PRINTER'S NO. 2136

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1613 Session of 2017

INTRODUCED BY CUTLER, PICKETT, MILLARD, RYAN, MACKENZIE, BAKER, DRISCOLL, SCHLOSSBERG, GREINER, A. HARRIS, WARD, KAUFFMAN, ROTHMAN, ZIMMERMAN, GODSHALL, PHILLIPS-HILL, DAY, V. BROWN, KAUFER, STURLA, MENTZER, GROVE, DeLUCA, KINSEY, FABRIZIO AND MATZIE, JUNE 23, 2017

REFERRED TO COMMITTEE ON HEALTH, JUNE 23, 2017

AN ACT

Amending Title 35 (Health and Safety) of the Pennsylvania Consolidated Statutes, providing for the Health Care Cost Containment Council, for its powers and duties, for health care cost containment through the collection and dissemination of data, for public accountability of health care costs and for health care for the indigent and creating incentives for hospitals and managed care organizations to improve health care outcomes and to reduce unnecessary and inappropriate services in the Commonwealth's medical assistance program.

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

Section 1. Title 35 of the Pennsylvania Consolidated Statutes is amended by adding a part to read:

PART II

REGULATED ENTITIES

Chapter

33. Health Care Cost Containment

35. Health Care Outcomes

CHAPTER 33

HEALTH CARE COST CONTAINMENT

Sec.

§ 3301. Short title of chapter.

This chapter shall be known and may be cited as the Health Care Cost Containment Act.

§ 3302. Definitions.

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

"Allowance." The maximum allowed combined payment from a payor and a patient to a provider for services rendered.

"Ambulatory service facility." A facility licensed in this Commonwealth which is not part of a hospital and which provides medical, diagnostic or surgical treatment to patients not

requiring hospitalization, including ambulatory surgical facilities, ambulatory imaging or diagnostic centers, birthing centers, freestanding emergency rooms and any other facilities providing ambulatory care which charge a separate facility charge. The term does not include the offices of private physicians or dentists, whether for individual or group practices.

"Charge" or "rate." The amount billed by a provider for specific goods or services provided to a patient, prior to any adjustment for contractual allowances.

"Council." The Health Care Cost Containment Council.

"Covered services." Any health care services or procedures connected with episodes of illness or injury that require either inpatient hospital care or major ambulatory service, including any initial and follow-up outpatient services associated with the episode of illness or injury before, during or after inpatient hospital care or major ambulatory service. The term does not include routine outpatient services connected with episodes of illness that do not require hospitalization or major ambulatory service.

"Data." Data collected by the council under section 3305 (relating to data submission and collection). The term includes raw data.

"Data source." The term includes a health care payor data source and a provider.

"Elective health care payor data source." An entity, including:

(1) An employer, labor union or health and welfare fund jointly or separately administered by an employer or labor union that purchases or self-funds a program of health care

benefits for its Commonwealth resident employees or members and their dependents; or

(2) A health benefit plan offered or administered by or on behalf of the Federal Government for Pennsylvania residents;

that elects to participate as a health care payor data source under this act.

"Health care facility." A general or special hospital, including:

(1) Psychiatric hospitals.

(2) Kidney disease treatment centers, including freestanding hemodialysis units.

(3) Ambulatory service facilities.

(4) Hospices, including hospices operated by an agency of State or local government.

"Health care insurer." A person, corporation or other entity that offers administrative, indemnity or payment services for health care in exchange for a premium or service charge under a program of health care benefits, including, but not limited to:

(1) An insurance company, association or exchange issuing health insurance policies in this Commonwealth governed by the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

(2) A hospital plan corporation as defined in 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations).

(3) A professional health service corporation as defined in 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

(4) A health maintenance organization governed by the act of December 29, 1972 (P.L.1701, No.364), known as the

Health Maintenance Organization Act.

(5) A third-party administrator governed by Article X of the act of May 17, 1921 (P.L.789, No.285), known as The Insurance Department Act of 1921.

The term does not include employers, labor unions or health and welfare funds jointly or separately administered by employers or labor unions that purchase or self-fund a program of health care benefits for their employees or members and their dependents.

"Health care payor data source." The term includes:

(1) A health care insurer.

(2) A government program to provide health care services to persons in this Commonwealth, whether directly or indirectly through contract, including any State program established under Title XIX or Title XXI of the Social Security Act (49 Stat. 620, 42 U.S.C. § 301 et seq.)

(3) A health benefit plan offered or administered by or on behalf of the Commonwealth or an agency or instrumentality of the Commonwealth.

(4) An elective health care payor data source.

(5) Any other payor for health care services in the Commonwealth other than:

(i) an individual person; or

(ii) an entity that otherwise meets the definition of an elective health care payor data source except that the entity does not elect to participate as a health care payor data source under this act.

"Health maintenance organization." An organized system which combines the delivery and financing of health care and which provides basic health services to voluntarily enrolled subscribers for a fixed prepaid fee, as defined in the Health

Maintenance Organization Act.

"Hospital." An institution licensed in this Commonwealth which is:

(1) A general, mental, chronic disease or other type of hospital.

(2) A kidney disease treatment center, including kidney disease treatment centers operated by an agency of State or local government.

"Major ambulatory service." Surgical or medical procedures, including diagnostic and therapeutic radiological procedures, commonly performed in hospitals or ambulatory service facilities, which are not of a type commonly performed, or which cannot be safely performed, in physicians' offices and which require special facilities such as operating rooms or suites or special equipment such as fluoroscopic equipment or computed tomographic scanners, or a postprocedure recovery room or short-term convalescent room.

"Medical procedure incidence variations." The variation in the incidence in the population of specific medical, surgical and radiological procedures in any given year, expressed as a deviation from the norm, as these terms are defined in the classical statistical definition of "variation," "incidence," "deviation" and "norm."

"Payment." The payments that providers actually accept for their services, exclusive of charity care, rather than the charges they bill.

"Payor." Any person or entity, including, but not limited to, health care insurers and purchasers, that make direct payments to providers for covered services.

"Physician." An individual licensed under the laws of this

Commonwealth to practice medicine and surgery within the scope of the act of October 5, 1978 (P.L.1109, No.261), known as the Osteopathic Medical Practice Act, or the act of December 20, 1985 (P.L.457, No.112), known as the Medical Practice Act of 1985.

"Preferred provider organization." Any arrangement between a health care insurer and providers of health care services which specifies rates of payment to such providers which differ from their usual and customary charges to the general public and which encourages enrollees to receive health services from such providers.

"Provider." A hospital, a health care facility, an ambulatory service facility or a physician.

"Provider quality." The extent to which a provider renders care that, within the capabilities of modern medicine, obtains for patients medically acceptable health outcomes and prognoses, adjusted for patient severity, and treats patients compassionately and responsively.

"Provider service effectiveness." The effectiveness of services rendered by a provider, determined by measurement of the medical outcome of patients grouped by severity receiving those services.

"Purchaser." Corporations, labor organizations or other entities that purchase benefits which provide covered services for their employees or members, either through a health care insurer or by means of a self-funded program of benefits, and a certified bargaining representative that represents a group or groups of employees for whom employers purchase a program of benefits which provide covered services, but excluding any entity defined in this section as a "health care insurer."

"Severity." In any patient, the measureable degree of the potential for failure of one or more vital organs.

§ 3303. Health Care Cost Containment Council.

(a) Establishment.--The Health Care Cost Containment Council is established as an independent council.

(b) Composition.--The council shall consist of voting members, composed of and appointed in accordance with the following:

(1) The Secretary of Health.

(2) The Secretary of Human Services.

(3) The Insurance Commissioner.

(4) Six representatives of the business community, at least one of whom represents small business, who are purchasers of health care, none of which is primarily involved in the provision of health care or health insurance, three of which shall be appointed by the President pro tempore of the Senate and three of which shall be appointed by the Speaker of the House of Representatives from a list of 12 qualified persons recommended by the Pennsylvania Chamber of Business and Industry. Three nominees shall be representatives of small business.

(5) Six representatives of organized labor, three of which shall be appointed by the President pro tempore of the Senate and three of which shall be appointed by the Speaker of the House of Representatives from a list of twelve qualified persons recommended by the Pennsylvania AFL-CIO.

(6) One representative of consumers who is not primarily involved in the provision of health care or health care insurance, appointed by the Governor from a list of three qualified persons recommended jointly by the Speaker of the

House of Representatives and the President pro tempore of the Senate.

(7) Two representatives of hospitals, appointed by the Governor from a list of five qualified hospital representatives recommended by the Hospital and Health System Association of Pennsylvania one of whom shall be a representative of rural hospitals. Each representative under this paragraph may appoint two additional delegates to act for the representative only at meetings of committees, as provided for in subsection (f).

(8) Two representatives of physicians, appointed by the Governor from a list of five qualified physician representatives recommended jointly by the Pennsylvania Medical Society and the Pennsylvania Osteopathic Medical Society. The representative under this paragraph may appoint two additional delegates to act for the representative only at meetings of committees, as provided for in subsection (f).

(8.1) An individual appointed by the Governor who has expertise in the application of continuous quality improvement methods in hospitals.

(8.2) One representative of nurses, appointed by the Governor from a list of three qualified representatives recommended by the Pennsylvania State Nurses Association.

(9) One representative of the Blue Cross and Blue Shield plans in Pennsylvania, appointed by the Governor from a list of three qualified persons recommended jointly by the Blue Cross and Blue Shield plans of Pennsylvania.

(10) One representative of commercial insurance carriers, appointed by the Governor from a list of three qualified persons recommended by the Insurance Federation of

Pennsylvania, Inc.

(11) One representative of health maintenance organizations, appointed by the Governor, from a list of three qualified persons recommended by the Managed Care Association of Pennsylvania.

(12) Representatives from the General Assembly as follows:

(i) One Senator appointed by the President pro tempore of the Senate.

(ii) One member of the House of Representatives appointed by the Speaker of the House of Representatives.

(13) In the case of each appointment to be made from a list supplied by a specified organization, it is incumbent upon that organization to consult with and provide a list which reflects the input of other equivalent organizations representing similar interests. Each appointing authority will have the discretion to request additions to the list originally submitted. Additional names will be provided not later than 15 days after such request. Appointments shall be made by the appointing authority no later than 90 days after receipt of the original list. If, for any reason, any specified organization supplying a list should cease to exist, then the respective appointing authority shall specify an equivalent organization to fulfill the responsibilities set forth in this chapter.

(c) Chairperson and vice chairperson.--The members shall annually elect, by a majority vote of the members, a chairperson and a vice chairperson of the council from among the members the council.

(d) Quorum.--Eleven members, at least four of whom shall be

council members under subsection (b)(5) through (12), shall constitute a quorum for the transaction of any business, and the act by the majority of the members present at any meeting in which there is a quorum shall be deemed to be the act of the council. A quorum may be met by members who are attending by electronic means under subsection (e)(1).

(e) Meetings.--All meetings of the council shall be advertised and conducted under 65 Pa.C.S. Ch. 7 (relating to open meetings), unless otherwise provided in this section. The following apply:

(1) The council shall meet at least once every two months and may provide for special meetings as it deems necessary. Meeting dates shall be set by a majority vote of the members of the council or by the call of the chairperson upon seven days' notice to council members. Attendance at the meeting may be accomplished by electronic means so long as each council member attending via electronic means can communicate in real time with the other members of the council.

(2) All meetings of the council shall be publicly advertised, as provided for in this subsection, and shall be open to the public, except that the council, through its bylaws, may provide for executive sessions of the council on subjects permitted to be discussed in such sessions under 65 Pa.C.S. Ch. 7. No act of the council shall be taken in an executive session.

(3) The council shall publish a schedule of its meetings in the Pennsylvania Bulletin and on its publicly accessible Internet website. The notice shall be published at least once in each calendar quarter and shall list the schedule of

meetings of the council to be held in the subsequent calendar quarter. The notice shall specify the date, time and place of the meeting and shall state that the council's meetings are open to the general public, except that no notice shall be required for executive sessions of the council.

(4) All action taken by the council shall be taken in open public session, and action of the council shall not be taken except upon the affirmative vote of a majority of the members of the council present during meetings at which a quorum is present.

(f) Bylaws.--The council shall adopt bylaws, not inconsistent with this chapter, and may appoint such committees or elect such officers subordinate to those provided for in subsection (c) as it deems advisable.

(g) Technical advisory group.--

(1) The council shall appoint a technical advisory group which shall, on an ad hoc basis, respond to issues presented to it by the council or committees of the council and shall make recommendations to the council. The technical advisory group shall include:

(i) Physicians.

(ii) Researchers.

(iii) Biostatisticians.

(iv) One representative of the Hospital and Healthsystem Association of Pennsylvania.

(v) One representative of the Pennsylvania Medical Society.

(2) The Hospital and Healthsystem Association of Pennsylvania and the Pennsylvania Medical Society representatives shall not be subject to executive committee

approval. In appointing other physicians, researchers and biostatisticians to the technical advisory group, the council shall consult with and take nominations from the representatives of:

(i) the Hospital Association of Pennsylvania;

(ii) the Pennsylvania Medical Society;

(iii) the Pennsylvania Osteopathic Medical Society; or

(iv) other like organizations.

(3) At its discretion and in accordance with this section, nominations shall be approved by the executive committee of the council. If the subject matter of any project exceeds the expertise of the technical advisory group, physicians in appropriate specialties who possess current knowledge of the issue under study may be consulted. The technical advisory group shall also review the availability and reliability of severity of illness measurements as they relate to small hospitals and psychiatric, rehabilitation and children's hospitals and shall make recommendations to the council based upon this review. Meetings of the technical advisory group shall be open to the general public.

(h) Payment data advisory group.--

(1) In order to assure the technical appropriateness and accuracy of payment data, the council shall establish a payment data advisory group to produce recommendations surrounding the collection of payment data, the analysis and manipulation of payment data and the public reporting of payment data. The payment data advisory group shall include technical experts and individuals knowledgeable in payment

systems and claims data. The advisory group shall consist of the following members appointed by the council:

(i) One member representing each plan under 40 Pa.C.S. Chs. 61 (relating to hospital plan corporations) and 63 (relating to professional health services plan corporations).

(ii) Two members representing commercial insurance carriers.

(iii) Three members representing health care facilities.

(iv) Three members representing physicians.

(2) The payment data advisory group shall meet at least four times a year and may provide for special meetings as may be necessary.

(3) The payment data advisory group shall review and concur with the technical appropriateness of the use and presentation of data and report its findings to the council prior to any vote to publicly release reports. If the council elects to release a report without addressing the technical concerns of the advisory group, it shall prominently disclose this in the public report and include the comments of the advisory group in the public report.

(4) The payment data advisory group shall exercise all powers necessary and appropriate to carry out its duties, including advising the council on the following:

(i) Collection of payment data by the council.

(ii) Manipulation, adjustments and methods used with payment data.

(iii) Public reporting of payment data by the council.

(i) Compensation and expenses.--The members of the council and any member of an advisory group appointed by the council shall not receive a salary or per diem allowance for serving as members or advisors of the council, but shall be reimbursed for actual and necessary expenses incurred in the performance of their duties. The expenses may include reimbursement of travel and living expenses while engaged in council business.

(j) Terms of council members.--

(1) The terms of the Secretary of Health, the Secretary of Human Services, the Insurance Commissioner and the legislative representatives shall be concurrent with their holding of public office. The council members under subsection (b)(5) through (12) shall each serve for a term of four years and shall continue to serve thereafter until their successors are appointed.

(2) Vacancies on the council shall be filled in the manner designated under subsection (b), within 60 days of the vacancy, except that, when vacancies occur among the representatives of business or organized labor, two nominations shall be submitted by the organization specified in subsection (b) for each vacancy on the council. If the officer required in subsection (b) to make appointments to the council fails to act within 60 days of the vacancy, the council chairperson may appoint one of the persons recommended for the vacancy until the appointing authority makes the appointment.

(3) Except for the Secretary of Health, the Secretary of Human Services, the Insurance Commissioner and the legislative representatives, a member may be removed for just cause by the appointing authority after recommendation by a

vote of at least 14 members of the council.

(4) No appointed member under subsection (b)(5) through (12) shall be eligible to serve more than two full consecutive terms of four years beginning on the effective date of this paragraph.

(k) Subsequent appointments.--Submission of lists of recommended persons and appointments of council members for succeeding terms shall be made in the same manner as prescribed in subsection (b), except that:

(1) Organizations required under subsection (b) to submit lists of recommended persons shall do so at least 60 days prior to expiration of the council members' terms.

(2) The officer required under subsection (b) to make appointments to the council shall make the appointments at least 30 days prior to expiration of the council members' terms. If the appointments are not made within the specified time, the council chairperson may make interim appointments from the lists of recommended individuals. An interim appointment shall be valid only until the appropriate officer under subsection (b) makes the required appointment. Whether the appointment is by the required officer or by the chairperson of the council, the appointment shall become effective immediately upon expiration of the incumbent member's term.

§ 3304. Powers and duties of council.

(a) General powers.--The council shall exercise all powers necessary and appropriate to carry out its duties, including the following:

(1) To employ an executive director, investigators and other staff necessary to comply with the provisions of this

chapter and regulations promulgated thereunder, to employ or retain legal counsel and to engage professional consultants, as it deems necessary to the performance of its duties. Any consultants, other than sole source consultants, engaged by the council shall be selected in accordance with the provisions for contracting with vendors set forth in section 3314 (relating to contracts with vendors).

(2) To fix the compensation of all employees and to prescribe their duties. Notwithstanding the independence of the council under section 3303(a) (relating to Health Care Cost Containment Council), employees under this paragraph shall be deemed employees of the Commonwealth for the purposes of participation in the Pennsylvania Employee Benefit Trust Fund.

(3) To make and execute contracts and other instruments, including those for purchase of services and purchase or leasing of equipment and supplies, necessary or convenient to the exercise of the powers of the council. Any such contract shall be in accordance with the provision for contracting with vendors set forth in section 3314. This requirement does not include the execution of lease agreements for office space so long as the Commonwealth or a Commonwealth agency has available office space within a 10-mile radius of Harrisburg, Pennsylvania, which may be utilized by the council.

(4) To conduct examinations and investigations, to conduct audits, under the provisions of subsection (c), and to hear testimony and take proof, under oath or affirmation, at public or private hearings, on any matter necessary to its duties.

(5) To provide hospitals with individualized data on patient safety indicators under section 3305(c)(8) (relating to data submission and collection). The data shall be risk adjusted and made available to hospitals electronically and free of charge on a quarterly basis within 45 days of receipt of the corrected quarterly data from the hospitals. The data is intended to provide the patient safety committee of each hospital with information necessary to assist in conducting patient safety analysis.

(6) To do all things necessary to carry out its duties under the provisions of this chapter.

(b) Rules and regulations.--

(1) The council may promulgate rules and regulations as necessary and appropriate to implement this act.

(2) Regulations promulgated by the council shall be promulgated in accordance with the act of June 25, 1982 (P.L.633, No.181), known as the Regulatory Review Act.

(3) Rules and regulations in effect prior to the effective date of this section shall remain in effect.

(c) Audit powers.--The council shall have the right to independently audit all information required to be submitted by data sources as needed to corroborate the accuracy of the submitted data, pursuant to the following:

(1) Audits of information submitted by providers or health care insurers shall be performed on a sample and issue-specific basis, as needed by the council, and shall be coordinated, to the extent practicable, with audits performed by the Commonwealth. All health care insurers and providers are hereby required to make those books, records of accounts and any other data needed by the auditors available to the

council at a convenient location within 30 days of written notification by the council.

(2) Audits of information submitted by purchasers shall be performed on a sample basis, unless there exists reasonable cause to audit specific purchasers, but in no case shall the council have the power to audit financial statements of purchasers.

(3) All audits performed by the council shall be performed at the expense of the council.

(4) The results of audits of providers or health care insurers shall be provided to the audited providers and health care insurers on a timely basis, not to exceed 30 days beyond presentation of audit findings to the council.

(d) General duties and functions.--The council is hereby authorized to and shall perform the following duties and functions:

(1) Develop a computerized system for the collection, analysis and dissemination of data. The council may contract with a vendor who will provide data processing services. The council shall assure that the system will be capable of processing all data required to be collected under this chapter. Any vendor selected by the council shall be selected in accordance with the provisions of section 3314, and the vendor shall relinquish any and all proprietary rights or claims to the database created as a result of implementation of the data processing system.

(2) Establish a Pennsylvania Uniform Claims and Billing Form for all data sources and all providers, which shall be utilized and maintained by all data sources and all providers for all services covered under this chapter.

(3) Establish a health care payor claims data submission manual for all health care payor data sources. The manual shall be utilized by all health care payor data sources to submit data to be used by the council to establish and maintain a health care payor claims database.

(4) Collect and disseminate data, as specified in sections 3305 and 3306 (relating to data dissemination and publication), and other information from data sources to which the council is entitled, prepared according to formats, time frames and confidentiality provisions as specified in sections 3305 and 3308 (relating to Right-to-Know Law and access to council data), and by the council. The council shall begin collection of the data identified in paragraph (3) within 12 months of the effective date of this section.

(5) Adopt and implement a methodology to collect and disseminate data reflecting provider quality, provider service effectiveness, utilization and the cost of health care services under sections 3305 and 3306.

(6) Subject to the restrictions on access to raw data set forth in section 3308, issue special reports and make available raw data to a purchaser requesting it. Sale by a recipient or exchange or publication by a recipient, other than a purchaser, of council raw data to other parties without the express written consent of, and under terms approved by, the council shall be unauthorized use of data under section 3308(d).

(7) On an annual basis, publish in the Pennsylvania Bulletin a list of all the raw data reports it has prepared under section 3308(g) and a description of the data obtained through each computer-to-computer access it has provided

under section 3308(g) and of the names of the parties to whom the council provided the reports or the computer-to-computer access during the previous month.

(8) Promote competition in the health care and health insurance markets.

(9) Assure that the use of council data does not raise access barriers to care.

(10) Provide information on the allowed and paid costs of medical services in terminology that may be reasonably understood by the average individual consumer of health care services. The council shall present the cost information in conjunction with information on quality of care delivery, if quality information is reasonably available to the council, so that the average individual consumer of health care services may use the information to inform purchasing decisions.

(11) Make annual reports to the General Assembly on the rate of increase in the cost of health care in this Commonwealth, including, but not limited to, the following:

(i) The rate of increase in health insurance premiums in this Commonwealth.

(ii) Regional trends in cost of health care and health insurance premiums.

(iii) The effectiveness of the council in carrying out the legislative intent of this chapter.

(iv) The quality and effectiveness of health care and access to health care for all citizens of this Commonwealth.

(12) In the discretion of the council, make recommendations on the need for further health care cost

containment legislation.

(13) Conduct studies and publish reports analyzing the effects that outpatient, alternative health care delivery systems have on health care costs. The systems shall include, but are not limited to, health maintenance organizations (HMOs); preferred provider organizations (PPOs); primary health care facilities; home health care; attendant care; ambulatory service facilities; freestanding emergency centers; birthing centers; and hospice care. The reports shall be submitted to the General Assembly and shall be made available to the public.

(14) Conduct studies and make reports concerning the utilization of experimental and nonexperimental transplant surgery and other highly technical and experimental procedures, including costs and mortality rates.

§ 3305. Data submission and collection.

(a) Submission of data.--

(1) The council is authorized to collect and data sources are required to submit, upon request of the council, all data required in this section, according to uniform submission formats, coding systems, the health care payor claims data submission manual and other technical specifications necessary to render the incoming data substantially valid, consistent, compatible and manageable using electronic data processing according to data submission schedules. The schedules shall avoid, to the extent possible, submission of identical data from more than one data source. The uniform submission formats, coding systems and other technical specifications may be established by the council pursuant to its authority under section 3304(b) (relating to

powers and duties of council). If payor data is requested by the council, it shall, to the extent possible, be obtained from primary payor sources. The council shall not require any data source to contract with any specific vendor for submission of any specific data elements to the council.

(2) In carrying out its responsibilities, the council shall not require health care facilities to report data elements which are not included in the manual developed by the National Uniform Billing Committee. The council shall publish in the Pennsylvania Bulletin a list of no more than 35 diseases, procedures and medical conditions for which data under subsections (c)(22) and (e) shall be required. The list shall not represent more than 50% of total hospital discharges, based upon the previous year's hospital discharge data. Subsequent to the publication of the list, any data submission requirements under subsections (c)(22) and (e) previously in effect shall be null and void for diseases, procedures and medical conditions not found on the list. All other data elements under subsection (c) shall continue to be required from data sources. The council shall review the list and may add no more than a net of three diseases, procedures or medical conditions per year over a five-year period. The adjusted list of diseases, procedures and medical conditions shall at no time be more than 50% of total hospital discharges.

(b) Pennsylvania Uniform Claims and Billing Form.--The council shall maintain a Pennsylvania Uniform Claims and Billing Form format. The council shall furnish the claims and billing form format to all data sources, and the claims and billing form shall be utilized and maintained by all data sources for all

services covered by this chapter. The Pennsylvania Uniform Claims and Billing Form shall consist of the Uniform Hospital Billing Form, as developed by the National Uniform Billing Committee, with additional fields as necessary to provide all of the data set forth in subsections (c) and (e) and those data elements identified in subsection (d) that, in the council's discretion, should be included.

(c) Data elements.--For each covered service performed in this Commonwealth, the council shall be required to collect the following data elements:

(1) uniform patient identifier, continuous across multiple episodes and providers;

(2) patient date of birth;

(3) patient sex;

(4) patient race, consistent with the method of collection of race/ethnicity data by the United States Bureau of the Census and the United States Standard Certificates of Live Birth and Death;

(5) patient zip code number;

(6) date of admission;

(7) date of discharge;

(8) principal and secondary diagnoses by standard code, including external cause of injury, complication, infection and childbirth;

(9) principal procedure by council-specified standard code and date;

(10) up to three secondary procedures by council-specified standard codes and dates;

(11) uniform health care facility identifier, continuous across episodes, patients and providers;

(12) uniform identifier of admitting physician, by unique physician identification number established by the council, continuous across episodes, patients and providers;

(13) uniform identifier of consulting physicians, by unique physician identification number established by the council, continuous across episodes, patients and providers;

(14) total charges of health care facility, segregated into major categories, including, but not limited to, room and board, radiology, laboratory, operating room, drugs, medical supplies and other goods and services according to guidelines specified by the council;

(15) actual payments to health care facility, segregated, if available, according to the categories specified in paragraph (14);

(16) charges of each physician or professional rendering service relating to an incident of hospitalization or treatment in an ambulatory service facility;

(17) actual payments to each physician or professional rendering service under paragraph (16);

(18) uniform identifier of primary payor;

(19) zip code number of facility where health care service is rendered;

(20) uniform identifier for payor group contract number;

(21) patient discharge status; and

(22) provider service effectiveness and provider quality under section 3304(d).

(d) Pennsylvania health care payor claims data submission manual.--

(1) The health care payor claims data submission manual shall define the data elements needed to establish and

maintain a health care payor claims database for all claims paid on behalf of patients receiving health care in this Commonwealth. The health care payor claims database shall not be limited in its data collection by the definition of "covered services" in section 3302 (relating to definitions). A health care payor data source shall comply with the manual to submit data.

(2) The health care payor claims data submission manual shall use and build upon existing data collection standards and methods, and shall include, for each claim, including each medical, dental and pharmacy claim:

(i) Each of the uniform identifier data elements set forth in subsection (c).

(ii) Other eligibility and provider data files associated with the claim as necessary;

(iii) The billed, allowed and paid amounts; and

(iv) Other data elements, as identified in the health care payor claims data submission manual, to further the intent of this chapter, including:

(A) Additional patient and provider identifiers.

(B) Patient demographic information.

(C) Data necessary to identify the date and time of service and the location and type of provider and facility, such as a hospital, office or clinic.

(D) Data describing the nature of health care services provided to the patient, including diagnosis codes.

(E) Other data relating to health care costs, prices and utilization.

(e) Provider quality and provider service effectiveness data

elements.--In carrying out its duty to collect data on provider quality and provider service effectiveness under subsection (c)(22) and section 3304(d)(5), the council shall define a methodology to measure provider service effectiveness, which may include additional data elements to be specified by the council sufficient to carry out its responsibilities under section 3304(d)(5). The council shall not require health care insurers to report on data elements that are not reported to nationally recognized accrediting organizations, to the Department of Health, the Department of Human Services or the Insurance Department, in quarterly or annual reports. The council shall not require reporting by health care insurers in different formats than are required for reporting to nationally recognized accrediting organizations or on quarterly or annual reports submitted to the Department of Health, the Department of Human Services or the Insurance Department. The council may adopt the quality findings as reported to nationally recognized accrediting organizations. Additional quality data elements must be defined and released for public comment prior to use.

(f) Reserve field utilization and addition or deletion of data elements.--The council shall include in the Pennsylvania Uniform Claims and Billing Form a reserve field. The council may utilize the reserve field by adding other data elements beyond those required to carry out its responsibilities under subsections (c) and (e) and section 3304(d)(4) and (5), or the council may delete data elements from the Pennsylvania Uniform Claims and Billing Form only by a majority vote of the council and only pursuant to the following procedure:

(1) The council shall obtain a cost-benefit analysis of the proposed addition or deletion which shall include the

cost to data sources of any proposed additions.

(2) The council shall publish notice of the proposed addition or deletion, along with a copy or summary of the cost-benefit analysis, in the Pennsylvania Bulletin, and the notice shall include provision for a 60-day comment period.

(3) The council may hold additional hearings or request such other reports as it deems necessary and shall consider the comments received during the 60-day comment period and any additional information gained through the hearings or other reports in making a final determination on the proposed addition or deletion.

(g) Other data required to be submitted.--Each provider and health care payor data source is hereby required to submit, and the council is hereby authorized to collect, in accordance with submission dates and schedules established by the council, the following additional data in its possession, provided the data is not available to the council from public records:

(1) Audited annual financial reports of all hospitals and ambulatory service facilities providing covered services as defined in section 3302.

(2) The Medicare cost report for Medical Assistance or successor forms, including the settled Medicare cost report.

(3) Additional data, including, but not limited to, data which can be used in reports about:

(i) the incidence of medical and surgical procedures in the population for individual providers;

(ii) physicians who provide covered services and accept medical assistance patients;

(iii) physicians who provide covered services and accept Medicare assignment as full payment;

(iv) mortality rates for specified diagnoses and treatments, grouped by severity, for individual providers;

(v) rates of infection for specified diagnoses and treatments, grouped by severity, for individual providers;

(vi) morbidity rates for specified diagnoses and treatments, grouped by severity, for individual providers;

(vii) readmission rates for specified diagnoses and treatments, grouped by severity, for individual providers;

(viii) rate of incidence of postdischarge professional care for selected diagnoses and procedures, grouped by severity, for individual providers; and

(ix) data from other public sources.

(4) Any other data the council requires to carry out its responsibilities under section 3304(d).

(h) Review and correction of data.--The council shall provide a reasonable period for data sources to review and correct the data submitted under this section which the council intends to prepare and issue in reports to the General Assembly, to the general public or in special studies and reports under section 3309 (relating to special studies and reports). When corrections are provided, the council shall correct the appropriate data in its data files and subsequent reports.

(i) Allowance for clarification or dissents.--The council shall maintain a file of written statements submitted by data sources who wish to provide an explanation of data that they feel might be misleading or misinterpreted. The council shall

provide access to the file to any person and shall, where practical, in its reports and data files indicate the availability of such statements. When the council agrees with such statements, it shall correct the appropriate data and comments in its data files and subsequent reports.

(j) Allowance for correction.--The council shall verify the patient safety indicator data submitted by hospitals under subsection (c)(8) within 60 days of receipt. The council may allow hospitals to make changes to the data submitted during the verification period. After the verification period, but within 45 days of receipt of the adjusted hospital data, the council shall risk adjust the information and provide reports to the patient safety committee of the relevant hospital.

(k) Availability of data.--Nothing in this chapter shall prohibit a purchaser from obtaining from its health care insurer, nor relieve the health care insurer from the obligation of providing the purchaser, on terms consistent with past practices, data previously provided or additional data not currently provided to the purchaser by the health care insurer pursuant to any existing or future arrangement, agreement or understanding.

§ 3306. Data dissemination and publication.

(a) Public reports.--Subject to the restrictions on access to council data set forth in section 3308 (relating to Right-to-Know Law and access to council data) and utilizing the data collected under section 3305 (relating to data submission and collection), as well as other data, records and matters of record available to it, the council shall prepare and issue reports to the General Assembly and to the general public according to the following provisions:

(1) The council shall, for every provider of both inpatient and outpatient services within this Commonwealth and within appropriate regions and subregions, prepare and issue reports on provider quality and service effectiveness on diseases or procedures that, when ranked by volume, cost, payment and high variation in outcome, represent the best opportunity to improve overall provider quality, improve patient safety and provide opportunities for cost reduction. These reports shall provide comparative information on the following:

(i) Differences in mortality rates; differences in length of stay; differences in complication rates; differences in readmission rates; differences in infection rates; and other comparative outcome measures the council may develop that will allow purchasers, providers and consumers to make purchasing and quality improvement decisions based upon quality patient care and to restrain costs.

(ii) The incidence rate of selected medical or surgical procedures, the quality and service effectiveness and the payments received for those providers, identified by the name and type or specialty, for which these elements vary significantly from the norms for all providers.

(2) In preparing its reports under paragraph (1), the council shall ensure that factors which have the effect of either reducing provider revenue or increasing provider costs and other factors beyond a provider's control which reduce provider competitiveness in the marketplace are explained in the reports. The council shall also ensure that any

clarifications and dissents submitted by individual providers under section 3305(i) are noted in any reports that include release of data on that individual provider.

(b) Raw data reports and computer access to council data.--The council shall provide special reports derived from raw data and a means for computer-to-computer access to its raw data to a purchaser under section 3308(g). The council shall provide the reports and computer-to-computer access, at its discretion, to other parties under section 3308(i). The council shall provide these special reports and computer-to-computer access in as timely a fashion as the council's responsibilities to publish the public reports required in this section will allow. Any provision of special reports or computer-to-computer access by the council shall be made only subject to the restrictions on access to raw data set forth in section 3308(c) and only after payment for costs of preparation or duplication under section 3308(g) or (i).

§ 3307. Mandated health benefits.

In relation to current law or proposed legislation, the council shall, upon the request of the appropriate committee chairman in the Senate and in the House of Representatives or upon the request of the Secretary of Health or the Secretary of Human Services, provide information on the proposed mandated health benefit pursuant to the following:

(1) The General Assembly hereby declares that proposals for mandated health benefits or mandated health insurance coverage should be accompanied by adequate, independently certified documentation defining the social and financial impact and medical efficacy of the proposal. To that end, the council, upon receipt of such requests, is hereby authorized

to conduct a preliminary review of the material submitted by both proponents and opponents concerning the proposed mandated benefit. If, after this preliminary review, the council is satisfied that both proponents and opponents have submitted sufficient documentation necessary for a review under paragraphs (3) and (4), the council is directed to contract with individuals, pursuant to the selection procedures for vendors set forth in section 3314 (relating to contracts with vendors), who will constitute a Mandated Benefits Review Panel to review mandated benefits proposals and provide independently certified documentation, as provided for in this section.

(2) The panel shall consist of the following senior researchers, each of whom shall be a recognized expert:

(i) one in health research;

(ii) one in biostatistics;

(iii) one in economic research;

(iv) one, a physician, in the appropriate specialty with current knowledge of the subject being proposed as a mandated benefit; and

(v) one with experience in insurance or actuarial research.

(3) The Mandated Benefits Review Panel shall have the following duties and responsibilities:

(i) To review documentation submitted by a person proposing or opposing mandated benefits within 90 days of submission of the documentation to the panel.

(ii) To report to the council, pursuant to the council's review under subparagraph (i), the following:

(A) Whether or not the documentation is complete

as defined in paragraph (4).

(B) Whether or not the research cited in the documentation meets professional standards.

(C) Whether or not all relevant research respecting the proposed mandated benefit has been cited in the documentation.

(D) Whether or not the conclusions and interpretations in the documentation are consistent with the data submitted.

(4) A person proposing or opposing legislation mandating benefits coverage should, to provide the Mandated Benefits Review Panel with sufficient information to carry out the Mandated Benefits Review Panel's duties and responsibilities under paragraph (3), submit documentation to the council, pursuant to the procedure established under paragraph (5), which demonstrates the following:

(i) The extent to which the proposed benefit and the services the proposed benefit would provide are needed by, available to and utilized by the population of this Commonwealth.

(ii) The extent to which insurance coverage for the proposed benefit already exists or, if no coverage exists, the extent to which the lack of coverage results in inadequate health care or financial hardship for the population of this Commonwealth.

(iii) The demand for the proposed benefit from the public and the source and extent of opposition to mandating the benefit.

(iv) All relevant findings bearing on the social impact of the lack of the proposed benefit.

(v) If the proposed benefit mandates coverage of a particular therapy, the results of at least one professionally accepted, controlled trial comparing the medical consequences of the proposed therapy, alternative therapies and no therapy.

(vi) If the proposed benefit mandates coverage of an additional class of practitioners, the results of at least one professionally accepted, controlled trial comparing the medical results achieved by the additional class of practitioners and those practitioners already covered by benefits.

(vii) The results of any other relevant research.

(viii) Evidence of the financial impact of the proposed legislation, including at least the following:

(A) The extent to which the proposed benefit would increase or decrease cost for treatment or service.

(B) The extent to which similar mandated benefits in other states have affected charges, costs and payments for services.

(C) The extent to which the proposed benefit would increase the appropriate use of the treatment or service.

(D) The impact of the proposed benefit on administrative expenses of health care insurers.

(E) The impact of the proposed benefits on benefits costs of purchasers.

(F) The impact of the proposed benefits on the total cost of health care within this Commonwealth.

(5) The procedure for review of documentation shall be

as follows:

(i) A person wishing to submit information on proposed legislation mandating insurance benefits for review by the panel must submit the documentation specified under paragraph (4) to the council.

(ii) The council shall, within 30 days of receipt of the documentation:

(A) Publish in the Pennsylvania Bulletin notice of receipt of the documentation, a description of the proposed legislation, provision for a period of 60 days for public comment and the time and place at which a person may examine the documentation.

(B) Submit copies of the documentation to the Secretary of Health, the Secretary of Human Services and the Insurance Commissioner, who shall review and submit comments to the council on the proposed legislation within 30 days.

(C) Submit copies of the documentation to the panel, which shall review the documentation and issue their findings, subject to paragraph (3), within 90 days.

(iii) Upon receipt of the comments of the Secretary of Health, the Secretary of Human Services and the Insurance Commissioner and of the findings of the panel, under subparagraph (ii), but no later than 120 days following the publication required in subparagraph (ii), the council shall submit the comments and findings, together with the council's recommendations respecting the proposed legislation, to the Governor, the President pro tempore of the Senate, the Speaker of the House of

Representatives, the Secretary of Health, the Secretary of Human Services, the Insurance Commissioner and the person who submitted the information under subparagraph (i).

§ 3308. Right-to-Know Law and access to council data.

(a) Public access.--The information and data received by the council shall be utilized by the council for the benefit of the public and public officials. Subject to the specific limitations set forth in this section and section 3101.1 of the act of February 14, 2008 (P.L.6, No.3), known as the Right-to-Know Law, the council shall make determinations on requests for information in favor of access.

(b) Outreach programs.--The council shall develop and implement outreach programs designed to make the council's information understandable and usable to purchasers, providers, other Commonwealth agencies and the general public. The programs shall include efforts to educate through pamphlets, booklets, seminars and other appropriate measures and to facilitate making more informed health care choices.

(c) Limitations on access.--Unless specifically provided for under this chapter, neither the council nor any contracting system vendor shall release and no data source, person, member of the public or other user of any data of the council shall gain access to:

(1) Any raw data of the council which could reasonably be expected to reveal the identity of an individual patient.

(2) Any raw data of the council which could reasonably be expected to reveal the identity of any purchaser, other than a purchaser requesting data on the purchaser's own group or an entity entitled to the purchaser's data under

subsection (g).

(3) Any raw data disclosing discounts or allowances between identified payors and providers which is prejudicial to an individual payor or provider.

(d) Unauthorized use of data.--A person who knowingly releases council data violating raw data safeguards under this section to an unauthorized person commits a misdemeanor of the first degree and shall, upon conviction, be sentenced to pay a fine of $10,000 or to imprisonment for not more than five years, or both. An unauthorized person who knowingly receives or possesses the data commits a misdemeanor of the first degree.

(e) Unauthorized access to data.--If person inadvertently or by council error gains access to data that violates the safeguards under this section, the data must immediately be returned, without duplication, to the council with proper notification.

(f) Public access to records.--Each public report prepared by the council shall be a public record and shall be available to the public for a reasonable fee. Copies shall be provided, upon request of the chair, to the Health and Human Services Committee of the Senate and the Health Committee and Human Services Committee of the House of Representatives.

(g) Access to council raw data by purchasers.--Pursuant to sections 3304(d)(6) (relating to powers and duties of council) and 3306(b) (relating to data dissemination and publication) and subject to the limitations on access under subsection (c), the council shall provide access to the council's raw data to purchasers, excluding purchasers that provide covered services other than through the purchase of fully funded insurance from a health care insurer but that are not elective health care payor

data sources, in accordance with the following procedure:

(1) Special reports derived from raw data of the council shall be provided by the council to the purchaser requesting such reports.

(2) A means to enable computer-to-computer access by the purchaser to raw data of the council shall be developed, adopted and implemented by the council. The council shall provide the access to the council's raw data to a purchaser upon request.

(3) If an employer obtains from the council, under paragraph (1) or (2), data pertaining to the employer's employees and the employees' dependents for whom the employer purchases or otherwise provides covered services and who are represented by a certified collective bargaining representative, the collective bargaining representative shall be entitled to the data, after payment of fees under paragraph (4). If a certified collective bargaining representative obtains from the council, under paragraph (1) or (2), data pertaining to the employer's members and the member's dependents who are employed by and for whom covered services are purchased or otherwise provided by an employer, the employer shall be entitled to the data, after payment of fees under paragraph (4).

(4) In providing for access to its raw data, the council shall charge the purchasers which originally obtained the access a fee sufficient to cover the council's costs to prepare and provide special reports requested under paragraph (1) or to provide computer-to-computer access to its raw data requested under paragraph (2). If a second or subsequent party requests the information under paragraph (3), the

council shall charge the party a reasonable fee.

(h) Access to council raw data by State agencies.--The council shall develop and execute memoranda of understanding with any State agency upon request of that agency, including the Insurance Department, the Department of Health and the Department of Human Services, to allow the agency access to the data.

(i) Access to council raw data by other parties.--Subject to the limitations on access to council raw data under subsection (c), the council may provide special reports derived from the council's raw data or computer-to-computer access to parties other than purchasers provided access under subsection (g). The council may publish regulations that set forth the criteria and the procedure the council shall use in making determinations on the access, pursuant to the powers vested in the council under section 3304. In providing the access, the council shall charge the party requesting the access a reasonable fee.

§ 3309. Special studies and reports.

(a) Special studies.--A Commonwealth agency, the Senate or the House of Representatives may direct the council to publish or contract for publication of special studies, including, but not limited to, a special study on diseases and the cost of health care related to particular diseases in this Commonwealth. A special study published under this subsection shall become a public document.

(b) Special reports.--

(1) A Commonwealth agency, the Senate or the House of Representative may study and issue a report on the special medical needs, demographic characteristics, access or lack thereof to health care services and need for financing of

health care services of:

(i) Senior citizens, particularly low-income senior citizens, senior citizens who are members of minority groups and senior citizens residing in low-income urban or rural areas.

(ii) Low-income urban or rural areas.

(iii) Minority communities.

(iv) Women.

(v) Children.

(vi) Unemployed workers.

(vii) Veterans.

(2) The reports under paragraph (1) shall include information on the current availability of services to the targeted parts of the population under paragraph (1), whether access to the services has increased or decreased over the past 10 years and specific recommendations for the improvement of the primary care and health delivery systems of targeted parts of the population under paragraph (1), including disease prevention and comprehensive health care services. The agency may study and report on the effects of using prepaid, capitated or health maintenance organization health delivery systems as ways to promote the delivery of primary health care services to the underserved segments of the population enumerated above.

(3) The agency may study and report on the short-term and long-term fiscal and programmatic impact on the health care consumer of changes in ownership of hospitals from nonprofit to profit, whether through purchase, merger or the like. The agency may study and report on factors which have the effect of either reducing provider revenue or increasing

provider cost and other factors beyond a provider's control which reduce provider competitiveness in the marketplace.

§ 3310. Enforcement and penalty.

(a) Compliance enforcement.--The council shall have standing to bring an action in law or in equity through private counsel in any court of common pleas to enforce compliance with any provision of this chapter, except section 3309 (relating to special studies and reports), or any requirement or appropriate request of the council made under this chapter. The Attorney General is authorized and shall bring an enforcement action in aid of the council in a court of common pleas at the request of the council and in the name of the Commonwealth.

(b) Penalty.--

(1) Any person who fails to supply data under section 3305 (relating to data submission and collection) may be assessed a civil penalty not to exceed $1,000 for each day the data is not submitted.

(2) Any person who knowingly submits inaccurate data under section 3305 commits a misdemeanor of the third degree and shall, upon conviction, be sentenced to pay a fine of $1,000 or to imprisonment for not more than one year, or both.

§ 3311. Research and demonstration projects.

The council shall actively encourage research and demonstrations to design and test improved methods of assessing provider quality, provider service effectiveness, efficiency and cost containment. If no data submission requirements in a mandated demonstration exceed the current reserve field on the Pennsylvania Uniform Claims and Billing Form or the data submission requirements of the Pennsylvania health care payor

claims data submission manual, the council may:

(1) Authorize contractors engaged in health services research selected by the council, under section 3314 (relating to contracts with vendors), to have access to the council's raw data files, if the entity assumes a contractual obligation imposed by the council to assure patient identity confidentiality.

(2) Place data sources participating in research and demonstrations on different data submission requirements from other data sources in this Commonwealth.

(3) Require data source participation in research and demonstration projects if this is the only testing method the council determines is promising.

§ 3312. Grievances and grievance procedures.

(a) Procedures and requirements.--Pursuant to its powers to publish regulations under section 3304 (relating to powers and duties of council) and with the requirements of this section, the council may establish procedures and requirements for the filing, hearing and adjudication of grievances against the council of a data source. The procedures and requirements shall be published in the Pennsylvania Bulletin pursuant to law.

(b) Claims and hearings.--Grievance claims of a data source shall be submitted to the council or to a third party designated by the council. The council or the designated third party shall convene a hearing, if requested, and adjudicate the grievance.

§ 3313. Antitrust provisions.

A person or entity required or permitted to submit data or information under this chapter or receiving data or information from the council in accordance with this chapter are declared to be acting pursuant to State requirements embodied in this

chapter and shall be exempt from antitrust claims or actions grounded upon submission or receipt of the data or information.

§ 3314. Contracts with vendors.

A contract with a vendor other than a sole source vendor for purchase of services or for purchase or lease of supplies and equipment related to the council's powers and duties shall be let only after a public bidding process and only in accordance with the following provisions:

(1) The council shall prepare specifications fully describing the services to be rendered or equipment or supplies to be provided by a vendor and shall make the specifications available for inspection by a person at the council's offices during normal working hours and at other places and other times as the council deems advisable.

(2) The council shall publish notice of invitations to bid in the Pennsylvania Bulletin and on the council's publicly accessible Internet website. The notice shall include at least the following:

(i) The deadline for submission of bids by prospective vendors, which shall be no sooner than 30 days following the latest publication of the notice as prescribed under this paragraph.

(ii) The locations, dates and times during which prospective vendors may examine the specifications required under paragraph (1).

(iii) The date, time and place of the meeting or meetings of the council at which bids will be opened and accepted.

(iv) A statement to the effect that any person is eligible to bid.

(3) Bids shall be accepted as follows:

(i) A council member who is affiliated in any way with a bidder may not vote on the awarding of a contract for which the bidder has submitted a bid. A council member who has an affiliation with a bidder shall state the nature of the affiliation prior to a vote of the council.

(ii) Bids shall be opened and reviewed by the appropriate council committee, which shall make recommendations to the council on approval. Bids shall be accepted and the acceptance shall be announced only at a public meeting of the council as defined in section 3303(e) (relating to Health Care Cost Containment Council). A bid may not be accepted at an executive session of the council.

(iii) The council may require that a certified check, in an amount determined by the council, accompany every bid. If required, a bid may not be accepted unless accompanied by a certified check.

(4) In order to prevent a party from deliberately underbidding contracts in order to gain or prevent access to council data, the council may award a contract at the council's discretion, regardless of the amount of the bid, as follows:

(i) A bid accepted must reasonably reflect the actual cost of services provided.

(ii) A vendor selected by the council under this paragraph must be found by the council to be of the character and integrity as to assure, to the maximum extent possible, adherence to this chapter in the

provision of contracted services.

(iii) The council may require the selected vendor to furnish, within 20 days after the contract has been awarded, a bond with suitable and reasonable requirements guaranteeing the services to be performed with sufficient surety in an amount determined by the council. If the bond is not furnished within the time specified, the previous award shall be void.

(5) The council shall make efforts to assure that the council's vendors have established affirmative action plans to assure equal opportunity policies for hiring and promoting employees.

§ 3315. Reporting.

The council shall provide an annual report of its financial expenditures to the Appropriations Committee and Public Health and Welfare Committee of the Senate and the Appropriations Committee, the Health Committee and the Human Services Committee of the House of Representatives. Failure to issue a timely report will result in a prohibition on money being distributed from the General Fund to the council for the following fiscal year. Each appropriation from the General Fund to the council shall be held until 60 days after compliance with this section.

§ 3316. Severability.

The provisions of this chapter are severable. If a provision of this chapter or the provision's application to a person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of this chapter which can be given effect without the invalid provision or application.

CHAPTER 35

HEALTH CARE OUTCOMES

Subchapter

A. Preliminary Provisions

B. Medicaid Outcomes-Based Payment Programs

C. Hospital Outcomes Program

D. Managed Care Outcomes Program

SUBCHAPTER A

PRELIMINARY PROVISIONS

Sec.

3501. Definitions.

§ 3501. Definitions.

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

"All Patient Refined Diagnosis Related Groups." A version of Diagnosis Related Groups that further subdivide the Diagnosis Related Groups into four severity-of-illness and four risk-of-mortality subclasses within each Diagnosis Related Groups.

"Department." The Department of Human Services of the Commonwealth.

"Diagnosis Related Groups." A classification system that uses patient discharge information to classify patients into clinically meaningful groups.

"Hospital." A public or private institution licensed as a hospital under the laws of this Commonwealth that participates in the Medicaid program.

"Managed care organization." A licensed managed care organization with whom the department has contracted to provide or arrange for services to a Medicaid recipient.

"Medicaid program." The Commonwealth's Medicaid program.

"Potentially avoidable admission." An admission of an

individual to a hospital or long-term care facility that may have reasonably been prevented with adequate access to ambulatory care or health care coordination.

"Potentially avoidable complication." A harmful event or negative outcome with respect to an individual, including an infection or surgical complication, that:

(1) occurs after the person's admission to a hospital or long-term care facility; and

(2) may have resulted from the care, lack of care or treatment provided during the hospital or long-term care facility stay rather than from a natural progression of an underlying disease.

"Potentially avoidable emergency visit." Treatment of an individual in a hospital emergency room or freestanding emergency medical care facility for a condition that may not require emergency medical attention because the condition could be or could have been treated or prevented by a physician or other health care provider in a nonemergency setting.

"Potentially avoidable event." Any of the following:

(1) A potentially avoidable admission.

(2) A potentially avoidable ancillary service.

(3) A potentially avoidable complication.

(4) A potentially avoidable emergency visit.

(5) A potentially avoidable readmission.

(6) A combination of the events listed under this definition.

"Potentially avoidable readmission." A return hospitalization of an individual within a period specified by the department that may have resulted from a deficiency in the care or treatment provided to the individual during a previous

hospital stay or from a deficiency in post-hospital discharge follow-up. The term does not include a hospital readmission necessitated by the occurrence of unrelated events after the discharge. The term includes the readmission of an individual to a hospital for:

(1) The same condition or procedure for which the individual was previously admitted.

(2) An infection or other complication resulting from care previously provided.

(3) A condition or procedure that indicates that a surgical intervention performed during a previous admission was unsuccessful in achieving the anticipated outcome.

SUBCHAPTER B

MEDICAID OUTCOMES-BASED PAYMENT PROGRAMS

Sec.

§ 3511. Establishment.

The department shall establish the following linked Medicaid outcomes-based payment programs:

(1) A Hospital Outcomes Program designed to provide a hospital with information and incentives to reduce potentially avoidable events and reduce waste in Medicaid hospital services.

(2) A Managed Care Organization Outcomes Program designed to provide a Medicaid managed-care organization with information and incentives to reduce potentially avoidable events and reduce waste in Medicaid managed care programs.

§ 3512. Selection of potentially avoidable event methodology.

The department shall select a methodology for identifying potentially avoidable events and the costs associated with the events and for measuring hospital and managed care organization performance with respect to the events. The following shall apply:

(1) The department shall develop parameters for each of the potentially avoidable events in accordance with the selected methodology.

(2) To the extent possible, the methodology shall be one that has been used by a State program under Title XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 301 et seq.) or by a commercial payer in health care outcomes performance measurement and in outcome-based payment programs.

(3) The methodology shall be open, transparent and available for review by the public.

§ 3513. Statewide analysis of Medicaid system waste.

The department shall conduct a comprehensive analysis of relevant State databases to identify waste in the Medicaid system. The following shall apply:

(1) The analysis shall identify instances of potentially avoidable events in the Medicaid system and the costs associated with these cases.

(2) The overall estimate of waste shall by broken down into actionable categories, including, but not limited to, regions, hospitals, managed care organizations, physicians, service lines, Diagnosis Related Groups, medical conditions and procedures, patient characteristics, provider characteristics and Medicaid program type.

(3) Information collected from the potentially avoidable event study shall be utilized in the Hospital Outcomes

Program and Managed Care Organization Outcomes Program.

SUBCHAPTER C

HOSPITAL OUTCOMES PROGRAM

Sec.

§ 3521. Procedure.

The Hospital Outcomes Program shall:

(1) Target reduction of potentially avoidable readmissions and complications.

(2) Apply to each State acute care hospital participating in the Medicaid program, except that program adjustments may be made for certain types of hospitals.

(3) Be implemented in two phases:

(i) Phase 1, performance reporting.

(ii) Phase 2, the addition of outcomes-based financial incentives.

§ 3522. Phase 1 hospital performance reporting.

The department shall develop and maintain a reporting system to provide each hospital with regular confidential reports regarding the hospital's performance with respect to potentially avoidable readmissions and potentially avoidable complications. The department shall:

(1) Conduct ongoing analyses of relevant State claims databases to identify instances of potentially avoidable

complications and readmissions and the expenditures associated with the cases.

(2) Create or locate State complications and readmissions norms.

(3) Measure actual-to-expected hospital performance compared to State norms.

(4) Compare hospitals with the hospitals' peers using risk adjustment procedures that account for the severity of illness of each hospital's patients.

(5) Distribute reports to hospitals to provide them with actionable information to create policies, contracts and programs designed to improve target outcomes.

(6) Foster collaboration among hospitals in sharing best practices.

§ 3523. Hospital outcomes information sharing.

A hospital may share the information contained in the outcome performance reports with physicians and other health care providers providing services at the hospital to foster coordination and cooperation in the hospital's outcome improvement and waste reduction initiatives.

§ 3524. Phase 2 hospital financial incentives.

Beginning 12 months after implementation of Phase 1 performance reporting, the department shall establish financial incentives to motivate hospitals to improve on rates of reducing avoidable complications and readmissions.

§ 3525. Rate adjustment.

The department shall adjust the reimbursement that the hospital receives under the All Patient Refined Diagnosis Related Groups inpatient prospective payment system based on the hospital's performance with respect to exceeding or failing to

achieve outcome results based on the rates of potentially avoidable readmissions and complications. The methodology for determining a hospital's inpatient base rate adjustment shall:

(1) Apply to each hospital discharge.

(2) Determine a hospital-specific potentially avoidable outcome adjustment factor based on the hospital's actual versus expected risk-adjusted performance compared to the State average or best practice norm.

(3) Be based on a retrospective analysis of performance prospectively applied.

(4) Include both rewards and penalties.

(5) Be communicated to the hospitals in a clear and transparent manner.

§ 3526. Hospital Medicaid contract.

The department shall amend contracts with the department's participating hospitals as necessary to incorporate the financial incentives established under the Hospital Outcomes Program.

§ 3527. Hospital Outcomes Program budget neutrality.

The Hospital Outcomes Program shall be implemented in a budget-neutral manner with respect to aggregate Medicaid hospital expenditures.

SUBCHAPTER D

MANAGED CARE OUTCOMES PROGRAM

Sec.

§ 3531. Procedure.

The Managed Care Organization Outcomes Program shall:

(1) Target reduction of avoidable admissions, readmissions and emergency visits.

(2) Apply to each managed-care organizations participating in the Medicaid program.

(3) Be implemented in two phases:

(i) Phase 1, performance reporting.

(ii) Phase 2, the addition of outcomes-based financial incentives.

§ 3532. Phase 1 managed care organization performance reporting.

The department shall develop and maintain a reporting system to provide each managed care organization with regular confidential reports regarding the managed care organization's performance with respect to potentially avoidable admissions, readmissions and emergency visits. The department shall:

(1) Conduct ongoing analyses of relevant State claims databases to identify instances of potentially avoidable admissions, readmissions and emergency visits with potential excess expenditures associated with the cases.

(2) Create or locate State norms for admissions, readmissions and emergency visits.

(3) Measure actual-to-expected managed care organization performance compared to State norms.

(4) Compare managed care organizations with the managed care organizations' peers using risk adjustment procedures

that account for the chronic illness burden of each plan's enrollees.

(5) Distribute reports to managed care organizations to provide the managed care organizations with actionable information to create policies, contracts and programs designed to improve target outcomes.

§ 3533. Managed care organization outcomes information sharing.

A managed care organization may share the information contained in the outcome performance reports with the managed care organization's participating providers to foster coordination and cooperation in the managed care organization's outcome improvement and waste reduction initiatives.

§ 3534. Phase 2 managed care organization financial incentives.

Beginning 12 months after implementation of Phase 1 performance reporting, the department shall establish financial incentives to motivate the department's managed care organizations to improve on rates of reducing avoidable admissions, readmissions and emergency visits.

§ 3535. Premium adjustment.

The department shall adjust each managed care organization's capitation rate based on the managed care organization's performance with respect to exceeding or failing to achieve outcome results based on the rates of potentially avoidable readmissions, admissions and emergency visits. The methodology for determining a managed care organization's capitation rate adjustment shall:

(1) Apply to the plan's annual capitation rate.

(2) Determine a plan's specific potentially avoidable outcome adjustment factor based on the plan's actual versus expected risk-adjusted performance compared to the State

average or a best practice norm.

(3) Be based on a retrospective analysis of performance and prospectively applied.

(4) Contain both rewards and penalties.

(5) Include risk corridors.

(6) Be communicated to the managed care organizations in a clear and transparent manner.

§ 3536. Managed care organization Medicaid contracts.

The department shall amend contracts with the department's participating managed care organizations as necessary to incorporate the financial incentives established under the Managed Care Organization Outcomes Program.

§ 3537. Managed Care Organization Outcomes Program budget neutrality.

The Managed Care Organization Outcomes Program shall be implemented in a budget neutral manner with respect to aggregate Medicaid managed care expenditures.

Section 2. The following apply:

(1) Actions taken by the Health Care Cost Containment Council from the period from June 30, 2014, to the effective date of this section are validated.

(2) New positions on the Health Care Cost Containment Council created under 35 Pa.C.S. Ch. 33 shall be filled in the manner designated under 35 Pa.C.S. § 3303(b) no later than 60 days after the effective date of this section. Organizations required under 35 Pa.C.S. § 3303(b) to submit lists of recommended persons to fill new positions on the council shall do so no later than 30 days after the effective date of this section.

(3) There shall be no lapse in the employment

relationship for employees of the Health Care Cost Containment Council, including salary, seniority, benefits and retirement eligibility of the employees.

Section 3. This act shall take effect immediately.