No. 1980-105

AN ACT

HB 552

Amending the act of June 13, 1967 (P.L.31, No.21), entitled "An act to consolidate, editorially revise, and codify the public welfare laws of the Commonwealth," requiring the Department of Public Welfare to develop and implement a State plan for regulating and licensing personal care boarding homes, prohibiting abusive, fraudulent and deceptive acts and practices by providers of and persons eligible for State medical assistance; providing remedies and penalties therefor; imposing certain participation requirements on providers and persons eligible; providing for third party liability; and imposing powers and duties on the Attorney General, the Department of Public Welfare and the district attorneys.

The General Assembly finds and declares that it is in the interest of the people of Pennsylvania to establish a legal and regulatory basis for controlling medical assistance fraud and abuse of services reimbursed by Federal and State funds. The purpose of the act is not to penalize the majority of recipients and providers who abide by medical assistance laws and regulations, but rather to eliminate fraudulent, abusive and deceptive conduct and practices that may occur. It is in the public interest that medical assistance services be administered and regulated in a way that will ensure that public funds will be properly expended for essential services to medically needy persons.

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

Section 1. The act of June 13, 1967 (P.L.31, No.21), known as the "Public Welfare Code," is amended by adding a section to read:

Section 211. State Plan for Regulating and Licensing Personal Care Boarding Homes.—(a) In accordance with the statutory authority and responsibility vested in the department to regulate nonprofit boarding homes for adults which provide personal care and services and to license for profit personal care boarding homes for adults, pursuant to Articles IX and X, the department shall develop and implement a State plan for regulating and licensing said facilities as defined by section 1001 of this act.

(b) In developing rules and regulations for the State plan, the department shall:

(1) Distinguish between personal care homes serving less than eight persons and personal care homes serving more than eight persons.

(2) By July 1, 1981 adopt rules relating to the conduct of owners and employes of personal care boarding homes relative to the endorsement or delivery of public or private welfare, pension or insurance checks by a resident of a personal care boarding home.

(3) Not regulate or require the registration of boarding homes which merely provide room, board and laundry services to persons who do not need personal care boarding home services.

(c) Within three months following the effective date of this act, the department shall submit to the General Assembly for comment and review, and publish in the Pennsylvania Bulletin in accordance with the provisions of the Commonwealth Documents Law relating to the publication of regulations, a preliminary State plan for regulating and licensing personal care boarding homes.

(d) The preliminary plan shall include, but is not limited to, the following:

(1) Coordination of the department's statutory responsibilities with those of other State and local agencies having statutory responsibilities relating to personal care boarding homes, with particular attention given to the Department of Labor and Industry, the Department of Environmental Resources, the Department of Aging and the Pennsylvania Human Relations Commission. The Department of Labor and Industry shall promulgate rules and regulations applicable to personal care boarding homes on a Statewide basis consistent with size distinctions set forth in subsection (b) pertaining to construction and means of egress.

(2) Recommendations for changes in existing State law and proposed legislation to:

(i) Resolve inconsistencies that hinder the department's implementation of the State plan.

(ii) Promote the cost efficiency and effectiveness of visitations and inspections.

(iii) Delegate to other State and local agencies responsibility for visitations, inspections, referral, placement and protection of adults residing in personal care boarding homes.

(iv) Evaluate the State's fire and panic laws as applied to personal care boarding homes.

(3) Recommendations for implementation of fire safety and resident care standards relating to personal care boarding homes by cities of the first class, second class and second class A.

(4) A programmatic and fiscal impact statement regarding the effect of the plan on existing residential programs for the disabled, including but not limited to skilled nursing homes, intermediate care facilities, domiciliary care homes, adult foster care homes, community living arrangements for the mentally retarded and group homes for the mentally ill and the effect of the plan on recipients of Supplemental Security Income.

(5) Cost analysis of the entire plan and of all regulations that will be proposed pursuant to the plan.

(6) Number of personnel at the State, regional and county level required to inspect personal care boarding homes and monitor and enforce final rules and regulations adopted by the department.

(7) Process for relocating residents of personal care boarding homes whose health and safety are in imminent danger.

(e) If the department deems that it is in the best interest of the Commonwealth to develop a plan for implementation on a phased basis, the department shall submit a detailed schedule of the plan to the General Assembly which shall be part of the preliminary State plan.

(f) Within six months of the effective date of this act, the department shall adopt a final State plan which shall be submitted and published in the same manner as the preliminary plan.

(g) The final plan shall include the information required in the preliminary plan and, in addition, the cost to operators of personal care boarding homes for compliance with the regulations.

(h) At no time may the department change, alter, amend or modify the final State plan, except in emergency situations, without first publishing such change in the Pennsylvania Bulletin in accordance with the Commonwealth Documents Law relating to publication of regulations and without first submitting the proposed change to the General Assembly for comment and review. In an emergency, the department may change, alter, amend or modify the State plan without publishing the change or submitting the change to the General Assembly; but, within thirty days, the department shall submit and publish the change as otherwise required.

(i) The State plan shall not apply to any facility operated by a religious organization for the care of clergymen or other persons in a religious profession.

(j) Prior to January 1, 1985, department regulations shall not apply to personal care boarding homes in which services are integrated with, are under the same management as, and on the same grounds as a skilled nursing or intermediate care facility licensed for more than twenty-five beds and having an average daily occupancy of more than fifteen beds. Prior to January 1, 1985 the department may require registration of such facilities and may visit such facilities for the purpose of assisting residents and securing information regarding facilities of this nature.

(k) Any regulations by the department relating to the funding of residential care for the mentally ill or mentally retarded adults and any regulations of the Department of Aging relating to domiciliary care shall use as their base, regulations established in accordance with this section. Supplementary requirements otherwise authorized by law may be added.

(l) After initial approval, personal care boarding homes need not be visited or inspected annually; provided that the department shall schedule inspections in accordance with a plan that provides for the coverage of at least seventy-five percent of the licensed personal care boarding homes every two years and all homes shall be inspected at least once every three years.

(m) Regulations specifically related to personal care homes or personal care boarding home services adopted prior to the effective date of this act shall remain in effect until superseded by a final plan adopted in accordance with this section.

Section 2. The definition of "personal care home for adults" in section 1001 of the act is amended to read:

Section 1001. Definitions.—As used in this article—

* * *

"Personal care home for adults" means any premises **[operated for profit]** in which food, shelter and personal assistance or supervision are provided for a period exceeding twenty-four hours for more than **[two]** *three* adults who are not relatives of the operator and who require assistance or supervision in such matters as dressing, bathing, diet or medication prescribed for self administration.

* * *

Section 3. Article XIV of the act is amended to read:

ARTICLE XIV

[RESERVED] *FRAUD AND ABUSE CONTROL*

Section 1401. Definitions.—The following words and phrases when used in this article shall have, unless the context clearly indicates otherwise, the meanings given to them in this section:

"Eligible person" means anyone who lawfully receives or holds a medical assistance eligibility identification card from the department.

"Health services corporation" means a nonprofit hospital plan corporation or a nonprofit professional health service plan corporation approved under Pennsylvania law.

"Medical assistance" means medical services rendered to eligible persons under Articles IV and V of this act.

"Medical assistance program" means the services funded and operations administered by the department under Articles IV and V of this act.

"Medical facility" means a licensed or approved hospital, skilled nursing facility, intermediate care facility, clinic, shared health facility, pharmacy, laboratory or other medical institution.

"Practitioner" means any medical doctor, doctor of osteopathy, dentist, optometrist, podiatrist, chiropractor or other medical professional personnel licensed by the Commonwealth or by any other state who is authorized to participate in the medical assistance program.

"Provider" means any individual or medical facility which signs an agreement with the department to participate in the medical assistance program, including, but not limited to, licensed practitioners, pharmacies, hospitals, nursing homes, clinics, home health agencies and medical purveyors.

"Purveyor" means any person other than a practitioner, who, directly or indirectly, engages in the business of supplying to patients any medical supplies, equipment or services for which reimbursement

under the program is received, including, but not limited to, clinical laboratory services or supplies, x-ray laboratory services or supplies, inhalation therapy services or equipment, ambulance services, sick room supplies, physical therapy services or equipment and orthopedic or surgical appliances or supplies.

"Recipient" means an eligible person who receives medical assistance from a participating provider.

"Shared health facility" means an entity which provides the services of three or more health care practitioners, two or more of whom are practicing within different professions, in one physical location. To meet this definition, the practitioners must share any of the following: common waiting areas, examining rooms, treatment rooms, equipment, supporting staff or common records. In addition, to meet this definition, at least one practitioner must receive payment on a fee-for-services basis, and payments under the medical assistance program to any person or entity providing services or merchandise at the location must exceed thirty thousand dollars ($30,000) per year. "Shared health facility" does not mean or include any licensed or approved hospital facility, a skilled nursing facility, intermediate care facility, public health clinics, or any entity organized or operating as a facility wherein ambulatory medical services are provided by an organized group of practitioners all of whom practice the same profession pursuant to an arrangement between such group and a health services corporation or a Federally approved health maintenance organization operating under Pennsylvania law, and where a health services corporation or a health maintenance organization is reimbursed on a prepaid capitation basis for the provision of health care services under the medical assistance program.

Section 1402. Special Provider Participation Requirements.—(a) As a condition of participation in the medical assistance program, a medical facility shall be required to disclose to the department upon execution of a new provider agreement or renewal thereof the name and social security number of any person who has a direct or indirect ownership or control interest of five percent or more in such medical facility; such disclosure shall include the identity of any such person who has been convicted of a criminal offense under section 1407 and the specific nature of the offense involved. In addition to the disclosure required upon execution of a provider agreement, any change in such ownership or control interest of five percent or more shall be reported to the department within thirty days of the date such change occurs. Failure to submit a complete and accurate report shall constitute a deceptive practice under section 1407(a)(1) and will justify a termination of the provider agreement by the department.

(b) As a second condition of participation in the medical assistance program, a provider must maintain for a minimum of four years appropriate medical and financial records to fully support his claims

and charges for payment under the medical assistance program. Such records shall at reasonable times be made available for inspection, review and copying by the department or by other authorized State officers.

(c) Payments under the medical assistance program will be made directly to providers who have signed a provider agreement with the department. Providers shall not factor, assign, reassign or execute a power of attorney for the rights to any claims or payments for services rendered under the medical assistance program. Notwithstanding the above stated language a provider may use accounts receivables as collateral at a certified lending institution.

(d) Each skilled nursing facility or intermediate care facility shall maintain a complete and accurate record of all receipts and disbursements for medical assistance recipients' personal funds and shall furnish each such patient a quarterly report of all transactions recorded for that recipient.

Section 1403. Special Participation Requirements for Shared Health Facilities.—(a) The registration requirements are as follows:

(1) Each shared health facility shall register with the department and specify the kind or kinds of services the facility is authorized to provide and shall establish a uniform system of reports and internal audits which meet the requirements of the department. In addition, the owner of the premises upon which the facility is located, or the lessor of the structure in which the facility is located, if either has a role in operating the facility, shall file a statement specifying the kind or kinds of services the facility is authorized to provide, and shall establish a uniform system of reports and audits meeting the requirements of the department.

(2) Application for registration of a shared health facility shall be made upon forms prescribed by the department. The application shall contain:

(i) the name of the facility;

(ii) the kind or kinds of services to be provided;

(iii) the location and physical description of the facility;

(iv) the name, social security number and residence address of every person, partnership or corporation having any financial interest in the ownership (including leasehold ownership) of the facility and the structure in which the facility is located;

(v) the name, social security number and residence address of every person, partnership or corporation holding any mortgage, lien, leasehold or any other security interest in the shared health facility or in any equipment located in and used in connection with shared health facility and a brief description of such lien or security interest;

(vi) the name, residence address and professional license number of every practitioner participating in the shared health facility;

(vii) the name and residence address of the individual designated as operator to assume responsibility for the central coordination and management of the activities of the shared health facility; and

(viii) such other information as the department may require to carry out the provisions of this act.

(3) Each operator shall apply for an initial registration upon notification by the department and shall apply for renewal of such registration annually thereafter.

(b) The notification requirements are as follows:

(1) Each operator shall notify the department within fifteen days of any change in:

(i) the persons, partnerships or corporations having any financial interest in the ownership (including leasehold ownership) of the shared health facility; or

(ii) the persons, partnerships or corporations holding any mortgage, lien, leasehold or any other security interests in the shared health facility or in any equipment located in and used in connection with a shared health facility. A statement of the monetary and repayment provisions of that lien or security interest shall accompany such notification.

(2) Each operator shall notify the department within fifteen days of the termination of the services of the individual designated to assume responsibility for coordination and management of the activities of the shared health facility and of the name, residence address and professional qualifications of any new individual appointed to assume such central administrative responsibility.

(3) Each operator shall notify the department within fifteen days of any termination of the services of any practitioner in the shared health facility and of the name, residence address and license number of each practitioner newly participating in the facility.

(c) The minimum care requirements are as follows:

(1) To ensure quality, continuity and proper coordination of medical care, each shared health facility shall:

(i) designate an individual who shall coordinate and manage the facility's activities. The person so designated shall be responsible for compliance with the provisions of this act;

(ii) devise an appropriate means of assuring that a recipient will be treated by a practitioner familiar with the recipient's medical history;

(iii) post conspicuously the names and scheduled office hours of all practitioners practicing in the facility;

(iv) maintain proper recipient records which shall contain at least the following information:

(A) the full name, address and medical assistance record number of each recipient;

(B) the dates of all visits to all providers in the shared health facility;

(C) the chief complaint for each visit to each provider in the shared health facility;

(D) pertinent history and all physical examinations rendered by each provider in the shared health facility;

(E) diagnostic impressions for each visit to any provider in the shared health facility;

(F) all medications prescribed by any provider in the shared health facility;

(G) the precise dosage and prescription regimens for each medication prescribed by a provider in the shared health facility;

(H) all x-ray, laboratory work and electrocardiograms ordered at each visit by any provider in the shared health facility and their results;

(I) all referrals by providers in the shared health facility to other medical practitioners and the reason for such referrals; and

(J) a statement as to whether or not the recipient is expected to return for further treatment and the dates of all return appointments;

(v) assign a clearly identified general practitioner to each recipient. This assignment may be changed at any time at the recipient's request;

(vi) make available to registered recipients either:

(A) the central answering services telephone number of each recipient's designated practitioner service or such practitioner's personally designated colleagues; or

(B) a centralized twenty-four-hour-a-day, seven-day-weekly telephone line for off-hour recipient emergency questions;

(vii) maintain a central day-book registry which shall record:

(A) the name and medical assistance record number of all recipients entering the facility; and

(B) the chief complaint and the names of all providers whose services were requested by the recipient and/or to whom such recipient was referred;

(viii) insure that the physical facilities of each shared health facility shall provide for privacy for all recipients during examination, interview and treatment; and

(ix) post conspicuously the telephone number of the office within the department which is responsible for providing information concerning shared health facilities and/or for receiving complaints concerning the provision of health care services at shared health facilities.

(2) It shall be the responsibility of each facility's administrator to ensure that recipient records and summaries of all recipient visits include diagnosis and pharmaceuticals prescribed and are at all times available at either the facility or at a place immediately accessible to all health providers at the facility.

(3) Nothing in this act shall in any way be interpreted as infringing upon the recipient's rights to free selection of a personal practitioner.

(4) The department shall have the right to inspect the business records, recipient records, leases and other contracts executed by any provider in a shared health facility. Such inspections may be by site visits to the facility.

(d) Prohibited acts of shared health facilities are as follows:

(1) the rental fee for letting space to providers in a shared health facility shall not be calculated wholly or partially, directly or indirectly, as a percentage of earnings or billings of the provider for services rendered on the premises in which the shared health facility is located. The operator of each facility shall file a copy of each lease and any renewal thereof with the department;

(2) no purveyor, whether or not located in a building which houses a shared health facility, shall directly or indirectly offer, pay or give to any provider, and no provider shall directly or indirectly solicit, request, receive or accept from any purveyor any sum of money, credit or other valuable consideration for:

(i) recommending or procuring goods, services or equipment of such purveyor;

(ii) directing patronage or clientele to such purveyor; or

(iii) influencing any person to refrain from using or utilizing goods, services or equipment of any purveyor;

(3) no provider or purveyor shall demand or collect any reimbursement contrary to the fee schedule of the medical assistance program;

(4) no purveyor shall provide to a recipient eligible to receive benefits under the provisions of the medical assistance program any services, equipment, pharmaceutical or other medical supplies differing in quantity or in any other respect from that described in the payment invoice submitted by such purveyor to the department. No purveyor shall provide to any recipient eligible to receive benefits under the provisions of the program any services, equipment, pharmaceutical or medical supplies differing in quality, quantity or in any other respect from that prescribed by the provider;

(5) (i) no provider in a shared health facility or person employed in such facility shall refer a recipient to another provider located in such facility unless there is a medical justification for such referral and unless the records of the referring provider pertaining to such recipient clearly set forth the justification for such referral;

(ii) no provider practicing in a shared health facility who treats a recipient referred to him by another provider shall fail to communicate in writing to the referring provider the diagnostic evaluation and the therapy rendered. The referring provider shall incorporate such information into the recipient's permanent record;

(iii) the invoice submitted to the department by the provider to whom such recipient has been referred shall contain the name and provider number of the referring provider and identify the medical problem which necessitated the referral;

(6) if a pharmacy is located in or adjacent to the building in which a shared health facility is located, such shared health facility shall prominently post a notice in the common waiting room or area informing recipients that all pharmaceuticals prescribed by practitioners in the facility may be obtained at any participating pharmacy of the recipient's choice;

(7) all provider invoices submitted for services rendered at a shared health facility shall contain the provider number of the facility at which the service was performed, clearly identify the practitioner who provided the service and be signed by the provider after the service has been performed;

(8) all orders issued by providers for ancillary clinical services, including but not limited to, x-rays, electrocardiograms, clinical laboratory services, electroencephalograms, as well as orders for medical supplies and equipment, shall contain the prescriber's medical assistance number and the provider number assigned to the facility at which the order was written; and

(9) each provider and purveyor shall submit a true bill or invoice for services rendered in the program.

Section 1404. Special Recipient Participation Requirements.—(a) Any person applying for medical assistance benefits shall certify to the department that he or she has not transferred title to or ownership interests in any real or personal property to any third person or party within the two years immediately preceding such application; if such a transfer has occurred, the recipient must disclose the nature of the transfer and must demonstrate that it involves a bona fide arm's length transaction resulting in compensation paid to the transferor in an amount equal to or greater than the fair market value of the property as determined by the department.

(b) Any person applying for medical assistance benefits shall as a condition to eligibility, give the department the right of subrogation to any other private or public health insurance benefits to which such person is or may become entitled.

(c) Any person applying for medical assistance benefits shall authorize the department to inspect, review and copy any and all medical records relating to services received by the applicant or by any person for which the applicant is legally responsible. The department shall maintain the confidentiality of such records.

Section 1405. Freedom of Choice and Nondiscrimination.—(a) A recipient of medical assistance benefits shall, in all cases, have the freedom to obtain medical services from whichever participating provider or providers he so chooses; however, the participating provider so chosen is free to accept or reject the recipient as a patient.

(b) Once a provider has elected to participate in the medical assistance program and has signed an agreement with the department, such providers shall not refuse to render services to any recipient on the basis of sex, race, creed, color, national origin or handicap.

Section 1406. Restrictions on Provider Charges and Payments.—(a) All payments made to providers under the medical assistance program shall constitute full reimbursement to the provider for covered services rendered. Providers may not seek or request supplemental or additional payments from recipients for covered services unless authorized by law or regulation; nor may a provider charge a

recipient for other services to supplement a covered service paid for by the department. However, nothing in this act shall preclude charges for uncovered services rendered to a recipient.

(b) Charges made to the department by a provider for covered services or items furnished shall not exceed, in any case, the usual and customary charges made to the general public by such provider for the same services or items.

Section 1407. Provider Prohibited Acts, Criminal Penalties and Civil Remedies.—(a) It shall be unlawful for any person to:

(1) Knowingly or intentionally present for allowance or payment any false or fraudulent claim or cost report for furnishing services or merchandise under medical assistance, or to knowingly present for allowance or payment any claim or cost report for medically unnecessary services or merchandise under medical assistance, or to knowingly submit false information, for the purpose of obtaining greater compensation than that to which he is legally entitled for furnishing services or merchandise under medical assistance, or to knowingly submit false information for the purpose of obtaining authorization for furnishing services or merchandise under medical assistance.

(2) Solicit or receive or to offer or pay any remuneration, including any kickback, bribe or rebate, directly or indirectly, in cash or in kind from or to any person in connection with the furnishing of services or merchandise for which payment may be in whole or in part under the medical assistance program or in connection with referring an individual to a person for the furnishing or arranging for the furnishing of any services or merchandise for which payment may be made in whole or in part under the medical assistance program.

(3) Submit a duplicate claim for services, supplies or equipment for which the provider has already received or claimed reimbursement from any source.

(4) Submit a claim for services, supplies or equipment which were not rendered to a recipient.

(5) Submit a claim for services, supplies or equipment which includes costs or charges not related to such services, supplies or equipment rendered to the recipient.

(6) Submit a claim or refer a recipient to another provider by referral, order or prescription, for services, supplies or equipment which are not documented in the record in the prescribed manner and are of little or no benefit to the recipient, are below the accepted medical treatment standards, or are unneeded by the recipient.

(7) Submit a claim which misrepresents the description of services, supplies or equipment dispensed or provided; the dates of services; the identity of the recipient; the identity of the attending, prescribing or referring practitioner; or the identity of the actual provider.

(8) Submit a claim for reimbursement for a service, charge or item at a fee or charge which is higher than the provider's usual and customary charge to the general public for the same service or item.

(9) Submit a claim for a service or item which was not rendered by the provider.

(10) Dispense, render or provide a service or item without a practitioner's written order and the consent of the recipient, except in emergency situations, or submit a claim for a service or item which was dispensed, or provided without the consent of the recipient, except in emergency situations.

(11) Except in emergency situations, dispense, render or provide a service or item to a patient claiming to be a recipient without making a reasonable effort to ascertain by verification through a current medical assistance identification card, that the person or patient is, in fact, a recipient who is eligible on the date of service and without another available medical resource.

(12) Enter into an agreement, combination or conspiracy to obtain or aid another to obtain reimbursement or payments for which there is not entitlement.

(13) Make a false statement in the application for enrollment as a provider.

(14) Commit any of the prohibited acts described in section 1403(d)(1), (2), (4) and (5).

(b) (1) A person who violates any provision of subsection (a), excepting subsection (a)(11), is guilty of a felony of the third degree for each such violation with a maximum penalty of fifteen thousand dollars ($15,000) and seven years imprisonment. A violation of subsection (a) shall be deemed to continue so long as the course of conduct or the defendant's complicity therein continues; the offense is committed when the course of conduct or complicity of the defendant therein is terminated in accordance with the provisions of 42 Pa.C.S. § 5552(d)(relating to other offenses). Whenever any person has been previously convicted in any state or Federal court of conduct that would constitute a violation of subsection (a), a subsequent allegation, indictment or information under subsection (a) shall be classified as a felony of the second degree with a maximum penalty of twenty-five thousand dollars ($25,000) and ten years imprisonment.

(2) In addition to the penalties provided under subsection (b), the trial court shall order any person convicted under subsection (a):

(i) to repay the amount of the excess benefits or payments plus interest on that amount at the maximum legal rate from the date payment was made by the Commonwealth to the date repayment is made to the Commonwealth;

(ii) to pay an amount not to exceed threefold the amount of excess benefits or payments.

(3) Any person convicted under subsection (a) shall be ineligible to participate in the medical assistance program for a period of five years from the date of conviction. The department shall notify any provider so convicted that the provider agreement is terminated for five years, and the provider is entitled to a hearing on the sole issue of identity.

If the conviction is set aside on appeal, the termination shall be lifted.

(4) The Attorney General and the district attorneys of the several counties shall have concurrent authority to institute criminal proceedings under the provisions of this section.

(5) As used in this section the following words and phrases shall have the following meanings:

"Conviction" means a verdict of guilty, a guilty plea, or a plea of nolo contendere in the trial court.

"Medically unnecessary or inadequate services or merchandise" means services or merchandise which are unnecessary or inadequate as determined by medical professionals engaged by the department who are competent in the same or similar field within the practice of medicine.

(c) (1) If the department determines that a provider has committed any prohibited act or has failed to satisfy any requirement under section 1407(a), it shall have the authority to immediately terminate, upon notice to the provider, the provider agreement and to institute a civil suit against such provider in the court of common pleas for twice the amount of excess benefits or payments plus legal interest from the date the violation or violations occurred. The department shall have the authority to use statistical sampling methods to determine the appropriate amount of restitution due from the provider.

(2) Providers who are terminated from participation in the medical assistance program for any reason shall be prohibited from owning, arranging for, rendering or ordering any service for medical assistance recipients during the period of termination. In addition, such provider may not receive, during the period of termination, reimbursement in the form of direct payments from the department or indirect payments of medical assistance funds in the form of salary, shared fees, contracts, kickbacks or rebates from or through any participating provider.

(3) Notice of any action taken by the department against a provider pursuant to clauses (1) and (2) will be forwarded by the department to the Medicaid Fraud Control Unit of the Department of Justice and to the appropriate licensing board of the Department of State for appropriate action, if any. In addition, the department will forward to the Medicaid Fraud Control Unit of the Department of Justice and the appropriate Pennsylvania licensing board of the Department of State any cases of suspected provider fraud.

Section 1408. Recipient Prohibited Acts, Criminal Penalties and Civil Remedies.—(a) It shall be unlawful for any person to:

(1) knowingly or intentionally make or cause to be made false statement or representation of a material fact in any application for any benefit or payment;

(2) having knowledge of the occurrence of any event affecting his initial or continued right to any such benefit or payment or the initial

or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceal or fail to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized;

(3) having made application to receive any such benefit or payment for the use and benefit of himself or another and having received it, knowingly or intentionally converts such benefit or any part thereof to a use other than for the use and benefit of himself or such other person; or

(4) knowingly or intentionally visit more than three practitioners or providers, who specialize in the same field, in the course of one month for the purpose of obtaining excessive services or benefits beyond what is reasonably needed (as determined by medical professionals engaged by the department) for the treatment of a diagnosed condition of the recipient.

(5) borrow or use a medical assistance identification card for which he is not entitled or otherwise gain or attempt to gain medical services covered under the medical assistance program if he has not been determined eligible for the program.

(b) (1) A person who commits a violation of subsection (a)(1), (2) or (3) is guilty of a felony of the third degree for each violation thereof with a maximum penalty thereof of fifteen thousand dollars ($15,000) and seven years imprisonment.

(2) A person who commits a violation of subsection (a)(4) or (5) is guilty of a misdemeanor of the first degree for each violation thereof with a maximum penalty thereof of ten thousand dollars ($10,000) and five years imprisonment.

(c) (1) Anyone who is convicted of a violation of subsection (a)(1), (2), (3), (4) or (5) shall, upon notification by the department, forfeit any and all rights to medical assistance benefits for any period of incarceration.

(2) If the department determines that a recipient misuses or over-utilizes medical assistance benefits, the department is authorized to restrict a recipient to a provider of his choice for each medical specialty or type of provider covered under the medical assistance program.

(3) If the department determines that a general assistance eligible person who is also a medical assistance recipient has violated the provisions of subsection (a)(3), (4) or (5), the department shall have the authority to terminate such recipient's rights to any and all medical assistance benefits for a period up to one year.

(4) If the department determines that a recipient has violated the provisions of subsection (a)(3), (4) or (5), the department shall have the authority to institute a civil suit against such recipient in the court of common pleas for the amount of the benefits obtained by the

recipient in violation of subsection (a)(3), (4) or (5), plus legal interest from the date the violation or violations occurred.

(5) If it is found that a recipient or a member of his family or household, who would have been ineligible for medical assistance, possessed unreported real or personal property in excess of the amount permitted by law, the amount collectible shall be limited to an amount equal to the market value of such excess property or the amount of medical assistance granted during the period the excess property was held, whichever is less. Reimbursement of the overpayment shall be sought from the recipient, or person acting on the recipient's behalf and/or survivors benefiting from receiving such property. Proof of date of acquisition of such property must be provided by the recipient or person acting on his behalf.

Where a person receiving medical assistance for which he would have been ineligible due to possession of such unreported property and proof of date of acquisition of such property is not provided, it shall be deemed that such personal property was held by the recipient the entire time he was on medical assistance and reimbursement shall be for all medical assistance paid for the recipient or the value of such excess property, whichever is less. Reimbursement shall be sought from the recipient, the person acting on the recipient's behalf, the person receiving or holding such property, the recipient's estate and/or survivors benefiting from receiving such property.

The department is authorized to institute a civil suit in the court of common pleas to enforce any of the rights established by this section.

Section 1409. Third Party Liability.—(a) (1) No person having private health care coverage shall be entitled to receive the same health care furnished or paid for by a publicly funded health care program. For the purposes of this section, "publicly funded health care program" shall mean care for services rendered by a State or local government or any facility thereof, health care services for which payment is made under the medical assistance program established by the department or by its fiscal intermediary, or by an insurer or organization with which the department has contracted to furnish such services or to pay providers who furnish such services. For the purposes of this section, "privately funded health care" means medical care coverage contained in accident and health insurance policies or subscriber contracts issued by health plan corporations and nonprofit health service plans, certificates issued by fraternal benefit societies, and also any medical care benefits provided by self insurance plan including self insurance trust, as outlined in Pennsylvania insurance laws and related statutes.

(2) If such a person receives health care furnished or paid for by a publicly funded health care program, the insurer of his private health care coverage shall reimburse the publicly funded health care program, the cost incurred in rendering such care to the extent of the benefits provided under the terms of the policy for the services rendered.

(3) Each publicly funded health care program that furnishes or pays for health care services to a recipient having private health care coverage shall be entitled to be subrogated to the rights that such person has against the insurer of such coverage to the extent of the health care services rendered. Such action may be brought within three years from the date that service was rendered such person.

(4) When health care services are provided to a person under this section who at the time the service is provided has any other contractual or legal entitlement to such services, the secretary of the department shall have the right to recover from the person, corporation, or partnership who owes such entitlement, the amount which would have been paid to the person entitled thereto, or to a third party in his behalf, or the value of the service actually provided, if the person entitled thereto was entitled to services. The Attorney General may, to recover under this section, institute and prosecute legal proceedings against the person, corporation, health service plan or fraternal society owing such entitlement in the appropriate court in the name of the secretary of the department.

(5) The Commonwealth of Pennsylvania shall not reimburse any local government or any facility thereof, under medical assistance or under any other health program where the Commonwealth pays part or all of the costs, for care provided to a person covered under any disability insurance, health insurance or prepaid health plan.

(6) In local programs fully or partially funded by the Commonwealth, Commonwealth participation shall be reduced in the amount proportionate to the cost of services provided to a person.

(7) When health care services are provided to a dependent of a legally responsible relative, including but not limited to a spouse or a parent of an unemancipated child, such legally responsible relative shall be liable for the cost of health care services furnished to the individual on whose behalf the duty of support is owed. The department shall have the right to recover from such legally responsible relative the charges for such services furnished under the medical assistance program.

(b) (1) When benefits are provided or will be provided to a beneficiary under this section because of an injury for which another person is liable, or for which an insurer is liable in accordance with the provisions of any policy of insurance issued pursuant to Pennsylvania insurance laws and related statutes the department shall have the right to recover from such person or insurer the reasonable value of benefits so provided. The Attorney General or his designee may, at the request of the department, to enforce such right, institute and prosecute legal proceedings against the third person or insurer who may be liable for the injury in an appropriate court, either in the name of the department or in the name of the injured person, his guardian, personal representative, estate or survivors.

(2) The department may:

(i) compromise, or settle and release any such claims; or

(ii) waive any such claim, in whole or in part, or if the department determines that collection would result in undue hardship upon the person who suffered the injury, or in a wrongful death action upon the heirs of the deceased.

(3) No action taken in behalf of the department pursuant to this section or any judgment rendered in such action shall be a bar to any action upon the claim or cause of action of the beneficiary, his guardian, personal representative, estate, dependents or survivors against the third person who may be liable for the injury, or shall operate to deny to the beneficiary the recovery for that portion of any damages not covered hereunder.

(4) Where an action is brought by the department pursuant to this section, it shall be commenced within five years of the date the cause of action arises:

(i) The death of the beneficiary does not abate any right of action established by this section.

(ii) When an action or claim is brought by persons entitled to bring such actions or assert such claims against a third party who may be liable for causing the death of a beneficiary, any settlement, judgment or award obtained is subject to the department's claims for reimbursement of the benefits provided to the beneficiary under the medical assistance program.

(iii) Where the action or claim is brought by the beneficiary alone and the beneficiary incurs a personal liability to pay attorney's fees and costs of litigation, the department's claim for reimbursement of the benefits provided to the beneficiary shall be limited to the amount of the medical expenditures for the services to the beneficiary.

(5) If either the beneficiary or the department brings an action or claim against such third party or insurer, the beneficiary or the department shall within thirty days of filing the action give to the other written notice by personal service, or certified or registered mail of the action or claim. Proof of such notice shall be filed in such action or claim. If an action or claim is brought by either the department or beneficiary, the other may, at any time before trial on the facts, become a party to, or shall consolidate his action or claim with the other if brought independently.

(6) If an action or claim is brought by the department pursuant to subsection (a), written notice to the beneficiary, guardian, personal representative, estate or survivor given pursuant to this section shall advise him of his right to intervene in the proceeding, his right to recover the reasonable value of the benefits provided.

(7) In the event of judgment or award in a suit or claim against such third party or insurer:

(i) If the action or claim is prosecuted by the beneficiary alone, the court or agency shall first order paid from any judgment or award the

reasonable litigation expenses, as determined by the court, incurred in preparation and prosecution of such action or claim, together with reasonable attorney's fees, when an attorney has been retained. After payment of such expenses and attorney's fees the court or agency shall, on the application of the department, allow as a first lien against the amount of such judgment or award, the amount of the department's expenditures for the benefit of the beneficiary under the medical assistance program, as provided in subsection (d).

(ii) If the action or claim is prosecuted both by the beneficiary and the department, the court or agency shall first order paid from any judgment or award, the reasonable litigation expenses incurred in preparation and prosecution of such action or claim, together with reasonable attorney's fees based solely on the services rendered for the benefit of the beneficiary. After payment of such expenses and attorney's fees, the court or agency shall apply out of the balance of such judgment or award an amount of benefits paid on behalf of the beneficiary under the medical assistance program.

(8) The court or agency shall, upon further application at any time before the judgment or award is satisfied, allow as a further lien the amount of any expenditures of the department in payment of additional benefits arising out of the same cause of action or claim provided on behalf of the beneficiary under the medical assistance program, where such benefits were provided or became payable subsequent to the original order.

(9) No judgment, award, or settlement in any action or claim by a beneficiary to recover damages for injuries, where the department has an interest, shall be satisfied without first giving the department notice and an opportunity to perfect and satisfy his lien.

(10) When the department has perfected a lien upon a judgment or award in favor of a beneficiary against any third party for an injury for which the beneficiary has received benefits under the medical assistance program, the department shall be entitled to a writ of execution as lien claimant to enforce payment of said lien against such third party with interest and other accruing costs as in the case of other executions. In the event the amount of such judgment or award so recovered has been paid to the beneficiary, the department shall be entitled to a writ of execution against such beneficiary to the extent of the department's lien, with interest and other accruing costs as in the cost of other executions.

(11) Except as otherwise provided in this act, notwithstanding any other provision of law, the entire amount of any settlement of the injured beneficiary's action or claim, with or without suit, is subject to the department's claim for reimbursement of the benefits provided any lien filed pursuant thereto, but in no event shall the department's claim exceed one-half of the beneficiary's recovery after deducting for attorney's fees, litigation costs, and medical expenses relating to the injury paid for by the beneficiary.

(12) In the event that the beneficiary, his guardian, personal representative, estate or survivors or any of them brings an action against the third person who may be liable for the injury, notice of institution of legal proceedings, notice of settlement and all other notices required by this act shall be given to the secretary (or his designee) in Harrisburg except in cases where the secretary specifies that notice shall be given to the Attorney General. All such notices shall be given by the attorney retained to assert the beneficiary's claim, or by the injured party beneficiary, his guardian, personal representative, estate or survivors, if no attorney is retained.

(13) The following special definitions apply to subsection (b):

"Beneficiary" means any person who has received benefits or will be provided benefits under this act because of an injury for which another person may be liable. It includes such beneficiary's guardian, conservator, or other personal representative, his estate or survivors.

"Insurer" includes any insurer as defined in the act of May 17, 1921 (P.L.789, No.285), known as "The Insurance Department Act of one thousand nine hundred and twenty-one," including any insurer authorized under the Laws of this Commonwealth to insure persons against liability or injuries caused to another, and also any insurer providing benefits under a policy of bodily injury liability insurance covering liability arising out of ownership, maintenance or use of a motor vehicle which provides uninsured motorist endorsement of coverage pursuant to the act of July 19, 1974 (P.L.489, No.176), known as the "Pennsylvania No-fault Motor Vehicle Insurance Act."

Section 1410. Rules and Regulations.—The department shall have the power and its duty shall be to adopt rules and regulations to carry out the provisions of this article. Prior to the adoption of any rule or regulation pursuant to this amendatory act, the secretary shall send a copy to the members of the House Health and Welfare Committee and Senate Public Health and Welfare Committee. Each of those committees shall review the proposal and shall have thirty calendar days or five legislative days, whichever is the longer period, to reject their implementation or the secretary may thereafter implement the proposal.

Section 1411. Venue and Limitations on Actions.—Any civil actions or criminal prosecutions brought pursuant to this act for violations hereof shall be commenced within five years of the date the violation or violations occur. In addition, any such actions or prosecutions may be brought in any county where the offender has an office or place of business or where claims and payments are processed by the Commonwealth or where authorized by the Rules of the Pennsylvania Supreme Court.

Section 4. Section 4, act of April 27, 1927 (P.L.465, No.299), referred to as the Fire and Panic Act, is repealed insofar as it relates to personal care boarding homes.

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

APPROVED—The 10th day of July, A. D. 1980.

DICK THORNBURGH