LEGISLATIVE BILL 816

Approved by the Governor June 9, 1993

Introduced by Ashford, 6; Baack, 47; Dierks, 40; Hall, 7; Moore, 24; Warner, 25; Wehrbein, 2; Wesely, 26; Will, 8; Abboud, 12

AN ACT relating to health care; to amend sections 68-1030 and 68-1031, Reissue Revised Statutes of Nebraska, 1943; to adopt the Managed Care Plan Act; to change and eliminate provisions relating to contracts for goods and services under the medical assistance program; to eliminate provisions relating to pharmacy services; to repeal the original sections, and also sections 68-1023.01 and 68-1032, Reissue Revised Statutes of Nebraska, 1943; and to declare an emergency.

Be it enacted by the people of the State of Nebraska,

Section 1. Sections 1 to 19 of this act shall be known and may be cited as the Managed Care Plan Act.

Sec. 2. The Legislature finds that health care costs at the federal, state, and local levels now exceed and in the foreseeable future will exceed available public resources. In order to meet fiscal constraints, Nebraska must develop a method of managing the medical assistance program established under sections 68-1018 to 68-1025 in a manner that utilizes state and federal resources to the maximum advantage while also assuring that the program is operated in a cost-effective and efficient manner which provides quality of care and access to health care services for recipients of medical assistance. The use of managed care systems has significant potential to reduce the growth of health care costs incurred by the people of this state and by recipients of medical assistance who are an especially vulnerable population and who need greater access to health care. The Legislature finds that the development of a managed care plan for recipients of medical assistance is one method of improving health care for these individuals.

Sec. 3. For purposes of the Managed Care Plan Act:

(1) Commission shall mean the Managed Care Commission established by section 5 of this act;

(2) Consumer protection system shall mean a system which includes:

(a) Ensuring consumer protection from provider's financial conflicts of interest in managed care arrangements;

(b) Accommodation of consumer choice in the selection of providers within the scope of efficient care management standards;

(c) Allowance for the designation of appropriate specialists as primary care providers for individuals with chronic conditions requiring

specialty care;

(d) Ensuring the confidentiality of consumer records; and

(e) Provision for access to an ombudsman from whom recipients may receive assistance in the enforcement of the protections provided by the act and inclusion of a hearing process to resolve recipient appeals of organized decisions;

(3) Department shall mean the Department of Social Services;

(4) Director shall mean the Director of Social Services;

(5) Disproportionate-share hospital shall mean a hospital which, because of geographic location or for other reasons, serves a larger number of program recipients and other low-income individuals than other hospitals;

(6) Managed care system shall mean a system for providing health care services which integrates both the delivery and the financing of health care services in an attempt to provide access to medical services while containing the cost and use of medical care;

(7) Participating provider shall mean a health care provider that provides or arranges for medical assistance services to program recipients directly or indirectly under a managed care system;

(8) Plan shall mean the plan for implementing a managed care system required by sections 9 to 14 of this act;

(9) Program shall mean the medical assistance program established by sections 68-1018 to 68-1025;

(10) Program recipient shall mean any person eligible for or receiving benefits under the program; and

(11) Quality protection system shall mean a system which includes:

(a) Provision for utilization review and appeals to be conducted by similarly trained and licensed providers;

(b) Full access by recipients and providers to criteria for health care management and clinical practices used in evaluating care plans;

(c) Requirements for internal and external quality assurance, including measures for performance-based outcomes;

(d) Ensuring a substantial effort by managed care organizations to include existing specialty providers when establishing plans; and

(e) Creation of appropriate financial risks and incentives for providers that are consistent with standards for performance-based quality of care.

Sec. 4. The department with the assistance of the commission shall develop a plan to implement a managed care system as required by sections 9 to 14 of this act. Such plan shall be submitted by the department to the commission by October 1, 1993. The commission shall review the plan and make recommendations to the Governor and the Legislature by December 1, 1993. The managed care system shall incorporate risk-sharing mechanisms, create incentives for the efficient

delivery of health care services, and recognize the special needs of disproportionate-share hospitals.

Sec. 5. The Managed Care Commission is hereby established. The commission shall assist the department in preparing the plan.

Sec. 6. The commission shall consist of fifteen members appointed on or before July 30, 1993. The Governor or his or her designee, the Director of Social Services, and the Director of Health shall be members of the commission. The Director of Health shall serve as the chairperson of the commission. The Governor shall appoint additional members, including one physician licensed under the Uniform Licensing Law, one representative of one urban hospital, one representative of one rural hospital, one representative of businesses and industries in the state, one representative of the insurance industry, one representative of the home health care industry, and six representatives of the public. The representatives of the public shall represent a variety of perspectives and may include other health care professionals not specifically represented on the commission. At least three members of the public shall be public assistance recipients or advocates for persons receiving public assistance.

All members of the commission shall have a demonstrated knowledge of health care in Nebraska and of managed care programs and issues. All appointed members of the commission shall be residents of the state. In making the appointments and filling any vacancies pursuant to section 7 of this act, the Governor shall consult with professional and other interested organizations.

The term of each member shall be four years, except that of the initial members appointed by the Governor, two shall be appointed for terms of two years and three for terms of three years as designated by the Governor. Members shall serve until their successors are appointed and qualified.

After submission of the plan pursuant to section 4 or 18 of this act, the commission shall continue in existence until April 1, 1997, and shall review and evaluate the implementation of the managed care system authorized pursuant to the Managed Care Plan Act. The commission shall assess the effectiveness of such system and provide recommendations to the department that may improve such system.

Sec. 7. A vacancy on the commission occurring during the term of a member or as a result of the expiration of a two-year term or three-year term shall be filled by the Governor within thirty days after the date on which the vacancy occurs. The replacement shall represent the same profession or industry that the person causing the vacancy represented if such profession or industry is required to be represented on the commission by section 6 of this act.

Members of the commission shall be reimbursed for their actual and necessary expenses as provided in sections 81-1174 to 81-1177.

Sec. 8. The commission shall hold regular meetings as scheduled by the chairperson. Special or additional meetings may be held on the call of at least three members of the commission. A majority of the

members shall constitute a quorum at all meetings. Commission action on any item shall require a majority vote of those present at meetings at which there is a quorum.

Sec. 9. (1) The plan shall specify a structure for the managed care system which will provide program recipients with access to comprehensive and coordinated health care delivered in a cost-effective and efficient manner in accordance with applicable federal laws and regulations, the types of medical assistance which may be provided under the managed care system, and the steps for implementing such system and shall contain a timetable to ensure that such system is implemented in Nebraska no later than July 1, 1995, subject to sections 15 and 16 of this act.

(2) To the extent deemed feasible and appropriate, the managed care system recommended in the plan shall:

(a) Establish a primary care case management system;

(b) Promote access to and continuity of health care for program recipients;

(c) Prevent unnecessary utilization of health care services by program recipients;

(d) Educate program recipients on preventive health care and good health habits;

(e) Provide sufficient flexibility to enable the managed care system to be tailored to meet the individual health care needs of program recipients;

(f) Provide reasonable and adequate payment for health care providers participating in such system;

(g) Ensure that disproportionate-share-payment adjustments, as specified in section 1923 of the Social Security Act, are made to disproportionate-share hospitals participating in such system, regardless of whether such payments are received from the state directly or from the system and that such disproportionate-share-payment adjustments are made directly to disproportionate-share hospitals;

(h) Provide that managed care medicaid days are counted for purposes of determining a hospital's status as a disproportionate-share hospital;

(i) Consider the special circumstances of university medical centers and teaching hospitals which have higher costs of medical education programs than private hospitals;

(j) Specify the program recipients who will be eligible to participate in such system;

(k) Allow for copayments and deductibles for program recipients in the managed care system; and

(l) Include a quality protection system and consumer protection system for program recipients.

(3) In deciding which program recipients will be eligible to participate in the managed care system, the department and the commission shall consider whether certain program recipients should be excluded from participation in such system if such program recipients

have disabilities, chronic infirmities, or other special health care needs which may be more appropriately met outside such system.

Sec. 10. The plan shall include a comprehensive system to improve access for program recipients to primary care physicians statewide. The plan shall (1) provide a more equitable distribution of program care throughout the communities and regions of the state, (2) increase timely access to appropriate health care for program recipients, (3) promote greater collaboration between physicians and public health nurses to maximize resources, (4) promote a greater continuity of care through a physician-centered, multidisciplinary care system, (5) decrease opportunities for compliance abuse by program recipients, and (6) decrease inappropriate use of emergency room care.

Sec. 11. The plan shall include case management services targeted for high-risk pregnant women and their infants who are eligible for medical assistance under section 1915(g) of the federal Social Security Act, as amended. In determining risk under this section, the department shall include, but not be limited to, such factors as the pregnant woman's age, education, alcohol or drug dependency, weight, and medical and psychosocial conditions. For purposes of this section, case management services shall mean services which will assist eligible individuals in gaining access to needed medical, social, educational, and other services.

Sec. 12. The plan shall identify an entity to act as the administrator of the managed care system. The administrator shall be the department, a quasi-governmental entity to be created by the Legislature, or a private, independent entity under contract with the department. The administrator of such system shall have full operational responsibility for such system, including, but not limited to:

(1) Development of county-by-county implementation and operation plans for the managed care system which provide reasonable access to hospitalization and medical care services for program recipients;

(2) Administration of contracts and oversight of participating providers;

(3) Provision of technical assistance services to participating providers and potential providers;

(4) Establishment of peer review and utilization review functions for all participating providers, with the focus of such reviews being outcomes measurement of all participating providers;

(5) Development and management of a payment system for participating providers;

(6) Establishment and management of a comprehensive system for assuring the quality of care delivered by the managed care system, including a quality protection system and a consumer protection system for program recipients;

(7) Development of a health education and information program;

(8) Development and management of a participant enrollment system; and

(9) Establishment and maintenance of a claims resolution

procedure and a claims payment procedure to assure that all claims submitted are resolved and paid in a timely manner.

The plan may recommend that more than one entity administer certain components of the managed care system.

Sec. 13. The plan shall identify the geographic areas of the state in which a managed care system would be most effective, taking into account such factors as (1) the program-recipient population, (2) a high average cost per program recipient, (3) low community health center utilization and consistently high utilization of emergency room visits, (4) the number and duration of inpatient hospital admissions, and (5) the number of physician visits. The managed care system shall be implemented first in those geographic areas of the state which would benefit the most from such system.

Sec. 14. The plan shall require the administrator of the managed care system to obtain as favorable a pricing structure with participating providers as possible, either by negotiating contracts or by a bidding process. In contracting with participating providers, the administrator shall use its best efforts to contract for medical assistance services to be provided in a manner consistent with managed care principles, techniques, and practices directed at ensuring the most cost-effective and appropriate scope, duration, quality, and level of care, given the nature of the program recipients participating in such system, the services to be provided, and other factors affecting the pricing structure.

Sec. 15. After the plan has been submitted to the Legislature and the Governor, the department shall take all steps necessary, including the adoption and promulgation of rules and regulations, to assure that the plan is implemented as expeditiously as possible and not later than July 1, 1995. The department shall use its best efforts to obtain a federal waiver or waivers from any requirements of Title XIX of the Social Security Act when such action is necessary to implement the managed care system. If such waivers are not granted, the department shall modify such system so that it does meet the requirements of Title XIX of the Social Security Act before implementing such system.

Sec. 16. If the department is a party to any agreements which place limitations on the department's ability to implement a managed care system unless other parties to such agreements agree to waive such limitations, the department shall use its best efforts to seek waivers from such parties to allow the implementation of such system as provided in section 15 of this act.

Sec. 17. The managed care system implemented under the Managed Care Plan Act shall be annually evaluated by the commission as to the health care outcomes and cost-effectiveness. The department shall annually submit a report to the Legislature and the commission on the health care outcomes and cost-effectiveness of such system.

Sec. 18. If the department fails to submit a plan in accordance with the Managed Care Plan Act by January 1, 1994, the commission shall develop and approve a plan which meets the requirements of the act not later than March 30, 1994.

Sec. 19. In addition to other duties provided by the Managed Care Plan Act, the commission shall consider whether the managed care system established under the act should be expanded to include the Comprehensive Health Insurance Pool, the county medically indigent program, medically handicapped children's services, and employees of the State of Nebraska and its political subdivisions, including the University of Nebraska and the state colleges. The commission shall report its recommendations and findings to the Governor and the Legislature by December 1, 1993.

Sec. 20. That section 68-1030, Reissue Revised Statutes of Nebraska, 1943, be amended to read as follows:

68-1030. Under the authority provided in the Managed Care Plan Act and section 68-1021, the Director of Social Services may enter into contracts on a bid or negotiated basis with vendors to provide goods and services on behalf of recipients of medical assistance as set forth in section 68-1019. Such contracts may provide for the method of payment, including, but not limited to, a negotiated reimbursement rate, fee-for-service, capitation, retainer, prepaid, or other basis. Such contracts may also be entered into with health maintenance organizations.

Sec. 21. That section 68-1031, Reissue Revised Statutes of Nebraska, 1943, be amended to read as follows:

68-1031. ~~(1) The terms and conditions of any contract offered by the Department of Social Services under section 68-1030 shall not discriminate against or among vendors. Differences in prices among vendors based on factors including, but not limited to, market conditions, patient mix and method of payment, and price differences among vendors in different geographical areas shall not be deemed discrimination.~~

~~(2)~~ The ~~department~~ Department of Social Services may limit the offering of a contract under section 68-1030 to a specific geographic area. When the department contracts for a specific type of service covered under section 68-1019, in a specific geographic area, reimbursement for such service may be limited to those vendors contracting with the department. When reimbursement is limited to contracting vendors, nothing in sections 68-1029 to 68-1036 shall be construed to require noncontracting vendors to provide services for medical assistance recipients.

~~(3) Nothing in sections 68-1029 to 68-1036 shall be construed to limit the services reimbursed under section 68-1019.~~

Sec. 22. That original sections 68-1030 and 68-1031, Reissue Revised Statutes of Nebraska, 1943, and also sections 68-1023.01 and 68-1032, Reissue Revised Statutes of Nebraska, 1943, are repealed.

Sec. 23. Since an emergency exists, this act shall be in full force and take effect, from and after its passage and approval, according to law.