PRINTER'S NO. 2264

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1852 Session of 1995

INTRODUCED BY KUKOVICH, KING, THOMAS, BELARDI, CURRY, MELIO, DeWEESE, MIHALICH, STEELMAN, MANDERINO, STURLA, STABACK, MUNDY, HALUSKA, JOSEPHS, YOUNGBLOOD, RICHARDSON, TRELLO, PISTELLA AND MICHLOVIC, JUNE 21, 1995

REFERRED TO COMMITTEE ON HEALTH AND HUMAN SERVICES, JUNE 21, 1995

AN ACT

Amending the act of December 29, 1972 (P.L.1701, No.364), entitled "An act providing for the establishment of nonprofit corporations having the purpose of establishing, maintaining and operating a health service plan; providing for supervision and certain regulations by the Insurance Department and the Department of Health; giving the Insurance Commissioner and the Secretary of Health certain powers and duties; exempting the nonprofit corporations from certain taxes and providing penalties," adding and amending definitions; further providing for services to be provided and for certificates of authority; providing for a quality assurance plan, for credentialing, for medical records and standards, for certain rights of members, for additional powers and duties of the Department of Health and for a grievance procedure; and further providing for boards of directors and for penalties.

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

Section 1. Section 3 of the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act, amended December 19, 1980 (P.L.1300, No.234) and repealed in part December 20, 1982 (P.L.1409, No.326), is amended to read:

Section 3. Definitions.--As used in this act:

"Basic health services" means those health services, including as a minimum, but not limited to, emergency care, inpatient hospital and physician care, ambulatory physician care, and outpatient and preventive medical services. For medical assistance beneficiaries, the term shall include all services otherwise compensable under medical assistance, including, but not limited to, drug and alcohol treatment under sections 2334 and 2335 of the act of April 9, 1929 (P.L.177, No.175), known as "The Administrative Code of 1929," early and periodic screening, diagnosis and treatment for children under twenty-one years of age, even if the services are not listed in the State plan or the medical assistance fee schedule.

"Certified nurse practitioner" means a registered nurse licensed in this Commonwealth who is jointly certified by the State Board of Nursing and the State Board of Medicine in a particular clinical specialty area and who, while functioning in the expanded role as a professional nurse, performs acts of medical diagnosis or prescription of medical therapeutic or corrective measures in collaboration with and under the direction of a physician licensed to practice medicine in this Commonwealth.

"Commissioner" means the Insurance Commissioner of the Commonwealth of Pennsylvania.

"Council" means the Health Care Cost Containment Council.

"Direct provider" means an individual who is a direct provider of health care services under a benefit plan of a health maintenance organization or an individual whose primary current activity is the administration of health facilities in which such care is provided. An individual shall not be

considered a direct provider of health care solely because the individual is a member of the governing body of a health-related organization.

"Direct services ratio" means the ratio between an organization's medical revenues and medical expenses.

"Health maintenance organization" means an organized system which combines the delivery and financing of health care and which provides basic health services to voluntarily enrolled subscribers and to manditorily enrolled medical assistance beneficiaries, including those enrolled in any entity classified under Federal law as a health insuring organization for a fixed prepaid fee.

"Independent nonprofit consumer and family satisfaction team" means a not-for-profit entity utilizing a team comprised of consumers and family members to perform onsite personal interviews of people with severe mental illness and their families to determine the consumers' degree of satisfaction and if they feel their needs are being met.

"Managed care organization" means the party to a managed care plan which agrees to provide and/or reimburse health care, related equipment or services for members or subscribers.

"Managed care plan" means a system pursuant to which health care, related equipment or services are provided for members or subscribers whose access to other health care must be approved by a primary care practitioner selected by or for such member or subscriber from a panel of participating practitioners.

"Medical audit" means an onsite review of the quality of care being provided and the effectiveness of the quality assurance plan.

"Medical expenses" means the cost of providing health care

services.

"Medical revenues" means the income generated from providing health care services.

"Primary care physician" means a medical doctor or doctor of osteopathy who supervises, coordinates and provides initial and basic care to patients, initiates their referral for specialist care and maintains continuity of care. The term shall include pediatricians for individuals under eighteen years of age, specialists in obstetrics/gynecology for woman and other specialists.

"Primary care practitioner" means a licensed or certified professional who supervises, coordinates and provides initial and basic care to patients, initiates their referral for specialist care and maintains continuity of care. The term shall include, but not be limited to, primary care physicians, certified nurse practitioners and certified nurse-midwives for women during pregnancy.

"QAP" means a quality assurance plan.

"Secretary" means the Secretary of Health of the Commonwealth of Pennsylvania.

"Specialist" means a licensed treatment professional whose area of clinical practice is limited to a particular field or fields.

Section 2. Sections 4 and 5.1(b)(1) of the act, amended or added December 19, 1980 (P.L.1300, No.234), are amended to read:

Section 4. Services Which Shall be Provided.--(a) Any law to the contrary notwithstanding, any corporation may establish, maintain and operate a health maintenance organization upon receipt of a certificate of authority to do so in accordance with this act.

(b) Such health maintenance organizations shall:

(1) Provide either directly or through arrangements with others, basic health services to individuals enrolled;

(2) Provide either directly or through arrangements with other persons, corporations, institutions, associations or entities, basic health services; and

(3) Provide physicians' services (i) directly through physicians who are employes of such organization, (ii) under arrangements with one or more groups of physicians (organized on a group practice or individual practice basis) under which each such group is reimbursed for its services primarily on the basis of an aggregate fixed sum or on a per capita basis, regardless of whether the individual physician members of any such group are paid on a fee-for-service or other basis or (iii) under similar arrangements which are found by the secretary to provide adequate financial incentives for the provision of quality and cost-effective care.

(4) Every managed care plan must cover medically necessary services furnished as a result of a medical emergency by a nonparticipating provider.

Section 5.1. Certificate of Authority.--* * *

(b) A certificate of authority shall be jointly issued by order of the commissioner and secretary when:

(1) The secretary has found and determined that the applicant:

(i) has demonstrated the potential ability to assure both availability and accessibility of adequate personnel and facilities in a manner enhancing availability, accessibility and continuity of services;

(ii) has [arrangements for an ongoing quality of health care

assurance program] demonstrated, to the satisfaction of the secretary, that its internal quality assurance system can identify, evaluate and remedy problems relating to access, continuity, underutilization and quality of care in accordance with the requirements of section 5.2 of this act; and

(iii) has appropriate mechanisms whereby the health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis; and

* * *

Section 3. The act is amended by adding sections to read:

Section 5.2. Clinical Quality Assurance.--(a) All managed care organizations shall develop and adhere to a written plan of clinical quality assurance for monitoring, evaluating and assuring the delivery of quality health care by all practitioners providing services on its behalf.

(b) The QAP shall be submitted to and approved by the Department of Health prior to the organization's enrolling members or for existing organizations, within six months of the effective date of this section, and shall be reviewed and approved by the Department of Health at least every twelve months thereafter.

(c) The QAP shall include the elements set forth in sections 5.3, 5.4, 5.5, 5.6 and 5.7 of this act, those elements which the Department of Health may by regulation require and the following elements:

(1) An identifiable structure for performing quality assurance functions within the organization, including required regular meetings, contemporaneous records of such meetings and direct accountability of the quality assurance entity or

entities to the governing body of the organization.

(2) A detailed set of quality assurance objectives which include a timetable for implementation and accomplishment.

(3) A system of continuous review by physicians and other health professionals with feedback to participating health professionals and health maintenance organization staff regarding performance and patient results.

(4) A methodology for assuring that the range of review includes all demographic groups, care settings and types of services.

(5) A system for evaluating health outcomes, consistent with current technology.

(6) Written guidelines for quality of care studies and related monitoring activities which include specification of the clinical or health service delivery areas to be monitored and which reflect the population served by the managed care organization in terms of age groups, disease categories and special risk status.

(7) For the medical assistance population, a system which monitors and evaluates, at a minimum, care and services in certain areas of concern selected by the Department of Public Welfare. The Secretary of Public Welfare is required to establish standards by which managed care plans are found to have improved the health status of medical assistance clients enrolled in the plan with an emphasis to be placed on the health needs of women and children.

(8) A methodology for identifying quality indicators relating to specific clinical or health service delivery areas which are objective, measurable and based on current knowledge and clinical experience.

(9) Health service delivery standards or practice guidelines, consistent with standards and guidelines developed by commonly accepted sources in the medical community, which are aimed not only at cure, but also at maintaining function and improving quality of life and which are:

(i) updated continuously pursuant to a mechanism specified in the plan;

(ii) disseminated to providers as they are adopted;

(iii) developed for the full spectrum of populations enrolled in the plan;

(iv) based on reasonable scientific knowledge;

(v) focused on the process and outcomes of health care delivery, as well as access to such care; and

(vi) applied to the organization's providers, whether they are organized in groups, as individuals or in combinations.

(10) A methodology for the evaluation and monitoring by appropriate clinicians, including multidisciplinary teams where indicated, of individual cases where there are questions about care.

(11) Provision for periodic medical audits at least once every twenty-four months by independent medical professionals approved by the Department of Health which include:

(i) medical record reviews to measure the level of conformity to the health services delivery standards or practice guidelines developed in accordance with section 9 of this act;

(ii) a search for trigger diagnoses which indicate a breakdown in delivery of care;

(iii) surveys of a sampling of enrollees to assure the accuracy of medical records; and

(iv) certification of the effectiveness of the QAP.

(12) A grievance system which meets the requirements of section 5.7 of this act.

(13) Procedures for taking remedial action, including suspension or termination of physicians and other professionals for inappropriate service or underservice.

(14) Provision for a year-end written report which shall be delivered promptly to the governing body and the Department of Health, and which shall be available to the public at no charge, which:

(i) addresses demonstrated improvements in quality and areas of deficiency;

(ii) makes recommendations for corrective action; and

(iii) assesses the effectiveness of all past corrective actions.

(15) A system for protecting and promoting members' rights set forth in section 5.5 of this act and for communicating members' rights to both providers and members.

(16) A system for assuring compliance with the medical records standards set forth in section 5.4 of this act.

(17) A system of credentialing and recredentialing which meets the standards set forth in section 5.3 of this act.

(18) A system for sharing a copy of any standard for coverage decisions not explicitly covered in the subscriber agreement with participating providers and the Department of Health, and for making members aware of their right to a copy pursuant to section 5.5(5) of this act.

(19) A system to insure that any initial decision regarding coverage is made by a person with expertise and experience in the field relevant to coverage sought or on the advice of a person with such expertise and experience. The system must have

protections to assure that no coverage is denied prior to review by a health professional with equal or greater qualifications in the relevant field.

(20) The organization's anticipated direct services ratio.

(21) The methodology to insure a provider network which demonstrates the full continuum of care, geographic availability, cultural sensitivity and planning for special needs populations.

(22) Evaluations by the independent nonprofit consumer and family satisfaction teams.

(23) A system to do discharge planning for enrollees about to be discharged from State mental hospitals or correctional facilities.

(d) The QAP shall specifically address any area which the Department of Health shall identify as being of concern, in a manner acceptable to the Department of Health.

Section 5.3. Credentialing and Recredentialing.--(a) The organization shall establish credentialing standards for all providers which shall be filed with the Department of Health.

(b) The organization shall establish an entity, answerable directly to the governing body, which shall be responsible to credential and recredential all providers. At a minimum, the entity must initially verify the following, where applicable:

(1) Current license and history of suspension or revocation.

(2) Graduation from medical school and residency.

(3) Work history.

(4) Clinical privileges and history of suspension.

(5) Liability claims history.

(6) Certification.

(7) History of sanctions by Medicare or Medicaid.

(8) History of revocation or suspension of DEA/BNDD number.

(9) History of active chemical dependency or abuse within the past twelve months.

(10) Compliance with continuing education requirements.

(c) The entity must recredential all providers at least every two years after a review of subsection (b)(1), (3), (4), (5), (7), (8), (9) and (10) of this section, plus all data from:

(1) Member complaints.

(2) Results of quality reviews performed by the Department of Health under section 5.6 of this act.

(3) Member satisfaction surveys performed by the council under this act.

(4) Medical record reviews as required by section 5.4(d) of this act.

Section 5.4. Medical Record Standards.--(a) The organization must require that all providers maintain medical records which are legible, dated and current and which identify the author.

(b) The organization must require that all providers' medical records contain, at a minimum, patient identification on each page, biographical data, complete and current history, allergies, types of immunizations for all individuals under eleven years of age, diagnoses, medications and courses of treatment, information on smoking, alcohol use and substance abuse, all referrals and the results thereof, emergency care, hospital discharge summaries and advance directives, if any have been executed.

(c) The organization must maintain an ongoing system of record review.

(d) The organization must require that all providers'

medical records are in conformity with good professional medical practice and appropriate health management.

Section 5.5. Member Rights.--The organization shall develop, adhere to and notify each member or his parent or legal guardian initially and at least every twelve months in his primary language of at least the following rights:

(1) The right to timely, fair and effective redress of grievances without retaliation by the organization or its providers.

(2) The right to a specific methodology for obtaining timely advance determinations upon request, on coverage and the extent of coverage for care and services, and the right to payment by the organization for care and services if a timely response to such a request has not been forthcoming.

(3) The right to confidentiality of all medical records and the right, consistent with Federal and State law, to copies of all medical records at cost.

(4) The right to appropriate and accessible care and services in a timely fashion.

(5) The right to a copy of written standards for coverage decisions which are not explicit in the subscription agreement, without charge to the member, upon request, or automatically upon a rejection or limitation of services.

(6) The right to a copy of the subscriber agreement.

(7) The right not to be discriminated against because of his health needs.

(8) The right to continue as a nongroup member if the member becomes ineligible to continue as part of a group.

(9) The right to be treated only by licensed programs and professionals in those areas of practice for which the State

licenses individuals or programs.

(10) The right to know the credentials of any provider.

(11) The right to be notified in advance, upon request, of the time, location and preliminary agenda for any meeting of the board of directors of the organization.

(12) The right to give advance directives to the organization and to have such directives followed, consistent with Federal and State law.

(13) The right to refuse any treatment without jeopardizing future treatment.

(14) The right to have prior coverage denials reviewed by a practitioner with expertise in the field of coverage sought.

(15) The right to bring a private action at law or equity to enforce any of the standards, rights or requirements of this act in a court of law and to be awarded costs and legal fees, if successful.

(16) The right to serve on a grievance review panel pursuant to a selection process set forth in the grievance procedure.

(17) The right to a decision regarding a request for a health care service or item within twenty-one days.

(18) The right to an independent professional second opinion paid for by the organization for use by members in grievance and hearing procedures.

(19) The right to re-enroll in a managed care plan upon discharge from a State mental hospital or a correctional facility, provided that the individual had been enrolled in the managed care plan prior to his incarceration or hospitalization and has a source of payment, including medical assistance.

Section 5.6. Department of Health Responsibilities.--(a) The Department of Health shall review and approve each

organization's QAP initially and at least every twelve months thereafter.

(b) As part of its annual review, the Department of Health shall review all of the following:

(1) Grievances and their disposition.

(2) Medical audits.

(3) Reports of the quality assurance entity to the governing body of the organization.

(4) Reports of the credentialing entity to the governing body.

(5) Enrollee satisfaction surveys.

(6) The rate of individuals who voluntarily disenroll and a survey of such individuals.

(7) The provider surveys.

(8) The organization's actual direct services ratio compared to the direct services ratio contained in the organization's QAP.

(9) Such records of the organization and its contractors as it deems appropriate to assure that the organization is adhering to its quality assurance plan.

(c) The Department of Health shall establish standards which, if not met by the organization, will cause the Department of Health to require the organization to obtain an independent medical audit, at the organization's expense, in addition to any independent medical audit which is a part of the organization's QAP, and to make the results of such audit publicly available.

(d) The Department of Health shall establish standards which must be met before an entity can qualify to perform independent medical audits. Such standards shall assure the competence of the entity and shall define and prohibit any conflict of

interest.

(e) The Department of Health shall designate categories of grievance, as specified in section 5.7(e) of this act.

(f) The Department of Health shall:

(1) Establish a process for review, upon request of the member or any party having standing to initiate a complaint, of appeals from grievance review hearings.

(2) Determine the merits of and decide the substantive issues relative to all such appeals after first obtaining and documenting the advice of experienced professionals in the field under review.

(3) Promptly notify the organization and the member of the decision in writing.

(g) The Department of Health shall annually report to the General Assembly on the quality of each organization in this Commonwealth and make the report available to the public. The report shall specifically reference the following:

(1) Any penalties levied and the reasons therefor.

(2) The number of individuals voluntarily disenrolled from the organization and the reasons for such disenrollment, if available.

(3) The number of individuals involuntarily disenrolled from the organization.

(4) Such other information related to quality, access, coordination and continuity of care and services as the Department of Health deems appropriate.

(h) The Department of Health shall annually report to the General Assembly regarding the adequacy of its own resources to carry out its quality assurance mandates and specify what, if any, additional resources are needed.

Section 5.7. Grievance Procedure.--(a) The organization shall maintain an internal grievance procedure for the prompt and effective resolution of member grievances pertaining to care and/or service, without charge to the member.

(b) The grievance procedure shall be described in writing, and both the procedure and the description shall be approved by the Department of Health as part of the QAP approval process.

(c) The organization shall provide each member twenty-one years of age or older with a copy of the written description of the grievance procedure in the primary language of the member:

(1) upon enrollment;

(2) at least once every twelve months thereafter; and

(3) upon the denial of care or services.

(d) The grievance procedure shall consist of a single level of review, which shall be initiated by any complaint or grievance to the organization, whether oral or written, made by or on behalf of a member as specified in the grievance procedure description. A parent, other family member for an enrollee with mental illness or mental retardation, guardian, attorney-in-fact, executor, administrator of estate, provider who has provided care or services which are in dispute or other person responsible for the bills of the member has standing to initiate a complaint on behalf of a member or former member.

(e) Upon receipt of a grievance or complaint, the organization shall refer the matter to an individual designated by the organization whose oversight responsibility shall be to initially investigate, categorize according to categories designated by the Department of Health and respond in writing to all complaints by or on behalf of members pertaining to delay, denial, quality, coordination, continuity, availability or

accessibility of care and/or services and to refer the matter to a review committee for a hearing, as set forth in subsection (k) of this section. The organization shall mail to the member or complainant copies of any documents which were considered as part of the determination being grieved or complained of.

(f) If the complaint pertains to a diagnostic or treatment decision, the organization shall, in addition to referring the matter to a review committee, provide for review by treatment professionals experienced in the field relevant to the matter complained of.

(g) As part of the initial investigation, the member or complainant shall be invited to submit written or oral statements and/or records on his behalf and shall be offered assistance by the organization in obtaining records from providers. In the cases involving members who have difficulty communicating, the organization shall assist the member in securing an independent advocate to assist the member in pursuing the grievance.

(h) The organization shall issue to the complainant a written response within ten working days of receipt of the grievance or complaint, or sooner if the situation calls for an immediate response, which shall state the following:

(1) The nature of the complaint.

(2) The specific steps that were taken to investigate the grievance or complaint.

(3) What, if any, steps the organization has taken or will take to remedy the problem complained of.

(4) The reason the organization is refusing to remedy the matter complained of, if applicable.

(5) Relevant information pertaining to the grievance

hearing, including time, location, makeup of the grievance committee, purpose of the hearing, list of issues to be decided and the name and telephone number of the individual to be contacted for further information.

(i) The organization may attempt to resolve the matter amicably at any time prior to the hearing.

(j) The review committee shall consist of at least three individuals, all of whom shall be members and none of whom may be employes of or hold any ownership interest in a managed care organization.

(k) (1) The member or complainant has the right to attend the review hearing but shall not be penalized for failure to attend. The hearing shall be held within thirty days of receipt of the complaint or grievance, at a time and location convenient to the member or complainant, who shall receive at least ten days' notice of the hearing. The member or complainant shall have the right to request and obtain the presence of relevant organization staff and providers who have been involved in the matter under consideration by the committee. The member or complainant shall have the right to appear personally and/or be represented by an individual of his choice and, with or through counsel, present evidence on his or her behalf, cross-examine witnesses of the organization and present arguments on his behalf, although strict rules of evidence do not apply.

(2) The decision shall be rendered within ten working days of the hearing, shall be in writing and shall contain a description of the matter in dispute, the evidence considered, the remedial actions which are to be taken, if any, the reasons therefor and the steps which the member or complainant must take if he wishes to appeal the decision to the Department of Health.

The decision shall be sent to the member or complainant and to the Department of Health within ten working days of the hearing and shall be binding on the organization to the extent that it is favorable to the member. The member shall have the right to appeal any decision of the committee to the Department of Health within thirty days of its receipt pursuant to a process to be established by the Department of Health.

(l) The grievance procedure shall contain specific provisions for an expedited review hearing, where necessary.

(m) The secretary or his designee is empowered and responsible to decide the substantive issues of any grievance which is appealed from the review committee. The secretary is empowered and responsible to order the managed care plan to provide or pay for services in accordance with the secretary's grievance decision.

(n) The internal grievance procedure shall not be construed as mandatory on the member, nor is exhaustion of the procedure to be construed as being a prerequisite to litigation against the organization.

Section 4. Sections 7 and 15 of the act, amended December 19, 1980 (P.L.1300, No.234), are amended to read:

Section 7. Board of Directors.--(a) A corporation receiving a certificate of authority to operate a health maintenance organization under the provisions of this act shall be organized in such a manner that assures that at least one-third of the membership of the board of directors of the health maintenance organization will be subscribers of the organization. Those subscribers shall not be current or former employes or individuals having an ownership interest in the plan, its subsidiaries or a corporation having a contract to provide

services to enrollees of the plan. Furthermore, those subscribers shall not work in a unit of a business having responsibility for employe health benefits. The subscriber board members shall reflect the diversity of the plan enrollees, including race, gender, age, economic status, disability and health status.

(b) The board of directors shall be elected in the manner stated in the corporation's charter or bylaws.

Section 15. Penalty.--(a) The commissioner and secretary may suspend or revoke any certificate of authority issued to a health maintenance organization under this act, or, in their discretion, impose a penalty of not more than one thousand dollars ($1,000) for each and every unlawful act committed, or prohibit the organization from enrolling new members, or require the organization to submit for approval and adhere to an approved plan of correction, which shall be available for review and comment by the membership or impose any combination of the aforementioned penalties, if they or either of them find that any of the following conditions exist:

(1) that the health maintenance organization is providing inadequate or poor quality care, thereby creating a threat to the health and safety of its subscribers;

(2) that the health maintenance organization is unable to fulfill its contractual obligations to its subscribers;

(3) that the health maintenance organization or any person on its behalf has advertised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner; or

(4) that the health maintenance organization has otherwise failed to substantially comply with this act.

(b) Before the commissioner or secretary, whichever is

appropriate, shall take any action as above set forth, he shall give written notice to the health maintenance organization, accused of violating the law, stating specifically the nature of such alleged violation and fixing a time and place, at least ten days thereafter, when a hearing of the matter shall be held. Hearing procedure and appeals from decisions of the commissioner or secretary shall be as provided in Title 2 of the Pennsylvania Consolidated Statutes (relating to administrative law and procedure).

(c) Any enrollee shall have the right to bring an action in Commonwealth Court for the enforcement of any of the provisions of this act.

Section 5. This act shall take effect in 60 days.