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THE GENERAL ASSEMBLY OF PENNSYLVANIA

# HOUSE BILL

## No. 1343 Session of 1993

INTRODUCED BY RICHARDSON, EVANS, STETLER AND JOSEPHS, APRIL 19, 1993

AS REPORTED FROM COMMITTEE ON HEALTH AND WELFARE, HOUSE OF REPRESENTATIVES, AS AMENDED, APRIL 27, 1993

AN ACT

Providing for managed health care for medical assistance; and conferring powers and duties on the Department of Public Welfare.

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

CHAPTER 1

PRELIMINARY PROVISIONS

Section 101. Short title.

This act shall be known and may be cited as the Medical Assistance Managed Health Care Act.

Section 102. Declaration of policy.

The General Assembly finds and declares as follows:

(1) In light of the rapidly escalating costs of the medical assistance program, it is necessary to contain costs without hurting recipients.

(2) In addition to containing costs of the medical assistance program with management practices like prior

authorization, second surgical opinions and limits on utilization of certain services, the department has demonstrated that managed care programs are more cost effective than the traditional fee-for-service delivery system.

(3) In managed care service delivery, effective and efficient use of the health care delivery system is dependent upon the appropriate referral as directed by a primary care manager to all services necessary for care of the patient.

(4) All recipients of medical assistance are best served by having access to their own primary care practitioner, which is a basic assumption of managed health care programs.

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:

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

"General assistance." Assistance granted under section 432(3) of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.

"Health Insuring Organization" or "HIO." An entity which pays for medical services provided to medical assistance recipients in exchange for a premium paid by the State medical assistance program and which also assumes an underwriting risk.

"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.

"Managed care program." A health insuring organization, a

health maintenance organization, a preferred provider organization, a primary care case management entity, a prepaid capitation program or a partial capitation program permitted under Federal medical assistance regulations.

"Medical assistance." Assistance granted under Article IV Subarticle (f) of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.

"Preferred Provider Organization" or "PPO." An entity organized and regulated under section 630 of 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 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).

"Primary care case management entity." A health care provider which:

(1) is a physician, group of physicians or entity employing or having other arrangements with physicians operating under a contract with the Department of Public Welfare to provide services under a primary care case management program;

(2) receives payment on a fee-for-service basis for the provision of specified health care items and services to enrolled individuals;

(3) receives a fixed fee per enrollee for a specified period for providing case management services, including approving and arranging for the provision of specified health care items and services on a referral basis, to enrolled individuals; and

(4) is not liable for any of the cost of furnishing

specified health care items or services to individuals who are eligible for medical assistance and who are enrolled with the entity, regardless of whether the cost exceeds per capita fixed payment.

"Recipient." An individual who receives assistance.

## CHAPTER 3

## MANDATE FOR MEDICAL ASSISTANCE PROGRAM DELIVERY

Section 301. Managed health care services.

Notwithstanding any other provisions of law to the contrary, the department shall, to the extent possible, require medical assistance recipients to receive their medical assistance services through managed care programs to the extent that this requirement does not interfere with the maximization of Federal financial participation in the Medical Assistance Program.

Section 302. Federal requirements.

For all recipients whose categories of assistance are eligible for Federal financial participation, the delivery of medical assistance services and items to these recipients through managed care programs shall meet all applicable Federal requirements and shall attain applicable Federal approvals.

## CHAPTER 5

## USE OF MANAGED CARE TO PROVIDE MEDICAL ASSISTANCE TO ALL RECIPIENTS

Section 501. Program establishment.

To the extent feasible and consistent with the department's obligation to maximize Federal funds, the department shall contract with managed care programs to provide medical assistance services to recipients.

Section 502. Exceptions for participation.

The department shall establish criteria to exempt recipients

from the managed care program. This criteria may include geographic accessibility or the exclusion of particular items or services from the department's managed care contract. The department shall insure that recipients may obtain services other than through a managed care program in the event of emergency, geographic unavailability or exclusion of services under a managed care contract. For services excluded from managed care programs, the department shall insure that these services are paid rates that are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities or programs.

Section 503. Standards and regulations.

(a) Federal standards.--At a minimum, managed care programs providing services under this act shall meet Federal requirements for quality assurance standards, grievance procedures, and enrollment and disenrollment procedures to insure sufficient safeguards for quality of care in service delivery to all medical assistance and general assistance recipients.

(b) State standards.--Managed care programs shall satisfy the following requirements:

(1) Managed care programs providing services under this act that are health maintenance organizations must also meet quality assurance and financial solvency requirements promulgated under the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act, OR ANY OTHER APPLICABLE STATUTE. <——

(2) Managed care programs providing services under this act that are preferred provider organizations must meet quality assurance and financial solvency requirements

promulgated under section 630 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, or under 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations), OR ANY OTHER APPLICABLE STATUTE. <—

(3) A managed care program not governed by paragraph (1) or (2) must meet quality assurance and financial solvency requirements as promulgated by the department. THESE REQUIREMENTS SHALL BE CONSISTENT WITH EXISTING FEDERAL AND STATE LAW. <—

Section 504. Payment limitations and standards.

(a) Standards.--The department shall:

(1) Develop plans to ensure that every recipient enrolled in a managed care program has a choice of primary care practitioner by making every attempt to have a choice of managed care programs, a choice of primary care practitioners within a managed care program or both to the extent possible within a given geographic area.

(2) Require each managed care program to make available to providers and the department all provider selection criteria and a description of the managed care program's utilization review process.

(b) Limitations.--The department may contract with entities operating managed care programs on a prepaid capitation or other basis as determined by the department. Payments to managed care programs on a capitated basis for direct patient care services other than case management services shall not exceed 95% of the cost of the medical assistance fee-for-service program or an actuarially derived calculation of medical assistance fee-for-service costs.

CHAPTER 9

MISCELLANEOUS PROVISIONS

Section 901. Guaranteed eligibility.

Recipients enrolled in managed care programs will be afforded a six-month guaranteed eligibility consistent with applicable Federal requirements.

Section 902. Implementation of plan.

Within 120 days of the effective date of this act, the department shall submit a report FOR APPROVAL to the majority and minority chairman of the Public Health and Welfare Committee of the Senate and the majority and minority chairman of the Health and Welfare Committee of the House of Representatives on its plan which should include a phase-in process to implement enrollment of all medical assistance recipients in managed care programs. <—

Section 903. Annual report.

The department shall submit an annual report on the medical assistance managed care program mandated by this act to the Governor and to the General Assembly beginning on July 1, 1994, and annually thereafter. The report shall detail the number of recipients receiving managed care and the managed care programs providing service in this Commonwealth and shall make projections for the next year. The report also shall detail assurances of the adequacy, accessibility, and availability of services delivered to recipients receiving managed care and the financial solvency of the managed care programs.

Section 904. Regulations.

(A) GENERAL RULE.--Within six months of the effective date of this act, the department shall promulgate regulations which: <—

(1) Provide for due process protection for providers and

recipients by specifying minimal selection and utilization review criteria for use by managed care programs.

(2) Include those other provisions as are necessary for implementation and administration of this act.

(B) SUBMISSION OF PROPOSED REGULATIONS.--ALL PROPOSED REGULATIONS OF THE DEPARTMENT UNDER THIS ACT SHALL BE SUBMITTED TO THE HEALTH AND WELFARE COMMITTEE OF THE SENATE AND THE HEALTH AND WELFARE COMMITTEE OF THE HOUSE OF REPRESENTATIVES FOR REVIEW, PRIOR TO THEIR SUBMISSION TO THE LEGISLATIVE REFERENCE BUREAU FOR FORMAL PROMULGATION. <—

Section 905. Effective date.

This act shall take effect as follows:

(1) Section 301 of this act shall take effect July 1, 1994.

(2) The remainder of this act shall take effect immediately.