No. 2008-44

AN ACT

HB 1788

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," in public assistance, further providing for medical assistance payments for institutional care; providing for payments for hospital readmissions and for maximum payment to practitioners for inpatient hospitalization; further providing for pharmaceutical and therapeutics committee; providing for Drug Utilization Review Board; further providing for Medicaid managed care organization assessments; in assessments for intermediate care facilities for mentally retarded persons, further providing for time periods; providing for hospital assessments; in departmental powers and duties as to licensing, providing for personal care home information; in fraud and abuse control, further providing for third-party liability; providing for Federal law recovery of medical assistance reimbursement; and further providing for data matching.

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

Section 1. Section 443.1(7) of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, is amended by adding a subclause to read:

Section 443.1. Medical Assistance Payments for Institutional Care.—The following medical assistance payments shall be made in behalf of eligible persons whose institutional care is prescribed by physicians:

* * *

(7) After June 30, 2007, payments to county and nonpublic nursing facilities enrolled in the medical assistance program as providers of nursing facility services shall be determined in accordance with the methodologies for establishing payment rates for county and nonpublic nursing facilities specified in the department's regulations and the Commonwealth's approved Title XIX State Plan for nursing facility services in effect after June 30, 2007. The following shall apply:

* * *

(iii) Subject to Federal approval of such amendments as may be necessary to the Commonwealth's approved Title XIX State Plan, the department shall do all of the following:

(A) For each fiscal year between July 1, 2008, and June 30, 2011, the department shall apply a revenue adjustment neutrality factor to county and nonpublic nursing facility payment rates. For each such fiscal year, the revenue adjustment neutrality factor shall limit the estimated aggregate increase in the Statewide day-weighted average payment rate so that the aggregate percentage rate of increase for the period that begins on July 1, 2005, and ends on the last day of the fiscal year is limited to the amount

permitted by the funds appropriated by the General Appropriations Act for those fiscal years.

(B) In calculating rates for nonpublic nursing facilities for fiscal year 2008-2009, the department shall continue to include costs incurred by county nursing facilities in the rate-setting database, as specified in the department's regulations in effect on July 1, 2007.

(C) The department shall propose regulations that phase out the use of county nursing facility costs as an input in the process of setting payment rates of nonpublic nursing facilities. The final regulations shall be effective July 1, 2009, and shall phase out the use of these costs in rate-setting over a period of three rate years, beginning fiscal year 2009-2010 and ending on June 30, 2012.

(D) The department shall propose regulations that establish minimum occupancy requirements as a condition for bed-hold payments. The final regulations shall be effective July 1, 2009, and shall phase in these requirements over a period of two rate years, beginning fiscal year 2009-2010.

* * *

Section 2. The act is amended by adding sections to read:

Section 443.9. Payments for Readmission to a Hospital Paid Through Diagnosis-Related Groups.—All of the following shall apply to eligible recipients readmitted to a hospital within fourteen days of the date of discharge:

(1) If the readmission is for the treatment of conditions that could or should have been treated during the previous admission, the department shall make no payment in addition to the hospital's original diagnosis-related group payment. If the combined hospital stay qualifies as an outlier, as set forth under the department's regulations, an outlier payment shall be made.

(2) If the readmission is due to complications of the original diagnosis and the result is a different diagnosis-related group with a higher payment, the department shall pay the higher diagnosis-related group payment rather than the original diagnosis-related group payment.

(3) If the readmission is due to conditions unrelated to the previous admission, the department shall consider the readmission as a new admission for payment purposes.

Section 443.10. Maximum Payment to Practitioners for Inpatient Hospitalization.—The maximum payment made to a practitioner for all services provided to an eligible recipient during any one period of inpatient hospitalization shall be the lowest of the following:

(1) The practitioner's usual charge to the general public for the same service.

(2) The medical assistance maximum allowable fee for the service.

(3) A maximum payment limit, per recipient per the period of inpatient hospitalization, established by the medical assistance program and

published as a notice in the Pennsylvania Bulletin. If the fee for the actual service exceeds the maximum payment limit, the fee for the actual procedure shall be the maximum payment for the period of inpatient hospitalization.

Section 3. Section 460 of the act, added June 30, 2007 (P.L.49, No.16), is amended to read:

Section 460. Pharmaceutical and Therapeutics Committee.—***(a)*** Any Commonwealth pharmacy program that establishes or maintains a preferred drug list **[and receives]** ***for the purpose of receiving*** supplemental rebates **[under]** ***consistent with*** section **[1927]** ***1927(d)(4)*** of the Social Security Act (49 Stat. 620, 42 U.S.C. § **[1396r-8]** ***1396r-8(d)(4)***) shall establish a pharmaceutical and therapeutics committee**[. The pharmaceutical and therapeutics committee shall]** ***that shall*** serve in an advisory capacity ***to the department and*** to the secretary for the purpose of developing and maintaining a preferred drug list **[and developing and maintaining drug utilization review controls for prescription drugs and medical devices]**.

(b) The committee shall publicize **[their]** ***its*** meetings pursuant to 65 Pa.C.S. Ch. 7 (relating to open meetings)**[, and the]**. ***The*** committee's deliberations, recommendations and decisions **[shall be considered official action and]** shall be open to the public ***except as limited by 65 Pa.C.S. §§ 707 (relating to exceptions to open meetings) and 708 (relating to executive sessions).***

Section 4. The act is amended by adding a section to read:

Section 460.1. Drug Utilization Review Board.—(a) The Drug Utilization Review Board shall be established by the department consistent with section 1927(g)(3) of the Social Security Act (42 U.S.C. § 1396r-8(g)(3)). The board shall have the following powers and duties:

(1) To advise the department and the secretary on the drug utilization review controls for prescription drugs as required by section 1927(g)(3) of the Social Security Act, including appropriate utilization protocols for individual medications and for therapeutic categories and prior authorization guidelines.

(2) To serve in an advisory capacity to the secretary for the purpose of developing and maintaining drug utilization review controls for prescription drugs and serve to promote patient safety by an increased review and awareness of outpatient prescribed drugs in the department's medical assistance program.

(b) The board shall publicize its meetings pursuant to 65 Pa.C.S. Ch. 7 (relating to open meetings). The committee's deliberations, recommendations and decisions shall be open to the public, except as limited by 65 Pa.C.S. §§ 707 (relating to exceptions to open meetings) and 708 (relating to executive sessions).

Section 5. Article VIII-B of the act is repealed:

[ARTICLE VIII-B
MEDICAID MANAGED CARE ORGANIZATION ASSESSMENTS

Section 801-B. Definitions.

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

"Assessment percentage." The rate assessed pursuant to this article on every Medicaid managed care organization.

"Assessment period." The time period identified in the contract.

"Assessment proceeds." The State revenue collected from the assessment provided for in this article, any Federal funds received by the Commonwealth as a direct result of the assessment and any penalties and interest received under section 810-B.

"Contract." The agreement between a Medicaid managed care organization and the Department of Public Welfare.

"County Medicaid managed care organization." A county, or an entity organized and controlled directly or indirectly by a county or a city of the first class, that is a party to a Medicaid managed care contract with the Department of Public Welfare.

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

"Medicaid." The program established under Title XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396 et seq.).

"Medicaid managed care organization." A Medicaid managed care organization as defined in section 1903(m)(1)(A) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396b(m)(1)(A)) that is a party to a Medicaid managed care contract with the Department of Public Welfare. The term shall include a county Medicaid managed care organization and a permitted assignee of a Medicaid managed care contract but shall not include an assignor of a Medicaid managed care contract.

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

"Social Security Act." 49 Stat. 620, 42 U.S.C. § 301 et seq.

Section 802-B. Authorization.

The department shall implement an assessment on each Medicaid managed care organization, subject to the conditions and requirements specified in this article.

Section 803-B. Implementation.

The assessment shall be implemented on an annual basis, through periodic submissions not to exceed five times per year by Medicaid managed care organizations, as a health care-related fee as defined in section 1903(w)(3)(B) of the Social Security Act, or any amendments thereto, and may be imposed and is required to be paid only to the extent that the revenues generated from the assessment qualify as the

State share of program expenditures eligible for Federal financial participation.

Section 804-B. Assessment percentage.

(a) Amount.—The assessment percentage shall be uniform for all Medicaid managed care organizations, determined in accordance with this section and implemented by the department as approved by the Governor after notification to and in consultation with the Medicaid managed care organizations. The assessment percentage shall be subject to the maximum aggregate amount that may be assessed pursuant to 42 CFR 433.68(f)(3)(i) (relating to permissible health care-related taxes after the transition period) or any subsequent maximum established by Federal law.

(b) Notice.—Subject to the provisions of subsection (c), the department shall notify each Medicaid managed care organization of a proposed assessment percentage. Medicaid managed care organizations shall have 30 days from the date of the proposed assessment percentage notice to provide written comments to the department regarding the proposed assessment. Upon expiration of the 30-day comment period, the department, after consideration of the comments, shall provide each Medicaid managed care organization with a second notice announcing the assessment percentage. Once effective, an assessment percentage will remain in effect until the department notifies each Medicaid managed care organization of a new assessment percentage in accordance with the notice provisions contained in this section.

(c) Initial assessment.—The initial assessment percentage may be imposed retroactively to the beginning of an assessment period beginning on or after July 1, 2004. Once effective, the initial assessment percentage will remain in effect until the department notifies each Medicaid managed care organization of a new assessment percentage in accordance with the notice provisions contained in this section.

Section 805-B. Calculation and payment.

Using the assessment percentage established under section 804-B, each Medicaid managed care organization shall calculate the assessment amount for each assessment period on a report form specified by the contract and shall submit the completed report form and total amount owed to the department on a due date specified by the contract. The Medicaid managed care organization shall report net operating revenue for purposes of the assessment calculation as specified in the contract.

Section 806-B. Use of assessment proceeds.

No Medicaid managed care organization shall be guaranteed a repayment of its assessment in derogation of 42 CFR 433.68(f), provided, however, in each fiscal year in which an assessment is implemented, the department shall use the assessment proceeds to maintain actuarially sound rates as defined in the contract for the Medicaid managed care organizations to the extent permissible under

Federal and State law or regulation and without creating a guarantee to hold harmless, as those terms are used in 42 CFR 433.68(f) (relating to permissible health care-related taxes after the transition period).

Section 807-B. Records.

Upon written request by the department, a Medicaid managed care organization shall furnish to the department such records as the department may specify in order to determine the amount of assessment due from the Medicaid managed care organization or to verify that the Medicaid managed care organization has calculated and paid the correct amount due. The requested records shall be provided to the department within 30 days from the date of the Medicaid managed care organization's receipt of the written request unless required at an earlier date for purposes of the department's compliance with a request from a Federal or another State agency.

Section 808-B. Payment of assessment.

In the event that the department determines that a Medicaid managed care organization has failed to pay an assessment or that it has underpaid an assessment, the department shall provide written notification to the Medicaid managed care organization within 180 days of the original due date of the amount due, including interest, and the date on which the amount due must be paid, which shall not be less than 30 days from the date of the notice. In the event that the department determines that a Medicaid managed care organization has overpaid an assessment, the department shall notify the Medicaid managed care organization in writing of the overpayment, and, within 30 days of the date of the notice of the overpayment, the Medicaid managed care organization shall advise the department to either authorize a refund of the amount of the overpayment or offset the amount of the overpayment against any amount that may be owed to the department by the Medicaid managed care organization.

Section 809-B. Appeal rights.

A Medicaid managed care organization that is aggrieved by a determination of the department relating to the assessment may file a request for review of the decision of the department by the Bureau of Hearings and Appeals within the department, which shall have exclusive primary jurisdiction in such matters. The procedures and requirements of 67 Pa.C.S. Ch. 11 (relating to medical assistance hearings and appeals) shall apply to requests for review filed pursuant to this section except that, in any such request for review, a Medicaid managed care organization may not challenge the assessment percentage determined by the department pursuant to section 804-B.

Section 810-B. Enforcement.

In addition to any other remedy provided by law, the department may enforce this article by imposing one or more of the following remedies:

(1) When a Medicaid managed care organization fails to pay an assessment or penalty in the amount or on the date required by this article, the department may add interest at the rate provided in section 806 of the act of April 9, 1929 (P.L.343, No.176), known as The Fiscal Code, to the unpaid amount of the assessment or penalty from the date prescribed for its payment until the date it is paid.

(2) When a Medicaid managed care organization fails to submit a report form concerning the calculation of the assessment or to furnish records to the department as required by this article, the department may impose a penalty against the Medicaid managed care organization in the amount of $1,000 per day for each day the report form or required records are not submitted or furnished to the department. If the $1,000 per day penalty is imposed, it shall commence on the first day after the date for which a report form or records are due.

(3) When a Medicaid managed care organization fails to pay all or part of an assessment or penalty within 30 days of the date that payment is due, the department may deduct the unpaid assessment or penalty and any interest owed from any capitation payments due to the Medicaid managed care organization until the full amount is recovered. Any deduction shall be made only after written notice to the Medicaid managed care organization.

(4) Upon written request by a Medicaid managed care organization to the secretary, the secretary may waive all or part of the interest or penalties assessed against a Medicaid managed care organization pursuant to this article for good cause as shown by the Medicaid managed care organization.

Section 811-B. Time periods.

The assessment authorized in this article shall not be imposed or paid prior to July 1, 2004, or in the absence of Federal financial participation as described in section 803-B. The assessment shall cease on June 30, 2008, or earlier if required by law.]

Section 6. Section 811-C of the act, amended November 29, 2004 (P.L.1272, No.154), is amended to read:

Section 811-C. Time periods.

[The assessment authorized in this article shall not be imposed prior to July 1, 2003, for private ICFs/MR and July 1, 2004, for public ICFs/MR and shall cease on June 30, 2009, or earlier if required by law.]

(a) Imposition.—The assessment authorized under this article shall not be imposed as follows:

(1) Prior to July 1, 2003, for private ICFs/MR.

(2) Prior to July 1, 2004, for public ICFs/MR.

(3) In the absence of Federal financial participation as described under section 803-C.

(b) Cessation.—The assessment authorized under this article shall cease June 30, 2013, or earlier, if required by law.

Section 7. The act is amended by adding articles to read:

ARTICLE VIII-E
HOSPITAL ASSESSMENTS

Section 801-E. Definitions.

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

"Assessment." The fee authorized to be implemented under this article on every general acute care hospital within a municipality.

"Bad debt expense." The cost of care for which a hospital expected payment from the patient or a third-party payor, but which the hospital subsequently determines to be uncollectible, as further described in the Medicare Provider Reimbursement Manual published by the United States Department of Health and Human Services.

"Charity care expense." The cost of care for which a hospital ordinarily charges a fee but which is provided free or at a reduced rate to patients who cannot afford to pay but who are not eligible for public programs, and from whom the hospital did not expect payment in accordance with the hospital's charity care policy, as further described in the Medicare Provider Reimbursement Manual published by the United States Department of Health and Human Services.

"Contractual allowance." The difference between what a hospital charges for services and the amounts that certain payers have agreed to pay for the services as further described in the Medicare Provider Reimbursement Manual published by the United States Department of Health and Human Services.

"Exempt hospital." A hospital that the Secretary of Public Welfare has determined meets one of the following:

(1) Is excluded under 42 CFR 412.23(a), (b), (d) and (f) (relating to excluded hospitals: classifications) as of March 20, 2008, from reimbursement of certain Federal funds under the prospective payment system described by 42 CFR Pt. 412 (relating to prospective payment systems for inpatient hospital services).

(2) Is a Federal veterans' affairs hospital.

(3) Is part of an institution with State-related status as that term is defined in 22 Pa.Code § 31.2 (relating to definitions) and provides over 100,000 days of care to medical assistance patients annually.

(4) Provides care, including inpatient hospital services, to all patients free of charge.

"General acute care hospital." A hospital other than an exempt hospital.

"Hospital." A facility licensed as a hospital under 28 Pa. Code Pt. IV Subpt. B (relating to general and special hospitals) and located within a municipality.

"Municipality." A city of the first class.

"Net operating revenue." Gross charges for facilities less any deducted amounts for bad debt expense, charity care expense and contractual allowances.

"Program." The Commonwealth's medical assistance program as authorized under Article IV.

Section 802-E. Authorization.

In order to generate additional revenues for the purpose of assuring that medical assistance recipients have access to hospital services and that all citizens have access to emergency department services, a municipality may, by ordinance, impose a monetary assessment on the net operating revenue reduced by all revenues received from Medicare of each general acute care hospital located in the municipality subject to the conditions and requirements specified under this article. The ordinance may include appropriate administrative provisions including, without limitation, provisions for the collection of interest and penalties. In each year in which the assessment is implemented, the assessment shall be subject to the maximum aggregate amount that may be assessed under 42 CFR 433.68(f)(3)(i) (relating to permissible health care-related taxes) or any other maximum established under Federal law.

Section 803-E. Implementation.

The assessment authorized under this article, once imposed, shall be implemented as a health-care related fee as defined under section 1903(w)(3)(B) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396b(w)(3)(B)) or any amendments thereto and may be collected only to the extent and for the periods that the secretary determines that revenues generated by the assessment will qualify as the State share of program expenditures eligible for Federal financial participation.

Section 804-E. Administration.

(a) Remittance.—Upon collection of the funds generated by the assessment authorized under this article, the municipality shall remit a portion of the funds to the Commonwealth for the purposes set forth under section 802-E, except that the municipality may retain funds in an amount necessary to reimburse it for its reasonable costs in the administration and collection of the assessment as set forth in an agreement to be entered into between the municipality and the Commonwealth acting through the secretary.

(b) Establishment.—There is established a restricted account in the General Fund for the receipt and deposit of funds under subsection (a). Funds in the account are hereby appropriated to the department for purposes of making supplemental or increased medical assistance payments for emergency department services to general acute care

hospitals within the municipality and to maintain or increase other medical assistance payments to hospitals within the municipality, as specified in the Commonwealth's approved Title XIX State Plan.

Section 805-E. No hold harmless.

No general acute care hospital shall be directly guaranteed a repayment of its assessment in derogation of 42 CFR 433.68(f) (relating to permissible health care-related taxes), except that, in each fiscal year in which an assessment is implemented, the department shall use a portion of the funds received under section 804-E(a) for the purposes outlined under section 804-E(b) to the extent permissible under Federal and State law or regulation and without creating an indirect guarantee to hold harmless, as those terms are used under 42 CFR 433.68(f)(i). The secretary shall submit any State Medicaid plan amendments to the United States Department of Health and Human Services that are necessary to make the payments authorized under section 804-E(b).

Section 806-E. Federal waiver.

To the extent necessary in order to implement this article, the department shall seek a waiver under 42 CFR 433.68(e) (relating to permissible health care-related taxes) from the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.

Section 807-E. Tax exemption.

Notwithstanding any exemptions granted by any other Federal, State or local tax or other law, including section 204(a)(3) of the act of May 22, 1933 (P.L.853, No.155), known as The General County Assessment Law, no general acute care hospital in the municipality shall be exempt from the assessment.

Section 808-E. Cessation.

The assessment authorized under this article shall cease June 30, 2013.

ARTICLE VIII-F
MEDICAID MANAGED CARE ORGANIZATION ASSESSMENTS

Section 801-F. Definitions.

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

"Assessment percentage." The rate assessed pursuant to this article on every Medicaid managed care organization.

"Assessment period." The time period identified in the contract.

"Assessment proceeds." The State revenue collected from the assessment provided for in this article, any Federal funds received by the Commonwealth as a direct result of the assessment and any penalties and interest received under section 810-F.

"Contract." The agreement between a Medicaid managed care organization and the Department of Public Welfare.

"County Medicaid managed care organization." A county, or an entity organized and controlled directly or indirectly by a county or a city of the first class, that is a party to a Medicaid managed care contract with the Department of Public Welfare.

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

"Medicaid." The program established under Title XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396 et seq.).

"Medicaid managed care organization." A Medicaid managed care organization as defined in section 1903(m)(1)(A) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396b(m)(1)(A)) that is a party to a Medicaid managed care contract with the Department of Public Welfare. The term shall include a county Medicaid managed care organization and a permitted assignee of a Medicaid managed care contract but shall not include an assignor of a Medicaid managed care contract.

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

"Social Security Act." 49 Stat. 620, 42 U.S.C. § 301 et seq.

Section 802-F. Authorization.

The department shall implement an assessment on each Medicaid managed care organization, subject to the conditions and requirements specified in this article.

Section 803-F. Implementation.

The assessment shall be implemented on an annual basis, through periodic submissions not to exceed five times per year by Medicaid managed care organizations, as a health care-related fee as defined in section 1903(w)(3)(B) of the Social Security Act, or any amendments thereto, and may be imposed and is required to be paid only to the extent that the revenues generated from the assessment qualify as the State share of program expenditures eligible for Federal financial participation.

Section 804-F. Assessment percentage.

(a) Amount.—The assessment percentage shall be uniform for all Medicaid managed care organizations, determined in accordance with this section and implemented by the department as approved by the Governor after notification to and in consultation with the Medicaid managed care organizations. The assessment percentage shall be subject to the maximum aggregate amount that may be assessed pursuant to 42 CFR 433.68(f)(3)(i) (relating to permissible health care-related taxes) or any subsequent maximum established by Federal law.

(b) Notice.—Subject to the provisions of subsection (c), the department shall notify each Medicaid managed care organization of a proposed assessment percentage. Medicaid managed care organizations shall have 30 days from the date of the proposed assessment percentage notice to provide written comments to the department regarding the proposed assessment. Upon expiration of the 30-day comment period, the department, after consideration of the comments, shall provide each

Medicaid managed care organization with a second notice announcing the assessment percentage. Once effective, an assessment percentage will remain in effect until the department notifies each Medicaid managed care organization of a new assessment percentage in accordance with the notice provisions contained in this section.

(c) Initial assessment.—The initial assessment percentage may be imposed retroactively to the beginning of an assessment period beginning on or after July 1, 2004. Once effective, the initial assessment percentage will remain in effect until the department notifies each Medicaid managed care organization of a new assessment percentage in accordance with the notice provisions contained in this section.

Section 805-F. Calculation and payment.

Using the assessment percentage established under section 804-F, each Medicaid managed care organization shall calculate the assessment amount for each assessment period on a report form specified by the contract and shall submit the completed report form and total amount owed to the department on a due date specified by the contract. The Medicaid managed care organization shall report net operating revenue for purposes of the assessment calculation as specified in the contract.

Section 806-F. Use of assessment proceeds.

No Medicaid managed care organization shall be guaranteed a repayment of its assessment in derogation of 42 CFR 433.68(f) (relating to permissable health care-related taxes), provided, however, in each fiscal year in which an assessment is implemented, the department shall use the assessment proceeds to maintain actuarially sound rates as defined in the contract for the Medicaid managed care organizations to the extent permissible under Federal and State law or regulation and without creating a guarantee to hold harmless, as those terms are used in 42 CFR 433.68(f).

Section 807-F. Records.

Upon written request by the department, a Medicaid managed care organization shall furnish to the department such records as the department may specify in order to determine the amount of assessment due from the Medicaid managed care organization or to verify that the Medicaid managed care organization has calculated and paid the correct amount due. The requested records shall be provided to the department within 30 days from the date of the Medicaid managed care organization's receipt of the written request unless required at an earlier date for purposes of the department's compliance with a request from a Federal or another State agency.

Section 808-F. Payment of assessment.

In the event that the department determines that a Medicaid managed care organization has failed to pay an assessment or that it has underpaid an assessment, the department shall provide written notification to the Medicaid managed care organization within 180 days of the original due

date of the amount due, including interest, and the date on which the amount due must be paid, which shall not be less than 30 days from the date of the notice. In the event that the department determines that a Medicaid managed care organization has overpaid an assessment, the department shall notify the Medicaid managed care organization in writing of the overpayment, and, within 30 days of the date of the notice of the overpayment, the Medicaid managed care organization shall advise the department to either authorize a refund of the amount of the overpayment or offset the amount of the overpayment against any amount that may be owed to the department by the Medicaid managed care organization.

Section 809-F. Appeal rights.

A Medicaid managed care organization that is aggrieved by a determination of the department relating to the assessment may file a request for review of the decision of the department by the Bureau of Hearings and Appeals within the department, which shall have exclusive primary jurisdiction in such matters. The procedures and requirements of 67 Pa.C.S. Ch. 11 (relating to medical assistance hearings and appeals) shall apply to requests for review filed pursuant to this section except that, in any such request for review, a Medicaid managed care organization may not challenge the assessment percentage determined by the department pursuant to section 804-F.

Section 810-F. Enforcement.

In addition to any other remedy provided by law, the department may enforce this article by imposing one or more of the following remedies:

(1) When a Medicaid managed care organization fails to pay an assessment or penalty in the amount or on the date required by this article, the department may add interest at the rate provided in section 806 of the act of April 9, 1929 (P.L.343, No.176), known as The Fiscal Code, to the unpaid amount of the assessment or penalty from the date prescribed for its payment until the date it is paid.

(2) When a Medicaid managed care organization fails to submit a report form concerning the calculation of the assessment or to furnish records to the department as required by this article, the department may impose a penalty against the Medicaid managed care organization in the amount of $1,000 per day for each day the report form or required records are not submitted or furnished to the department. If the $1,000 per day penalty is imposed, it shall commence on the first day after the date for which a report form or records are due.

(3) When a Medicaid managed care organization fails to pay all or part of an assessment or penalty within 30 days of the date that payment is due, the department may deduct the unpaid assessment or penalty and any interest owed from any capitation payments due to the Medicaid managed care organization until the full amount is recovered. Any deduction shall be made only after written notice to the Medicaid managed care organization.

(4) Upon written request by a Medicaid managed care organization to the secretary, the secretary may waive all or part of the interest or penalties assessed against a Medicaid managed care organization pursuant to this article for good cause as shown by the Medicaid managed care organization.

Section 811-F. Time periods.

The assessment authorized in this article shall not be imposed or paid prior to July 1, 2004, or in the absence of Federal financial participation as described in section 803-F. The assessment shall cease on June 30, 2013, or earlier if required by law.

Section 8. The act is amended by adding a section to read:

Section 1088. Personal Care Home Information.—The department shall post information on its Internet website relating to the licensure and inspection of personal care homes. The information shall be updated at least annually. The information shall include the following:

(1) Number of licensed personal care homes.

(2) Number of residents in licensed personal care homes.

(3) Number of personal care homes which have received an annual inspection.

(4) Number of personal care home inspectors, Statewide and by region.

(5) Ratio of department staff responsible for the licensure and inspection of personal care homes divided by the total number of licensed personal care homes.

(6) Number of personal care homes operating with a provisional license, Statewide and by county.

(7) Number of personal care homes operating with a full license, Statewide and by county.

(8) Number of personal care homes which the department has closed or taken legal action to close.

(9) For each personal care home, a licensing inspection summary which lists any violation under this article.

(10) Summary of types of violations which are listed in licensing inspection summaries, in accordance with the classification of violations set forth under this article.

(11) Upon implementation of a financial penalty program, the Internet website shall include information relating to assessed financial penalties against licensed personal care homes as provided for in this article.

(12) A summary of the specific plans of the department to ensure compliance with this article regarding inspection of licensed personal care homes and enforcement of regulations.

(13) Other information the department deems pertinent.

Section 9. Section 1409 of the act, amended or added July 10, 1980 (P.L.493, No.105), June 16, 1994 (P.L.319, No.49) and July 7, 2005 (P.L.177, No.42), is amended to read:

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

(ii) Notwithstanding subclause (i), if a beneficiary has commenced an action to recover damages for an injury for which benefits are provided or will be provided and if the department was not provided with adequate notice under this section or section 1409.1, the department may commence an action under this section within the later of seven years of the date the cause of action arises or two years from the date the department discovers the settlement or judgment. Notice shall be adequate if all of the following notices have been provided to the department, if required:

(A) Notice of suit under clause (5)(i) from either the beneficiary or any third party or insurer.

(B) Notice of any election from the beneficiary under clause (5)(iii).

(C) Notice of settlement under clause (5)(iv) from either the beneficiary or any third party or insurer.

(D) Notice of any allocation proceeding under section 1409.1(b)(3).

(iii) The following shall apply:

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

[(ii)] *(B)* 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)] *(C)* 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.

(D) Where benefits are provided or will be provided for a minor's care, any statute of limitation or repose applicable to an action or claim in which the minor's medical expenses may be sought shall be tolled until the minor reaches the age of majority. The period of minority shall not be deemed a portion of the time period within which the action must be commenced. As used in this clause, the term "minor" shall mean any individual who has not yet attained the age of 18.

(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 *by* 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.]** *Any third party or insurer that has received information indicating that the beneficiary received benefits under the medical assistance program shall give written notice to the department by personal service or by certified or registered mail of the action or claim. Proof of the notices shall be filed in the action or claim.*

(i) If a beneficiary files an action or claim that does not seek recovery of expenses for which benefits under the medical assistance program are provided, the beneficiary shall include in the notice to the department a statement that the action or claim does not seek recovery of the expenses.

(ii) If a parent files an action or claim that does not seek recovery of a minor's medical expenses paid by the medical assistance program, the

parent shall include in the notice to the department a statement that the action or claim does not seek the recovery of the expenses.

(iii) If a beneficiary files an action or claim that seeks the recovery of expenses for which benefits under the medical assistance program are provided and later elects not to seek recovery of the expenses, the beneficiary shall provide reasonable notice to the department by personal service or by certified or registered mail. Notice shall be reasonable if it allows the department sufficient time to petition to intervene in the action and prosecute its claim.

(iv) Notice of any settlement shall be provided to the department by the beneficiary and any third party or insurer within thirty days of the settlement. Where judicial approval of the settlement is required, reasonable notice of the settlement shall be provided to the department before a judicial hearing for approval of the settlement. Notice is reasonable if it allows the department sufficient time to intervene in the action and prosecute its claim.

(v) 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.

(vi) The beneficiary may include as part of his claim the amount of benefits that have been or will be provided by the medical assistance program.

(6) If an action or claim is brought by the department pursuant to subsection **[(a)]** ***(b)(1)***, 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**[,]** ***and*** his right to recover the reasonable value of the benefits provided.

(7) **[In]** ***Except as provided under section 1409.1, in*** the event of judgment, award or settlement 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 expenditures for the benefit of the beneficiary under the medical assistance program.

(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.

(iii) With respect to claims against third parties for the cost of medical assistance services delivered through a managed care organization contract, the department shall recover the actual payment to the hospital or other medical provider for the service. If no specific payment is identified by the managed care organization for the service, the department shall recover its fee schedule amount for the service.

(8) **[Upon]** ***Except as provided under section 1409.1, upon*** application of the department, the court or agency shall allow a lien against any third party payment or trust fund resulting from a judgment, award or settlement in the amount of any expenditures 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, when such benefits were provided or became payable subsequent to the date of the judgment, award or settlement.

(9) Unless otherwise directed by the department, no payment or distribution shall be made to a claimant or a claimant's designee of the proceeds of any action, claim or settlement where the department has an interest without first satisfying or assuring satisfaction of the interest of the Commonwealth. Any person who, after receiving notice of the department's interest, knowingly fails to comply with the obligations established under this clause shall be liable to the department, and the department may sue to recover from the person.

(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]** ***The beneficiary's obligations under this subsection shall be met 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 ***this*** 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."

(c) Following notice and hearing, the department may administratively impose a penalty of up to five thousand dollars ($5,000) per violation upon any person who wilfully fails to comply with the obligations imposed under this section.

Section 10. The act is amended by adding a section to read:

Section 1409.1. Federal Law Recovery of Medical Assistance Reimbursement.—(a) To the extent that Federal law limits the department's recovery of medical assistance reimbursement to the medical portion of a beneficiary's judgment, award or settlement in a claim against a third party, the provisions of this section shall apply.

(b) In the event of judgment, award or settlement in a suit or claim against a third party or insurer:

(1) 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 the action or claim, together with reasonable attorney fees. After payment of the expenses and attorney fees, the court or agency shall allocate the judgment or award between the medical portion and other damages and shall allow the department a first lien against the medical portion of the judgment or award, the amount of the expenditures for the benefit of the beneficiary under the medical assistance program.

(2) 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 the action or claim, together with reasonable attorney fees based solely on the services rendered for the benefit of the beneficiary. After payment of the expenses and attorney fees, the court or agency shall allocate the judgment or award between the medical portion and other damages and shall make an award to the department out of the medical portion of the judgment or award the amount of benefits paid on behalf of the beneficiary under the medical assistance program.

(3) The department shall be given reasonable advance notice before the court makes any allocation of a judgment or award under this section.

(4) The provisions of section 1409(b)(7)(iii) shall apply to this section.

Section 11. Section 1413 of the act, added July 7, 2005 (P.L.177, No.42), is amended to read:

Section 1413. Data Matching.—(a) All entities providing health insurance or health care coverage to individuals residing within this Commonwealth shall provide such information on coverage and benefits, as the department may specify, for any recipient of medical assistance or child support services identified by the department by name and either policy number or Social Security number. ***The information the department may specify in its request may include information needed to determine during what period individuals or their spouses or their dependents may be or may have been covered by the entity and the nature of the coverage that is or was provided by the entity, including the name, address and identifying number of the plan.***

(b) All entities providing health insurance or health care coverage to individuals residing within this Commonwealth shall ***accept the department's right of recovery and the assignment to the department of any right of an individual or any other entity to payment for an item or service for which payment has been made by the medical assistance program and shall*** receive, process and pay claims for reimbursement submitted by the department ***or its authorized contractor*** with respect to medical assistance recipients who have coverage for such claims.

(c) To the maximum extent permitted by Federal law and notwithstanding any policy or plan provision to the contrary, a claim by the department for reimbursement of medical assistance shall be deemed timely filed with the entity providing health insurance or health care coverage ***and shall not be denied solely on the basis of the date of submission of the claim, the type or format of the claim or a failure to present proper documentation at the point of sale that is the basis of the claim,*** if it is filed as follows:

(1) within five years of the date of service for all dates of service occurring on or before June 30, 2007; or

(2) within three years of the date of service for all dates of service occurring on or after July 1, 2007.

(c.1) Any action by the department to enforce its rights with respect to a claim submitted by the department under this section must be commenced within six years of the department's submission of the claim. All entities providing health care coverage within this Commonwealth shall respond within forty-five days to any inquiry by the department regarding a claim for payment for any health care item or service that is submitted not later than three years after the date of provision of the health care item or service.

(d) The department is authorized to enter into agreements with entities providing health insurance and health care coverage for the purpose of carrying out the provisions of this section. The agreement shall provide for the electronic exchange of data between the parties at a mutually agreed-upon frequency, but no less ***frequently*** than **[once every two months]** ***monthly***, and may also allow for payment of a fee by the department to the entity providing health insurance or health care coverage.

(e) Following notice and hearing, the department may impose a penalty of up to one thousand dollars ($1,000) per violation upon any entity that wilfully fails to comply with the obligations imposed by this section.

(e.1) It is a condition of doing business in this Commonwealth that every entity subject to this section comply with the provisions of this section and agree not to deny a claim submitted by the department on the basis of a plan or contract provision that is inconsistent with subsection (c).

(f) This section shall apply to every entity providing health insurance or health care coverage within this Commonwealth, including, but not limited to, plans, policies, contracts or certificates issued by:

(1) A stock insurance company incorporated for any of the purposes set forth in section 202(c) of the act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921."

(2) A mutual insurance company incorporated for any of the purposes set forth in section 202(d) of "The Insurance Company Law of 1921."

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

(4) A health maintenance organization as defined in the act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act."

(5) A fraternal benefit society as defined in section 2403 of "The Insurance Company Law of 1921."

(6) A person who sells or issues contracts or certificates of insurance which meet the requirements of this act.

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

(8) Health care plans subject to the Employee Retirement Income Security Act of 1974 (Public Law 93-406, 88 Stat. 829), ***self-insured plans, service benefit plans, managed care organizations, pharmacy benefit managers and every other organization that is, by statute, contract or***

agreement, legally responsible for the payment of a claim for a health care service or item to the maximum extent permitted by Federal law.

Section 12. (1) The addition of Article VIII-F of the act shall apply retroactively to July 1, 2008.

(2) The amendment or addition of sections 1409 and 1409.1 of the act shall apply to actions filed on or after the effective date of this section.

Section 13. This act shall take effect as follows:

(1) The following provisions shall take effect immediately:

(i) The amendment or addition of sections 443.1(7), 460, 811-C, and Article VIII-E of the act.

(ii) This section.

(iii) Section 12 of this act.

(2) The addition of section 1088 of the act shall take effect December 31, 2008.

(3) The remainder of this act shall take effect in 60 days.

APPROVED—The 4th day of July, A.D. 2008.

EDWARD G. RENDELL