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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 20 Session of 1991

INTRODUCED BY KUKOVICH, RICHARDSON, PISTELLA, JOSEPHS, KOSINSKI, STUBAN, VAN HORNE, STISH, GIGLIOTTI, LAUGHLIN, PESCI, BELARDI, HARPER, McNALLY, FREEMAN, ROEBUCK, STURLA, RITTER, HALUSKA, MARKOSEK, GEORGE, WAMBACH, DeLUCA, LaGROTTA, KASUNIC, ROBINSON, CAPPABIANCA, HANNA, CARN, TIGUE, HERMAN, BELFANTI, MIHALICH, DALEY, BUNT, JAMES, BISHOP, VEON, MAIALE, TANGRETTI, TRELLO, HUGHES, MELIO, PRESTON, LEVDANSKY, TRICH, WILLIAMS, R. C. WRIGHT, THOMAS, STEELMAN, TELEK, BLAUM AND RUDY, MARCH 11, 1991

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

AN ACT

~~Providing a comprehensive plan for health care for the indigent, for operation of medical assistance, for primary health care programs, for access to health care, for health insurance reform and for studies on health care; further providing for State funds and for powers and duties of administrative agencies; imposing penalties; and making repeals.~~ <—

PROVIDING A COMPREHENSIVE PLAN FOR HEALTH CARE FOR CHILDREN, FOR OPERATION OF MEDICAL ASSISTANCE, FOR PRIMARY HEALTH CARE PROGRAMS, FOR ACCESS TO HEALTH CARE, AND FOR STUDIES ON HEALTH CARE; ESTABLISHING THE BUREAU OF RURAL AND INNER-CITY HEALTH CARE SERVICES; FURTHER PROVIDING FOR STATE FUNDS AND FOR POWERS AND DUTIES OF ADMINISTRATIVE AGENCIES; IMPOSING PENALTIES; MAKING APPROPRIATIONS; AND MAKING REPEALS. <—

~~TABLE OF CONTENTS~~ <—

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

~~Section 3103. Severability.~~

~~Section 3104. Repeals.~~

~~Section 3105. Expiration.~~

~~Section 3106. Effective date.~~

TABLE OF CONTENTS <—

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

~~CHAPTER 1~~ <—

~~GENERAL PROVISIONS~~

~~Section 101. Short title.~~

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

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

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

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

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

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

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

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

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

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

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

~~(2) Care be provided in appropriate settings by 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

assistance (MA)).

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

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

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

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

CHAPTER 5

MEDICAL ASSISTANCE PROGRAM

Section 501. Hospital responsibilities under medical assistance program.

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

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

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

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

~~medical assistance;~~

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

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

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

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

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

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

~~Section 502. Medical assistance outreach.~~

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

~~include:~~

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

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

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

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

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

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

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

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

~~(b) Applications for medical assistance and children's 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~~

~~waived.~~

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

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

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

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

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

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

~~(d) Noncompliance.--If the EPSDT program is found to be in noncompliance with the provisions of this section or has failed to take sufficient outreach efforts to enroll any county's 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~~

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

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

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

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

~~(iii) The Insurance Commissioner.~~

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

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

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

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

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

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

~~(x) The Majority Chairman and the Minority Chairman 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~~

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

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

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

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

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

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

~~reasonable and necessary.~~

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

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

~~(c) Limitations.--~~

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

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

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

~~(1) To the fullest extent practicable, grants shall be 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.~~

~~(e) 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 (e) 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~~

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

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

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

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

~~(m) Dedicated funding.--The Children's Health Fund for 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~~

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

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

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

~~(d) Waiver of requirements.--The department may grant a 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~~

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

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

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

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

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

~~section 1301(a).~~

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

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

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

~~(c) Protections.--Any insurer, nonprofit hospital plan, professional health service corporation or managed care organization may not 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 contract or policy subject to this section.~~

~~(2) Decline to enroll any person protected by this section in a 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 prior 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 prior 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 prior contract or policy is required for the insurer, nonprofit hospital plan, professional health service corporation or managed care organization issuing or entering into a succeeding contract or policy to comply with this section, the issuer of the prior contract or policy shall, at the request of the issuer of the succeeding contract or policy, furnish a statement as to the existence and terms of any preexisting condition exclusion period or waiting period under the prior contract or policy. If an exclusion period or a waiting period exists under the replaced contract or policy, the issuer of the subsequent contract or policy shall calculate the amount of time remaining on the period based on the terms of the prior contract of policy.~~

~~(e) Duplication.--Nothing in this section shall be construed as requiring any employer or any insurer, nonprofit hospital plan, professional health service corporation or managed care 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~~

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

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

~~Section 1304. Preexisting conditions.~~

~~(a) Disease or condition specific condition exclusion limited.--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 exclude, limit or reduce coverage or benefits in a group contract or policy beyond the waiting periods permitted under this act for a specifically named or described preexisting disease, condition or genetic predisposition on the basis of its preexistence.~~

~~(b) Mandated offer to all group members.--When offering a contract or policy to a group, any insurer, professional health service corporation, nonprofit hospital plan corporation or 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

~~level. Such amount must be net, following reasonable collection procedures, consistently applied, and may not include any costs or services for which reimbursement could have been secured from 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.~~

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

~~(3) Underinsured inpatient charity care which is defined as the allowable audited cost of services provided to underinsured persons below 150% of the Federal poverty level, following reasonable collection procedures, consistently applied. Such amount may not include payment for goods or services which could have 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.~~

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

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

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

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

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

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

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

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

~~(7) Rewriting the provider handbook and reorganizing 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

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

~~Section 3103. Severability.~~

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

~~Section 3104. Repeals.~~

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

~~Section 3105. Expiration.~~

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

~~Section 3106. Effective date.~~

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

CHAPTER 1 <——

GENERAL PROVISIONS

SECTION 101. SHORT TITLE.

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

SECTION 102. LEGISLATIVE FINDINGS AND INTENT.

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

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

(2) THE UNINSURED HEALTH CARE POPULATION OF THIS

COMMONWEALTH IS OVER ONE MILLION PERSONS, AND MANY THOUSANDS MORE LACK ADEQUATE INSURANCE COVERAGE. APPROXIMATELY TWO-THIRDS OF THE UNINSURED ARE EMPLOYED OR DEPENDENTS OF 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 IN THE AMOUNT OF CHARITABLE UNCOMPENSATED HEALTH CARE THEY PROVIDE.

(7) ALTHOUGH THE PROPER IMPLEMENTATION BY HOSPITALS OF

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

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

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

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

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

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

(3) EQUITY CAN 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:

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

"CHILD." A PERSON UNDER 19 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.

"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.

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

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

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

"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 ASSISTANCE (MA)).

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

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

CHAPTER 5

MEDICAL ASSISTANCE PROGRAM

SECTION 501. HOSPITAL RESPONSIBILITIES UNDER MEDICAL ASSISTANCE PROGRAM.

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

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

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

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

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

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

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

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

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

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

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

SECTION 502. MEDICAL ASSISTANCE OUTREACH.

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

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

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

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

PERSONS WITH ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS);

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

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

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

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

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

(B) APPLICATIONS FOR MEDICAL ASSISTANCE AND CHILDREN'S 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.

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

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

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

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

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

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 WAIVED.

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

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

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

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

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

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

(D) NONCOMPLIANCE.--IF THE EPSDT PROGRAM IS FOUND TO BE IN NONCOMPLIANCE WITH THE PROVISIONS OF THIS SECTION OR HAS FAILED TO TAKE SUFFICIENT OUTREACH EFFORTS TO ENROLL ANY COUNTY'S 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 ADVICE FROM THE CONSUMER SUBCOMMITTEE OF THE MAAC AND OTHER APPROPRIATE SUBCOMMITTEES 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 COMMONWEALTH, EXERCISING PUBLIC POWERS, INCLUDING ALL POWERS NECESSARY OR APPROPRIATE TO CARRY OUT AND EFFECTUATE THE PURPOSES AND PROVISIONS OF THIS SECTION.

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

(I) THE SECRETARY OF HEALTH OR A DESIGNEE.

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

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

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

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

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

(VII) A REPRESENTATIVE APPOINTED BY THE CHILD HEALTH

SUBCOMMITTEE OF THE MEDICAL ASSISTANCE ADVISORY COMMITTEE.

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

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

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

(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 OR THEIR DESIGNEES.

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

(2) ALL INITIAL APPOINTMENTS TO THE AUTHORITY SHALL BE MADE 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) THE PRESENCE OF EIGHT 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 AND IN COMPLIANCE WITH REQUIREMENTS OF THE INDEPENDENT REGULATORY REVIEW COMMISSION.

(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 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 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 YEARS. VACANCIES ON THE AUTHORITY SHALL BE FILLED IN THE SAME MANNER IN WHICH THEY WERE DESIGNATED WITHIN 60 DAYS OF THE VACANCY.

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

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

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

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

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

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

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

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

(C) LIMITATIONS.--

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

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

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

(1) TO THE FULLEST EXTENT PRACTICABLE, GRANTS SHALL BE MADE TO APPLICANTS THAT CONTRACT WITH PROVIDERS TO PROVIDE STATEWIDE 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 AND WHENEVER POSSIBLE, TO PURSUE AND UTILIZE AVAILABLE PUBLIC AND PRIVATE FUNDS. THIS SHALL INCLUDE CONTRACTING WITH QUALIFIED, COST-EFFECTIVE PROVIDERS, INCLUDING HOSPITAL OUTPATIENT DEPARTMENTS, HMO'S, 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.

(E) 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 (E) 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 UP TO THE AGE OF SIX WHOSE FAMILY INCOME IS LESS THAN OR UP TO 185% OF THE FEDERAL POVERTY LEVEL AND SHALL BE FREE TO CHILDREN FROM AGE SIX UP TO AGE NINETEEN WHOSE FAMILY INCOME IS LESS THAN 100% OF THE FEDERAL POVERTY LEVEL. THOSE FAMILIES WITH INCOME HIGHER THAN THE INCOME ELIGIBILITY LEVELS FOR FREE CARE MAY PURCHASE COVERAGE FOR THEIR CHILDREN AT COST. THERE SHALL BE NO COPAYMENTS OR DEDUCTIBLES OF ANY KIND FOR UNINSURED CHILDREN WHOSE FAMILY INCOME IS LESS THAN 100% OF THE FEDERAL POVERTY

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

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

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

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

(M) DEDICATED FUNDING.--THE CHILDREN'S HEALTH FUND FOR 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.

CHAPTER 11

ACCESS TO HEALTH CARE

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

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

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

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

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

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

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

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

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

(7) ADMINISTER SUMS APPROPRIATED TO CARRY OUT THE

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

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

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

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

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

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

(2) THE SECRETARY OF HEALTH.

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

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

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

(III) ONE MEMBER WHO IS LICENSED IN OBSTETRICS-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

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

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

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

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

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

SECTION 1104. REPORT TO GENERAL ASSEMBLY.

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

SECTION 1105. EXPIRATION.

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

SECTION 1106. MEDICAL SCHOLARSHIP AND LOAN FORGIVENESS FUND.

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

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

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

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

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

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

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

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

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

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

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

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

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

(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

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

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

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

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

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

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

SECTION 1107. MOBILE HEALTH CLINICS.

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

(1) PROVIDE TWO GRANTS FROM SUMS APPROPRIATED BY THE GENERAL ASSEMBLY TO HEALTH CARE PROVIDERS, HEALTH CARE NETWORKS, TEACHING HOSPITALS OR DENTAL SCHOOLS TO ASSIST IN THE PURCHASE OF VEHICLES, MEDICAL OR DENTAL EQUIPMENT OR THE COORDINATION OF ACTIVITIES LEADING TO THE ESTABLISHMENT OF ONE MOBILE HEALTH CLINIC AND ONE MOBILE DENTAL CLINIC IN RURAL MEDICALLY UNDERSERVED DESIGNATED SHORTAGE AREAS.

(2) IN AWARDING GRANTS, GIVE PREFERENCE TO PROGRAMS WHICH EVIDENCE COORDINATION OF EXISTING SERVICES, PARTICULARLY SERVICES FOR INFANTS AND CHILDREN, AND THE POOLING OF RESOURCES BY APPLICANTS.

(3) AWARD GRANTS IN AN AMOUNT WHICH IS THE LESSER OF $500,000 OR 50% OF THE COST OF THE VEHICLE, EQUIPMENT OR COORDINATION OF ACTIVITIES LEADING TO THE ESTABLISHMENT OF A RURAL MOBILE HEALTH CLINIC.

(4) AWARD GRANTS TO PRIOR YEAR'S GRANTEES IN AN AMOUNT WHICH IS THE LESSER OF $500,000 OR 50% OF THE PROGRAM PROJECT COST TO ENTER A FOLLOW-UP PHASE FOR THE PRIOR YEAR'S PROGRAM.

(B) ELIGIBILITY.--ALL HEALTH CARE PROVIDERS, HEALTH CARE NETWORKS, TEACHING HOSPITALS AND DENTAL SCHOOLS LOCATED IN THIS COMMONWEALTH MAY APPLY FOR GRANTS TO PROVIDE MOBILE HEALTH CLINIC SERVICES TO RURAL MEDICALLY UNDERSERVED DESIGNATED SHORTAGE AREAS IN THIS COMMONWEALTH.

(C) ANNUAL REPORT.--THE BUREAU SHALL ANNUALLY, ON OR BEFORE MARCH 15, REPORT TO THE GENERAL ASSEMBLY THE RESULTS AND PROGRESS OF THE PROGRAM ESTABLISHED UNDER THIS SECTION.

CHAPTER 15

STUDIES AND HEARINGS ON HEALTH CARE

SECTION 1501. HOSPITAL UNCOMPENSATED CHARITY CARE STUDY.

(A) CHARITY CARE DATA.--IF SUFFICIENT FUNDING IS AVAILABLE,

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 LEVEL. SUCH AMOUNT MUST BE NET, FOLLOWING REASONABLE COLLECTION PROCEDURES, CONSISTENTLY APPLIED, AND MAY NOT INCLUDE ANY COSTS OR SERVICES FOR WHICH REIMBURSEMENT COULD HAVE BEEN SECURED FROM 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.

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

(3) UNDERINSURED INPATIENT CHARITY CARE WHICH IS DEFINED AS THE ALLOWABLE AUDITED COST OF SERVICES PROVIDED TO UNDERINSURED PERSONS BELOW 150% OF THE FEDERAL POVERTY LEVEL, FOLLOWING REASONABLE COLLECTION PROCEDURES, CONSISTENTLY APPLIED. SUCH AMOUNT MAY NOT INCLUDE PAYMENT FOR GOODS OR SERVICES WHICH COULD HAVE 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.

(4) UNINSURED INPATIENT CHARITY CARE WHICH IS DEFINED AS THE ALLOWABLE AUDITED COST OF SERVICES PROVIDED TO PERSONS WITHOUT PUBLIC OR PRIVATE INSURANCE COVERAGE, WITH INCOME BELOW 150% OF THE POVERTY LEVEL, FOLLOWING REASONABLE COLLECTION PROCEDURES, CONSISTENTLY APPLIED. SUCH AMOUNT MAY NOT INCLUDE PAYMENT FOR GOODS OR SERVICES WHICH COULD HAVE 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 APPOINT MEMBERS TO A JOINT SELECT COMMITTEE TO STUDY THE FEASIBILITY OF IMPLEMENTING MATERIAL IMPROVEMENTS IN THE PROCESSING OF CLAIMS FOR MEDICAL ASSISTANCE REIMBURSEMENTS TO PROVIDERS, AND IN THE USE OF PENNSYLVANIA MEDICAL ASSISTANCE BY ITS LOW-INCOME CITIZENS. THE STUDY SHALL INCLUDE, BUT NOT BE LIMITED TO, THE FOLLOWING:

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

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

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

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

INCIDENCE OF ERROR AND EXPLAINING HOW TO AVOID SUCH ERRORS.

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

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

(7) REWRITING THE PROVIDER HANDBOOK AND REORGANIZING 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.--IF SUFFICIENT FUNDING IS AVAILABLE, THE HEALTH CARE COST CONTAINMENT COUNCIL, THROUGH ITS MANDATED BENEFITS REVIEW COMMITTEE, IS DIRECTED, SUBJECT TO THE AVAILABILITY OF SUFFICIENT AND ADEQUATE CARRIER DATA, TO STUDY THE COSTS AND EFFECTIVENESS OF EXISTING MANDATED HEALTH BENEFITS/MANDATED PROVIDERS TO BUSINESSES. FOR EACH OF THE EXISTING MANDATED HEALTH BENEFITS/PROVIDERS, 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/PROVIDERS.

(2) THE EXTENT TO WHICH ELIMINATION OF THE EXISTING BENEFIT/PROVIDER 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/PROVIDER IN REDUCING FURTHER MORE COSTLY MEDICAL PROCEDURES.

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

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

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

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

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

(9) THE IMPACT OF THE EXISTING BENEFIT/PROVIDER 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. APPROPRIATION.

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

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

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

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

SECTION 3102. SEVERABILITY.

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

SECTION 3103. REPEALS.

ALL ACTS AND PARTS OF ACTS ARE REPEALED INSOFAR AS THEY ARE INCONSISTENT WITH THIS ACT.

SECTION 3104. EXPIRATION.

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

SECTION 3105. EFFECTIVE DATE.

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