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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1 Session of 2009

INTRODUCED BY EACHUS, DeLUCA, DeWEESE, BISHOP, BRIGGS, CALTAGIRONE, DALEY, DONATUCCI, FRANKEL, GIBBONS, GRUCELLA, HARHAI, HOUGHTON, MARKOSEK, McGEEHAN, McILVAINE SMITH, MELIO, READSHAW, SANTARSIERO, SEIP, SIPTROTH, SOLOBAY, STABACK, MANDERINO, YUDICHAK, DePASQUALE, BRENNAN, McCALL, CONKLIN, KULA, BELFANTI, SANTONI, M. O'BRIEN, JOSEPHS, R. TAYLOR, MUNDY, MURPHY, JOHNSON, CARROLL, YOUNGBLOOD, THOMAS AND FREEMAN, MAY 21, 2009

AS AMENDED ON SECOND CONSIDERATION, HOUSE OF REPRESENTATIVES, JUNE 10, 2009

AN ACT

Establishing the Expanded Adult Basic Coverage Insurance Program AND THE PHYSICIAN RETENTION LOAN FORGIVENESS PROGRAM IN THE PENNSYLVANIA HIGHER EDUCATION ASSISTANCE AGENCY; PROVIDING FOR POWERS AND DUTIES OF THE PENNSYLVANIA HIGHER EDUCATION ASSISTANCE AGENCY AND FOR HEALTH CARE COVERAGE FOR TELEHEALTH; ESTABLISHING THE HOSPITAL ELECTRONIC INFORMATION INCENTIVE PAYMENT PROGRAM AND THE DENTISTS FOR MEDICAL ASSISTANCE PATIENTS PROGRAM IN THE DEPARTMENT OF PUBLIC WELFARE; making appropriations; and making related repeals.

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

CHAPTER 1

PRELIMINARY PROVISIONS

Section 101. Short title.

This act shall be known and may be cited as the Expanded Adult Basic Coverage Insurance Program Act.

Section 102. Definitions.

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

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Department." The Insurance Department of the Commonwealth.

CHAPTER 3

PENNSYLVANIA EXPANDED ADULT BASIC COVERAGE INSURANCE PROGRAM

Section 301. Scope of chapter.

This chapter relates to offering health care coverage to eligible adults.

Section 302. Definitions.

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

"Behavioral health services." Mental health or substance abuse services.

"Benefit package." Insurance coverage which provides the benefits set forth under section 303(h) for eligible adults.

"Children's Health Insurance Program." The Children's Health Care Program established under Article XXIII of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

"Chronic care and disease management." A model of health care that manages chronic diseases in accordance with evidence-based treatment guidelines and includes all of the following:

(1) Planned, regular interactions with caregivers to systematically assess the patient's condition and guide patient self-care to prevent exacerbation and complications of the chronic illness.

(2) Support for the patient's role as self-manager through education and continuing follow-up initiated by the health care practice.

(3) Use of information systems to organize care and monitor patient progress.

"Contractor." An insurer or other entity or its subsidiaries awarded a contract to provide health care services under this

chapter.

"Eligible adult." A low-income adult who meets all of the following:

(1) Legally resides within the United States OR HAS PERMANENT LEGAL ALIEN STATUS. ←

(2) Is a resident of this Commonwealth at the time of application to the program.

(3) Is not currently covered by a health insurance plan, a self-insurance plan or a self-funded plan AND DOES NOT QUALIFY FOR HEALTH INSURANCE AS A CHILD OF AN INSURED PARENT UNDER SECTION 315. ←

(4) Has not been covered by a health insurance plan, a self-insurance plan or a self-funded plan during the six months immediately preceding the determination of eligibility, except if one of the following apply:

(i) The low-income adult is eligible to receive benefits under the act of December 5, 1936 (2nd Sp.Sess., 1937 P.L.2897, No.1), known as the Unemployment Compensation Law.

(ii) The low-income adult was covered under a health insurance plan, a self-insurance plan or a self-funded plan, but, at the time of application for coverage, is no longer employed and is ineligible to receive benefits under the Unemployment Compensation Law.

(iii) The low-income adult lost coverage as a result of divorce or separation from a covered individual or the death of a covered individual.

(iv) The low-income adult lost coverage as a result of a change in employment status of a covered individual resulting in either of the exceptions set forth under

subparagraph (i) or (ii) and both the eligible adult and the spouse are low-income adults and applying for coverage.

(v) The low-income adult is transferring from another government-subsidized health insurance program, including a transfer that occurs as a result of failure to meet income eligibility requirements.

(5) The low-income adult is ineligible to receive continuous eligibility coverage under Title XIX or XXI of the Social Security Act (49 Stat. 620, 42 U.S.C. § 301 et seq.), except for benefits authorized under a waiver granted by the United States Department of Health and Human Services to implement the program.

(6) The low-income adult is ineligible for Medicare.

"Enrollee." An eligible adult who meets all the requirements of this chapter and is enrolled in the Pennsylvania Expanded Adult Basic Coverage Insurance Program.

"Health benefit plan." An insurance coverage plan that provides the benefits set forth under section 303(h). The term shall not include any of the following:

(1) An accident-only policy.

(2) A credit-only policy.

(3) A long-term care or disability income policy.

(4) A specified-disease policy.

(5) A Medicare supplement policy.

(6) A Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement policy.

(7) A fixed-indemnity policy.

(8) A dental-only policy.

(9) A vision-only policy.

(10) A workers' compensation policy.

(11) An automobile medical payment policy under 75 Pa.C.S. (relating to vehicles).

(12) Other similar policies providing for limited benefits.

"Health maintenance organization" or "HMO." An entity organized and regulated under the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

"Hospital." A hospital as defined and licensed under the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

"Hospital plan corporation." A hospital plan corporation as defined in 40 Pa.C.S. § 6101 (relating to definitions).

"Insurer." A company or health insurance entity licensed in this Commonwealth to issue any individual or group health, sickness or accident policy or subscriber contract or certificate or plan that provides medical or health care coverage by a health care facility or licensed health care provider that is offered or governed under any of the following:

(1) The act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

(2) The act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

(3) The act of May 18, 1976 (P.L.123, No.54), known as the Individual Accident and Sickness Insurance Minimum Standards Act.

(4) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

"Low-income adult." An individual who is at least 19 years of age but less than 65 years of age and whose household income is less than 200% of the Federal poverty level at the time of eligibility determination.

"Medical assistance." The State program of medical assistance established under the Act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.

"Medicare." The Federal program established under Title XVIII of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1395 et seq.).

"Offeror." An insurer that submits a bid or proposal in response to a ~~solicitation~~ REQUEST FOR PROPOSALS issued under section 303(h). ←

"Pre-existing condition." A disease or physical condition for which medical advice, diagnosis, care or treatment was recommended or received prior to the effective date of coverage.

"Premium assistance program." A component of the Pennsylvania Expanded Adult Basic Coverage Insurance Program, approved under a State plan or approved waiver, under which the Commonwealth pays part or all of the premium for an enrollee's group health insurance or coverage under a group health plan.

"Prescription drug." A controlled substance, other drug or device for medication dispensed by order of an appropriately licensed medical professional.

"Professional health services plan corporation." A not-for-profit corporation operating under the provisions of 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

"Program." The Pennsylvania Expanded Adult Basic Coverage Insurance Program.

"Unemployment Compensation Law." The act of December 5, 1936 (1937 2nd Sp.Sess., P.L.2897, No.1), known as the Unemployment Compensation Law.

"Wait-list enrollee." An eligible adult who meets all the requirements of this chapter who is not enrolled in the program due to insufficient appropriations, but who individually purchases the benefit package.

Section 303. Pennsylvania Expanded Adult Basic Coverage Insurance Program.

(a) Program establishment.--There is established in the department the Pennsylvania Expanded Adult Basic Coverage Insurance Program. The program is contingent on, and shall not be authorized without, sufficient Federal financial participation to fund the program. Appropriations to the department for the program shall be used for contracts to provide basic health care insurance for eligible adults and administration of outreach activities ~~and for program operating costs~~. The department shall, to the greatest extent practicable, ensure that all eligible adults in this Commonwealth have access to the program established in this section.

(b) Eligible adult responsibilities.--An eligible adult seeking to purchase coverage under the program shall:

(1) Submit an application to the department or a contractor.

(2) Pay to the department, or the contractor with whom the eligible adult is to be enrolled, the amount of the premium specified under this subsection. Except to the extent that changes may be necessary to meet Federal requirements under section 310, subsidies for the 2009-2010 fiscal year shall result in the following premium amount based on

household income for a health benefit plan:

(i) For an enrollee whose household income is not greater than 150% of the Federal poverty level, a monthly premium of $0.

(ii) For an enrollee whose household income is greater than 150% but not greater than 175% of the Federal poverty level, a monthly premium of $40.

(iii) For an enrollee whose household income is greater than 175% but not greater than 200% of the Federal poverty level, a monthly premium of $50.

(3) Be responsible for any required copayments for health care services rendered under the benefit package in subsection (h).

(4) Notify the department or the contractor with whom the eligible adult is enrolled of any change in the eligible adult's household income.

(c) Purchase of insurance.--An eligible adult's payment to the department or the contractor with whom the eligible adult is enrolled under subsection (b)(2) shall be used to purchase the benefit package and shall be remitted so that it is received by the department or the contractor before the first day of the month for which coverage is provided. A grace period for remittance shall be permitted as provided by Federal or State law.

(d) Premium assistance program.--The department shall implement a premium assistance program permitted under Federal regulations and as permitted through a Federal waiver or State plan amendment made under this chapter. Notwithstanding any other law to the contrary, in the event that it is more cost-effective to purchase health care from an enrollee's employer-

based program and the employer-based program provides, at a minimum, the benefits package described in subsection (h)(8), employer-based coverage may be purchased in place of enrollment in the program established under this chapter. An insurer shall honor a request for enrollment and purchase of employee group health insurance requested on behalf of an enrollee.

(e) Waiting list.—The department shall maintain a waiting list of eligible adults who have applied for ~~coverage~~ A HEALTH BENEFIT PLAN under the program but who are not enrolled due to insufficient appropriations. An eligible adult on the waiting list may purchase the benefit package at the monthly per-member premium cost negotiated by the department. The department shall create a procedure to remove eligible adults from the waiting list and enroll them in the program based upon available funding.

(f) Entitlements and claims.--Nothing in this chapter shall constitute an entitlement derived from the Commonwealth or a claim on any funds of the Commonwealth. The Department of Public Welfare, in conjunction with the department, shall seek approval of State plan amendments and revisions to Federal waivers as are necessary to ensure that expenditures in the program shall not exceed available funding.

(g) Department responsibilities.--The department shall work in consultation and cooperation with other appropriate Commonwealth agencies, including the Department of Public Welfare, to carry out the functions of this chapter and shall:

(1) Administer the program on a Statewide basis.

(2) Enter into contracts for health care insurance ~~for the benefit package~~ IN ACCORDANCE WITH 62 PA.C.S. (RELATING TO PROCUREMENT). Contracts may be awarded on a multiple-

award basis.

(3) (i) In order to effectuate the program promptly upon receipt of all applicable waivers and approvals from the Federal government, contracts as currently exist under the Adult Basic Program or the Physical Health Health Choices Program of the Department of Public Welfare may be amended to provide benefits under the program established in this section or may otherwise procure services outside the competitive procurement process.

(ii) This paragraph shall expire at the same time as the contracts awarded under this section, but not later than 18 months after the effective date of this section.

(4) Subject to Federal requirements, impose reasonable cost-sharing arrangements establishing and adjusting copayments to be incorporated into the program by contractors, thereby encouraging appropriate use by contractors of cost-effective health care providers who will provide quality health care. Changes to copayments shall be forwarded to the Legislative Reference Bureau for publication as notices in the Pennsylvania Bulletin.

(5) Conduct monitoring, oversight and audits of executed contracts for enforcement purposes.

(6) Ensure that the eligibility of enrollees receiving subsidization of the benefit package is redetermined on an annual basis.

(7) Monitor, review and evaluate each contractor's benefit package for the adequacy, accessibility and availability of the services required under subsection (h).

(8) Establish and coordinate development, implementation

and supervision of an outreach plan to ensure that all those who may be eligible are aware of the program. The outreach plan shall include provisions for:

(i) Reaching special populations, including nonwhite and non-English speaking individuals and individuals with disabilities.

(ii) Reaching different geographic areas, including rural and inner-city areas.

(iii) Assuring that special efforts are coordinated within the overall outreach activities throughout this Commonwealth.

(iv) Allowing for the acceptance of applications at county assistance offices operated by the Department of Public Welfare.

(9) Prepare and submit, by March 1, 2010, and annually thereafter, a report to the chairman and minority chairman of the Banking and Insurance Committee of the Senate and to the chairman and minority chairman of the Insurance Committee of the House of Representatives regarding the number of eligible adults purchasing coverage under the program with a geographic distribution, the identity of the contractors, the scope of the services being provided, the level of outreach, the cost of the insurance and the amount an eligible adult contributes toward the insurance, including any copayments and adjustments to the premiums. The annual report shall be made available for public inspection and posted on the department's publicly accessible Internet website.

(10) Undertake efforts as are required to seek receipt of and qualify for Federal financial participation.

(h) ~~Solicitation.--The department shall solicit bids or~~ ←

~~proposals for the program. The solicitation~~ REQUEST FOR PROPOSALS.--IN ACCORDANCE WITH SUBSECTION (G)(2) THE DEPARTMENT SHALL ISSUE A REQUEST FOR PROPOSALS FOR THE PROGRAM. THE REQUEST shall require an offeror to assure that if selected as a contractor it will do all of the following:

(1) Ensure that enrollees and wait-list enrollees have access to qualified, cost-effective health care providers.

(2) Contract with qualified, cost-effective health care providers, which shall include primary health care physicians, certified registered nurse practitioners, physician assistants, clinical nurse specialists, nurse-midwives, clinics and health maintenance organizations, to provide health care for organizations, to provide health care for enrollees and wait-list enrollees in a manner that best manages the costs of the services and utilizes other appropriate medical cost-effective methods and in a manner consistent with the provider's permitted scope of practice.

(3) Ensure that the individual applying for coverage is an eligible adult. If a review of the individual's application for coverage indicates that the individual is not eligible for adult basic coverage insurance, but may be eligible for medical assistance, the application for benefits and all accompanying documentation shall be promptly transmitted to the appropriate county assistance office for a determination of eligibility for medical assistance or other Federal, State and local resources available to the individual.

(4) Not prohibit enrollment based upon a preexisting condition nor exclude a diagnosis or treatment for the condition based on the condition's preexistence.

(5) Provide an insurance identification card to each enrollee or wait-list enrollee covered under a contract executed under this section. The card shall not identify the enrollee or wait-list enrollee as low income.

(6) Require each provider providing primary care services under this section to make necessary arrangements for admission to hospitals and for necessary specialty care.

(7) Not pay any claim on behalf of an enrollee or wait-list enrollee unless all other Federal, State and local resources are first utilized and utilize subrogation and coordination of benefits processes so that the program is the payor of last resort.

(8) Provide a benefit package to enrollees and wait-list enrollees consistent with the scope and duration requirements determined by the department. The Commonwealth may elect to provide any benefit independently and outside the scope of any contract entered into with any contractor to provide the benefit package under the program. The benefit package determined by the department may include any of the following services:

(i) Preventive and wellness care.

(ii) Outpatient primary care and specialist services.

(iii) Inpatient hospitalization.

(iv) Outpatient services.

(v) Emergency care.

(vi) Laboratory and radiology.

(vii) Clinic services.

(viii) Prescription drugs.

(ix) Diabetic medical supplies and equipment.

(x) Emergency dental care.

(xi) Maternity care.

(xii) Skilled nursing.

(xiii) Home health, palliative and hospice care.

(xiv) Chronic care and disease management.

(xv) Inpatient and outpatient behavioral health services.

(i) Bids or proposals.--Each professional health service plan corporation, hospital plan corporation, health maintenance organization owned or controlled by a professional health service plan corporation or a hospital plan corporation and each entity that provides services under the Department of Public Welfare's Physical Health HealthChoices Program shall be required to submit a bid or proposal to the department to carry out the purposes of this chapter. Each professional health service plan corporation and hospital plan corporation, and subsidiaries and affiliates doing business in this Commonwealth, shall submit a bid or proposal to the department to carry out the purposes of this section in the geographic area serviced by that entity. Each health maintenance organization owned or controlled by a health service plan corporation or hospital plan corporation shall submit a bid or proposal with all eligible licenses and certificates of authority under its control, in all service zones in which it is licensed to do business in more than 50% of the counties in that zone. The service zones shall be determined by the department in consultation with the Department of Health and the Department of Public Welfare. Each entity that provides services under the Physical Health HealthChoices Program of the Department of Public Welfare shall submit a bid or proposal in all counties in which it provides

the services. All other insurers may submit a bid or proposal to the department to carry out the purposes of this section.

(j) Reviewing, scoring and selecting bids or proposals.--The department, in consultation with the Department of Public Welfare, shall review and score bids or proposals on the basis of all of the requirements for the program. The department may include other criteria in the solicitation and in the scoring and selection of the bids or proposals that the department, in the exercise of its administrative duties under this section and in consultation with the Department of Public Welfare, deems necessary. The department shall:

(1) Select, to the greatest extent practicable, offerors that contract with providers to provide health care services on a cost-effective basis and that use appropriate cost-management methods that enable the program to provide coverage to the maximum number of eligible adults and that, whenever possible, pursue and utilize available public and private funds.

(2) Select, to the greatest extent practicable, only offerors that comply with all procedures relating to coordination of benefits as required by the department and the Department of Public Welfare.

(3) Select offerors that limit administrative expenses to no more than 10% of the amount of the contract. If a contractor presents documented evidence that administrative expenses for operational changes from the previous AdultBasic Program to the program implemented under this act are in excess of 10% of the amount of the contract, the department shall make an additional allotment of funds, not to exceed 1% of the amount of the contract, to the contractor to the

extent that the department finds the expenses reasonable and necessary.

(k) Rates and negotiations.--Rates for the program shall be approved annually by the department and may vary by region and contractor. Rates shall be based on an actuarially sound and adequate review. THE DEPARTMENT MAY NOT REQUIRE A CONTRACTOR TO NEGOTIATE A CONTRACT WITH A HEALTH CARE PROVIDER THAT CONDITIONS REIMBURSEMENTS PAID TO A HEALTH CARE PROVIDER AT A RATE THAT IS AT OR BELOW THE REIMBURSEMENT RATE PAID TO A HEALTH CARE PROVIDER UNDER MEDICAL ASSISTANCE. The department shall not negotiate a contract for a period in excess of four years.

(l) Limitation.--In no case shall the total aggregate amount of annual contracts entered into pursuant to this section exceed the amount of the aggregate annual appropriations to the department for the program.

Section 304. Duties of contractors.

A contractor that contracts with the department to provide a health benefit plan to eligible adults:

(1) Shall process claims for the coverage.

(2) Shall implement copayment adjustments as soon as practicable following publication in the Pennsylvania Bulletin, but in no event more than 120 days following publication.

(3) May not deny coverage to an eligible adult who has been approved by the department to participate in the program.

(4) Shall provide to the department all data, including individual claims data, as the department determines is necessary for use in performance measurement and program improvement.

(5) Shall fulfill all requirements of any contract issued to it pursuant to this section.

Section 305. Premiums and charges.

(a) Limitation on fees.--No eligible adult shall be assessed a fee or other charge, other than those specified in this chapter, as a requirement for participating in the program.

(b) Premium adjustment.--For each fiscal year beginning after June 30, 2010, the department may adjust the premium amounts under section 303(b)(2) to reflect changes in the cost of medical services and shall forward notice of the new premium amounts to the Legislative Reference Bureau for publication as a notice in the Pennsylvania Bulletin.

(c) Copayment adjustment.--For each fiscal year beginning after June 30, 2010, the department ~~may~~ SHALL adjust the copayment amounts under section 303(b)(3) to reflect changes in the cost of medical services and shall forward notice of the new premium amounts to the Legislative Reference Bureau for publication as a notice in the Pennsylvania Bulletin.

Section 306. Data matching.

(a) Covered adults.--All entities providing health insurance or health care coverage within this Commonwealth shall, at least once every month, provide the names, identifying information and any additional information on coverage and benefits as the department may specify for persons for whom the entities provide insurance or coverage.

(b) Use of information.--The department shall use the information obtained under subsection (a) to determine whether another entity has primary liability for health care claims paid by the program. If a determination is made that the enrollee or wait-list enrollee has other health care coverage, the

eligibility of the enrollee or wait-list enrollee shall be reevaluated, as shall the most cost-effective means of providing coverage for that enrollee or wait-list enrollee.

Section 307. Information sharing.

Notwithstanding any provision of law to the contrary, the program and other departments or programs of the Commonwealth with information relating to the eligibility of individuals for a Commonwealth program, shall share the information with each other for purposes of determining and coordinating eligibility for any State program. Those departments and programs include, but are not limited to, the Department of Revenue, the Department of Labor and Industry, the Department of Public Welfare, the Children's Health Insurance Program and the program. The information shall be confidential, shall be exempt from disclosure under the act of February 14, 2008 (P.L.6, No.3), known as the Right-to-Know Law, and may not be subject to subpoena and may not be made public by any department or program, except that it may be disclosed to another Commonwealth agency or law enforcement official of the Federal or State government at any time so long as the agency or office receiving the information agrees in writing to hold it confidential and in a manner consistent with this act. No individual who receives information while acting under the authority of this act shall be permitted or required to testify in a private civil or other action concerning the information subject to this section.

Section 308. Regulations.

The department ~~may~~ SHALL promulgate regulations for the implementation and administration of the program. Until final regulations are adopted, the department shall operate the program under interim guidelines consistent with this chapter.

Section 309. Funding.

(a) Funding contingency for subsidization.--Subsidization of premiums and copayments paid under subsection (b) is contingent upon the amount of the funding available to the program and the Federal poverty levels approved by the Federal waiver or State plan amendments granted under section 310, and is limited to eligible adults who are in compliance with the requirements under this chapter.

(b) Use of funding.--Funding shall be used by the department to pay the difference between the total monthly cost of the health benefit plan and the premium payments and copayments by the eligible adult and for administration and outreach activities required under subsection 303(f).

Section 310. Federal waivers or State plan amendments.

(a) Application for waivers or amendments.--The Department of Public Welfare, in cooperation with the department, shall apply for all applicable waivers from the Federal Government and shall seek approval to amend the State plan under Title XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396 et seq.) as necessary to carry out the provisions of this chapter.

(b) Notice of approval.--If the Department of Public Welfare receives approval of a waiver or approval of a State plan amendment, it shall notify the department and shall transmit notice of the waiver or State plan amendment approvals to the Legislative Reference Bureau for publication as a notice in the Pennsylvania Bulletin.

(c) Program changes.--The department is authorized to change the benefits under section 303(h), the premium amounts payable under section 303(b) and any eligibility requirements under this chapter in order for the program to meet Federal requirements.

Section 311. Federal funds.

Notwithstanding any other provision of law, the Department of Public Welfare, in cooperation with the department, shall do all of the following:

(1) Seek the receipt of Federal financial participation under Title XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396 et seq.) for coverage and services provided under this article.

(2) Qualify for available Federal financial participation under Title XIX of the Social Security Act.

Section 312. Federal programs.

If the Federal Government enacts programs similar to the program, the program shall be construed to only supplement the Federal programs; and adults qualified for coverage under the Federal program shall utilize that Federal program before utilizing the program.

Section 313. Establishment.

There is established within the State Treasury a special fund to be known as the Pennsylvania Expanded Adult Basic Coverage Insurance Program Fund.

Section 314. Deposits into fund and appropriation.

(a) Health Care Provider Retention Account.--On the effective date of this section, the sum of $362,000,000 shall be transferred from the Health Care Provider Retention Account to the Pennsylvania Expanded Adult Basic Coverage Insurance Program Fund.

(b) Tobacco Settlement Act.--Notwithstanding section 5101(b), funds appropriated under section 306(b)(1)(vi) of the act of June 26, 2001 (P.L.755, No.77), known as the Tobacco Settlement Act, for the program established in former Chapter 13

of that act, shall be deposited into the Pennsylvania Expanded Adult Basic Coverage Insurance Program Fund.

(c) Premium tax.--Commencing with calendar years beginning after December 31, 2010, every hospital plan corporation and professional health service plan corporation operating in this Commonwealth shall pay the tax on gross premiums payable under Article IX of the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971. The tax payable in calendar year 2011 shall be for gross premiums received in calendar year 2010. Notwithstanding the provisions of any law to the contrary, the sums received by the Commonwealth as a result of this tax shall be deposited into the Pennsylvania Expanded Adult Basic Coverage Insurance Program Fund. This subsection shall not be effective if the Agreement on Community Health Reinvestment entered into February 2, 2005, by the department and Capital BlueCross, Highmark, Inc., Hospital Service Association of Northeastern Pennsylvania and Independence Blue Cross and published in the Pennsylvania Bulletin at 35 Pa.B. 4155 (July 23, 2005) is extended or otherwise renegotiated to continue, at least, at the level of Annual Community Health Reinvestment contributed under that agreement. In that event, the sums received by the Commonwealth shall be deposited into the Pennsylvania Expanded Adult Basic Coverage Insurance Program Fund.

(d) Appropriation.--Money in the Pennsylvania Expanded Adult Basic Coverage Insurance Program Fund is appropriated, upon approval of the Governor, for health care coverage and services under this chapter.

SECTION 315. CERTAIN CHILDREN OF INSURED PARENTS.

(A) GENERAL RULE.--AN INSURER THAT ISSUES, DELIVERS, EXECUTES OR RENEWS GROUP HEALTH CARE INSURANCE IN THIS

COMMONWEALTH, UNDER WHICH COVERAGE OF A CHILD WOULD OTHERWISE TERMINATE AT A SPECIFIED AGE, SHALL, AT THE OPTION OF THE POLICYHOLDER, PROVIDE COVERAGE TO A CHILD OF AN INSURED EMPLOYEE BEYOND THAT SPECIFIED AGE, UP THROUGH AND INCLUDING THE AGE OF 29, AT THE INSURED EMPLOYEE'S EXPENSE, AND PROVIDED THAT THE CHILD MEET ALL OF THE FOLLOWING REQUIREMENTS:

(1) IS NOT MARRIED.

(2) HAS NO DEPENDENTS.

(3) IS A RESIDENT OF THIS COMMONWEALTH OR IS ENROLLED AS A FULL-TIME STUDENT AT AN INSTITUTION OF HIGHER EDUCATION.

(4) IS NOT PROVIDED COVERAGE AS A NAMED SUBSCRIBER, INSURED, ENROLLEE OR COVERED PERSON UNDER ANY OTHER GROUP OR INDIVIDUAL HEALTH INSURANCE POLICY OR ENROLLED IN OR ENTITLED TO BENEFITS UNDER ANY GOVERNMENT HEALTH CARE BENEFITS PROGRAM, INCLUDING BENEFITS UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT (49 STAT. 620, 42 U.S.C. § 1395 ET SEQ.).

(B) INCREASE IN PREMIUM.--INSURERS MAY DETERMINE INCREASES IN PREMIUMS RELATED TO CONTINUATION OF COVERAGE FOR THE ADULT DEPENDENT PAST THE LIMITING AGE OF 19.

(C) EXCLUSIONS.--THIS SECTION SHALL NOT INCLUDE THE FOLLOWING TYPES OF INSURANCE OR ANY COMBINATION THEREOF:

(1) HOSPITAL INDEMNITY.

(2) ACCIDENT.

(3) SPECIFIED DISEASE.

(4) DISABILITY INCOME.

(5) DENTAL.

(6) VISION.

(7) CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS) SUPPLEMENT.

(8) MEDICARE SUPPLEMENT.

(9) LONG-TERM CARE.

(10) OTHER LIMITED BENEFIT PLANS.

(11) INDIVIDUAL HEALTH INSURANCE POLICIES.

(D) DEFINITIONS.--AS USED IN THIS SECTION, THE FOLLOWING WORDS AND PHRASES SHALL HAVE THE MEANINGS GIVEN TO THEM IN THIS SUBSECTION:

"HEALTH CARE INSURANCE" A GROUP HEALTH, SICKNESS OR ACCIDENT POLICY OR SUBSCRIBER CONTRACT OR CERTIFICATE ISSUED BY AN ENTITY SUBJECT TO ANY ONE OF THE FOLLOWING:

(1) THE ACT OF MAY 17, 1921 (P.L.682, NO.284), KNOWN AS THE INSURANCE COMPANY LAW OF 1921.

(2) THE ACT OF DECEMBER 29, 1972 (P.L.1701, NO.364), KNOWN AS THE HEALTH MAINTENANCE ORGANIZATION ACT.

(3) THE ACT OF MAY 18, 1976 (P.L.123, NO.54), KNOWN AS THE INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS ACT.

(4) 40 PA.C.S. CH. 61 (RELATING TO HOSPITAL PLAN CORPORATIONS) OR 63 (RELATING TO PROFESSIONAL HEALTH SERVICES PLAN CORPORATIONS).

CHAPTER 5

PHYSICIAN RETENTION LOAN FORGIVENESS

SECTION 501. PURPOSE.

THE PURPOSE OF THIS CHAPTER IS TO IMPROVE PATIENT ACCESS TO HEALTH CARE BY ASSISTING THE COMMONWEALTH WITH RECRUITMENT AND RETENTION OF PHYSICIANS.

SECTION 502. DEFINITIONS.

THE FOLLOWING WORDS AND PHRASES WHEN USED IN THIS CHAPTER SHALL HAVE THE MEANINGS GIVEN TO THEM IN THIS SECTION UNLESS THE CONTEXT CLEARLY INDICATES OTHERWISE:

"AGENCY." THE PENNSYLVANIA HIGHER EDUCATION ASSISTANCE

AGENCY.

"HEALTH CARE FACILITY." AS DEFINED IN SECTION 103 OF THE ACT OF JULY 19, 1979 (P.L.130, NO.48), KNOWN AS THE HEALTH CARE FACILITIES ACT.

"PHYSICIAN." A MEDICAL DOCTOR OR DOCTOR OF OSTEOPATHY.

"PROGRAM." THE PHYSICIAN RETENTION LOAN FORGIVENESS PROGRAM ESTABLISHED BY THIS CHAPTER.

SECTION 503. PROGRAM.

(A) ESTABLISHMENT.--THE PHYSICIAN RETENTION LOAN FORGIVENESS PROGRAM IS ESTABLISHED IN THE AGENCY.

(B) APPLICATIONS.--THE AGENCY SHALL PROMULGATE GUIDELINES FOR THE SELECTION OF CANDIDATES TO THE PROGRAM BASED UPON THE FOLLOWING CRITERIA:

(1) DEMONSTRATED NEED.

(2) WILLINGNESS TO CONTINUE PRACTICING AS A PHYSICIAN IN THIS COMMONWEALTH AFTER COMPLETING THE PROGRAM.

(C) ELIGIBILITY.--A PROGRAM APPLICANT MUST BE:

(1) A CITIZEN OF THE UNITED STATES.

(2) LICENSED TO PRACTICE MEDICINE IN THIS COMMONWEALTH AND SPECIALIZING IN ONE OF THE FOLLOWING:

(I) INTERNAL MEDICINE.

(II) FAMILY MEDICINE.

(III) PEDIATRICS.

(IV) OBSTETRICS AND GYNECOLOGY.

(D) SELECTION.--THE AGENCY SHALL GIVE PREFERENCE TO PHYSICIANS IN THE FOLLOWING ORDER:

(1) RECIPIENTS OF LOANS WHO BY CONTRACT WITH THE AGENCY AGREE TO PRACTICE MEDICINE IN AN AREA OF THIS COMMONWEALTH THAT IS REPORTED BY THE DEPARTMENT OF HEALTH AS MEDICALLY UNDERSERVED OR IN A PRIMARY CARE HEALTH PROFESSIONAL SHORTAGE

AREA.

(2) COMMONWEALTH PHYSICIANS COMPLETING TRAINING IN THIS COMMONWEALTH.

(3) OUT-OF-STATE APPLICANTS COMPLETING TRAINING IN THIS COMMONWEALTH.

(4) COMMONWEALTH NATIVES COMPLETING OUT-OF-STATE TRAINING.

(5) OUT-OF-STATE CANDIDATES COMPLETING OUT-OF-STATE TRAINING.

(E) VERIFICATION.--THE AGENCY SHALL MONITOR AND VERIFY A PHYSICIAN'S FULFILLMENT OF ALL REQUIREMENTS UNDER THIS CHAPTER.

SECTION 504. AMOUNT OF LOAN FORGIVENESS.

(A) PHYSICIANS PRACTICING FULL TIME.--A PHYSICIAN ACCEPTED INTO THE PROGRAM PRACTICING FULL TIME MAY BE REIMBURSED AN AMOUNT UP TO 100% OF THE TOTAL LOAN FOR PHYSICIAN TRAINING BASED UPON THE FOLLOWING REPAYMENT ASSISTANCE SCHEDULE:

(1) FIRST YEAR OF SERVICE, 10%.

(2) SECOND YEAR OF SERVICE, 10%.

(3) THIRD YEAR OF SERVICE, 10%.

(4) FOURTH YEAR OF SERVICE, 10%.

(5) FIFTH YEAR OF SERVICE, 10%.

(6) SIXTH YEAR OF SERVICE, 10%.

(7) SEVENTH YEAR OF SERVICE, 10%.

(8) EIGHTH YEAR OF SERVICE, 10%.

(9) NINTH YEAR OF SERVICE, 10%.

(10) TENTH YEAR OF SERVICE, 10%.

(B) PHYSICIANS PRACTICING PART TIME.--A PHYSICIAN ACCEPTED INTO THE PROGRAM PRACTICING PART TIME MAY BE REIMBURSED AN AMOUNT DIRECTLY PROPORTIONAL TO THE NUMBER OF HOURS WORKED OF THE TOTAL LOAN FOR PHYSICIAN TRAINING BASED UPON THE FOLLOWING

REPAYMENT ASSISTANCE SCHEDULE:

(1) FIRST YEAR OF SERVICE, 10%.

(2) SECOND YEAR OF SERVICE, 10%.

(3) THIRD YEAR OF SERVICE, 10%.

(4) FOURTH YEAR OF SERVICE, 10%.

(5) FIFTH YEAR OF SERVICE, 10%.

(6) SIXTH YEAR OF SERVICE, 10%.

(7) SEVENTH YEAR OF SERVICE, 10%.

(8) EIGHTH YEAR OF SERVICE, 10%.

(9) NINTH YEAR OF SERVICE, 10%.

(10) TENTH YEAR OF SERVICE, 10%.

SECTION 505. CONTRACT.

(A) GENERAL RULE.--PHYSICIANS RECEIVING LOAN FORGIVENESS SHALL ENTER INTO A CONTRACT WITH THE AGENCY. THE CONTRACT SHALL INCLUDE, BUT NOT BE LIMITED TO, THE FOLLOWING TERMS AND CONDITIONS:

(1) THE PHYSICIAN SHALL AGREE TO PRACTICE NOT FEWER THAN TEN FULL CONSECUTIVE YEARS IN A LICENSED HEALTH CARE FACILITY IN THIS COMMONWEALTH IMMEDIATELY FOLLOWING COMPLETION OF TRAINING PURSUANT TO THE SCHEDULE PROVIDED IN SECTION 5.

(2) THE PHYSICIAN SHALL AGREE TO ACCEPT MEDICARE AND MEDICAID PATIENTS.

(3) THE PHYSICIAN SHALL AGREE NOT TO DISCRIMINATE AGAINST PATIENTS BASED ON THE ABILITY TO PAY.

(4) THE PHYSICIAN SHALL PERMIT THE AGENCY TO MONITOR COMPLIANCE WITH THE WORK REQUIREMENT.

(5) THE AGENCY SHALL CERTIFY COMPLIANCE OF THE PHYSICIAN RECEIVING A LOAN FORGIVENESS AWARD FOR YEARS SUBSEQUENT TO THE INITIAL YEAR OF THE LOAN.

(6) THE CONTRACT SHALL BE RENEWABLE ON AN ANNUAL BASIS

UPON CERTIFICATION BY THE AGENCY THAT THE PHYSICIAN HAS COMPLIED WITH THE TERMS OF THE CONTRACT.

(7) THE CONTRACT SHALL TERMINATE IF THE PHYSICIAN DIES, IS NOT ABLE TO PERFORM THE DUTIES OF A PHYSICIAN OR IS NOT ABLE TO MAINTAIN THE PHYSICIAN'S LICENSE TO PRACTICE MEDICINE DUE TO PHYSICAL OR MENTAL DISABILITY.

(8) IF THE PHYSICIAN'S LICENSE TO PRACTICE IS SUSPENDED OR REVOKED, THE AGENCY SHALL HAVE THE AUTHORITY TO TERMINATE THE PHYSICIAN'S PARTICIPATION IN THE PROGRAM AND REQUIRE REPAYMENT OF ALL LOAN FORGIVENESS PAYMENTS RENDERED TO DATE.

(9) A PHYSICIAN WHO FAILS TO BEGIN OR COMPLETE THE OBLIGATIONS CONTRACTED FOR SHALL REIMBURSE THE COMMONWEALTH ALL AMOUNTS RECEIVED UNDER THIS CHAPTER AND INTEREST THEREON AS DETERMINED BY THE AGENCY. BOTH THE PHYSICIAN AND THE AGENCY SHALL MAKE EVERY EFFORT TO RESOLVE CONFLICTS IN ORDER TO PREVENT A BREACH OF CONTRACT.

(B) CONTRACT ENFORCEMENT.--THE AGENCY SHALL HAVE THE AUTHORITY TO SEEK GARNISHMENT OF WAGES FOR THE COLLECTION OF DAMAGES PROVIDED FOR IN SUBSECTION (A)(9).

SECTION 506. DISQUALIFICATION.

ANY PERSON WHO KNOWINGLY OR INTENTIONALLY PROCURES, OBTAINS OR AIDS ANOTHER TO PROCURE OR OBTAIN LOAN FORGIVENESS UNDER THIS CHAPTER THROUGH FRAUDULENT MEANS SHALL BE DISQUALIFIED FROM PARTICIPATION AND SHALL BE LIABLE TO THE AGENCY FOR AN AMOUNT EQUAL TO THREE TIMES THE AMOUNT OBTAINED.

SECTION 507. TAX CONSEQUENCES.

LOAN FORGIVENESS PAYMENTS RECEIVED BY A PHYSICIAN SHALL NOT BE CONSIDERED TAXABLE INCOME FOR PURPOSES OF ARTICLE III OF THE ACT OF MARCH 4, 1971 (P.L.6, NO.2), KNOWN AS THE TAX REFORM CODE OF 1971.

SECTION 508. REGULATIONS.

THE AGENCY SHALL ADOPT REGULATIONS AND PROCEDURES NECESSARY TO CARRY OUT THE PURPOSES OF THIS CHAPTER.

SECTION 509. FUNDING.

LOAN FORGIVENESS PAYMENTS SHALL BE MADE FROM THE HEALTH CARE PROVIDER RETENTION ACCOUNT.

CHAPTER 7

TELEHEALTH

SECTION 701. DEFINITIONS.

THE FOLLOWING WORDS AND PHRASES WHEN USED IN THIS CHAPTER SHALL HAVE THE MEANINGS GIVEN TO THEM IN THIS SECTION UNLESS THE CONTEXT CLEARLY INDICATES OTHERWISE:

"HEALTH CARE PROFESSIONAL." AN INDIVIDUAL WHO IS LICENSED, CERTIFIED OR OTHERWISE REGULATED TO PROVIDE HEALTH CARE SERVICES UNDER THE LAWS OF THIS COMMONWEALTH.

"HEALTH CARE SERVICES." SERVICES FOR THE DIAGNOSIS, PREVENTION, TREATMENT, CURE OR RELIEF OF A HEALTH CONDITION, INJURY, DISEASE OR ILLNESS.

"TELEHEALTH." THE REMOTE INTERACTION BETWEEN A HEALTH CARE PROFESSIONAL AND A PATIENT THROUGH THE USE OF ANY OF THE FOLLOWING:

(1) A VIDEO CAMERA TRANSMISSION.

(2) A COMPUTER VIDEO TRANSMISSION.

(3) AN ELECTRONIC HEALTH MONITORING DEVICE.

(4) ANOTHER TELECOMMUNICATIONS DEVICE THAT DELIVERS HEALTH INFORMATION CONCERNING A PATIENT TO A HEALTH CARE PROFESSIONAL.

SECTION 702. PROVISION OF COVERAGE.

AN INSURER THAT ISSUES, DELIVERS, EXECUTES OR RENEWS HEALTH CARE INSURANCE IN THIS COMMONWEALTH SHALL PROVIDE COVERAGE FOR

TELEHEALTH IF A HEALTH CARE PROFESSIONAL CERTIFIES ALL OF THE FOLLOWING:

(1) THAT THE USE OF TELEHEALTH IS APPROPRIATE FOR THE PATIENT.

(2) THAT THE HEALTH CARE PROFESSIONAL WILL BE able TO MAINTAIN PROPER DIRECT EXAMINATION OF THE PATIENT OR THAT DIRECT EXAMINATION OF THE PATIENT IS NOT NECESSARY.

(3) THAT THE USE OF TELEHEALTH WILL RESULT IN LOWER HEALTH CARE COSTS THAN IF IT WERE NOT USED.

CHAPTER 41

HOSPITAL ELECTRONIC INFORMATION INCENTIVE PAYMENT PROGRAM

SECTION 4101. SCOPE OF CHAPTER.

THIS CHAPTER ESTABLISHES THE HOSPITAL ELECTRONIC INFORMATION INCENTIVE PAYMENT PROGRAM.

SECTION 4102. DEFINITIONS.

THE FOLLOWING WORDS AND PHRASES WHEN USED IN THIS CHAPTER SHALL HAVE THE MEANINGS GIVEN TO THEM IN THIS SECTION UNLESS THE CONTEXT CLEARLY INDICATES OTHERWISE:

"DEPARTMENT." THE DEPARTMENT OF PUBLIC WELFARE OF THE COMMONWEALTH.

"ELIGIBLE HOSPITAL." AN ACUTE CARE HOSPITAL OR CRITICAL ACCESS HOSPITAL WHICH IS A MEANINGFUL ELECTRONIC HEALTH RECORD USER AS DEFINED UNDER SECTION 4102 OF THE AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009 (PUBLIC LAW 111-5, 123 STAT. 115).

SECTION 4103. HOSPITAL ELECTRONIC INFORMATION INCENTIVE PAYMENT PROGRAM.

(A) ESTABLISHMENT.--THERE IS ESTABLISHED WITHIN THE DEPARTMENT A PROGRAM TO BE KNOWN AS THE HOSPITAL ELECTRONIC INFORMATION INCENTIVE PAYMENT PROGRAM. THE PROGRAM SHALL PROVIDE FINANCIAL ASSISTANCE TO CERTAIN ACUTE CARE HOSPITALS AND

CRITICAL ACCESS HOSPITALS FOR THE IMPLEMENTATION OF ELECTRONIC HEALTH RECORD SYSTEMS.

(B) APPLICATION.--THE DEPARTMENT SHALL ESTABLISH A PAYMENT INCENTIVE PROGRAM CONSISTENT WITH THE PROVISIONS OF SECTION 4102 OF THE AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009 (PUBLIC LAW 111-5, 123 STAT. 115) TO PROVIDE ASSISTANCE TO ELIGIBLE HOSPITALS FOR THE IMPLEMENTATION OF ELECTRONIC HEALTH RECORD SYSTEMS.

CHAPTER 43

DENTISTS FOR MEDICAL ASSISTANCE PATIENTS

SECTION 4301. SCOPE OF CHAPTER.

THIS CHAPTER RELATES TO DENTISTS FOR MEDICAL ASSISTANCE PATIENTS.

SECTION 4302. PURPOSE.

THE PURPOSE OF THIS CHAPTER IS TO HELP MEET THE INADEQUACIES FOR IMPROVING CARE TO THOSE ON MEDICAL ASSISTANCE, TO BRING DENTISTS INTO COMMUNITIES WHERE THERE IS A NEED AND TO PROVIDE AN INCENTIVE TO STUDENTS OF THIS COMMONWEALTH TO PURSUE HIGHER EDUCATION AND TRAINING IN DENTISTRY IN ORDER TO MAINTAIN THE QUALITY OF HEALTH CARE SERVICES IN THIS COMMONWEALTH.

SECTION 4303. DEFINITIONS.

THE FOLLOWING WORDS AND PHRASES WHEN USED IN THIS CHAPTER SHALL HAVE THE MEANINGS GIVEN TO THEM IN THIS SECTION UNLESS THE CONTEXT CLEARLY INDICATES OTHERWISE:

"DENTIST." A DOCTOR OF DENTAL SURGERY OR DOCTOR OF DENTAL MEDICINE WHO IS LICENSED WITHIN THIS COMMONWEALTH TO PRACTICE DENTISTRY.

"DEPARTMENT." THE DEPARTMENT OF PUBLIC WELFARE OF THE COMMONWEALTH.

"PROGRAM." THE DENTISTS FOR MEDICAL ASSISTANCE PATIENTS PROGRAM ESTABLISHED UNDER THIS CHAPTER.

SECTION 4304. PROGRAM.

(A) ESTABLISHMENT.--THE DENTISTS FOR MEDICAL ASSISTANCE PATIENTS PROGRAM IS ESTABLISHED WITHIN THE DEPARTMENT.

(B) ADMINISTRATION.--THE COMMONWEALTH SHALL ADMINISTER THE PROGRAM ON A STATEWIDE BASIS AND UTILIZE FUNDS IN THE PROGRAM TO ENCOURAGE RECENTLY GRADUATED DENTISTS TO PROVIDE CARE TO PATIENTS ON MEDICAL ASSISTANCE IN EACH OF THE COUNTIES BASED ON NEED. THE COMMONWEALTH SHALL PROVIDE AN ANNUAL SUPPLEMENTAL SALARY OF $80,000 TO RECENTLY GRADUATED DENTISTS WITHIN THREE YEARS FROM THE DATE OF GRADUATION WHO DEDICATE 50% OF THEIR PRACTICE TO CARING FOR PATIENTS ON MEDICAL ASSISTANCE. DENTISTS WITHIN SIX YEARS FROM THE DATE OF GRADUATION SHALL RECEIVE AN ANNUAL SUPPLEMENTAL SALARY OF $30,000 IF THEY DEDICATE 20% OF THEIR PRACTICE TO SERVING PATIENTS ON MEDICAL ASSISTANCE.

(C) APPLICATIONS.--THE DEPARTMENT SHALL PROMULGATE GUIDELINES FOR THE SELECTION OF CANDIDATES TO THE PROGRAM BASED ON THE FOLLOWING CRITERIA:

(1) DEMONSTRATED NEED.

(2) WILLINGNESS TO CONTINUE PRACTICING AND SERVING PATIENTS ON MEDICAL ASSISTANCE IN THIS COMMONWEALTH AFTER EXPIRATION OF THE PROGRAM.

(D) ELIGIBILITY.--DENTISTS MUST BE WITHIN THREE YEARS FROM THE DATE OF GRADUATION FROM AN ACCREDITED DENTAL SCHOOL TO RECEIVE AN ANNUAL SUPPLEMENTAL SALARY OF $80,000 OR WITHIN SIX YEARS FROM THE DATE OF GRADUATION FROM AN ACCREDITED DENTAL SCHOOL TO RECEIVE AN ANNUAL SUPPLEMENTAL SALARY OF $30,000 FROM THE COMMONWEALTH. PARTICIPATING DENTISTS SHALL NOT BE ELIGIBLE TO RECEIVE REIMBURSEMENTS FROM THE COMMONWEALTH FOR SERVING

PATIENTS ON MEDICAL ASSISTANCE BEYOND THIS PROGRAM.

(E) SELECTION.--THE DEPARTMENT SHALL GIVE PREFERENCE TO DENTISTS IN THE FOLLOWING ORDER:

(1) RECIPIENTS OF FUNDS WHO, BY CONTRACT WITH THE DEPARTMENT, AGREE TO PRACTICE DENTISTRY IN AN AREA OF THIS COMMONWEALTH THAT IS REPORTED BY THE DEPARTMENT AS AN AREA WHERE A SHORTAGE OF DENTISTS WHO SERVE PATIENTS ON MEDICAL ASSISTANCE EXISTS.

(2) COMMONWEALTH NATIVES COMPLETING TRAINING IN THIS COMMONWEALTH.

(3) OUT-OF-STATE CANDIDATES COMPLETING TRAINING IN THIS COMMONWEALTH.

(4) COMMONWEALTH NATIVES COMPLETING OUT-OF-STATE TRAINING.

(5) OUT-OF-STATE CANDIDATES COMPLETING OUT-OF-STATE TRAINING.

(F) VERIFICATION.--THE DEPARTMENT SHALL MONITOR AND VERIFY A DENTIST'S FULFILLMENT OF ALL REQUIREMENTS UNDER THIS CHAPTER.

SECTION 4305. CONTRACT.

(A) GENERAL RULE.--DENTISTS RECEIVING FUNDS SHALL ENTER INTO A CONTRACT WITH THE DEPARTMENT. THE CONTRACT SHALL INCLUDE, BUT NOT BE LIMITED TO, THE FOLLOWING TERMS AND CONDITIONS:

(1) THE DENTIST SHALL AGREE TO PROVIDE CARE TO THE ESTABLISHED PERCENTAGE OF PATIENTS ON MEDICAL ASSISTANCE IN RELATION TO THE TOTAL NUMBER OF PATIENTS SERVED.

(2) THE DENTIST SHALL PERMIT THE DEPARTMENT TO MONITOR COMPLIANCE WITH THE PERCENTAGE REQUIREMENT.

(3) THE CONTRACT SHALL BE RENEWABLE ON AN ANNUAL BASIS UPON CERTIFICATION BY THE DEPARTMENT THAT THE DENTIST HAS COMPLIED WITH THE TERMS OF THE CONTRACT. CONTRACTS MAY BE

RENEWABLE FOR A TOTAL OF SIX YEARS.

(4) THE CONTRACT SHALL TERMINATE IF THE DENTIST DIES, IS NOT ABLE TO PERFORM THE DUTIES OF A DENTIST OR IS NOT ABLE TO MAINTAIN THE DENTIST'S LICENSE TO PRACTICE DENTISTRY DUE TO PHYSICAL OR MENTAL DISABILITY.

(5) IF A DENTIST'S LICENSE TO PRACTICE IS SUSPENDED OR REVOKED, THE DEPARTMENT SHALL HAVE THE AUTHORITY TO TERMINATE THE DENTIST'S PARTICIPATION IN THE PROGRAM AND DEMAND REPAYMENT OF ALL FUNDS RENDERED TO DATE.

(6) A DENTIST WHO FAILS TO BEGIN OR COMPLETE THE OBLIGATIONS CONTRACTED FOR SHALL REIMBURSE THE COMMONWEALTH ALL AMOUNTS RECEIVED UNDER THIS CHAPTER AND INTEREST THEREON AS DETERMINED BY THE DEPARTMENT. BOTH THE DENTIST AND THE DEPARTMENT SHALL MAKE EVERY EFFORT TO RESOLVE CONFLICTS IN ORDER TO PREVENT A BREACH OF CONTRACT.

(B) CONTRACT ENFORCEMENT.--THE DEPARTMENT SHALL HAVE THE AUTHORITY TO SEEK GARNISHMENT OF WAGES FOR THE COLLECTION OF DAMAGES PROVIDED FOR UNDER SUBSECTION (A)(6).

SECTION 4306. FUNDING.

THE DEPARTMENT IS AUTHORIZED TO USE FUNDS SPECIFICALLY APPROPRIATED BY THE GENERAL ASSEMBLY AND ANY FUNDS, CONTRIBUTIONS OR PAYMENTS WHICH MAY BE AVAILABLE TO THE DEPARTMENT BY ANOTHER COMMONWEALTH AGENCY, THE FEDERAL GOVERNMENT OR ANY PUBLIC OR PRIVATE SOURCE FOR THE PURPOSE OF IMPLEMENTING THIS SECTION.

SECTION 4307. REPORTING REQUIREMENTS.

THE DEPARTMENT SHALL SUBMIT ANNUALLY TO THE CHAIRMAN AND MINORITY CHAIRMAN OF THE PUBLIC HEALTH AND WELFARE COMMITTEE OF THE SENATE AND THE CHAIRMAN AND MINORITY CHAIRMAN OF THE HEALTH AND HUMAN SERVICES COMMITTEE OF THE HOUSE OF REPRESENTATIVES A

REPORT THAT PROVIDES DETAILS OF THE DEPARTMENT'S EXPENDITURES, INCLUDING ADMINISTRATIVE EXPENDITURES, UNDER THIS SECTION.

SECTION 4308. REGULATIONS.

THE DEPARTMENT SHALL ADOPT RULES AND REGULATIONS TO CARRY OUT THE PROVISIONS OF THIS CHAPTER.

CHAPTER 51

MISCELLANEOUS PROVISIONS

Section 5101. Repeals.

(a) Declaration of policy.--The General Assembly declares that the repeal under subsection (b) is necessary to effectuate this act.

(b) Specific.--Chapter 13 of the act of June 26, 2001 (P.L.755, No.77), known as the Tobacco Settlement Act, is repealed.

(c) Inconsistent.--All acts and parts of acts are repealed insofar as they are inconsistent with this act.

Section 5102. Effective date.

This act shall take effect in 90 days.