FEASIBLE FOR ALL INTERESTS.
16 THE MAGNITUDE OF THIS NEED ALSO REQUIRES THAT IT BE DONE ON A
17 TIME-PHASED, COST-MANAGED AND PLANNED BASIS.

18 (B) INTENT.--IT IS THE INTENT OF THE GENERAL ASSEMBLY AND
19 THE PURPOSE OF THIS ACT THAT:

20 (1) ELIGIBLE CITIZENS OF THIS COMMONWEALTH HAVE ACCESS
21 TO COST-EFFECTIVE, COMPREHENSIVE HEALTH COVERAGE WHEN THEY
22 ARE UNABLE TO AFFORD COVERAGE OR OBTAIN IT.

23 (2) CARE BE PROVIDED IN APPROPRIATE SETTINGS BY
24 EFFICIENT PROVIDERS, CONSISTENT WITH HIGH QUALITY CARE AND AT
25 AN APPROPRIATE STAGE, SOON ENOUGH TO AVERT THE NEED FOR
26 OVERLY EXPENSIVE TREATMENT.

27 (3) EQUITY CAN BE ASSURED AMONG HEALTH PROVIDERS AND
28 PAYORS BY PROVIDING A MECHANISM FOR PROVIDERS, EMPLOYERS, THE
29 PUBLIC SECTOR AND PATIENTS TO SHARE IN FINANCING INDIGENT
30 HEALTH CARE.

1 SECTION 103. DEFINITIONS.

2 THE FOLLOWING WORDS AND PHRASES WHEN USED IN THIS ACT SHALL
3 HAVE THE MEANINGS GIVEN TO THEM IN THIS SECTION UNLESS THE
4 CONTEXT CLEARLY INDICATES OTHERWISE:

5 "BUREAU." THE BUREAU OF RURAL AND INNER-CITY HEALTH CARE
6 SERVICES IN THE DEPARTMENT OF HEALTH.

7 "CHILD." A PERSON UNDER 19 YEARS OF AGE.

8 "COUNCIL." THE HEALTH CARE COST CONTAINMENT COUNCIL.

9 "DEPARTMENT." THE DEPARTMENT OF PUBLIC WELFARE OF THE
10 COMMONWEALTH.

11 "DISPROPORTIONATE SHARE HOSPITAL." EACH HOSPITAL, INCLUDING
12 DISTINCT PARTS, PROVIDING A CERTAIN NUMBER OR PERCENTAGE OF
13 INPATIENT SERVICES PAID THROUGH THE MEDICAL ASSISTANCE PROGRAM,
14 AS DEFINED IN REGULATIONS OF THE DEPARTMENT OF PUBLIC WELFARE
15 AND THE FEDERALLY APPROVED MEDICAL ASSISTANCE STATE PLAN.

16 "EPSDT." EARLY AND PERIODIC SCREENING, DIAGNOSIS AND
17 TREATMENT.

18 "GROUP." ANY GROUP FOR WHICH A HEALTH INSURANCE POLICY IS
19 WRITTEN IN THE COMMONWEALTH OF PENNSYLVANIA.

20 "HEALTH MAINTENANCE ORGANIZATION" OR "HMO." AN ENTITY
21 ORGANIZED AND REGULATED UNDER THE ACT OF DECEMBER 29, 1972
22 (P.L.1701, NO.364), KNOWN AS THE HEALTH MAINTENANCE ORGANIZATION
23 ACT.

24 "HEALTH SERVICE CORPORATION." A PROFESSIONAL HEALTH SERVICE
25 CORPORATION AS DEFINED IN 40 PA.C.S. (RELATING TO INSURANCE).

26 "HILL-BURTON PROGRAM." THE HOSPITAL SURVEY AND CONSTRUCTION
27 PROGRAM PROVIDED IN THE HILL-BURTON ACT (60 STAT. 1040, 42
28 U.S.C. § 291 ET SEQ.).

29 "HOSPITAL." AN INSTITUTION HAVING AN ORGANIZED MEDICAL STAFF
30 WHICH IS ENGAGED PRIMARILY IN PROVIDING TO INPATIENTS, BY OR

1 UNDER THE SUPERVISION OF PHYSICIANS, DIAGNOSTIC AND THERAPEUTIC
2 SERVICES FOR THE CARE OF INJURED, DISABLED, PREGNANT, DISEASED
3 OR SICK OR MENTALLY ILL PERSONS. THE TERM INCLUDES FACILITIES
4 FOR THE DIAGNOSIS AND TREATMENT OF DISORDERS WITHIN THE SCOPE OF
5 SPECIFIC MEDICAL SPECIALTIES, INCLUDING FACILITIES WHICH PROVIDE
6 CARE AND TREATMENT EXCLUSIVELY FOR THE MENTALLY ILL AND DRUG OR
7 ALCOHOL INPATIENT DETOXIFICATION OR REHABILITATIVE CARE. THE
8 TERM DOES NOT INCLUDE INPATIENT NONHOSPITAL ACTIVITY AS
9 DESCRIBED IN 28 PA. CODE § 701.1 (RELATING TO GENERAL
10 DEFINITIONS), PUBLICLY OWNED INPATIENT FACILITIES OR SKILLED OR
11 INTERMEDIATE CARE NURSING FACILITIES. THE TERM ALSO DOES NOT
12 INCLUDE A FACILITY WHICH IS OPERATED BY A RELIGIOUS ORGANIZATION
13 FOR THE PURPOSE OF PROVIDING HEALTH CARE SERVICES EXCLUSIVELY TO
14 CLERGYMEN OR OTHER PERSONS IN A RELIGIOUS PROFESSION WHO ARE
15 MEMBERS OF A RELIGIOUS DENOMINATION OR A FACILITY PROVIDING
16 TREATMENT SOLELY ON THE BASIS OF PRAYER OR SPIRITUAL MEANS.

17 "HOSPITAL PLAN CORPORATION." A HOSPITAL PLAN CORPORATION AS
18 DEFINED IN 40 PA.C.S. (RELATING TO INSURANCE).

19 "INSURER." AN ENTITY SUBJECT TO THE ACT OF MAY 17, 1921
20 (P.L.682, NO.284), KNOWN AS THE INSURANCE COMPANY LAW OF 1921.

21 "MAAC." THE MEDICAL ASSISTANCE ADVISORY COMMITTEE.

22 "MANAGED CARE ORGANIZATION." A HEALTH MAINTENANCE
23 ORGANIZATION ORGANIZED AND REGULATED UNDER THE ACT OF DECEMBER
24 29, 1972 (P.L.1701, NO.364), KNOWN AS THE HEALTH MAINTENANCE
25 ORGANIZATION ACT; A RISK-ASSUMING PREFERRED PROVIDER
26 ORGANIZATION OR EXCLUSIVE PROVIDER ORGANIZATION, ORGANIZED AND
27 REGULATED UNDER THE ACT OF MAY 17, 1921 (P.L.682, NO.284), KNOWN
28 AS THE INSURANCE COMPANY LAW OF 1921.

29 "MEDICAL ASSISTANCE." THE STATE PROGRAM OF MEDICAL
30 ASSISTANCE ESTABLISHED UNDER THE ACT OF JUNE 13, 1967 (P.L.31,

1 NO.21), KNOWN AS THE PUBLIC WELFARE CODE.

2 "MEDICAID." THE FEDERAL MEDICAL ASSISTANCE PROGRAM
3 ESTABLISHED UNDER TITLE XIX OF THE SOCIAL SECURITY ACT (PUBLIC
4 LAW 74-271, 42 U.S.C. § 301 ET SEQ.).

5 "MEDICALLY INDIGENT." FAMILIES AND INDIVIDUALS WHO LACK
6 SUFFICIENT INCOME OR FINANCIAL RESOURCES THROUGH INSURANCE OR
7 OTHER MEANS TO PAY FOR NECESSARY HEALTH CARE SERVICES.

8 "MEDICALLY UNDERSERVED DESIGNATED SHORTAGE AREA." A RURAL OR
9 INNER-CITY AREA DESIGNATED BY THE SECRETARY OF HEALTH AS A
10 PHYSICIAN SHORTAGE AREA OR A MEDICALLY UNDERSERVED AREA OR
11 CRITICAL MANPOWER SHORTAGE AREA AS DEFINED BY THE UNITED STATES
12 DEPARTMENT OF HEALTH AND HUMAN SERVICES.

13 "MIC." THE FEDERAL MATERNAL, INFANT AND CHILD CARE PROGRAM.

14 "PARENT." A NATURAL PARENT, STEPPARENT, ADOPTIVE PARENT,
15 GUARDIAN OR CUSTODIAN OF A CHILD.

16 "SPECIALTY AND SUPPLEMENTAL HEALTH SERVICES." SERVICES NOT
17 INCLUDED AS PRIMARY HEALTH SERVICES, SUCH AS HOSPITAL CARE, HOME
18 HEALTH SERVICES, REHABILITATIVE SERVICES, MENTAL HEALTH
19 SERVICES, DRUG AND ALCOHOL SERVICES AND AMBULATORY SURGICAL
20 SERVICES.

21 "SPEND-DOWN." THE QUALIFYING PROCEDURE FOR THE PENNSYLVANIA
22 MEDICAL ASSISTANCE PROGRAM SET FORTH IN 55 PA. CODE, CH. 181
23 (RELATING TO INCOME PROVISIONS FOR CATEGORICALLY NEEDY NONMONEY
24 PAYMENT (NMP-MA) AND MEDICALLY NEEDY ONLY (MNO-MA) MEDICAL
25 ASSISTANCE (MA)).

26 "TITLE XIX." TITLE XIX OF THE SOCIAL SECURITY ACT (PUBLIC
27 LAW 74-271, 42 U.S.C. § 301 ET SEQ.).

28 "WIC." THE FEDERAL WOMEN, INFANTS AND CHILDREN PROGRAM.

29 CHAPTER 5

30 MEDICAL ASSISTANCE PROGRAM

1 SECTION 501. HOSPITAL RESPONSIBILITIES UNDER MEDICAL ASSISTANCE
2 PROGRAM.

3 (A) NECESSARY CARE.--EACH LICENSED ACUTE CARE HOSPITAL SHALL
4 NOT DENY NECESSARY AND TIMELY HEALTH CARE DUE TO A PERSON'S
5 INABILITY TO PAY IN ADVANCE FROM CURRENT INCOME OR RESOURCES FOR
6 ALL OR PART OF THAT CARE.

7 (B) INSTALLMENT AGREEMENTS.--HOSPITALS SHALL ENTER INTO
8 REASONABLE INSTALLMENT AGREEMENTS TO COVER THE SPEND-DOWN COST
9 OF THE CARE NECESSARY FOR THE PERSON TO QUALIFY FOR MEDICAL
10 ASSISTANCE COVERAGE. WITHIN SIX MONTHS OF THE EFFECTIVE DATE OF
11 THIS ACT, THE DEPARTMENT SHALL ISSUE GUIDELINES TO ENSURE
12 UNIFORMITY OF THIS PROVISION AND COMPLIANCE WITH FEDERAL AND
13 STATE REQUIREMENTS.

14 (C) PROHIBITIONS.--IT IS UNLAWFUL FOR ANY HOSPITAL LICENSED
15 BY THE COMMONWEALTH:

16 (1) TO REQUIRE, AS A CONDITION OF ADMISSION OR
17 TREATMENT, ASSURANCE FROM THE PATIENT OR ANY OTHER PERSON
18 THAT THE PATIENT IS NOT ELIGIBLE FOR OR WILL NOT APPLY FOR
19 MEDICAL ASSISTANCE;

20 (2) TO DENY OR DELAY ADMISSION OR TREATMENT OF A PERSON
21 SOLELY BECAUSE OF HIS CURRENT OR POSSIBLE FUTURE STATUS AS A
22 MEDICAL ASSISTANCE RECIPIENT;

23 (3) TO TRANSFER A PATIENT TO ANOTHER HEALTH CARE
24 PROVIDER BECAUSE OF HIS CURRENT OR POSSIBLE STATUS AS A
25 MEDICAL ASSISTANCE RECIPIENT;

26 (4) TO DISCHARGE A PATIENT FROM CARE BECAUSE OF HIS
27 CURRENT OR POSSIBLE FUTURE STATUS AS A MEDICAL ASSISTANCE
28 RECIPIENT; OR

29 (5) TO DISCOURAGE ANY PERSON WHO WOULD BE ELIGIBLE FOR
30 THE MEDICAL ASSISTANCE PROGRAM FROM APPLYING OR SEEKING

1 NEEDED HEALTH CARE OR NEEDED ADMISSION TO A HEALTH CARE
2 FACILITY BECAUSE OF HIS INABILITY TO PAY FOR THAT CARE.

3 (D) APPLICATION FOR MEDICAL ASSISTANCE.--HOSPITALS SHALL
4 PROVIDE UNINSURED PATIENTS WITH ASSISTANCE IN COMPLETING AN
5 APPLICATION FOR MEDICAL ASSISTANCE AS SOON AS PRACTICABLE AFTER
6 ADMISSION TO THE HOSPITAL.

7 (E) ACCESS TO ALL SERVICES.--HOSPITAL MEDICAL STAFF SHALL
8 ENSURE THAT ALL MEDICAL ASSISTANCE RECIPIENTS HAVE FULL ACCESS
9 TO ALL AVAILABLE INPATIENT PHYSICIAN SERVICES AND ANY DEPARTMENT
10 OF THE FACILITY. THE HOSPITAL MEDICAL STAFF SHALL ESTABLISH AN
11 OUTPATIENT PHYSICIAN REFERRAL SERVICE TO ASSIST MEDICAL
12 ASSISTANCE RECIPIENTS WITH REFERRALS TO PRIMARY CARE AND
13 SPECIALIST PHYSICIANS ON AN EQUITABLE, ROTATING BASIS. EACH
14 MEDICAL STAFF SHALL BE DEEMED TO HAVE ESTABLISHED AN OUTPATIENT
15 REFERRAL SERVICE IF IT PARTICIPATES IN A COMPARABLE
16 MULTI-HOSPITAL, COUNTY OR REGIONAL REFERRAL SERVICE OPERATED BY A
17 COUNTY OR STATE MEDICAL SOCIETY.

18 SECTION 502. MEDICAL ASSISTANCE OUTREACH.

19 (A) CONTENT OF PROGRAM.--THE DEPARTMENT SHALL ESTABLISH AND
20 ADMINISTER AN OUTREACH PROGRAM TO ENROLL PEOPLE WHO ARE ELIGIBLE
21 FOR MEDICAL ASSISTANCE BUT HAVE NOT ENROLLED. THIS SHALL
22 INCLUDE:

23 (1) PROVIDING FOR ON-SITE APPLICATIONS AND ELIGIBILITY
24 DETERMINATION AT ALL DISPROPORTIONATE SHARE HOSPITALS AND
25 FEDERAL QUALIFIED HEALTH CENTERS.

26 (2) DEVELOPING A PROGRAM OF PUBLIC SERVICE ANNOUNCEMENTS
27 TO BE AIRED ON TELEVISION AND RADIO ON A REGULAR STATEWIDE
28 BASIS, ADVISING CITIZENS OF:

29 (I) EXPANDED MEDICAL ASSISTANCE ELIGIBILITY FOR
30 PREGNANT WOMEN, INFANTS, THE ELDERLY, THE DISABLED,

1 PERSONS WITH ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS);

2 (II) GENERAL ELIGIBILITY REQUIREMENTS, SPEND-DOWN,
3 EXPEDITED ISSUANCE OF MEDICAL ASSISTANCE CARDS, AND HOW
4 AND WHERE TO APPLY; AND

5 (III) AVAILABILITY OF PRIMARY AND SPECIALTY CARE
6 PHYSICIANS WHO ACCEPT MEDICAL ASSISTANCE.

7 (3) PROVIDING TO MEDICAL ASSISTANCE RECIPIENTS PERIODIC
8 NOTIFICATION OF PRIMARY AND SPECIALTY CARE PHYSICIAN
9 AVAILABILITY, PROCEDURE TO ACCESS PHYSICIANS, COMPLAINT
10 PROCEDURES AND CONSUMER RIGHTS.

11 (4) DEVELOPING PAMPHLETS AND INFORMATIONAL SERVICES FOR
12 MEDICAL ASSISTANCE PROVIDERS TO HELP PROVIDERS INFORM
13 PATIENTS ABOUT MEDICAL ASSISTANCE OPTIONS AND ELIGIBILITY.

14 (5) PROVIDING THE GENERAL ASSEMBLY AND THE PUBLIC AN
15 ANNUAL REPORT FOR EACH FISCAL YEAR, DETAILING THE OUTREACH
16 AND ENROLLMENT EFFORTS TAKEN BY EACH COUNTY ASSISTANCE
17 OFFICE, AND REPORTING BY COUNTY ON THE NUMBER OF CITIZENS
18 ENROLLED IN THE MEDICAL ASSISTANCE PROGRAM AND THE PROJECTED
19 MEDICAL ASSISTANCE ELIGIBLE POPULATION OF EACH COUNTY.

20 (B) APPLICATIONS FOR MEDICAL ASSISTANCE AND CHILDREN'S
21 HEALTH CARE PLAN.--

22 (1) PERSONS TAKING APPLICATIONS FOR MEDICAL ASSISTANCE,
23 INCLUDING PERSONS AT SITES OTHER THAN COUNTY ASSISTANCE
24 OFFICES, SHALL OFFER TO TAKE AN APPLICATION FOR COVERAGE
25 UNDER THE CHILDREN'S HEALTH CARE PLAN, AS ESTABLISHED UNDER
26 CHAPTER 7, FOR ANY CHILD. PERSONS TAKING APPLICATIONS FOR THE
27 CHILDREN'S HEALTH CARE PLAN SHALL PROMPTLY FORWARD THE
28 APPLICATIONS TO THE ENTITY DESIGNATED BY THE HEALTH SERVICE
29 CORPORATION AND HOSPITAL PLAN CORPORATIONS TO ADMINISTER THE
30 PLAN.

1 (2) THE DEPARTMENT SHALL SUPPLY AN APPLICATION FORM FOR
2 ENROLLMENT IN THE CHILDREN'S HEALTH CARE PLAN UNDER CHAPTER 7
3 WITH ANY NOTICE OF TERMINATION FROM MEDICAL ASSISTANCE WHERE
4 A CHILD UNDER 19 YEARS OF AGE IS AMONG THE PERSONS BEING
5 TERMINATED.

6 (C) INCREASING MANAGED CARE SERVICES.--THE DEPARTMENT SHALL:

7 (1) COORDINATE EFFORTS TO INCREASE THE NUMBER OF MANAGED
8 CARE ORGANIZATIONS PROVIDING HEALTH SERVICES TO MEDICAL
9 ASSISTANCE RECIPIENTS.

10 (2) INCREASE THE NUMBER OF MEDICAL ASSISTANCE RECIPIENTS
11 ENROLLED IN COORDINATED MANAGED-CARE PROGRAMS TO 50% OF ALL
12 MEDICAL ASSISTANCE RECIPIENTS WHEREVER POSSIBLE WITHIN 24
13 MONTHS OF THE EFFECTIVE DATE OF THIS ACT.

14 (3) REPORT TO THE LEGISLATURE AT THE END OF THE 24-MONTH
15 PERIOD ON THE STATUS OF ITS EFFORTS TO IMPLEMENT THIS
16 SECTION.

17 (4) PROMULGATE REGULATIONS TO MEET THE REQUIREMENTS OF
18 THIS SECTION.

19 SECTION 503. PENNSYLVANIA CHILDREN'S MEDICAL ASSISTANCE
20 PROGRAM.

21 (A) COVERAGE.--

22 (1) THE DEPARTMENT SHALL AMEND ITS MEDICAL ASSISTANCE
23 REGULATIONS TO PROVIDE ALL MEDICALLY NECESSARY HEALTH CARE,
24 DIAGNOSTIC SERVICES, REHABILITATIVE SERVICES AND TREATMENT
25 FOR WHICH FEDERAL FINANCIAL PARTICIPATION IS AVAILABLE, TO
26 ALL CHILDREN ENROLLED UNDER THIS SECTION.

27 (2) HEALTH CARE SERVICES SHALL BE PROVIDED IN SUFFICIENT
28 AMOUNT, DURATION AND SCOPE, REQUIRED FOR EACH ENROLLED
29 CHILD'S MEDICAL CONDITION.

30 (B) ENROLLMENT.--

1 (1) EVERY CHILD SHALL BE IMMEDIATELY ENROLLED IN THE
2 EPSDT PROGRAM UPON AUTHORIZATION FOR MEDICAL ASSISTANCE. ANY
3 PARENT WISHING NOT TO PARTICIPATE IN THE EPSDT PROGRAM MUST
4 SIGN A FORM DETAILING THE HEALTH CARE BENEFITS THAT ARE BEING
5 WAIVED.

6 (2) AT TIME OF AUTHORIZATION, OR SHORTLY THEREAFTER, FOR
7 MEDICAL ASSISTANCE FOR ANY CHILD, OR THE ADDITION OF A NEW
8 CHILD, THE DEPARTMENT OR ITS DESIGNEE SHALL ASSIST THE PARENT
9 IN MAKING AN APPOINTMENT FOR THE CHILD FOR A EPSDT SCREEN
10 WITH THE RECOGNIZED EPSDT PROVIDER OF THE PARENT'S CHOICE.

11 (3) PERIODICALLY, THE DEPARTMENT OR ITS DESIGNEE SHALL
12 DETERMINE WHETHER THE CHILDREN ARE CURRENT IN THEIR SCREENS
13 AND IF THEY ARE IN NEED OF ASSISTANCE IN ARRANGING HEALTH,
14 DENTAL, MENTAL HEALTH OR OTHER TREATMENT. ASSISTANCE SHALL BE
15 PROVIDED THE PARENT BY THE DEPARTMENT OR ITS DESIGNEE, IF
16 NEEDED, IN ARRANGING FOR SUCH CARE, SCREEN OR TRANSPORTATION
17 THEREFOR.

18 (C) AUDIT.--THE DEPARTMENT SHALL ANNUALLY CONDUCT A
19 PERFORMANCE ANALYSIS OF THE EPSDT PROGRAM, INCLUDING THE
20 FOLLOWING:

21 (1) THE OUTREACH EFFORTS AT SCHOOLS, DAY-CARE
22 FACILITIES, HOSPITALS, ETC., TO ENROLL CHILDREN IN THE
23 MEDICAL ASSISTANCE AND EPSDT PROGRAM.

24 (2) OF THOSE CHILDREN ENROLLED IN MEDICAL ASSISTANCE,
25 THE PERCENTAGE OF CHILDREN CURRENT IN THEIR SCREENS AND FOR
26 WHOM NEEDED TREATMENT AND SERVICES HAVE BEEN OBTAINED.

27 (3) COORDINATION OF MIC, WIC, EPSDT, MENTAL HEALTH, DRUG
28 AND ALCOHOL, STATE AND COUNTY HEALTH CENTERS AND OTHER
29 SERVICES IN THE COUNTY AVAILABLE TO CHILDREN ON MEDICAL
30 ASSISTANCE.

1 (D) NONCOMPLIANCE.--IF THE EPSDT PROGRAM IS FOUND TO BE IN
2 NONCOMPLIANCE WITH THE PROVISIONS OF THIS SECTION OR HAS FAILED
3 TO TAKE SUFFICIENT OUTREACH EFFORTS TO ENROLL ANY COUNTY'S
4 ELIGIBLE CHILDREN UNDER THIS SECTION, THE DEPARTMENT SHALL
5 IMMEDIATELY FILE A CORRECTIVE ACTION PLAN. THE DEPARTMENT SHALL
6 DO QUARTERLY COMPLIANCE REVIEWS OF THE EPSDT PROGRAM UNTIL IT
7 HAS CORRECTED THE IDENTIFIED PERFORMANCE DEFICIENCIES.

8 (E) PUBLICITY.--THE DEPARTMENT SHALL DEVELOP AND WIDELY
9 UTILIZE A MEDIA CAMPAIGN FOR USE ON TELEVISION, RADIO AND LOCAL
10 NEWSPAPERS, ADVISING PENNSYLVANIA'S CITIZENS OF THE AVAILABILITY
11 OF HEALTH CARE FOR LOW-INCOME CHILDREN UNDER THIS SECTION.

12 (F) REPORT TO GENERAL ASSEMBLY.--THE DEPARTMENT SHALL
13 PROVIDE A WRITTEN ANNUAL REPORT TO THE GENERAL ASSEMBLY
14 DETAILING ON A COUNTY BY COUNTY BASIS THE FINDINGS OF THE
15 PERFORMANCE AUDITS SET FORTH IN THIS SECTION AND EVALUATING THE
16 MEDIA CAMPAIGN USED BY THE DEPARTMENT TO INFORM CITIZENS ABOUT
17 THE AVAILABILITY OF HEALTH COVERAGE FOR LOW-INCOME CHILDREN
18 UNDER THIS SECTION.

19 (G) ADVISORY COMMITTEE.--THE MAAC SHALL, ON A QUARTERLY
20 BASIS, REVIEW COUNTY ASSISTANCE AND DEPARTMENTAL IMPLEMENTATION
21 OF THIS SECTION AND TO ADVISE THE DEPARTMENT ON CHANGES IN
22 POLICY NEEDED TO MAXIMIZE THE AVAILABILITY OF TIMELY AND COST-
23 EFFECTIVE HEALTH CARE TO PENNSYLVANIA'S LOW-INCOME CHILDREN WHO
24 DEPEND ON MEDICAL ASSISTANCE FOR THEIR HEALTH CARE. IN ITS
25 REVIEW, THE MAAC SHALL SEEK ADVICE FROM THE CONSUMER
26 SUBCOMMITTEE OF THE MAAC AND OTHER APPROPRIATE SUBCOMMITTEES OF
27 THE MAAC; THE PENNSYLVANIA CHAPTER OF THE AMERICAN ACADEMY OF
28 PEDIATRICIANS; THE PENNSYLVANIA ACADEMY OF FAMILY PHYSICIANS;
29 THE DEVELOPMENTAL DISABILITY PLANNING COUNCIL AND OTHER
30 INTERESTED GROUPS.

1 CHAPTER 7

2 PRIMARY HEALTH CARE PROGRAMS

3 SECTION 701. CHILDREN'S HEALTH CARE.

4 (A) THE CHILDREN'S HEALTH FUND AUTHORITY.--THE CHILDREN'S
5 HEALTH FUND AUTHORITY IS ESTABLISHED AS AN AGENCY OF THE
6 COMMONWEALTH, EXERCISING PUBLIC POWERS, INCLUDING ALL POWERS
7 NECESSARY OR APPROPRIATE TO CARRY OUT AND EFFECTUATE THE
8 PURPOSES AND PROVISIONS OF THIS SECTION.

9 (1) THE CHILDREN'S HEALTH FUND AUTHORITY SHALL CONSIST
10 OF 15 VOTING MEMBERS, COMPOSED OF AND APPOINTED IN ACCORDANCE
11 WITH THE FOLLOWING:

12 (I) THE SECRETARY OF HEALTH OR A DESIGNEE.

13 (II) THE SECRETARY OF PUBLIC WELFARE OR A DESIGNEE.

14 (III) A REPRESENTATIVE FROM THE UNIVERSITY OF
15 PITTSBURGH SCHOOL OF PUBLIC HEALTH APPOINTED BY THE
16 PRESIDENT PRO TEMPORE OF THE SENATE FROM A LIST OF THREE
17 PERSONS RECOMMENDED BY THE SCHOOL OF PUBLIC HEALTH.

18 (IV) ONE REPRESENTATIVE FROM THE PENNSYLVANIA
19 CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS, APPOINTED
20 BY THE PRESIDENT PRO TEMPORE OF THE SENATE FROM A LIST OF
21 THREE QUALIFIED PERSONS RECOMMENDED BY THE ACADEMY.

22 (V) ONE REPRESENTATIVE FROM THE PENNSYLVANIA ACADEMY
23 OF FAMILY PHYSICIANS, APPOINTED BY THE SPEAKER OF THE
24 HOUSE OF REPRESENTATIVES FROM A LIST OF THREE QUALIFIED
25 PERSONS RECOMMENDED BY THE ACADEMY.

26 (VI) A REPRESENTATIVE FROM THE DEVELOPMENTAL
27 DISABILITIES PLANNING COUNCIL, APPOINTED BY THE GOVERNOR
28 FROM A LIST OF THREE QUALIFIED PERSONS RECOMMENDED BY THE
29 COUNCIL.

30 (VII) A REPRESENTATIVE APPOINTED BY THE CHILD HEALTH

1 SUBCOMMITTEE OF THE MEDICAL ASSISTANCE ADVISORY
2 COMMITTEE.

3 (VIII) A REPRESENTATIVE OF THE CHILDREN'S HOSPITAL
4 OF PHILADELPHIA APPOINTED BY THE SPEAKER OF THE HOUSE OF
5 REPRESENTATIVES FROM A LIST OF THREE PERSONS SUBMITTED BY
6 THE HOSPITAL.

7 (IX) A PARENT OF A CHILD WHO RECEIVES PRIMARY HEALTH
8 CARE FUNDED BY THE AUTHORITY, APPOINTED BY THE GOVERNOR
9 FROM A LIST OF PARENT APPLICANTS.

10 (X) A REPRESENTATIVE FROM THE PENNSYLVANIA NURSES
11 ASSOCIATION (PNA) APPOINTED BY THE CHAIRMAN OF THE HEALTH
12 AND WELFARE COMMITTEE OF THE HOUSE OF REPRESENTATIVES
13 FROM A LIST OF THREE QUALIFIED PERSONS RECOMMENDED BY
14 PNA.

15 (XI) THE MAJORITY CHAIRMAN AND THE MINORITY CHAIRMAN
16 OF THE PUBLIC HEALTH AND WELFARE COMMITTEE OF THE SENATE
17 AND THE MAJORITY CHAIRMAN AND THE MINORITY CHAIRMAN OF
18 THE HEALTH AND WELFARE COMMITTEE OF THE HOUSE OF
19 REPRESENTATIVES OR THEIR DESIGNEES.

20 (XII) A REPRESENTATIVE OF A HOSPITAL THAT SERVES A
21 RURAL POPULATION APPOINTED BY THE CHAIRMAN OF THE PUBLIC
22 HEALTH AND WELFARE COMMITTEE OF THE SENATE FROM A LIST OF
23 THREE PERSONS RECOMMENDED BY THE HOSPITAL ASSOCIATION OF
24 PENNSYLVANIA.

25 (2) ALL INITIAL APPOINTMENTS TO THE AUTHORITY SHALL BE
26 MADE WITHIN 60 DAYS OF THE EFFECTIVE DATE OF THIS ACT, AND
27 THE AUTHORITY SHALL COMMENCE OPERATIONS IMMEDIATELY
28 THEREAFTER. IF ANY SPECIFIED ORGANIZATION SHOULD CEASE TO
29 EXIST OR FAIL TO MAKE A RECOMMENDATION WITHIN 90 DAYS OF A
30 REQUEST TO DO SO, THE AUTHORITY SHALL SPECIFY A NEW

1 EQUIVALENT ORGANIZATION TO FULFILL THE RESPONSIBILITIES OF
2 THIS SECTION.

3 (3) THE MEMBERS OF THE AUTHORITY SHALL ANNUALLY ELECT,
4 BY A MAJORITY VOTE OF THE MEMBERS, A CHAIRPERSON AND VICE
5 CHAIRPERSON FROM AMONG THE MEMBERS OF THE AUTHORITY.

6 (4) THE AUTHORITY MAY APPOINT STAFF NECESSARY TO CARRY
7 OUT ITS FUNCTIONS.

8 (5) THE PRESENCE OF EIGHT MEMBERS SHALL CONSTITUTE A
9 QUORUM FOR THE TRANSACTING OF ANY BUSINESS. ANY ACT BY A
10 MAJORITY OF THE MEMBERS PRESENT AT ANY MEETING AT WHICH THERE
11 IS A QUORUM SHALL BE DEEMED TO BE THAT OF THE AUTHORITY.

12 (6) ALL MEETINGS OF THE AUTHORITY SHALL BE ADVERTISED
13 PURSUANT TO THE ACT OF JULY 3, 1986 (P.L.388, NO.84), KNOWN
14 AS THE SUNSHINE ACT, UNLESS OTHERWISE PROVIDED IN THIS
15 SECTION. THE AUTHORITY SHALL MEET AT LEAST QUARTERLY AND MAY
16 PROVIDE FOR SPECIAL MEETINGS AS IT DEEMS NECESSARY. MEETING
17 DATES SHALL BE SET BY A MAJORITY VOTE OF MEMBERS OF THE
18 AUTHORITY OR BY CALL OF THE CHAIRPERSON UPON SEVEN DAYS'
19 NOTICE TO ALL MEMBERS. THE AUTHORITY SHALL PUBLISH A SCHEDULE
20 OF ITS MEETINGS IN THE PENNSYLVANIA BULLETIN AND AT LEAST
21 FOUR NEWSPAPERS OF GENERAL CIRCULATION IN THIS COMMONWEALTH.
22 NOTICE SHALL BE PUBLISHED AT LEAST ONCE IN EACH CALENDAR
23 QUARTER AND SHALL LIST A SCHEDULE OF MEETINGS OF THE
24 AUTHORITY TO BE HELD IN THE SUBSEQUENT CALENDAR QUARTER.
25 NOTICE SHALL SPECIFY THE DATE, TIME AND PLACE OF THE MEETING
26 AND SHALL STATE THAT THE AUTHORITY'S MEETINGS ARE OPEN TO THE
27 GENERAL PUBLIC. ALL ACTION TAKEN BY THE AUTHORITY SHALL BE
28 TAKEN IN OPEN PUBLIC SESSION AND SHALL NOT BE TAKEN EXCEPT
29 UPON A MAJORITY VOTE OF THE MEMBERS PRESENT AT A MEETING AT
30 WHICH A QUORUM IS PRESENT.

1 (7) THE AUTHORITY SHALL ADOPT REGULATIONS NOT
2 INCONSISTENT WITH THIS SECTION AND IN COMPLIANCE WITH
3 REQUIREMENTS OF THE INDEPENDENT REGULATORY REVIEW COMMISSION.

4 (8) THE MEMBERS OF THE AUTHORITY SHALL NOT RECEIVE A
5 SALARY OR PER DIEM ALLOWANCE FOR SERVING AS MEMBERS OF THE
6 AUTHORITY BUT SHALL BE REIMBURSED FOR ACTUAL AND NECESSARY
7 EXPENSES INCURRED IN THE PERFORMANCE OF THEIR DUTIES.

8 (9) TERMS OF AUTHORITY MEMBERS SHALL BE AS FOLLOWS:

9 (I) THE TERMS OF THE SECRETARY OF HEALTH AND THE
10 SECRETARY OF PUBLIC WELFARE SHALL BE CONCURRENT WITH
11 THEIR HOLDING OF PUBLIC OFFICE. THE TERMS OF LEGISLATIVE
12 MEMBERS SHALL BE CONCURRENT WITH THE LEGISLATIVE SESSION
13 IN WHICH THEY BECAME MEMBERS. THE APPOINTED AUTHORITY
14 MEMBERS SHALL SERVE FOR A TERM OF THREE YEARS AND SHALL
15 CONTINUE TO SERVE THEREAFTER UNTIL THEIR SUCCESSORS ARE
16 APPOINTED.

17 (II) AN APPOINTED MEMBER SHALL NOT BE ELIGIBLE TO
18 SERVE MORE THAN TWO FULL CONSECUTIVE TERMS OF THREE
19 YEARS. VACANCIES ON THE AUTHORITY SHALL BE FILLED IN THE
20 SAME MANNER IN WHICH THEY WERE DESIGNATED WITHIN 60 DAYS
21 OF THE VACANCY.

22 (III) A MEMBER MAY BE REMOVED FOR JUST CAUSE BY THE
23 APPOINTING AUTHORITY AND A VOTE OF AT LEAST EIGHT MEMBERS
24 OF THE AUTHORITY.

25 (B) DISTRIBUTION OF FUNDS.--THE AUTHORITY SHALL PROVIDE FOR
26 THE EXPANDED ACCESS TO PRIMARY HEALTH CARE FOR ELIGIBLE CHILDREN
27 THROUGH THE DISTRIBUTION OF THE CHILDREN'S HEALTH FUND FOR
28 HEALTH CARE FOR INDIGENT CHILDREN AS ESTABLISHED BY SECTION 1296
29 OF THE ACT OF MARCH 4, 1971 (P.L.6, NO.2), KNOWN AS THE TAX
30 REFORM CODE OF 1971.

1 (1) NO LESS THAN 75% OF THE FUNDS FROM THE CHILDREN'S
2 HEALTH FUND SHALL BE USED TO FUND THOSE PRIMARY HEALTH CARE
3 PROGRAMS DEFINED IN SUBSECTION (E) AND PROVIDED FOR BY
4 ENTITIES ESTABLISHED UNDER 40 PA.C.S. CH. 61 (RELATING TO
5 HOSPITAL PLAN CORPORATIONS) OR 63 (RELATING TO PROFESSIONAL
6 HEALTH SERVICES PLAN CORPORATIONS), THE ACT OF MAY 17, 1921
7 (P.L.682, NO.284), KNOWN AS THE INSURANCE COMPANY LAW OF 1921
8 OR THE ACT OF DECEMBER 29, 1972 (P.L.1701, NO.364), KNOWN AS
9 THE HEALTH MAINTENANCE ORGANIZATION ACT.

10 (I) NO MORE THAN 5% OF THE AMOUNT STATED IN THIS
11 PARAGRAPH SHALL BE USED FOR ADMINISTRATION EXPENSES IN
12 PROVIDING THOSE PRIMARY HEALTH CARE PROGRAMS DEFINED IN
13 SUBSECTION (E) AND NO MORE THAN AN ADDITIONAL 5% MAY BE
14 USED TO PROVIDE OUTREACH SERVICES.

15 (II) THE PRIMARY HEALTH CARE PROGRAM PROVIDER SHALL
16 PROVIDE DOCUMENTED EVIDENCE OF THE COSTS OF THE OUTREACH
17 SERVICES UNDER ITS PROGRAM TO THE AUTHORITY, AND THE
18 AUTHORITY MAY ADJUST THE AMOUNT OF THE FUND USED FOR THE
19 OUTREACH SERVICES, BUT AT NO TIME SHALL IT BE GREATER
20 THAN 5% OF 75% OF THE FUND. THE PRIMARY HEALTH CARE
21 PROGRAM PROVIDER MAY ALSO PRESENT DOCUMENTED EVIDENCE OF
22 ADMINISTRATIVE COSTS IN EXCESS OF THOSE PROVIDED FOR IN
23 SUBPARAGRAPH (I), AND THE AUTHORITY MAY INCREASE THE
24 AMOUNT ALLOWED FOR ADMINISTRATIVE COSTS, BUT AT NO TIME
25 MAY THAT ALLOWANCE BE GREATER THAN 10% OF 75% OF THE
26 FUND, EXCLUSIVE OF OUTREACH COSTS.

27 (2) THE AUTHORITY SHALL PURSUE THE ACQUISITION OF
28 FEDERAL AND PRIVATE SUPPLEMENTAL FUNDS FOR PROVIDING BENEFITS
29 UNDER THIS ACT WHENEVER POSSIBLE.

30 (3) ALL GRANTS MADE PURSUANT TO THIS SUBSECTION SHALL BE

1 ON AN EQUITABLE BASIS BASED ON THE NUMBER OF ENROLLED
2 ELIGIBLE CHILDREN OR ELIGIBLE CHILDREN ANTICIPATED TO BE
3 ENROLLED. THE AUTHORITY SHALL USE ITS BEST EFFORTS TO PROVIDE
4 GRANTS THAT ENSURE THAT ELIGIBLE CHILDREN HAVE ACCESS TO
5 BASIC PRIMARY HEALTH CARE SERVICES TO BE PROVIDED UNDER THIS
6 SECTION ON AN EQUITABLE STATEWIDE BASIS.

7 (C) LIMITATIONS.--

8 (1) NO MORE THAN 1% OF THE FUNDS FROM THE CHILDREN'S
9 HEALTH FUND MAY BE USED FOR EXPENSES OF MEMBERS OF THE
10 AUTHORITY AND FOR ADMINISTRATION.

11 (2) NO MORE THAN 25% OF THE FUNDS FROM THE CHILDREN'S
12 HEALTH FUND MAY BE USED FOR DEMONSTRATION PROJECTS FOR THE
13 PROVISION OF MOBILE HEALTH CARE UNITS IN UNDERSERVED RURAL
14 AND INNER-CITY AREAS, AND TO LINK PRIMARY HEALTH CARE
15 SERVICES WITH DENTAL, HEARING AND VISION CARE FOR ELIGIBLE
16 CHILDREN. NO MORE THAN .05% OF 25% OF THE FUND MAY BE USED
17 FOR THE PROVISION OF MOBILE HEALTH CARE UNITS. ALL GRANTS
18 MADE PURSUANT TO THIS SUBSECTION SHALL BE TO ANY ORGANIZATION
19 OR CORPORATION PROVIDING PRIMARY HEALTH SERVICES OR WILLING
20 TO PROVIDE PRIMARY HEALTH SERVICES IN ACCORDANCE WITH
21 SUBSECTION (E) FOR ELIGIBLE CHILDREN.

22 (D) GRANT CRITERIA.--THE CHILDREN'S HEALTH FUND AUTHORITY
23 SHALL ANNUALLY ACCEPT APPLICATIONS FOR GRANTS TO BE MADE
24 PURSUANT TO THIS SECTION BY THE AUTHORITY PURSUANT TO THE
25 FOLLOWING:

26 (1) TO THE FULLEST EXTENT PRACTICABLE, GRANTS SHALL BE
27 MADE TO APPLICANTS THAT CONTRACT WITH PROVIDERS TO PROVIDE
28 STATEWIDE PRIMARY CARE SERVICES FOR ENROLLEES ON A BASIS BEST
29 CALCULATED TO MANAGE COSTS OF THE PROGRAM, INCLUDING, BUT NOT
30 LIMITED TO, PURCHASING HEALTH CARE SERVICES ON A CAPITATED

1 BASIS, USING MANAGED HEALTH CARE TECHNIQUES AND, WHERE
2 APPROPRIATE, OTHER COST MANAGEMENT METHODS. THE AUTHORITY
3 SHALL REQUIRE GRANTEES TO USE APPROPRIATE COST MANAGEMENT
4 METHODS SO THAT THE CHILDREN'S HEALTH FUND CAN BE USED TO
5 PROVIDE THE BASIC PRIMARY BENEFIT SERVICES TO THE MAXIMUM
6 NUMBER OF ELIGIBLE CHILDREN AND WHENEVER POSSIBLE, TO PURSUE
7 AND UTILIZE AVAILABLE PUBLIC AND PRIVATE FUNDS. THIS SHALL
8 INCLUDE CONTRACTING WITH QUALIFIED, COST-EFFECTIVE PROVIDERS,
9 INCLUDING HOSPITAL OUTPATIENT DEPARTMENTS, HMO'S, CLINICS,
10 GROUP PRACTICES AND INDIVIDUAL PRACTITIONERS.

11 (2) TO THE FULLEST EXTENT PRACTICABLE, THE AUTHORITY
12 SHALL ENSURE THAT ELIGIBLE CHILDREN HAVE ACCESS TO PRIMARY
13 HEALTH CARE PROVIDED BY THE CHILDREN'S HEALTH FUND THAT HAS
14 ADEQUATE PRIMARY CARE PHYSICIANS AND THAT PROVIDES ADEQUATE
15 FREEDOM OF CHOICE OF PHYSICIANS WITHIN A REASONABLE AND
16 CONVENIENT TRAVEL DISTANCE.

17 (3) TO THE FULLEST EXTENT PRACTICABLE, THE AUTHORITY
18 SHALL ENSURE THAT ANY GRANTEE WHO DETERMINES THAT A CHILD IS
19 NOT ELIGIBLE BECAUSE THE CHILD IS ELIGIBLE FOR MEDICAL
20 ASSISTANCE PROVIDE IN WRITING TO THE FAMILY OF THE CHILD THE
21 TELEPHONE NUMBER OF THE COUNTY ASSISTANCE OFFICE OF THE
22 DEPARTMENT WHERE THE FAMILY CAN CALL TO APPLY FOR MEDICAL
23 ASSISTANCE.

24 (E) ELIGIBLE PRIMARY HEALTH CARE COVERAGE FOR FUNDING.--ALL
25 GRANTEES FUNDED SHALL INCLUDE THE FOLLOWING MINIMUM BENEFIT
26 PACKAGE FOR ELIGIBLE CHILDREN:

27 (1) PREVENTIVE CARE, WHICH SHALL INCLUDE WELL-CHILD CARE
28 VISITS IN ACCORDANCE WITH THE SCHEDULE ESTABLISHED BY THE
29 AMERICAN ACADEMY OF PEDIATRICS AND THE SERVICES RELATED TO
30 THOSE VISITS, INCLUDING, BUT NOT LIMITED TO, IMMUNIZATIONS,

1 WELL-CHILD CARE, HEALTH EDUCATION, TUBERCULOSIS TESTING AND
2 DEVELOPMENTAL SCREENING IN ACCORDANCE WITH ROUTINE SCHEDULE
3 OF WELL-CHILD VISITS. CARE SHALL ALSO INCLUDE A COMPREHENSIVE
4 PHYSICAL EXAMINATION, INCLUDING X-RAYS IF NECESSARY, FOR ANY
5 CHILD EXHIBITING SYMPTOMS OF POSSIBLE CHILD ABUSE.

6 (2) DIAGNOSIS AND TREATMENT OF ILLNESS OR INJURY,
7 INCLUDING ALL SERVICES RELATED TO THE DIAGNOSIS AND TREATMENT
8 OF SICKNESS AND INJURY AND OTHER CONDITIONS PROVIDED ON AN
9 AMBULATORY BASIS, SUCH AS WOUND DRESSING AND CASTING TO
10 IMMOBILIZE FRACTURES.

11 (3) INJECTIONS AND MEDICATIONS PROVIDED AT THE TIME OF
12 THE OFFICE VISIT OR THERAPY, OUTPATIENT SURGERY PERFORMED IN
13 THE OFFICE OR FREESTANDING AMBULATORY SERVICE CENTER,
14 INCLUDING ANESTHESIA PROVIDED IN CONJUNCTION WITH SUCH
15 SERVICE, AND EMERGENCY MEDICAL SERVICE.

16 (4) EMERGENCY ACCIDENT AND EMERGENCY MEDICAL CARE.

17 (5) AVAILABILITY OF 24-HOUR-A-DAY, 7 DAY-A-WEEK ACCESS
18 TO THE SERVICES IN THIS SUBSECTION.

19 (F) WAIVER.--THE AUTHORITY MAY GRANT A WAIVER OF THE MINIMUM
20 BENEFIT PACKAGE OF SUBSECTION (E) UPON DEMONSTRATION BY THE
21 APPLICANT THAT THEY ARE PROVIDING PRIMARY HEALTH CARE SERVICES
22 FOR ELIGIBLE CHILDREN THAT MEET THE PURPOSE AND INTENT OF THIS
23 SECTION.

24 (G) INPATIENT HOSPITAL CARE.--TO ENSURE THAT INPATIENT
25 HOSPITAL CARE IS PROVIDED TO ELIGIBLE CHILDREN, ALL PRIMARY CARE
26 PHYSICIANS PROVIDING PRIMARY CARE SERVICES TO ELIGIBLE CHILDREN
27 UNDER THIS CHAPTER SHALL MAKE THE NECESSARY ARRANGEMENTS THROUGH
28 THE SPEND-DOWN PROVISIONS OF MEDICAL ASSISTANCE FOR ADMISSION TO
29 THE HOSPITAL AND FOR THE NECESSARY SPECIALTY CARE FOR A CHILD
30 NEEDING SUCH CARE AND SHALL CONTINUE TO CARE FOR THE CHILD AS A

1 MEDICAL ASSISTANCE PROVIDER IN THE HOSPITAL AS APPROPRIATE.

2 (H) ELIGIBILITY FOR ENROLLMENT IN PROGRAMS RECEIVING FUNDING
3 THROUGH THE CHILDREN'S HEALTH FUND AUTHORITY.--

4 (1) ANY ORGANIZATION OR CORPORATION RECEIVING FUNDS FROM
5 THE CHILDREN'S HEALTH FUND AUTHORITY SHALL ENROLL ANY CHILD
6 WHO MEETS ALL OF THE FOLLOWING:

7 (I) IS UNDER 19 YEARS OF AGE.

8 (II) IS A RESIDENT OF THIS COMMONWEALTH AND OF A
9 COUNTY SERVED BY THE ORGANIZATION OR CORPORATION.

10 (III) IS NOT ELIGIBLE FOR NOR COVERED BY A HEALTH
11 INSURANCE PLAN, A SELF-INSURANCE PLAN OR THE MEDICAL
12 ASSISTANCE PROGRAM.

13 (IV) IS QUALIFIED UNDER SUBSECTION (I).

14 (2) COVERAGE SHALL NOT BE DENIED ON THE BASIS OF A
15 PREEXISTING CONDITION.

16 (3) THE AUTHORITY MAY PERMIT ENROLLMENT BY CHILDREN WITH
17 HEALTH INSURANCE COVERAGE FOR INPATIENT HOSPITAL CARE, BUT
18 LITTLE OR NO COVERAGE FOR THE PRIMARY HEALTH CARE SERVICES
19 FUNDED BY THE AUTHORITY IF, AFTER THE FIRST YEAR OF
20 OPERATION, THERE APPEARS TO BE SUFFICIENT REVENUE TO DO SO.

21 (I) FREE CARE.--THE PROVISION OF PRIMARY HEALTH SERVICES FOR
22 ELIGIBLE CHILDREN SHALL BE FREE TO ALL CHILDREN UP TO THE AGE OF
23 SIX WHOSE FAMILY INCOME IS LESS THAN OR UP TO 185% OF THE
24 FEDERAL POVERTY LEVEL AND SHALL BE FREE TO CHILDREN FROM AGE SIX
25 UP TO AGE NINETEEN WHOSE FAMILY INCOME IS LESS THAN 100% OF THE
26 FEDERAL POVERTY LEVEL. THOSE FAMILIES WITH INCOME HIGHER THAN
27 THE INCOME ELIGIBILITY LEVELS FOR FREE CARE MAY PURCHASE
28 COVERAGE FOR THEIR CHILDREN AT COST. THERE SHALL BE NO
29 COPAYMENTS OR DEDUCTIBLES OF ANY KIND FOR UNINSURED CHILDREN
30 WHOSE FAMILY INCOME IS LESS THAN 100% OF THE FEDERAL POVERTY

1 LEVEL; AND, IN NO CASE, MAY THE COPAYMENTS OR DEDUCTIBLES EXCEED
2 0.1% OF THE FAMILY INCOME.

3 (J) ANNUAL REPORT.--THE AUTHORITY SHALL PROVIDE THE GENERAL
4 ASSEMBLY AND THE PUBLIC WITH AN ANNUAL REPORT FOR EACH FISCAL
5 YEAR, OUTLINING PRIMARY HEALTH SERVICES FUNDED FOR THE YEAR,
6 DETAILING THE OUTREACH AND ENROLLMENT EFFORTS BY EACH GRANTEE
7 AND REPORTING BY COUNTY THE NUMBER OF CHILDREN FOR WHOM PRIMARY
8 CARE IS FUNDED BY THE AUTHORITY AND THE PROJECTED ELIGIBLE
9 CHILDREN.

10 (K) ROLE OF THE HEALTH SERVICE CORPORATION AND HOSPITAL PLAN
11 CORPORATIONS.--BY JANUARY 1, 1993, EACH HEALTH SERVICE
12 CORPORATION AND HOSPITAL PLAN CORPORATION DOING BUSINESS IN THIS
13 COMMONWEALTH SHALL FILE A LETTER OF INTENT WITH THE AUTHORITY TO
14 APPLY FOR FUNDS FROM THE AUTHORITY IN THE AREA SERVICED BY THE
15 CORPORATION. EACH HEALTH SERVICE CORPORATION AND HOSPITAL PLAN
16 CORPORATION SHALL PROVIDE INSURANCE IDENTIFICATION CARDS TO
17 THOSE ELIGIBLE CHILDREN COVERED UNDER PROGRAMS RECEIVING GRANTS
18 FROM THE AUTHORITY. THE CARD SHALL NOT SPECIFICALLY IDENTIFY THE
19 HOLDER AS LOW INCOME.

20 (L) RATE FILING REQUEST INFORMATION.--THE INSURANCE
21 COMMISSIONER SHALL MAKE A COPY AND FORWARD TO THE AUTHORITY ALL
22 RELEVANT INFORMATION AND DATA FILED BY EACH HEALTH SERVICE
23 CORPORATION AND HOSPITAL PLAN CORPORATION DOING BUSINESS IN THIS
24 COMMONWEALTH AS PART OF ANY RATE FILING REQUEST FOR PROGRAMS
25 RECEIVING GRANTS UNDER THIS SECTION BY THE CORPORATION.

26 (M) DEDICATED FUNDING.--THE CHILDREN'S HEALTH FUND FOR
27 HEALTH CARE FOR INDIGENT CHILDREN, AS ESTABLISHED BY SECTION
28 1296 OF THE TAX REFORM CODE OF 1971 SHALL BE DEDICATED
29 EXCLUSIVELY FOR DISTRIBUTION BY THE CHILDREN'S HEALTH FUND
30 AUTHORITY PURSUANT TO THIS SECTION.

1 CHAPTER 11

2 ACCESS TO HEALTH CARE

3 SECTION 1101. BUREAU OF RURAL AND INNER-CITY HEALTH CARE
4 SERVICES.

5 (A) ESTABLISHMENT.--THERE IS HEREBY ESTABLISHED WITHIN THE
6 DEPARTMENT OF HEALTH THE BUREAU OF RURAL AND INNER-CITY HEALTH
7 CARE SERVICES.

8 (B) POWERS AND DUTIES.--UPON THE ADVICE AND RECOMMENDATIONS
9 OF THE ADVISORY COMMITTEE, THE BUREAU SHALL:

10 (1) COORDINATE THE HEALTH SERVICES PROVIDED BY THE
11 DEPARTMENT TO MEDICALLY UNDERSERVED RESIDENTS.

12 (2) COORDINATE THE SERVICES PROVIDED FOR MEDICALLY
13 UNDERSERVED RESIDENTS BY VARIOUS LOCAL, COUNTY AND REGIONAL
14 AGENCIES AND GROUPS, INCLUDING SERVICES PROVIDED FOR CHILDREN
15 UNDER THIS ACT.

16 (3) ADMINISTER THE PROGRAMS ESTABLISHED UNDER THIS ACT
17 TO INCREASE THE NUMBERS OF PHYSICIANS PRACTICING IN MEDICALLY
18 UNDERSERVED DESIGNATED SHORTAGE AREAS.

19 (4) ADMINISTER THE PROGRAMS ESTABLISHED UNDER THIS ACT
20 TO INCREASE ACCESS TO HEALTH CARE FOR RURAL AND INNER-CITY
21 RESIDENTS.

22 (5) ANNUALLY REVIEW AND UPDATE THE DESIGNATION OF
23 PHYSICIAN, MEDICALLY UNDERSERVED AND CRITICAL MANPOWER
24 SHORTAGE AREAS AND REPORT TO THE GENERAL ASSEMBLY THE THEN-
25 CURRENT STATUS OF THE NEED FOR HEALTH CARE SERVICES AND
26 PROVIDERS IN THE AREAS SO DESIGNATED.

27 (6) CONSULT WITH AND RECEIVE RECOMMENDATIONS FROM THE
28 ADVISORY COMMITTEE IN DETERMINING AND FULFILLING RURAL AND
29 INNER-CITY HEALTH CARE NEEDS.

30 (7) ADMINISTER SUMS APPROPRIATED TO CARRY OUT THE

1 REQUIREMENTS OF THIS ACT TO INCREASE THE NUMBERS OF RURAL AND
2 INNER-CITY FAMILY PRACTICE PHYSICIANS AND TO INCREASE ACCESS
3 TO HEALTH CARE FOR RURAL AND INNER-CITY RESIDENTS.

4 (8) ADVISE AND MAKE RECOMMENDATIONS TO THE PENNSYLVANIA
5 HIGHER EDUCATION ASSISTANCE AGENCY ON THE ADMINISTRATION OF
6 THE MEDICAL SCHOLARSHIP AND LOAN FUND ESTABLISHED UNDER THIS
7 ACT.

8 SECTION 1102. RURAL AND INNER-CITY HEALTH CARE SERVICES
9 ADVISORY COMMITTEE.

10 (A) ESTABLISHMENT AND PURPOSE.--THERE IS HEREBY ESTABLISHED
11 THE RURAL AND INNER-CITY HEALTH CARE SERVICES ADVISORY COMMITTEE
12 WHICH SHALL PROVIDE ADVICE AND RECOMMENDATIONS TO THE BUREAU ON
13 THE RURAL AND INNER-CITY PROGRAMS CREATED UNDER THIS ACT AND ON
14 ALL OTHER HEALTH CARE MATTERS IMPACTING ON MEDICALLY UNDERSERVED
15 DESIGNATED SHORTAGE AREAS.

16 (B) COMPOSITION.--THE COMMITTEE SHALL INCLUDE THE FOLLOWING:

17 (1) ONE MEMBER APPOINTED BY THE PRESIDENT PRO TEMPORE OF
18 THE SENATE, ONE BY THE MINORITY LEADER OF THE SENATE, ONE BY
19 THE SPEAKER OF THE HOUSE OF REPRESENTATIVES AND ONE BY THE
20 MINORITY LEADER OF THE HOUSE OF REPRESENTATIVES.

21 (2) THE SECRETARY OF HEALTH.

22 (3) TEN MEMBERS APPOINTED BY THE GOVERNOR AS FOLLOWS:

23 (I) TWO MEMBERS WHO ARE LICENSED FAMILY PHYSICIANS
24 ENGAGED IN PRACTICE IN A MEDICALLY UNDERSERVED DESIGNATED
25 SHORTAGE AREA.

26 (II) ONE MEMBER WHO IS LICENSED IN GENERAL
27 PEDIATRICS ENGAGED IN PRACTICE IN A MEDICALLY UNDERSERVED
28 DESIGNATED SHORTAGE AREA.

29 (III) ONE MEMBER WHO IS LICENSED IN OBSTETRICS-
30 GYNECOLOGY ENGAGED IN PRACTICE IN A MEDICALLY UNDERSERVED

DESIGNATED SHORTAGE AREA.

(IV) ONE REPRESENTATIVE OF A RURAL HOSPITAL.

(V) ONE REPRESENTATIVE OF AN INNER-CITY HOSPITAL.

(VI) ONE LICENSED OSTEOPATHIC PHYSICIAN PRACTICING
IN A MEDICALLY UNDERSERVED DESIGNATED SHORTAGE AREA.

(VII) TWO REGISTERED NURSES PRACTICING IN A
MEDICALLY UNDERSERVED DESIGNATED SHORTAGE AREA.

(VIII) ONE DENTIST PRACTICING IN A MEDICALLY
UNDERSERVED DESIGNATED SHORTAGE AREA.

(C) TERMS OF OFFICE.--LEGISLATIVE MEMBERS SHALL SERVE TERMS
COTERMINOUS WITH THAT OF THEIR LEGISLATIVE OFFICE. ALL OTHER
MEMBERS SHALL SERVE FOUR YEARS OR THE TERM OF THE OFFICE BY
WHICH HE HOLDS MEMBERSHIP ON THE COMMITTEE AND UNTIL HIS
SUCCESSOR HAS BEEN APPOINTED AND QUALIFIED, BUT NO LONGER THAN
SIX MONTHS BEYOND THE APPLICABLE PERIOD.

(D) QUORUM.--EIGHT MEMBERS SHALL CONSTITUTE A QUORUM.
SECTION 1103. FAMILY PRACTICE INCENTIVE GRANT DEMONSTRATION
PROGRAM.

THE PENNSYLVANIA HIGHER EDUCATION ASSISTANCE AGENCY (PHEAA)
SHALL ADMINISTER UPON THE ADVICE AND RECOMMENDATIONS OF THE
ADVISORY COMMITTEE A GRANT PROGRAM TO BE KNOWN AS THE FAMILY
PRACTICE INCENTIVE GRANT DEMONSTRATION PROGRAM. PHEAA SHALL
ADMINISTER THIS PROGRAM BY ALLOCATING SUMS APPROPRIATED FOR THIS
PURPOSE BY THE GENERAL ASSEMBLY AS GRANTS APPROVED BY THE
ADVISORY COMMITTEE TO THE MEDICAL SCHOOLS AND OSTEOPATHIC
MEDICAL COLLEGES OF THE COMMONWEALTH AS FOLLOWS:

(1) PRIMARY GRANTS OF NOT MORE THAN \$200,000 PER
RECIPIENT PER YEAR SHALL BE AWARDED TO THE MEDICAL SCHOOLS OR
OSTEOPATHIC MEDICAL COLLEGES THAT HAVE DEVELOPED INNOVATIVE
PROJECTS TO INCREASE THE TOTAL NUMBER OF FAMILY PRACTITIONERS

1 IN THIS COMMONWEALTH AND THE NUMBERS OF FAMILY PRACTITIONERS
2 CHOOSING TO SERVE IN RURAL OR INNER-CITY DESIGNATED SHORTAGE
3 AREAS.

4 (2) A ONE-TIME \$100,000 FOLLOW-UP GRANT MAY BE AWARDED
5 TO A PRIOR YEAR'S GRANTEE IF THE GRANTEE HAS SHOWN EVIDENCE
6 OF A GOOD FAITH EFFORT TO PROVIDE MORE FAMILY PHYSICIANS FOR
7 THIS COMMONWEALTH.

8 (3) ONE PRIMARY GRANT OF \$100,000 PER YEAR SHALL BE
9 AWARDED TO THE PENNSYLVANIA ACADEMY OF FAMILY PHYSICIANS TO
10 DEVELOP AN INNOVATIVE PROGRAM TO INCREASE THE NUMBER OF
11 FAMILY PRACTICE RESIDENTS CURRENTLY IN TRAINING IN
12 COMMONWEALTH HOSPITAL RESIDENCY PROGRAMS TO LOCATE THEIR
13 PRACTICES IN MEDICALLY UNDERSERVED DESIGNATED SHORTAGE AREAS
14 OF THIS COMMONWEALTH.

15 (4) AN ANNUAL FOLLOW-UP GRANT MAY BE AWARDED TO THE
16 ACADEMY TO CONTINUE THE PROGRAM OF LOCATING FAMILY PHYSICIANS
17 IN MEDICALLY UNDERSERVED DESIGNATED SHORTAGE AREAS OF THIS
18 COMMONWEALTH.

19 (5) ONE PRIMARY GRANT OF \$100,000 PER YEAR SHALL BE
20 AWARDED TO THE PENNSYLVANIA MEDICAL SOCIETY TO DEVELOP AN
21 OUTREACH PROGRAM FOR THE PURPOSE OF INFORMING AND ENCOURAGING
22 PRIMARY CARE PHYSICIANS TO PRACTICE IN THIS COMMONWEALTH.

23 SECTION 1104. REPORT TO GENERAL ASSEMBLY.

24 THE BUREAU SHALL ANNUALLY REPORT, ON OR BEFORE MARCH 15, TO
25 THE GENERAL ASSEMBLY ON THE PROGRESS OF THE PROGRAM ESTABLISHED
26 UNDER THIS CHAPTER.

27 SECTION 1105. EXPIRATION.

28 THE FAMILY PRACTICE INCENTIVE GRANT DEMONSTRATION PROGRAM
29 SHALL EXPIRE JUNE 30, 1996, UNLESS REENACTED BY THE GENERAL
30 ASSEMBLY.

1 SECTION 1106. MEDICAL SCHOLARSHIP AND LOAN FORGIVENESS FUND.

2 (A) ESTABLISHMENT.--THERE IS HEREBY ESTABLISHED IN
3 PENNSYLVANIA HIGHER EDUCATION ASSISTANCE AGENCY (PHEAA) A
4 SPECIAL FUND TO BE KNOWN AS THE MEDICAL SCHOLARSHIP AND LOAN
5 FORGIVENESS FUND.

6 (B) ADMINISTRATION AND PURPOSE.--PHEAA SHALL ADMINISTER THE
7 FUND UPON THE ADVICE AND RECOMMENDATIONS OF THE ADVISORY
8 COMMITTEE TO PROVIDE FOR THE REPAYMENT OF RURAL AND INNER-CITY
9 PRIMARY CARE PHYSICIANS' AND NURSE PRACTITIONERS' STUDENT LOANS
10 AND FOR MEDICAL SCHOOL OR OSTEOPATHIC MEDICAL COLLEGE
11 SCHOLARSHIPS FOR RESIDENTS OF THIS COMMONWEALTH.

12 (C) REPAYMENT ASSISTANCE.--PHEAA MAY PROVIDE ASSISTANCE FOR
13 THE REPAYMENT OF ANY STUDENT LOAN FOR EDUCATION AT AN
14 INSTITUTION OF HIGHER LEARNING IN THIS COMMONWEALTH, INCLUDING
15 LOANS FOR UNDERGRADUATE EDUCATION, RECEIVED BY A PHYSICIAN OR
16 NURSE PRACTITIONER AND EXECUTED PRIOR TO THE EFFECTIVE DATE OF
17 THIS ACT. AFTER THE EFFECTIVE DATE OF THIS ACT, PHEAA, WITH THE
18 ADVICE AND UPON THE RECOMMENDATION OF THE ADVISORY COMMITTEE,
19 SHALL MAKE LOANS FROM THE FUND CREATED UNDER THIS ACT USING THE
20 CRITERIA DEVELOPED BY PHEAA THAT ARE NOT INCONSISTENT WITH THIS
21 ACT. PHEAA MAY NOT PROVIDE REPAYMENT ASSISTANCE FOR A LOAN THAT
22 IS IN DEFAULT AT THE TIME OF THE APPLICATION.

23 (D) ELIGIBILITY.--TO BE CONSIDERED FOR LOAN REPAYMENT
24 ASSISTANCE, AN APPLICANT SHALL MEET THE FOLLOWING REQUIREMENTS:

25 (1) (I) BE ENROLLED AS A FULL-TIME STUDENT IN AN
26 ACCREDITED COMMONWEALTH MEDICAL OR NURSING SCHOOL OR
27 OSTEOPATHIC MEDICAL COLLEGE; OR

28 (II) HAVE A MEDICAL DEGREE FROM AN ACCREDITED
29 MEDICAL SCHOOL OR OSTEOPATHIC MEDICAL COLLEGE AND HAVE
30 COMPLETED AN APPROVED GRADUATE TRAINING PROGRAM IN

1 PRIMARY CARE MEDICINE AND BE LICENSED TO PRACTICE
2 MEDICINE IN THIS COMMONWEALTH OR HAVE A NURSING DEGREE
3 FROM AN ACCREDITED NURSING PROGRAM.

4 (2) AGREE TO SERVE IN A MEDICALLY UNDERSERVED DESIGNATED
5 SHORTAGE AREA OF THIS COMMONWEALTH AS A PRIMARY CARE
6 PHYSICIAN OR NURSE PRACTITIONER ONE YEAR FOR EACH \$12,500 IN
7 LOANS REPAID BY PHEAA.

8 (E) CONTRACTS.--EACH RECIPIENT OF A LOAN SHALL ENTER INTO A
9 CONTRACT WITH PHEAA WHICH SHALL BE CONSIDERED A CONTRACT WITH
10 THIS COMMONWEALTH. IN EXECUTING THE CONTRACTS, PHEAA SHALL GIVE
11 PRIORITY TO THOSE APPLICANTS WHO AGREE TO ENGAGE IN PRIMARY CARE
12 PRACTICE A MINIMUM OF THREE YEARS IN A MEDICALLY UNDERSERVED
13 DESIGNATED SHORTAGE AREA. THE CONTRACT SHALL CONTAIN THE
14 FOLLOWING TERMS AND CONDITIONS:

15 (1) AN UNLICENSED APPLICANT SHALL APPLY FOR A LICENSE TO
16 PRACTICE MEDICINE IN THIS COMMONWEALTH AT THE EARLIEST
17 PRACTICABLE OPPORTUNITY.

18 (2) WITHIN SIX MONTHS AFTER LICENSURE AND THE COMPLETION
19 OF ALL REQUIREMENTS FOR THE PRIMARY CARE SPECIALTY, THE
20 APPLICANT SHALL ENGAGE IN THE PRACTICE OF PRIMARY CARE
21 MEDICINE IN THE MEDICALLY UNDERSERVED DESIGNATED SHORTAGE
22 AREA SELECTED BY THE BUREAU UPON THE ADVICE AND
23 RECOMMENDATION OF THE ADVISORY COMMITTEE.

24 (3) THE APPLICANT SHALL AGREE TO SERVE ONE FULL YEAR FOR
25 EACH LOAN REPAYMENT OF \$12,500 MADE ON HIS BEHALF.

26 (4) THE PHYSICIAN OR NURSE PRACTITIONER SHALL TREAT
27 PATIENTS IN THE AREA ELIGIBLE FOR MEDICAL ASSISTANCE AND
28 MEDICARE. THE PHYSICIAN SHALL PROVIDE SERVICES FOR CHILDREN
29 COVERED UNDER THE PROGRAM ESTABLISHED IN SECTION 701.

30 (5) THE PHYSICIAN OR NURSE PRACTITIONER SHALL PRACTICE

ON A FULL-TIME BASIS IN THE DESIGNATED SHORTAGE AREA.

(6) THE PHYSICIAN SHALL PERMIT THE BUREAU TO MONITOR THE PRACTICE TO DETERMINE COMPLIANCE WITH THE TERMS OF THE CONTRACT.

(7) PHEAA SHALL CERTIFY COMPLIANCE WITH THE TERMS OF THE CONTRACT FOR PURPOSES OF RECEIPT BY THE PHYSICIAN OR NURSE PRACTITIONER OF LOANS FOR YEARS SUBSEQUENT TO THE INITIAL YEAR OF THE LOAN.

(8) THE CONTRACT SHALL BE RENEWABLE ON AN ANNUAL BASIS UPON CERTIFICATION BY PHEAA THAT THE PHYSICIAN OR NURSE PRACTITIONER HAS COMPLIED WITH THE TERMS OF THE CONTRACT.

(9) IN THE EVENT OF THE RECIPIENT'S DEATH OR TOTAL OR PERMANENT DISABILITY, PHEAA SHALL NULLIFY THE SERVICE OBLIGATION OF THE RECIPIENT AND PHEAA SHALL REPAY THE LOAN IN FULL.

(10) IN THE EVENT THE RECIPIENT IS CONVICTED OF A FELONY OR MISDEMEANOR OR THE APPROPRIATE LICENSING BOARD HAS DETERMINED THAT THE RECIPIENT HAS COMMITTED AN ACT OF GROSS NEGLIGENCE IN THE PERFORMANCE OF SERVICE OBLIGATIONS OR WHERE THE LICENSE TO PRACTICE HAS BEEN REVOKED OR SUSPENDED BY THE APPROPRIATE LICENSING BOARD, PHEAA SHALL HAVE THE AUTHORITY TO TERMINATE THE RECIPIENT'S SERVICE IN THE PROGRAM AND DEMAND REPAYMENT OF THE OUTSTANDING LOAN.

(11) NO PHYSICIAN OR NURSE PRACTITIONER MAY RECEIVE REPAYMENT ASSISTANCE FOR MORE THAN FIVE YEARS.

(12) LOAN RECIPIENTS WHO FAIL TO FULFILL THE OBLIGATIONS CONTRACTED FOR SHALL PAY TO PHEAA THE FULL AMOUNT RECEIVED PLUS INTEREST FROM THE DATE OF THE ORIGINAL LOAN AT THE RATE OF 2% ABOVE THE PRIME RATE AT THE TIME OF THE BREACH.

DETERMINATION AS TO THE TIME OF BREACH SHALL BE MADE BY THE

1 ADVISORY COMMITTEE. BOTH THE RECIPIENT AND THE BUREAU SHALL
2 MAKE EVERY EFFORT TO RESOLVE CONFLICTS IN ORDER TO PREVENT A
3 BREACH.

4 (F) SCHOLARSHIPS.--TO BE CONSIDERED FOR SCHOLARSHIP
5 ASSISTANCE, AN APPLICANT SHALL MEET THE FOLLOWING CRITERIA:

6 (1) HAVE SUCCESSFULLY COMPLETED UNDERGRADUATE EDUCATION
7 AT AN INSTITUTE OF HIGHER LEARNING OF THIS COMMONWEALTH.

8 (2) AGREE TO ENGAGE IN THE PRACTICE OF PRIMARY CARE
9 MEDICINE FOR A MINIMUM OF FOUR YEARS IN A MEDICALLY
10 UNDERSERVED DESIGNATED SHORTAGE AREA TO WHICH HE IS ASSIGNED
11 BY THE BUREAU IN ACCORDANCE WITH THE PROVISIONS OF THIS ACT
12 AFTER COMPLETION OF ALL REQUIREMENTS FOR LICENSURE AS A
13 PHYSICIAN IN THIS COMMONWEALTH AND OF THE PRIMARY CARE
14 SPECIALTY.

15 (3) MEET SUCH CRITERIA AS SHALL BE DEVELOPED BY THE
16 BUREAU UPON THE ADVICE AND RECOMMENDATIONS OF THE ADVISORY
17 COMMITTEE AS ARE NOT INCONSISTENT WITH THIS ACT.

18 (G) ASSIGNMENT CRITERIA.--THE BUREAU, UPON THE ADVICE AND
19 RECOMMENDATION OF THE ADVISORY COMMITTEE, SHALL ESTABLISH
20 CRITERIA FOR ASSIGNING RECIPIENTS TO A MEDICALLY UNDERSERVED
21 DESIGNATED SHORTAGE AREA. IN MAKING THE ASSIGNMENTS, THE AGENCY
22 SHALL MATCH THE CHARACTERISTICS AND PREFERENCES OF THE RECIPIENT
23 WITH THOSE OF THE AREA, POPULATION GROUP OR HEALTH CARE FACILITY
24 TO THE EXTENT POSSIBLE TO MAXIMIZE THE PROBABILITY OF THE
25 RECIPIENT'S REMAINING IN THE AREA UPON COMPLETION OF THE
26 ASSIGNMENT PERIOD.

27 SECTION 1107. MOBILE HEALTH CLINICS.

28 (A) ESTABLISHMENT OF PROGRAM.--THERE IS HEREBY ESTABLISHED
29 THE MOBILE HEALTH CLINIC DEMONSTRATION PROGRAM WHICH SHALL BE
30 ADMINISTERED BY THE BUREAU. THE BUREAU SHALL:

1 THE HEALTH CARE COST CONTAINMENT COUNCIL SHALL COLLECT EACH YEAR
2 COMMENCING WITH THE CALENDAR YEAR BEGINNING JANUARY 1, 1993, THE
3 FOLLOWING CHARITY CARE DATA FROM ALL ACUTE CARE HOSPITALS
4 LICENSED IN THIS COMMONWEALTH:

5 (1) CATASTROPHIC INPATIENT AND OUTPATIENT COSTS WHICH
6 ARE DEFINED AS THE ALLOWABLE AUDITED COSTS OF SERVICES
7 PROVIDED TO PERSONS ABOVE 150% OF THE POVERTY LEVEL, WITH AN
8 UNPAID PERSONAL LIABILITY GREATER THAN ANNUAL FAMILY INCOME,
9 LESS AN AMOUNT EQUIVALENT TO 150% OF THE FEDERAL POVERTY
10 LEVEL. SUCH AMOUNT MUST BE NET, FOLLOWING REASONABLE
11 COLLECTION PROCEDURES, CONSISTENTLY APPLIED, AND MAY NOT
12 INCLUDE ANY COSTS OR SERVICES FOR WHICH REIMBURSEMENT COULD
13 HAVE BEEN SECURED FROM THE MEDICAL ASSISTANCE OR MEDICARE
14 PROGRAM OR OTHER THIRD-PARTY PAYOR, NOR ANY COSTS OR SERVICES
15 RENDERED BY A HOSPITAL IN FULFILLMENT OF ANY CHARITY CARE
16 OBLIGATION FUNDING FROM FOUNDATIONS OR FEDERAL OR STATE
17 SOURCES INCLUDING FUNDING UNDER THE HILL-BURTON PROGRAM.

18 (2) MEDICAL ASSISTANCE WHICH IS DEFINED AS THE INPATIENT
19 AND OUTPATIENT PATIENT-PAY AMOUNT FOR MEDICAL ASSISTANCE
20 RECIPIENTS WHICH HAS BEEN UNABLE TO BE COLLECTED FOLLOWING
21 REASONABLE COLLECTION PROCEDURES, CONSISTENTLY APPLIED.

22 (3) UNDERINSURED INPATIENT CHARITY CARE WHICH IS DEFINED
23 AS THE ALLOWABLE AUDITED COST OF SERVICES PROVIDED TO
24 UNDERINSURED PERSONS BELOW 150% OF THE FEDERAL POVERTY LEVEL,
25 FOLLOWING REASONABLE COLLECTION PROCEDURES, CONSISTENTLY
26 APPLIED. SUCH AMOUNT MAY NOT INCLUDE PAYMENT FOR GOODS OR
27 SERVICES WHICH COULD HAVE BEEN REIMBURSED UNDER THE MEDICAL
28 ASSISTANCE OR MEDICARE PROGRAM OR OTHER THIRD-PARTY PAYOR,
29 NOR ANY COSTS OR SERVICES RENDERED BY A HOSPITAL IN
30 FULFILLMENT OF ANY CHARITY CARE OBLIGATION FUNDING FROM

1 FOUNDATIONS OR FEDERAL OR STATE SOURCES INCLUDING FUNDING
2 UNDER THE HILL-BURTON PROGRAM.

3 (4) UNINSURED INPATIENT CHARITY CARE WHICH IS DEFINED AS
4 THE ALLOWABLE AUDITED COST OF SERVICES PROVIDED TO PERSONS
5 WITHOUT PUBLIC OR PRIVATE INSURANCE COVERAGE, WITH INCOME
6 BELOW 150% OF THE POVERTY LEVEL, FOLLOWING REASONABLE
7 COLLECTION PROCEDURES, CONSISTENTLY APPLIED. SUCH AMOUNT MAY
8 NOT INCLUDE PAYMENT FOR GOODS OR SERVICES WHICH COULD HAVE
9 BEEN REIMBURSED UNDER THE MEDICAL ASSISTANCE OR MEDICARE
10 PROGRAM OR OTHER THIRD-PARTY PAYOR, NOR ANY COSTS OR SERVICES
11 RENDERED BY A HOSPITAL IN FULFILLMENT OF ANY CHARITY CARE
12 OBLIGATION FUNDING FROM FOUNDATIONS OR FEDERAL OR STATE
13 SOURCES INCLUDING FUNDING UNDER THE HILL-BURTON PROGRAM.

14 (5) ADDITIONAL DATA THAT THE COUNCIL BELIEVES IS
15 NECESSARY IN DETERMINING CHARITY CARE PROVIDED BY ACUTE CARE
16 HOSPITALS.

17 (B) RECOMMENDATIONS TO GENERAL ASSEMBLY.--COMMENCING MARCH
18 1, 1994, AND EVERY MARCH 1 THEREAFTER, THE COUNCIL SHALL SUBMIT
19 RECOMMENDATIONS TO THE GOVERNOR AND THE GENERAL ASSEMBLY AS TO
20 WHETHER A SOURCE OF FUNDING IS REQUIRED FOR UNCOMPENSATED
21 CHARITY CARE PROVIDED BY ACUTE CARE HOSPITALS IN THIS
22 COMMONWEALTH. THESE RECOMMENDATIONS SHALL BE BASED ON DATA
23 COLLECTION FOR UNCOMPENSATED CHARITY CARE AS DEFINED IN THIS
24 SECTION FOR THE PRECEDING CALENDAR YEAR.

25 (C) ANNUAL HEARINGS OF THE GENERAL ASSEMBLY.--THE HEALTH AND
26 WELFARE COMMITTEE OF THE HOUSE OF REPRESENTATIVES AND THE PUBLIC
27 HEALTH AND WELFARE COMMITTEE OF THE SENATE SHALL HOLD ANNUAL
28 JOINT PUBLIC HEARINGS IN EACH REGION TO REVIEW THE COUNCIL'S
29 RECOMMENDATIONS FOR THE LEVEL OF FUNDING REQUIRED FOR CHARITY
30 CARE.

1 SECTION 1502. MEDICAL ASSISTANCE REIMBURSEMENT.

2 (A) JOINT HEARINGS.--THE HEALTH AND WELFARE COMMITTEE OF THE
3 HOUSE OF REPRESENTATIVES AND THE PUBLIC HEALTH AND WELFARE
4 COMMITTEE OF THE SENATE SHALL HOLD JOINT PUBLIC HEARINGS IN EACH
5 REGION OF THIS COMMONWEALTH TO REVIEW THE ADEQUACY OF PAYMENTS
6 TO PROVIDERS UNDER THE MEDICAL ASSISTANCE PROGRAM.

7 (B) JOINT SELECT COMMITTEE ON MEDICAL ASSISTANCE
8 REIMBURSEMENT PROCEDURES.--THE PRESIDENT PRO TEMPORE OF THE
9 SENATE AND THE SPEAKER OF THE HOUSE OF REPRESENTATIVES SHALL
10 APPOINT MEMBERS TO A JOINT SELECT COMMITTEE TO STUDY THE
11 FEASIBILITY OF IMPLEMENTING MATERIAL IMPROVEMENTS IN THE
12 PROCESSING OF CLAIMS FOR MEDICAL ASSISTANCE REIMBURSEMENTS TO
13 PROVIDERS, AND IN THE USE OF PENNSYLVANIA MEDICAL ASSISTANCE BY
14 ITS LOW-INCOME CITIZENS. THE STUDY SHALL INCLUDE, BUT NOT BE
15 LIMITED TO, THE FOLLOWING:

16 (1) THE COST-EFFECTIVENESS OF CONTRACTING THE ENTIRE
17 MEDICAL ASSISTANCE REIMBURSEMENT PROCESS TO A FISCAL
18 INTERMEDIARY.

19 (2) EXPLANATION SECTIONS IN ALL CLAIM FORMS SO THAT THEY
20 CONTAIN A CLEAR DESCRIPTION IN ENGLISH OF THE APPLICABLE
21 CODES AND MESSAGES IN ORDER THAT PROVIDERS AND RECIPIENT'S
22 CAN RESPOND TO OR COMPLETE THE FORM.

23 (3) ADDITIONAL STAFFING OF THE 800 TELEPHONE NUMBER SO
24 THAT PROVIDERS AND BENEFICIARIES CAN VERIFY ELIGIBILITY TO
25 RECEIVE BENEFITS, INQUIRE AS TO APPLICABLE ELIGIBILITY
26 REQUIREMENTS AND COVERAGE RESTRICTIONS, AND RECEIVE A
27 VERIFICATION NUMBER AS TO PRECLUDE DENIAL FOR REASONS
28 INCONSISTENT WITH THE INFORMATION RECEIVED BY TELEPHONE.

29 (4) DEVELOPMENT OF A SPECIAL TRAINING FOR PROVIDERS,
30 IDENTIFYING THOSE PARTS OF THE CLAIM FORMS WITH THE GREATEST

1 INCIDENCE OF ERROR AND EXPLAINING HOW TO AVOID SUCH ERRORS.

2 (5) SUBMISSION OF CLAIMS BY PROVIDERS ON FLOPPY DISKS,
3 TAPE TO TAPE BILLING OR TELECOMMUNICATIONS.

4 (6) DEVELOPMENT OF COMPUTER SOFTWARE THAT WILL
5 AUTOMATICALLY IDENTIFY ERRORS BY VALIDITY EDIT WHICH VERIFIES
6 THAT THE DATA ENTERED INTO ANY FIELD OR CLAIM LINE ON A CLAIM
7 IS APPROPRIATE FOR THAT FIELD OR CLAIM LINE.

8 (7) REWRITING THE PROVIDER HANDBOOK AND REORGANIZING
9 PROVIDER BULLETINS ON A REGULAR BASIS TO MAKE THESE DOCUMENTS
10 MORE UNDERSTANDABLE AND USABLE.

11 (C) REPORTS.--EACH COMMITTEE SHALL ISSUE A REPORT BY
12 DECEMBER 31, 1992, AND THE GENERAL ASSEMBLY SHALL ENACT
13 LEGISLATION, IF NECESSARY, TO ADJUST MEDICAL ASSISTANCE PROVIDER
14 REIMBURSEMENT TO COMPLY WITH FEDERAL REQUIREMENTS AND TO
15 IMPLEMENT CHANGES IN MEDICAL ASSISTANCE REIMBURSEMENT
16 PROCEDURES.

17 SECTION 1503. COST OF MANDATED HEALTH BENEFITS.

18 (A) CONTENT OF STUDY.--IF SUFFICIENT FUNDING IS AVAILABLE,
19 THE HEALTH CARE COST CONTAINMENT COUNCIL, THROUGH ITS MANDATED
20 BENEFITS REVIEW COMMITTEE, IS DIRECTED, SUBJECT TO THE
21 AVAILABILITY OF SUFFICIENT AND ADEQUATE CARRIER DATA, TO STUDY
22 THE COSTS AND EFFECTIVENESS OF EXISTING MANDATED HEALTH
23 BENEFITS/MANDATED PROVIDERS TO BUSINESSES. FOR EACH OF THE
24 EXISTING MANDATED HEALTH BENEFITS/PROVIDERS, THE REVIEW PANEL
25 SHALL DETERMINE THE FINANCIAL IMPACT AND HEALTH CARE
26 EFFECTIVENESS OF THE EXISTING BENEFIT, INCLUDING AT LEAST:

27 (1) THE NUMBER OF PERSONS UTILIZING THE EXISTING
28 BENEFIT/PROVIDERS.

29 (2) THE EXTENT TO WHICH ELIMINATION OF THE EXISTING
30 BENEFIT/PROVIDER AS A MANDATED HEALTH BENEFIT WOULD RESULT IN

1 INADEQUATE HEALTH CARE FOR THE POPULATION OF THIS
2 COMMONWEALTH.

3 (3) THE COST-EFFECTIVENESS OF THE EXISTING
4 BENEFIT/PROVIDER IN REDUCING FURTHER MORE COSTLY MEDICAL
5 PROCEDURES.

6 (4) THE IMPACT OF THE EXISTING BENEFIT/PROVIDER ON THE
7 TOTAL COST OF HEALTH CARE WITHIN THIS COMMONWEALTH.

8 (5) THE IMPACT OF THE EXISTING BENEFIT/PROVIDER ON
9 HEALTH INSURANCE COSTS OF HEALTH CARE PURCHASERS.

10 (6) THE IMPACT OF THE EXISTING BENEFIT/PROVIDER ON
11 ADMINISTRATIVE EXPENSES OF HEALTH CARE INSURERS.

12 (7) THE EXTENT TO WHICH ELIMINATION OF THE EXISTING
13 BENEFIT/PROVIDER AS A MANDATED HEALTH BENEFIT/MANDATED
14 PROVIDER WOULD RESULT IN INCREASED MEDICAL ASSISTANCE
15 EXPENDITURES AND CHARITY CARE.

16 (8) THE EXTENT TO WHICH ELIMINATION OF THE EXISTING
17 BENEFIT/PROVIDER AS A MANDATED HEALTH BENEFIT/MANDATED
18 PROVIDER COULD BE PAID FOR BY THE PERSON RECEIVING THE
19 EXISTING BENEFIT/PROVIDER.

20 (9) THE IMPACT OF THE EXISTING BENEFIT/PROVIDER ON THE
21 ABILITY OF SMALL BUSINESSES TO PURCHASE HEALTH INSURANCE FOR
22 THEIR EMPLOYEES AND ON THE ABILITY OF SELF-EMPLOYED PERSONS
23 TO PURCHASE HEALTH INSURANCE.

24 (B) FINDINGS AND RECOMMENDATIONS.--THE REVIEW PANEL SHALL
25 ISSUE A REPORT TO THE COUNCIL BY JUNE 30, 1993, OUTLINING THEIR
26 FINDINGS ON THE COSTS AND EFFECTIVENESS OF THE EXISTING MANDATED
27 HEALTH BENEFITS. AFTER REVIEW OF THE PANEL'S REPORT, THE COUNCIL
28 SHALL SUBMIT A FINAL REPORT TO THE GOVERNOR AND THE GENERAL
29 ASSEMBLY BY DECEMBER 31, 1993, OUTLINING THEIR FINDINGS ON THE
30 COSTS AND EFFECTIVENESS OF THE EXISTING MANDATED HEALTH BENEFITS

1 AND RECOMMENDATIONS AS TO WHETHER ANY OR ALL EXISTING MANDATED
2 HEALTH BENEFITS SHOULD BE ELIMINATED.

3 SECTION 1504. PHYSICIAN ACCEPTANCE OF MEDICAL ASSISTANCE
4 PATIENTS.

5 THE COUNCIL SHALL, FOR ALL PROVIDERS WITHIN THIS COMMONWEALTH
6 AND WITHIN THE APPROPRIATE REGIONS AND SUBREGIONS WITHIN THIS
7 COMMONWEALTH, PREPARE AND ISSUE QUARTERLY REPORTS THAT PROVIDE
8 INFORMATION ON THE NUMBER OF PHYSICIANS, BY SPECIALTY, ON THE
9 STAFF OF EACH HOSPITAL OR AMBULATORY SERVICE FACILITY AND THE
10 NUMBER AND NAMES OF THOSE PHYSICIANS, BY SPECIALTY, ON THE STAFF
11 THAT ACCEPT MEDICAL ASSISTANCE PATIENTS.

12 SECTION 1505. SUBSIDIES PROVIDED BY HEALTH SERVICE CORPORATION
13 AND HOSPITAL PLAN CORPORATIONS.

14 THE HEALTH SERVICE CORPORATION AND HOSPITAL PLAN CORPORATIONS
15 PRESENTLY ARE EXEMPT FROM PAYING THE 2% PREMIUM TAX. IN LIEU OF
16 THIS EXEMPTION, AND AS PART OF THEIR OBLIGATION TO SERVE LOW-
17 INCOME SUBSCRIBERS, THE HEALTH SERVICE CORPORATION AND HOSPITAL
18 PLAN CORPORATIONS SHALL SUBMIT ANNUALLY, COMMENCING ON JANUARY
19 31, 1993, TO THE DEPARTMENT OF HEALTH AND THE DEPARTMENT OF
20 INSURANCE DATA DOCUMENTING THEIR SUBSIDIES TO HEALTH CARE
21 PURCHASERS THAT THEY PROVIDE IN LIEU OF THEIR EXEMPTION FROM THE
22 2% PREMIUM TAX. IN SUBMITTING THIS DATA, THE HEALTH SERVICE
23 CORPORATION AND HOSPITAL PLAN CORPORATIONS SHALL INDICATE WHICH
24 SUBSIDIES ARE BASED ON THE INCOME OF THE HEALTH CARE PURCHASER
25 OR BENEFICIARY.

26 CHAPTER 31

27 MISCELLANEOUS PROVISIONS

28 SECTION 3101. APPROPRIATION.

29 (1) THE SUM OF \$500,000, OR AS MUCH THEREOF AS MAY BE
30 NECESSARY, IS HEREBY APPROPRIATED TO THE DEPARTMENT OF HEALTH

1 FOR THE FISCAL YEAR JULY 1, 1992, TO JUNE 30, 1993, FOR
2 START-UP COSTS AND EXPENSES OF THE BUREAU OF RURAL AND INNER-
3 CITY HEALTH CARE SERVICES.

4 (2) THE SUM OF \$3,500,000, OR AS MUCH THEREOF AS MAY BE
5 NECESSARY, IS HEREBY APPROPRIATED TO THE PENNSYLVANIA HIGHER
6 EDUCATION ASSISTANCE AGENCY FOR THE FISCAL YEAR JULY 1, 1992,
7 TO JUNE 30, 1993, TO CARRY OUT THE PROVISIONS OF SECTIONS
8 1103 AND 1106.

9 (3) THE SUM OF \$1,000,000, OR AS MUCH THEREOF AS MAY BE
10 NECESSARY, IS HEREBY APPROPRIATED TO THE BUREAU OF RURAL AND
11 INNER-CITY HEALTH CARE SERVICES FOR THE FISCAL YEAR JULY 1,
12 1992, TO JUNE 30, 1993, TO CARRY OUT THE PROVISIONS OF
13 SECTION 1107.

14 SECTION 3102. SEVERABILITY.

15 THE PROVISIONS OF THIS ACT ARE SEVERABLE. IF ANY PROVISION OF
16 THIS ACT OR ITS APPLICATION TO ANY PERSON OR CIRCUMSTANCE IS
17 HELD INVALID, THE INVALIDITY SHALL NOT AFFECT OTHER PROVISIONS
18 OR APPLICATIONS OF THIS ACT WHICH CAN BE GIVEN EFFECT WITHOUT
19 THE INVALID PROVISION OR APPLICATION.

20 SECTION 3103. REPEALS.

21 ALL ACTS AND PARTS OF ACTS ARE REPEALED INsofar AS THEY ARE
22 INCONSISTENT WITH THIS ACT.

23 SECTION 3104. EXPIRATION.

24 THIS ACT SHALL EXPIRE DECEMBER 31, 1999, UNLESS REENACTED BY
25 THE GENERAL ASSEMBLY.

26 SECTION 3105. EFFECTIVE DATE.

27 THIS ACT SHALL TAKE EFFECT SEPTEMBER 1, 1992, OR IMMEDIATELY,
28 WHICHEVER IS LATER.