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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1168 Session of 2005

Report of the Committee of Conference

To the Members of the House of Representatives and Senate:

We, the undersigned, Committee of Conference on the part of the House of Representatives and Senate for the purpose of considering House Bill No. 1168, entitled:
"An act 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,' further providing for special provider participation requirements,"

respectfully submit the following bill as our report:

SAMUEL H. SMITH

MICHAEL R. VEON

DAVID G. ARGALL

(Committee on the part of the House of Representatives.)

DAVID J. BRIGHTBILL

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(Committee on the part of the Senate.)

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AN ACT

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," providing for use of medical expenses to establish medical assistance eligibility, for lifetime limit on unpaid medical expenses, for penalty period for asset transfer, for treatment of life estates and annuities, for community spouse income, for eligibility for home and community-based services, for verification of eligibility and for eligibility redetermination of persons for medical assistance; further providing for medical assistance payments for institutional care, for other medical assistance payments, for reimbursement for certain items and services and for relatives' responsibility; providing for medical assistance benefit packages, for coverage, copayments, premiums and rates, for definitions of limited applicability, for rebates, for pharmacy management systems, for enrollment limitation and for established drug regimens; further providing for other computations affecting counties, for special provider participation requirements and for third-party liability; and providing for data matching, for special needs trusts, for a health insurance premium payment program and for parity in insurance coverage for State-owned psychiatric hospitals.

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 sections to read:

Section 441.3. Use of Medical Expenses to Establish Eligibility for Medical Assistance.--Notwithstanding any other provision of law to the contrary, in determining eligibility for retroactive and prospective medical assistance, only medical expenses incurred on or after the first day of the third month before the month of application may be deducted from countable income, provided that the expenses were not previously deducted in determining eligibility for medical assistance and are not subject to payment by another party, including medical assistance.

Section 441.4. Lifetime Limit on Allowable Income Deductions for Medical Expenses When Determining Payment Toward the Cost of

Long-Term Care Services.--(a) Necessary medical or remedial care expenses recognized under Federal or State law but not paid for by the medical assistance program are allowable income deductions when determining a recipient's payment toward the cost of long-term care services. An allowable income deduction for unpaid medical expenses incurred prior to the authorization of medical assistance eligibility and those medical expenses incurred for long-term care services after medical assistance is authorized shall be subject to a lifetime maximum of ten thousand dollars ($10,000), unless application of the limit would result in undue hardship.

(b) As used in this section, the term "undue hardship" shall mean that either:

(1) denial of medical assistance would deprive the individual of medical care and endanger the individual's health or life; or

(2) the individual or a financially dependent family member would be deprived of food, shelter or the necessities of life.

Section 441.5. Penalty Period for Asset Transfer.--(a) Pursuant to section 1917(c) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396p(c)), the department shall impose a penalty of ineligibility for all ineligible days, whether for full months or for a partial month's period of ineligibility, or both, when an applicant, recipient or spouse of an applicant or a recipient of the services set forth in subsection (b) transfers assets for less than fair market value within or after the look-back period as defined in section 1917(c) of the Social Security Act. Transfers totaling five hundred dollars ($500) or less in a calendar month shall not be subject to the penalty.

(b) The ineligibility period set forth in subsection (a)

shall apply to all of the following:

(1) Nursing facility services.

(2) Services equivalent to those provided in a nursing facility.

(3) Home and community-based services furnished under a waiver granted under section 1915(c) or (d) of the Social Security Act (42 U.S.C. § 1396n(c) or (d)).

Section 441.6. Treatment of Life Estates, Annuities and Other Contracts in Determining Medical Assistance Eligibility.--(a) As a condition of eligibility for medical assistance, every applicant or recipient who owns a life estate in property with retained rights to revoke, amend or redesignate the remainderman must exercise those rights as directed by the department. The acceptance of medical assistance shall be an assignment by operation of law to the department of any right to revoke, amend or redesignate the remainderman of a life estate in property.

(b) Any provision in any annuity or other contract for the payment of money owned by an applicant or recipient of medical assistance, or owned by a spouse or other legally responsible relative of such applicant or recipient, that has the effect of limiting the right of such owner to sell, transfer, or assign the right to receive payments thereunder, or restricts the right to change the designated beneficiary thereunder, is void.

(c) In determining eligibility for medical assistance, there shall be a rebuttable presumption that any annuity or contract to receive money is marketable without undue hardship.

(d) Upon approval by the Federal Government of any required state plan amendment implementing this subsection and notwithstanding subsections (b) and (c), a commercial annuity or contract purchased by or for an individual using that

individual's assets will not be considered an available resource if the annuity meets all of the following conditions:

(1) Is an irrevocable guaranteed annuity.

(2) Guarantees to pay out principal and interest in equal monthly installments with no balloon payment to the individual so that payments are paid out over the actuarial life expectancy of the annuitant, as set forth in life expectancy tables approved by the department.

(3) Names the department as the residual beneficiary of any funds remaining due under the annuity at time of death of the annuitant, not to exceed the amount of medical assistance expended on the individual during his or her lifetime.

(4) Is issued by an insurance company licensed and approved to do business in this Commonwealth.

(e) This section applies to all annuity, life insurance and other contracts entered into on or after the effective date of this section and to life estates owned by any individual who applies or reapplies for medical assistance on or after the effective date of this section.

Section 441.7. Income for the Community Spouse.--(a) When a community spouse has income below the monthly maintenance needs allowance as determined under the department's regulations and Title XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396 et seq.), the institutionalized spouse may transfer additional resources to the community spouse only in accordance with this section.

(b) The institutionalized spouse may transfer income to the community spouse in an amount equal to the difference between:

(1) The community spouse's monthly maintenance needs allowance; and

(2) The community spouse's income from all sources.

(c) Resources of the institutionalized spouse may be used to purchase an annuity in accordance with this subsection. The following shall apply:

(1) The annuity purchased may provide the community spouse with monthly income equal to the difference between:

(i) the community spouse's monthly maintenance needs allowance; and

(ii) the community spouse's income from all sources if the community spouse survives the institutionalized spouse.

(2) The annuity purchased to provide income for the community spouse must meet all of the following conditions:

(i) Be actuarially sound.

(ii) Be guaranteed.

(iii) Pay in equal monthly payments so that payments are paid out over the actuarial life expectancy of the annuitant, as set forth in life expectancy tables approved by the department.

(iv) Name the department as the contingent beneficiary in the event that the community spouse predeceases the expiration of the guaranteed period of the annuity, not to exceed the amount of all medical assistance expended on behalf of the institutionalized spouse.

(3) If an annuity is purchased and the community spouse's income from all sources including the annuity is less than the monthly maintenance needs allowance, the institutionalized spouse may transfer sufficient income to bring the community spouse's income up to the monthly maintenance needs allowance.

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

"Community spouse" means the spouse of an institutionalized

spouse.

"Institutionalized spouse" means an individual who is:

(1) in a medical institution;

(2) in a nursing facility or receiving services equivalent to those provided in a nursing facility; or

(3) receiving home and community-based services in lieu of nursing facility care pursuant to a waiver granted under section 1915(c) or (d) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396n(c) or (d)).

Section 441.8. Eligibility for Home and Community-based Services.--As a condition of eligibility for home and community-based services, an applicant shall be subject to all medical and financial eligibility requirements for medical assistance including:

(1) Medical eligibility for the payment of nursing facility care or the equivalent level of care in a medical institution.

(2) Financial eligibility requirements under Federal and State law, including the provisions of sections 1917 and 1924 of the Social Security Act (49 Stat. 620, 42 U.S.C. §§1396p and 1396r-5).

(3) All other eligibility requirements for medical assistance under Federal and State law.

Section 441.9. Verification of Eligibility.--(a) Except as set forth in subsection (b), income shall be verified prior to authorization of medical assistance or during a redetermination of a recipient's eligibility unless the verification is pending from a third party and the applicant has cooperated in the verification attempt in accordance with department regulations.

(b) Notwithstanding subsection (a), the department may authorize medical assistance for pregnant women, children, the

elderly or people with disabilities if third-party, automated sources of verification are used to verify income within sixty days of the date of authorization.

(c) Except as prohibited by Federal law, it shall be a condition of eligibility for medical assistance that an applicant or recipient consent to the disclosure of information about the age, residence, citizenship, employment, applications for employment, income and resources of the applicant or recipient which is in the possession of third parties. Consent shall be effective to authorize a third party to release information requested by the department. Except in a case of suspected fraud, the department shall attempt to notify the applicant or recipient prior to contacting a third party for information about the applicant or recipient.

Section 442.3. Eligibility Redetermination of Persons on Medical Assistance.--(a) Unless the medical assistance recipient is a member of the class of persons described in subsection (b), the department shall make an eligibility redetermination every six months.

(b) Persons not subject to an eligibility redetermination every six months are:

(i) Persons receiving long-term care services.

(ii) Persons who are receiving medical assistance in an elderly or disabled category.

(iii) Pregnant women.

(iv) Children under one year of age.

(v) Children living with relatives other than a parent when the adult's income does not affect eligibility.

(vi) Children in foster care or adoption assistance programs.

(vii) Persons receiving Extended Medical Coverage (EMC).

(c) During the fiscal year beginning July 1, 2005, the department shall perform eligibility determinations in accordance with this section for at least 50% of the persons not described in subsection (b). For fiscal years beginning after June 30, 2006, the department shall perform eligibility determinations for at least 95% of the persons not described in subsection (b).

(d) Nothing in this section shall be construed to limit the department in determining the number or frequency of redeterminations of any person on assistance.

Section 2. Section 443.1 of the act, amended July 15, 1976 (P.L.993, No.202), is amended 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:

(1) [The reasonable cost of inpatient hospital care, as specified by regulations of the department adopted under Title XIX of the Federal Social Security Act and certified to the department by the Auditor General for a bed patient on a continuous twenty-four hour a day basis in a multi bed accommodation of a hospital, exclusive of a hospital or distinct part of a hospital wherein twenty-five percent of patients remain six months or more.] Payments as determined by the department for inpatient hospital care consistent with Title XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396 et seq.). To be eligible for such payments a hospital must be qualified to participate under Title XIX of the [Federal] Social Security Act and have entered into a written agreement with the

department regarding matters designated by the secretary as necessary to efficient administration, such as hospital utilization, maintenance of proper cost accounting records and access to patients' records. Such efficient administration shall require the department to permit participating hospitals to utilize the same fiscal intermediary for this Title XIX program as such hospitals use for the Title XVIII program;

(2) The cost of skilled nursing and intermediate nursing care in State-owned geriatric centers, institutions for the mentally retarded, institutions for the mentally ill, and the cost of skilled and intermediate nursing care provided prior to June 30, 2004, in county homes which meet the State and Federal requirements for participation under Title XIX of the [Federal] Social Security Act and which are approved by the department. This cost in county homes shall be as specified by the regulations of the department adopted under Title XIX of the [Federal] Social Security Act and certified to the department by the Auditor General; elsewhere the cost shall be determined by the department;

(3) Rates on a cost-related basis established by the department for skilled nursing home or intermediate care in a non-public nursing home, when furnished by a nursing home licensed or approved by the department and qualified to participate under Title XIX of the [Federal] Social Security Act and provided prior to June 30, 2004;

(4) [The cost of care in any mental hospital or in a public tuberculosis hospital.] Payments as determined by the department for inpatient psychiatric care consistent with Title XIX of the Social Security Act. To be eligible for such payments a hospital must be qualified to participate under Title XIX of the

[Federal] Social Security Act and have entered into a written agreement with the department regarding matters designated by the secretary as necessary to efficient administration, such as hospital utilization, maintenance of proper cost accounting records and access to patients' records. Care in a private mental hospital provided under the fee for service delivery system shall be limited to [sixty days in a benefit period.] thirty days in any fiscal year for recipients aged twenty-one years or older who are eligible for medical assistance under Title XIX of the Social Security Act and for recipients aged twenty-one years or older who are eligible for general assistance-related medical assistance. Exceptions to the thirty-day limit may be granted under section 443.3. Only persons aged twenty-one years or under and aged sixty-five years or older shall be eligible for care in a public mental [or tuberculosis] hospital. This cost shall be [the reasonable cost, as determined by the department for a State institution or] as specified by regulations of the department adopted under Title XIX of the [Federal] Social Security Act and certified to the department by the Auditor General for county and non-public institutions[.];

(5) On or after July 1, 2004, and until such time as regulations are adopted pursuant to subclause (iii), payments to county and non-public nursing facilities certified to participate as providers under Title XIX of the Social Security Act for nursing facility services shall be calculated and made as specified in the department's regulations in effect on July 1, 2003, except as may be otherwise required by:

(i) the Commonwealth's approved Title XIX Plan for nursing facility services;

(ii) regulations promulgated by the department pursuant to

section 454; and

(iii) regulations promulgated by the department pursuant to section 204(1)(iv) of the act of July 31, 1968 (P.L.769, No.240), referred to as the Commonwealth Documents Law, specifying the methods and standards which the department will use to set rates and make payments for nursing facility services effective July 1, 2006. Notwithstanding any other provision of law, including section 814-A, the promulgation of regulations under this subsection shall, until June 30, 2006, be exempt from the following:

(A) Section 205 of the Commonwealth Documents Law.

(B) Section 204(b) of the act of October 15, 1980 (P.L.950, No.164), known as the "Commonwealth Attorneys Act."

(C) The act of June 25, 1982 (P.L.633, No.181), known as the "Regulatory Review Act."

(6) For public nursing home care provided on or after July 1, 2005, the department shall recognize the costs incurred by county nursing facilities to provide services to eligible persons as medical assistance program expenditures to the extent the costs qualify for Federal matching funds and so long as the costs are allowable as determined by the department and reported and certified by the county nursing facilities in a form and manner specified by the department. Notwithstanding this paragraph, county nursing facilities shall be paid based upon rates determined in accordance with paragraph (5).

Section 3. Section 443.3 of the act, amended November 28, 1973 (P.L.364, No.128), is amended to read:

Section 443.3. Other Medical Assistance Payments.--(a) Payments on behalf of eligible persons shall be made for other services, as follows:

(1) Rates established by the department for outpatient services as specified by regulations of the department adopted under Title XIX of the [Federal] Social Security Act (49 Stat. 620, 42 U.S.C. § 1396 et seq.) consisting of preventive, diagnostic, therapeutic, rehabilitative or palliative services; furnished by or under the direction of a physician, chiropractor or podiatrist, by a hospital or outpatient clinic which qualifies to participate under Title XIX of the [Federal] Social Security Act, to a patient to whom such hospital or outpatient clinic does not furnish room, board and professional services on a continuous, twenty-four hour a day basis.

(2) Rates established by the department for (i) other laboratory and X-ray services prescribed by a physician, chiropractor or podiatrist and furnished by a facility other than a hospital which is qualified to participate under Title XIX of the [Federal] Social Security Act, (ii) physician's services consisting of professional care by a physician, chiropractor or podiatrist in his office, the patient's home, a hospital, a nursing [home] facility or elsewhere, (iii) the first three pints of whole blood, (iv) remedial eye care, as provided in Article VIII consisting of medical or surgical care and aids and services and other vision care provided by a physician skilled in diseases of the eye or by an optometrist which are not otherwise available under this Article, (v) special medical services for school children, as provided in the Public School Code of 1949, consisting of medical, dental, vision care provided by a physician skilled in diseases of the eye or by an optometrist or surgical care and aids and services which are not otherwise available under this article.

(3) Notwithstanding any other provision of law, for

recipients aged twenty-one years or older receiving services under the fee for service delivery system who are eligible for medical assistance under Title XIX of the Social Security Act and for recipients aged twenty-one years or older receiving services under the fee for service delivery system who are eligible for general assistance-related categories of medical assistance, the following medically necessary services:

(i) Psychiatric outpatient clinic services not to exceed five hours or ten one-half-hour sessions per thirty consecutive day period.

(ii) Psychiatric partial hospitalization not to exceed five hundred forty hours per fiscal year.

(b) The department may grant exceptions to the limits specified in this section, section 443.1(4) or in the department's regulations when any of the following circumstances applies:

(1) The department determines that the recipient has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of or result in the rapid, serious deterioration of the health of the recipient.

(2) The department determines that granting a specific exception to a limit is a cost-effective alternative for the medical assistance program.

(3) The department determines that granting an exception to a limit is necessary in order to comply with Federal law.

(c) The Secretary of Public Welfare shall promulgate regulations pursuant to section 204(1)(iv) of the act of July 31, 1968 (P.L.769, No.240), referred to as the Commonwealth Documents Law, to implement this section. Notwithstanding any

other provision of law, the promulgation of regulations under this subsection shall, until December 31, 2005, be exempt from all of the following:

(1) Section 205 of the Commonwealth Documents Law.

(2) Section 204(b) of the act of October 15, 1980 (P.L.950, No.164), known as the "Commonwealth Attorneys Act."

(3) The act of June 25, 1982 (P.L.633, No.181), known as the "Regulatory Review Act."

Section 4. Section 443.6(b) of the act, amended June 16, 1994 (P.L.319, No.49), is amended to read:

Section 443.6. Reimbursement for Certain Medical Assistance Items and Services.--* * *

(b) Payment for the following medical assistance items and services shall be made only after prior authorization has been secured:

(1) Prostheses and orthoses.

(2) Purchase of appliances or equipment if the appliance or equipment costs more than [one hundred dollars ($100).] six hundred dollars ($600): Provided, however, That the department may require prior authorization for the purchase of specific appliances or equipment that cost less than six hundred dollars ($600).

(3) Rental of medical appliances or equipment for a period in excess of [three months.] six months: Provided, however, That the department may require prior authorization for the rental of medical appliances or equipment for a period of less than six months.

(4) Oxygen and related equipment in the home unless a physician states that the physical surroundings in the home are suitable for the use of oxygen and that the recipient is

adequately prepared and able to use the equipment.

(5) Dental services as the department may provide, including but not necessarily limited to, dental prostheses and appliances. [, extractions related to dental prostheses and appliances, and other extractions as may be provided by department regulations.]

(6) Orthopedic shoes or other supportive devices for the feet when such shoes or devices are prescribed by a physician for the purpose of correcting or otherwise treating abnormalities of the feet or legs which cause serious detrimental medical effects.

(7) Other items or services as the department may authorize by publication of notice in the Pennsylvania Bulletin.

* * *

Section 5. Section 447 of the act is amended by adding a subsection to read:

Section 447. Relatives' Responsibility; Repayment.--* * *

(c) The custodial parents of a dependent child under eighteen years of age who is disabled as defined by section 1611 of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1382) and who is not receiving benefits pursuant to Title XVI of the Social Security Act (42 U.S.C. § 1381 et seq.) shall be required to verify their income as a condition of eligibility of the child.

Section 6. The act is amended by adding sections to read:

Section 454. Medical Assistance Benefit Packages; Coverage, Copayments, Premiums and Rates.--(a) Notwithstanding any other provision of law to the contrary, the department shall promulgate regulations as provided in subsection (b) to establish provider payment rates; the benefit packages and any

copayments for adults eligible for medical assistance under Title XIX of the Social Security Act (49 Stat 620, 42 U.S.C. § 1396 et seq.) and adults eligible for medical assistance in general assistance-related categories; and the premium requirements for disabled children whose family income is above two hundred percent of the Federal poverty income limit. The regulations shall authorize and describe the available benefit packages and any copayments and premiums. The regulations shall also specify the effective date for provider payment rates.

(b) For purposes of implementing this section, and notwithstanding any other provision of law, including section 814-A of this act, the secretary shall promulgate regulations pursuant to section 204(1)(iv) of the act of July 31, 1968 (P.L.769, No.240), referred to as the Commonwealth Documents Law, which shall, until December 31, 2005, be exempt from all of the following acts:

(1) Section 205 of the Commonwealth Documents Law.

(2) Section 204(b) of the act of October 15, 1980 (P.L.950, No.164), known as the "Commonwealth Attorneys Act."

(3) The act of June 25, 1982 (P.L.633, No.181), known as the "Regulatory Review Act."

(c) The department is authorized to grant exceptions to any limits specified in the benefit packages adopted under this section or when any of the following circumstances applies:

(1) The department determines the recipient has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of or result in the rapid, serious deterioration of the health of the recipient.

(2) The department determines that granting a specific exception to a limit is a cost-effective alternative for the

medical assistance program.

(3) The department determines that granting an exception to a limit is necessary in order to comply with Federal law.

(d) As used in this section:

"Adult" means recipients twenty-one years of age or older, except when in relation to copayments, for which the term means recipients eighteen years of age or older.

"Benefit packages" means the list of items and services covered by medical assistance, including any limitations on covered items and services.

Section 455. Definitions of Limited Applicability.--The following words and phrases when used in sections 456 and 457 shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Commonwealth pharmacy program" means any of the following: the Medical Assistance Fee for Service Program, the General Assistance Fee for Service Program, PACE, PACENET, the Special Pharmaceutical Benefit Program in the Department of Public Welfare, the End Stage Renal Program in the Department of Health, the Public Employees Benefit Trust Fund, the Children's Health Insurance Program, the Workers' Compensation Program, the Department of Corrections and any other pharmacy program administered by the Commonwealth that is recognized by the Centers for Medicare and Medicaid as a State Pharmaceutical Assistance Program. The term shall not include managed care organizations under contract with the department.

"Least expensive" means the lowest cost to the Commonwealth within each Commonwealth pharmacy program. The net cost shall include the amount paid by the Commonwealth to a pharmacy for a drug under the current retail pharmacy reimbursement formula

less any discounts or rebates, including those invoiced during the previous calendar quarter and inclusive of all dispensing fees.

"Manufacturer" means an entity which is engaged in any of the following:

(1) The production, preparation, propagation, compounding, conversion or processing of prescription drug products directly or indirectly by extraction from substances of natural origin, independently by means of chemical synthesis or by a combination of extraction and chemical synthesis.

(2) The packaging, repackaging, labeling or relabeling or distribution of prescription drug products. The term shall also include the entity holding legal title to or possession of the national drug code number for the covered prescription drug. The term does not include a wholesale distributor of drugs, drugstore chain organization or retail pharmacy licensed by the Commonwealth.

"National drug code number" means the identifying drug number maintained by the Food and Drug Administration. The complete 11-digit number must include the labeler code, product code and package size code.

Section 456. Rebates.--(a) Any Commonwealth pharmacy program that requires a manufacturer to remit a rebate to the program as a condition of participation shall have a clearly defined remittance procedure. The procedure shall include a process for the efficient collection of rebates that are not in dispute and a dispute resolution process.

(b) The development of the remittance procedure shall include consideration of the feasibility of a uniform procedure among Commonwealth pharmacy programs.

(c) A surcharge penalty may be levied by any Commonwealth pharmacy program against any manufacturer for the collection of past due rebates that are not in dispute, unless the surcharge is prohibited by Federal law. The penalty may be levied on any rebate more than one year past due. The surcharge shall be in addition to any interest and penalties authorized under existing law or contractual agreement and shall be equal to fifteen percent of the principal owed for each year that the rebate is past due. The calculation of the surcharge shall be prorated for any portion of the year that the rebate is past due. Notice shall be provided to the manufacturer prior to applying the surcharge to any past due manufacturer's rebates. The manufacturer shall be provided with thirty days from the date of the notice to satisfy any past due claims.

Section 457. Pharmacy Management Systems.--(a) Each Commonwealth pharmacy program shall develop and implement:

(1) an online claims adjudication system; and

(2) a uniform, coordinated and standardized auditing procedure. Nothing shall preclude the implementation of successful systems and auditing procedures utilized in an existing Commonwealth pharmacy program.

(b) Each Commonwealth pharmacy program shall ensure that a therapeutic drug utilization review system is established to monitor and correct misutilization of drug therapies. The system shall provide prospective and retrospective analysis of potentially dangerous drug interactions, duplicative therapies, maximum allowable dosing, therapy duration and drug utilization. Nothing shall preclude the implementation of successful systems utilized in an existing Commonwealth pharmacy program.

(c) Each Commonwealth pharmacy program shall ensure that a

surveillance utilization review system is established to monitor, identify and investigate potential drug misutilization. The system shall monitor potential fraud and abuse by enrollees, providers and prescribers for all appropriate Commonwealth pharmacy programs. Nothing shall preclude the implementation of successful systems utilized in an existing Commonwealth pharmacy program.

(d) Each Commonwealth pharmacy program shall establish a procedure to ensure that, notwithstanding the provisions of the act of November 24, 1976 (P.L.1163, No.259), referred to as the Generic Equivalent Drug Law, a brand name product shall be dispensed and not substituted with an A-rated generic therapeutically equivalent drug if it is the least expensive alternative for the specific Commonwealth pharmacy program.

Section 458. Enrollment Limitation.--Upon enrollment in a managed care plan, an eligible person who retains eligibility shall maintain enrollment in the managed care plan for not less than twelve months unless a waiver is granted by the department.

Section 459. Established Drug Regimens.--When determining prior authorization criteria for a preferred drug class, the department shall consider the potential destabilizing effect on the recipient's health by any change in the recipient's established drug regimen including, but not limited to, prescription drugs for human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), behavioral health, hemophilia, hepatitis C, biologic drugs, immunosuppressants and anticonvulsants.

Section 7. Section 472 of the act, amended July 9, 1976 (P.L.543, No.132), is amended to read:

Section 472. Other Computations Affecting Counties.--To

compute for each month the amount expended as medical assistance for public nursing home care on behalf of persons at each public medical institution operated by a county, county institution district or municipality and the amount expended in each county for aid to families with dependent children on behalf of children in foster family homes or child-caring institutions, plus the cost of administering such assistance. From such total amount the department shall deduct the amount of Federal funds properly received or to be received by the department on account of such expenditures, and shall certify the remainder increased or decreased, as the case may be, by any amount by which the sum certified for any previous month differed from the amount which should have been certified for such previous month, and by the proportionate share of any refunds of such assistance, to each appropriate county, county institution district or municipality. The amounts so certified shall become obligations of such counties, county institution districts or municipalities to be paid to the department for assistance: Provided, however, That [for the fiscal year 1976-77, the obligations of the counties shall be the amounts so certified representing aid to dependent children foster care as computed above and three-fourths of the amount so certified above for public nursing home care: And provided further, That for fiscal year 1977-78 and thereafter, the obligations of counties shall be the amounts so certified representing aid to dependent children foster care as computed above plus one-half of the amount so certified above for public nursing home care: And provided further, That for the fiscal year 1978-79, the obligations of the counties shall be the amounts so certified representing aid to dependent children foster care as computed above plus one-quarter of the amount so

certified above for public nursing home care: And provided further, That] for fiscal year 1979-80 and thereafter, the obligations of the counties shall be the amounts so certified representing aid to dependent children foster care as computed above plus one-tenth of the amount so certified above for public nursing home care[.]: And provided further, That as to public nursing home care, for fiscal year 2005-2006 and thereafter, the obligations of the counties shall be the amount so certified above, less nine-tenths of the non-Federal share of payments made by the department during the fiscal year to county homes for public nursing care at rates established in accordance with section 443.1(5).

Section 7.1. Section 1402(d) of the act, added July 10, 1980 (P.L.493, No.105), is amended and the section is amended by adding a subsection to read:

Section 1402. Special Provider Participation Requirements.--* * *

(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.

(e) Each nursing facility shall be inspected at least twice annually for compliance with this act and regulations of the department.

Section 8. Section 1409(b)(7) and (8) of the act, added July 10, 1980 (P.L.493, No.105), are amended to read:

Section 1409. Third Party Liability.--* * *

(b) * * *

(7) In the event of judgment [or], 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 [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.

(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) [The court or agency shall, upon further application at any time before the judgment or award is satisfied, allow as a further lien] 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 [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] when such benefits were provided or became payable subsequent to the [original order] date of the judgment, award or settlement.

* * *

Section 9. The act is amended by adding sections 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.

(b) All entities providing health insurance or health care coverage to individuals residing within this Commonwealth shall receive, process and pay claims for reimbursement submitted by the department 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 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.

(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 than once every two months, 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 willfully fails to comply with the obligations imposed by this section.

(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) to the maximum extent permitted by Federal law.

Section 1414. Special Needs Trusts.--(a) A special needs trust must be approved by a court of competent jurisdiction if required by rules of court.

(b) A special needs trust shall comply with all of the following:

(1) The beneficiary shall be an individual under the age of sixty-five who is disabled, as that term is defined in Title XVI of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1381 et seq).

(2) The beneficiary shall have special needs that will not be met without the trust.

(3) The trust shall provide:

(i) That all distributions from the trust must be for the sole benefit of the beneficiary.

(ii) That any expenditure from the trust must have a reasonable relationship to the needs of the beneficiary.

(iii) That upon the death of the beneficiary, or upon the earlier termination of the trust, the department and any other state that provided medical assistance to the beneficiary must

be reimbursed from the funds remaining in the trust up to an amount equal to the total medical assistance paid on behalf of the beneficiary before any other claimant is paid: Provided, however, That in the case of an account in a pooled trust, the trust shall provide that no more than fifty percent of the amount remaining in the beneficiary's pooled trust account may be retained by the trust without any obligation to reimburse the department.

(4) The department, upon review of the trust, must determine that the trust conforms to the requirements of Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.), this section, any other State law and any regulations or statements of policy adopted by the department to implement this section.

(c) If at any time it appears that any of the requirements of subsection (b) are not satisfied or the trustee refuses without good cause to make payments from the trust for the special needs of the beneficiary, and provided that the department or any other public agency in this Commonwealth has a claim against trust property, the department or other public agency may petition the court for an order terminating the trust.

(d) Before the funding of a special needs trust, all liens and claims in favor of the department for repayment of cash and medical assistance shall first be satisfied.

(e) At the death of the beneficiary or upon earlier termination of the trust, the trustee shall notify and request a statement of claim from the department, addressed to the secretary.

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

"Pooled trust" means a trust subject to the act of December 9, 2002 (P.L.1379, No.168), known as the "Pooled Trust Act."

"Special needs" means those items, products or services not covered by the medical assistance program, insurance or other third-party liability source for which a beneficiary of a special needs trust or his parents are personally liable, and that can be provided to the beneficiary to increase the beneficiary's quality of life, to assist in, and are related to, the treatment of the beneficiary's disability. The term may include medical expenses, dental expenses, nursing and custodial care, psychiatric/psychological services, recreational therapy, occupational therapy, physical therapy, vocational therapy, durable medical needs, prosthetic devices, special rehabilitative services or equipment, disability-related training, education, transportation and travel expenses, dietary needs and supplements, related insurance and other goods and services specified by the department.

"Special needs trust" means a trust or an account in a pooled trust that is established in compliance with this section for a beneficiary who is an individual who is disabled, as such term is defined in Title XVI of the Social Security Act (42 U.S.C. § 1382c(a)(3)), as amended, consists of assets of the individual, and is established for the purpose or with the effect of establishing or maintaining the beneficiary's resource eligibility for medical assistance.

Section 1415. Health Insurance Premium Payment Program.--(a) The department is authorized to purchase employe group health care coverage on behalf of any medical assistance recipient whenever it is cost effective to do so.

(b) Upon request of the department, every insurer shall

provide the department with benefit information needed to determine the eligibility of a medical assistance recipient for employe group health care coverage.

(c) Every insurer shall honor a request for enrollment and purchase of employe group health insurance submitted by the department with respect to a medical assistance recipient with consideration for enrollment season restrictions, but no enrollment restrictions shall delay enrollment more than ninety days from the date of the department's request. Once enrolled, the insurer shall honor a request for disenrollment submitted by the department, without imposing personal liability upon the medical assistance recipient, whenever it is no longer cost effective for the department to pay the premiums or when the recipient is no longer eligible for medical assistance.

(d) The department may administratively impose a civil penalty of up to one thousand dollars ($1,000) per violation against any insurer who fails to comply with the requirements of this section.

(e) This section shall apply to all such policies, contracts, certificates or programs issued, renewed, modified, altered, amended or reissued on or after the effective date of this section.

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

(1) The term "insurer" includes:

(i) 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."

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

Law of 1921."

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

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

(v) A fraternal benefit society as defined in 40 Pa.C.S. Ch. 63.

(vi) A health maintenance organization as defined in the "Health Maintenance Organization Act."

(vii) Any other person who sells or issues contracts or certificates of insurance.

(viii) A person, including an employer or third party administrator, providing or administering employee group health care coverage, to the maximum extent permitted by Federal law.

(2) The phrase "employe group health care coverage" means health care coverage that the department is authorized to purchase for medical assistance recipients in section 1906 of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396e).

Section 1416. Parity in Insurance Coverage for State-Owned Psychiatric Hospitals.--(a) No insurer providing inpatient psychiatric care coverage to individuals covered by that insurer's plan shall deny payment to a State-owned psychiatric hospital for medically necessary services provided to that individual solely on the basis that the hospital is a government-owned facility; has no signed provider agreement with the insurer; or does not participate in the insurer's network.

(b) The provision of psychiatric services at a State-owned psychiatric hospital shall be an assignment by operation of law to the hospital of the individual's right to recover for such

services from that individual's insurer. The department may sue for and recover any amounts due from that individual's insurer.

(c) In determining the medical necessity of any inpatient psychiatric stay at a State-owned psychiatric hospital, it shall be rebuttably presumed that the patient could not be treated in an alternative setting if either of the following applies:

(1) The stay was required by court order.

(2) The patient was transferred to the State-owned psychiatric hospital from an acute psychiatric care facility, or from an acute psychiatric care unit of a general hospital, because the patient was determined medically inappropriate for discharge.

(d) State-owned psychiatric hospitals may enter into provider agreements with insurers and may accept payments under such provider agreements as payment in full, excluding the patient's liability for unpaid deductible and coinsurance amounts. In the absence of a provider agreement, the insurer shall make payment for a hospital stay at its usual rate of payment to contracted psychiatric hospital providers, or in the absence of such a rate, the rate that the medical assistance program would pay for such care.

(e) The department may administratively impose a penalty of up to one thousand dollars ($1,000) per violation against any insurer that fails to comply with the requirements of this section.

(f) For the purposes of this section, the term "insurer" includes:

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

(5) A fraternal benefit society as defined in 40 Pa.C.S. Ch. 63.

(6) 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."

(7) Any other person who sells or issues contracts or certificates of insurance.

(8) Any person, including an employer or third-party administrator, providing or administering employe group health care coverage, to the maximum extent permitted by Federal law.

Section 10. This act shall take effect immediately.