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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 2318 Session of 2000

INTRODUCED BY COSTA, DeWEESE, VEON, DeLUCA, BELARDI, READSHAW, WALKO, TRELLO, VAN HORNE, MICHLOVIC, FRANKEL, GRUCELA, SOLOBAY, YUDICHAK, FREEMAN, CURRY, DALEY, MANN, STURLA, STABACK, GEORGE, HARHAI, HORSEY, JOSEPHS, LAUGHLIN, MELIO, MYERS, ROONEY, SHANER, STEELMAN, TANGRETTI, THOMAS, TRAVAGLIO, YOUNGBLOOD AND BROWNE, MARCH 7, 2000

REFERRED TO COMMITTEE ON HEALTH AND HUMAN SERVICES, MARCH 7, 2000

AN ACT

Providing for Medicaid Patient Protection, for powers and duties of Department of Public Welfare, for rights of beneficiaries, for application to existing contracts, for provider protections and for grievances.

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

Section 1. Short title.

This act shall be known and may be cited as the Medicaid Patient Protection Act.

Section 2. Findings.

The General Assembly finds as follows:

(1) The medical assistance program provides health insurance coverage for approximately 1.4 million Pennsylvanians at a cost of over $6,000,000,000 annually.

(2) The Department of Public Welfare is moving the health care service component of the medical assistance

program toward Statewide mandatory managed care through contracts with private vendors for prepaid medical services. Over half of the beneficiaries are currently enrolled in managed care organizations.

(3) There is no clear state statutory or regulatory framework for the medical assistance managed care program; the existing program operates exclusively based on the provisions of these contracts.

(4) Consequently, the General Assembly finds that there is a clear and compelling need to establish a basic statutory framework for Medicaid Managed Care, including establishing the basic responsibilities of the department, the basic duties and obligations of the contractors and the basic rights of beneficiaries.

Section 3. 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:

"Alternative contractor." An entity other than a health maintenance organization licensed by the Department of Health and the Insurance Department. The term includes all risk-assuming physician hospital organizations, preferred provider organizations, county governments, pharmacies, durable medical equipment providers, federally qualified health centers and provider sponsored organizations.

"Appeal." A request for reversal of a denial of service.

"Complaint." An issue presented to a managed care organization, in either written or oral form.

"Contractor." An entity which contracts with the Department of Public Welfare to provide prepaid medical services under the

act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.

"Denial of service." A determination made by a managed care organization or subcontractor or failure to act in response to a qualified provider's or consumer's request for approval to provide in-plan services of a specific duration and scope which:

(1) disapproves the request completely;

(2) approves provision of the requested service, but for a lesser scope or duration than requested; or

(3) disapproves provision of the requested service, but approves provision of an alternative service.

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

"Emergency services." A condition that a reasonable person would believe would result in death or serious bodily injury if not treated, including active labor, or where services are needed to evaluate or stabilize such a condition.

"Enrollee." A person eligible to receive services under the medical assistance program who is enrolled in the HealthChoices Program.

"Fair hearing." A hearing conducted by the Bureau of Hearings and Appeals of the Department of Public Welfare in response to an appeal.

"Grievance." A complaint which cannot be resolved to the member's satisfaction or an issue presented by the member to a managed care organization for grievance consideration. To the extent this definition is not in accordance with the act of June 17, 1998 (P.L.464, No.68), entitled "An act amending the act of May 17, 1921 (P.L.682, No.284), entitled 'An act relating to insurance; amending, revising, and consolidating the law

providing for the incorporation of insurance companies, and the regulation, supervision, and protection of home and foreign insurance companies, Lloyds associations, reciprocal and inter-insurance exchanges, and fire insurance rating bureaus, and the regulation and supervision of insurance carried by such companies, associations, and exchanges, including insurance carried by the State Workmen's Insurance Fund; providing penalties; and repealing existing laws,' providing for automobile insurance issuance, renewal, cancellation and refusal; providing for quality health care accountability and protection, for responsibilities of managed care plans, for disclosure, for utilization review, for complaints and grievances, for departmental powers and duties and for penalties; providing for comprehensive health care for uninsured children; and making repeals," this act shall apply.

"HealthChoices Program." Pennsylvania's program to provide mandatory managed health care to medical assistance consumers.

"Managed care organization." An entity which manages the purchase and provision of physical or behavioral health services under the HealthChoices Program.

"Medical assistance consumer." A person eligible to receive services under the medical assistance program.

"Medical assistance program." The program established and operated by the Department of Public Welfare pursuant to Subarticle (f) of Article IV of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.

"Medical necessity." A determination of medical necessity for covered care and services, whether made on a prior authorization, concurrent review or post-utilization basis.

"Member." An enrollee.

"Plan." A managed care organization which manages the purchase and provision of physical or behavioral health services.

"Provider." A person, firm or corporation enrolled in the Pennsylvania Medical Assistance Program, which provides services or supplies to medical assistance consumers.

"Subcontractor." An individual, business firm, university, governmental entity or nonprofit organization having a contract to perform part or all of a managed care organization's responsibilities under a contract with the Department of Public Welfare. The term does not cover contracts with utilities or salaried employees.

Section 4. Powers and duties of department.

(a) General rule.--The department shall establish a sound quality review process and shall monitor the quality of care performed by managed care organizations contracting with the department.

(b) Reports.--The department shall provide the following reports, information and data to the General Assembly and make them publicly available:

(1) The department shall conduct independent actuarial reviews of the rates for prepaid medical services. The department shall no less than every three years contract to have an independent actuarial assessment of the rate determination process used by the department, including review of reimbursement for impact upon quality and the adequacy of rates paid to each contractor.

(2) The department shall audit plans' compliance with their contracts annually, including all standards specified in Federal and State law.

(3) The department shall require each contractor to submit annually data that allows the department and consumers to evaluate and compare the performance and quality of care offered by each contractor. In consultation with the Medical Assistance Advisory Committee, quality experts, managed care organizations and other stakeholders, the department shall annually establish performance and quality indicators it will use and shall require each contractor to provide the information and data in a timely fashion.

(4) The department shall annually prepare region-by-region report cards allowing the comparison of contractors and shall provide these report cards to each beneficiary. At a minimum, the department shall require each contractor to provide the following information.

(i) The results of an annual consumer satisfaction survey based on a protocol established by the department. The department shall include standard questions developed by the department, a survey instrument approved by the department and a survey technique endorsed by the department. The survey shall include beneficiaries who are former members as well as current members of a contractor's plan.

(ii) Indicators incorporated into contracts for prepaid health services in force prior to the effective date of this act.

(iii) Indicators used by the National Committee for Quality Assurance HEDIS system.

(iv) Indicators used by the Foundation for Accountability.

(v) The most current medical loss ratio for the

contractor.

(vi) Quarterly data on emergency room claims and denials.

(vii) The number and percentage of children who have been fully immunized pursuant to the schedule adopted by the American Academy of Pediatrics.

(viii) The number and percentage of women who received prenatal care in the first trimester of their pregnancies.

(ix) The number and percentage of low birth weight children as a percentage of all live births, as well as the number of live births as a percentage of all births.

(x) The number and percentage of all beneficiaries who had a physical examination and well patient visit within the prior year.

(xi) The incidence of renal examinations within the past 24 months, hospitalization for inpatient diabetes-related treatment and other indicators of treatment of diabetes and diabetes-related illnesses.

(xii) The incidence of inpatient hospitalization of children under 21 years of age for asthma and asthma-related illnesses.

(xiii) The percentage of women with annual mammograms, percentage of women detected with stage 0 or stage 1 breast cancer and the incidence of radical mastectomies and breast conserving surgeries.

(xiv) The percentage of members living with human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS) who are currently receiving the medical care and prescriptions associated with Highly Active

Anti-Retroviral Therapy (HAART).

(xv) The number of appeals by reason code, the number of fair hearings and their outcomes, the number of complaints by reason and the number of resolved appeals at levels 1 and 2.

(5) The department shall require each plan to separate from their quarterly financial reports filed with the department and the Insurance Department the following information, separately, for both contracted medical assistance services and their entire line of services:

(i) Medical loss ratio.

(ii) Administrative expense ratio.

(iii) Enrollment, disenrollment and total member months.

(iv) Unpaid claims per member per month.

(v) Patient days per 1,000 enrollees.

(vi) Days in unpaid claims.

(vii) Net profit.

(viii) Claims as a percent of revenues.

(6) The department shall require each contractor to maintain adequate numbers and types of specialists to ensure that specialty services can be made available in a timely and geographically accessible manner, particularly behavioral health providers, dentists, pediatric primary care providers and specialists, home health services providers, durable medical equipment suppliers, federally qualified health centers and community health centers with federally qualified health centers level of care.

(7) In promulgating regulations under this act, the department shall specify the scope of services required,

standards for service networks, enrollment and disenrollment procedures and measures necessary to ensure that the requirements contained in contracts between the department and plans are clear and consistent. At a minimum, regulations must require plans to:

(i) Offer adequate numbers of primary care providers.

(ii) Give members sufficient information about choice of providers and plans.

(iii) Make appropriate provider assignments.

(iv) Allow members to switch primary care and specialist providers either on a regular or an emergency basis.

(v) Allow standing referrals in appropriate circumstances.

(vi) Permit certain specialists to act as primary care providers.

(vii) Educate members and providers about referral procedures.

(viii) Arrange out-of-network services when necessary.

(ix) Conform to a uniform drug formulary standard established by the department in consultation with the department's medical assistance advisory committee.

(x) Provide a 72-hour supply of medications for enrollees for prescriptions which cannot be filled because the prescribed medication is nonformulary or because prior authorization has not been obtained or because the consumer's eligibility status is in dispute.

(xi) Maintain a unit that responds immediately to

requests for off-formulary requests where medically indicated.

(xii) Maintain approved and authorized services until the time of periodic reviews or receipt of information indicating a material change in circumstances of the enrollee.

(xiii) Provide instruction and forms along with notice of a plan's need for additional information to determine whether to approve or deny a service which requires prior authorization where a provider has properly requested the service.

(xiv) Maintain and staff a 24-hour, seven-day-a-week toll-free hotline to respond to enrollees' inquiries, problems and to take oral grievances and complaints and assist enrollees in reducing them to writing.

(c) Alternative contracts.--The department may contract for the provision of prepaid medical services with alternative contractors if the contractors obtain a certificate of authority from the Insurance Department and the Department of Health.

(d) Notice of plan submissions.--The department shall publish notice of State plan submissions and amendments, invite written comments and hold public hearings.

(e) Rules and regulations.--The department shall establish such other rules, regulations and standards as may be necessary and are consistent with Federal and State law pertaining to enrollment of medical assistance consumers in managed care.

Section 5. Rights of beneficiaries.

All the rights and privileges accorded medical assistance consumers under Federal and State law or contract shall continue to be available and will not be adversely affected by provisions

of this act. Medical assistance consumers shall have the right:

(1) To participate in experimental treatments, clinical trials and alternative treatments.

(2) To continue in the care of a physician who no longer is a member of a network for 180 days or, in the case of a pregnant woman, for the duration of her pregnancy.

(3) To use a specialist as a primary care provider if the enrollee is chronically ill or disabled. The department shall adopt standards to facilitate this arrangement.

(4) To sue the contractor if denial of care by the contractor or the contractor's agent results in improper or inadequate care.

(5) Not to be denied any covered medically necessary benefit based solely on the presence or absence of a particular diagnosis or condition or because the recipient's condition is chronic, developmental, long-term, will not improve or is stable.

(6) To receive a response within three minutes to calls made to any person employed by a contractor or a benefits management subcontractor who could prevent or delay the delivery of medical benefits by a failure to respond to a telephone contact.

(7) To be assured access to all medical assistance services to which they are entitled even if the service is not reasonably available in an appropriate and timely manner directly or indirectly from the managed care organization or because of an emergency or geographic unavailability.

(8) To a 72-hour supply of medication when it has been prescribed but where a form of payment cannot be confirmed, prior authorization has not been obtained or the prescription

is nonformulary.

(9) To standards for uniformity among drug formularies and prior authorization processes which protect recipients' health and safety.

(10) To access to quality indicators which Federal and State law require that plans make available to the department, including results of plan quality studies, external reviews and compliance audits.

(11) To quality assurance provisions relating to the scope, accessibility, reasonableness, adequacy and continuity of medical care, services and supplies in the medical assistance managed care program; the recruitment, organization and adequacy of the provider network; and methods and rates of payment and reimbursement which ensure all of the above.

(12) To due process under the law, including the following due process protections:

(i) Clinical decisions made by qualified clinicians.

(ii) Grievance procedures accessible to enrollees who do not speak English or whose access may be limited by hearing or visual impairment or other physical disabilities.

(iii) Expedited, 48-hour, review if delay would significantly increase the risk to an enrollee's health.

(iv) Specified time frames for plans to reach decisions.

(v) Access to an independent medical assistance consumer assistance program to assist enrollees in filing complaints, grievances and hearing requests, as well as in attempts to resolve problems informally; and provision

of representation in the grievance and hearing processes.

(vi) Department fair hearing in addition to in-plan grievances and any other rights and remedies available under the law.

(13) When an enrollee responds to a notice with a timely request for a grievance, complaint or fair hearing, the service or benefit shall be continued pending completion of the appeal process or a fair hearing decision.

Section 6. Application to existing contracts.

To the extent that the provisions of this act materially affect the terms and conditions of an existing contract for prepaid medical services, the provisions of the contract shall remain in force until the contract is reopened or renegotiated. For the purposes of this section, the adjustment of rates shall constitute a reopening of a contract. The provisions of section 4(d) and (e) do not materially affect the terms and conditions of an existing contract and, therefore, do not require the reopening of a contract in order to be implemented.

Section 7. Provider protections.

The department shall require each plan to contract on an equal basis with any pharmacy, federally qualified health center or durable medical equipment supplier qualified to participate in the medical assistance program if the pharmacy, federally qualified health center or equipment supplier is willing to comply with the managed care organization's payment rates and terms and to adhere to quality standards established by the department.

Section 8. Grievances.

All grievances shall be committed to written form prior to processing, either by the member, the provider, the provider on

behalf of the member of the managed care organization; and the grievance log must be available to enrollees.

Section 9. Determinations of medical necessity.

A determination of medical necessity shall be in writing and be compensable under medical assistance. The managed care organization shall base its determination on medical information provided by the member, the member's family or caretaker and the primary care physician, as well as any other providers, programs and agencies that have evaluated the member. Medical necessity determinations must be made by qualified and trained providers. Satisfaction of any one of the following standards requires authorization of the service:

(1) The service or benefit will or is reasonably expected to prevent the onset of an illness, condition or disability.

(2) The service or benefit will or is reasonably expected to reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.

(3) The service or benefit will or is reasonably expected to assist the member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities that are appropriate for members of the same age.

Section 10. 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 11. Effective date.

This act shall take effect in 60 days.