RULES AND REGULATIONS

Title 55—PUBLIC WELFARE

DEPARTMENT OF PUBLIC WELFARE

[55 PA. CODE CHS. 1101, 1123, 1149, 1151 AND 1153]

Revisions to General Assistance and Medical Assistance Benefit Packages and Recipient Copayments for Adults

The Department of Public Welfare (Department), under the authority of sections 201(2), 403(b), 443.1, 443.3, 443.6, 448 and 454 of the Public Welfare Code (code) (62 P. S. §§ 201(2), 403(b), 443.1, 443.3, 443.6, 448 and 454), as amended by the act of July 7, 2005 (P. L. 177, No. 42) (Act 42), amends Chapters 1101, 1123, 1149, 1151 and 1153 to read as set forth in Annex A.

Omission of Proposed Rulemaking

Act 42 amended the code by amending and adding several new provisions. Specifically, Act 42 amended section 443.1(4), added section 443.3(b) and (c), amended 443.6 (62 P. S. § 443.6) and added section 454. Sections 443.1(4) and 443.3(b) of the code were amended to provide for limits on behavioral health services for adults eligible for Medical Assistance (MA) under Title XIX of the Social Security Act (42 U.S.C.A. §§ 1396—1396v) and adults eligible for State-only funded General Assistance (GA) MA benefits in the MA fee-for-service (FFS) delivery system. Section 443.6 of the code amended prior authorization (PA) requirements for purchase and rental of durable medical equipment (DME). Section 454 of the code provides that the Department shall promulgate final-omitted regulations to establish the benefit packages and any copayments for adults eligible for MA under Title XIX of the Social Security Act and adults eligible for GA MA benefits. The basis for the final-omitted regulations is section 204(1)(iv) of the act of July 31, 1968 (P. L. 769, No. 240) (45 P. S. § 1204(1)(iv)), known as the Commonwealth Documents Law (CDL). That section authorizes an agency to omit or modify notice of proposed rulemaking when the regulation relates to Commonwealth grants or benefits. In addition, section 454 of the code expressly exempts the Department's regulations from review under the Regulatory Review Act (71 P. S. §§ 745.1—745.15) and from review by the Attorney General under section 205 of the CDL (45 P. S. § 1205) and section 204(b) of the Commonwealth Attorneys Act (71 P. S. § 732-204(b)).

The Department is adopting this final-omitted rulemaking in accordance with section 454 of the code because the amendments pertain to the benefit packages and copayments for recipients 21 years of age and older who are eligible for MA under Title XIX of the Social Security Act and under the State-only-funded GA program.

Purpose

The purpose of this final-omitted rulemaking is to:

1. Amend the current regulations in Chapters 1101, 1151 and 1153 (relating to general provisions; inpatient psychiatric services; and outpatient psychiatric services) to codify the MA benefit packages, including service limits and the criteria for granting exceptions to the limits, for inpatient and outpatient psychiatric services for MA and GA recipients 21 years of age and older in the FFS delivery system, as enacted in sections 2 and 3 of Act 42 (amending section 443.1(4) of the code and adding sections 443.3(a)(3) and (b) to the code).

2. Amend the current regulations in Chapter 1101 to specify the MA benefit packages, including service limits and the criteria for granting exceptions to the limits, for physical health services for MA and GA recipients 21 years of age and older as authorized in section 6 of Act 42 (adding section 454 to the Code) and to make technical changes to clarify the scope of benefits for MA recipients who are not affected by the regulation.

3. Amend the current regulations in Chapter 1101 to revise the copayments for pharmaceutical services for certain MA and GA recipients 18 years of age and older, as authorized in section 6 of Act 42 (adding section 454 to the code), and to permit the managed care organizations (MCOs) that contract with the Department to impose copayments for certain services, as authorized under Federal law. See 42 CFR 438.108 and 447.60 (relating to cost sharing; cost-sharing requirements for services furnished by MCOs).

4. Amend the current regulations in Chapter 1123 (relating to medical supplies) to codify amendments to MA payment policies for purchase and rental of DME as enacted in section 4 of Act 42 (amending section 443.6(b) of the code).

5. Amend the current regulations in Chapter 1101 to conform to existing MA policies as effected by earlier amendments to the code as well as a court-approved stipulation of settlement.

6. Make various technical revisions throughout Chapters 1101, 1123, 1149, 1151 and 1153 to add definitions, delete obsolete terms and add or amend cross-references to enhance the readability of the regulations.

Background

The Department administers an MA Program under Title XIX of the Social Security Act for low-income, aged and disabled individuals, mothers with children, low-income workers with disabilities and women diagnosed with breast or cervical cancer. In addition, the Department administers an MA Program for GA recipients, principally single adults, that is funded solely by State funds and is not mandated by the Federal government. This Commonwealth is one of a few states that has a GA Program. Both MA programs provide a continuum of physical and behavioral health services, including long-term care, inpatient hospital, pharmacy, outpatient services such as physician, podiatric, medical and psychiatric clinic, chiropractic services, dental services, medical supplies and DME to approximately 1.8 million eligible MA recipients.

In State Fiscal Year (SFY) 2002-2003, the most recent year for which complete data is available, the MA expenditures for the Federal program were more than $9.2 billion. For the same State fiscal year, MA expenditures for GA recipients were more than $399 million, of which almost $84 million was expended for acute inpatient hospital care. MA expenditures have continued to increase at an exponential rate. The MA caseload is projected to increase by 5.9% in SFY 2005-2006. MA costs for the State fiscal year are projected to increase by 6.7% while State revenues for the same period are projected to increase by only 2.8%. In the face of the ever-increasing caseload and expenditures, advances in medical technology and treatment and stagnant State revenues, the

Department confronted the same challenge faced by Medicaid programs Nationwide to identify cost containment initiatives that would achieve the necessary savings without compromising the health care of the MA population by drastically reducing or even eliminating benefits.

To meet this challenge, during SFY 2004-2005 the Department implemented several MA initiatives to contain costs, generate additional revenue and enhance the quality of care before considering the last resort of modifying recipient benefit packages. For example, the Department expanded its primary case management program to include MA recipients 21 years of age and older in counties that are not included in HealthChoices, the Department's mandatory managed care program. The expanded program, known as ACCESS Plus, not only provides a medical home to MA recipients who previously did not have one but also offers a voluntary disease management program to provide case management services to MA recipients who have asthma, diabetes, congestive heart failure, chronic obstructive pulmonary disease or coronary artery disease. The Department increased the fees paid for primary care provider office visits by 30% to provide incentives to promote primary care.

The Department also began an initiative to expand PA of certain pharmaceuticals based on its assessment—informed by input from practitioners with expertise in the field—of the most efficacious and cost-effective drugs in a therapeutic class. The increased use of PA is intended in the first instance to minimize the use of unnecessary drug regimens. As part of the same initiative, the Department issued a Request for Proposals to implement a preferred drug list (PDL). By establishing a PDL, the Department will not only afford MA recipients the benefit of experts' review of the most efficacious and cost-effective drugs but also expects to generate additional revenue of $25 million to $37.5 million annually in supplemental rebates from drug manufacturers.

Finally, the Department obtained approval from the Centers for Medicare and Medicaid Services to impose provider assessments on MCOs, long-term care facilities and intermediate care facilities for the mentally retarded. Through these assessments, the Department realized $350 million in additional revenue to support the MA Program.

Even with the success of these initiatives, the Department was compelled to examine other aspects of the MA Program to achieve the needed savings. In conducting this review, the Department evaluated proposals that other State Medicaid programs have considered or implemented. These proposals include imposition of provider assessments, changes in recipient eligibility criteria, decreased benefits and reduced provider fees. From among the options that it had not yet pursued, the Department rejected changes in eligibility as inconsistent with its goal of maintaining comprehensive benefit packages for as many individuals as possible. The Department also rejected the wholesale elimination of even some benefits as inconsistent with the same goal as well as counterproductive, since elimination of MA benefits would likely result in increased expenditures for more costly services and the shifting of costs to other programs within the Department and other Commonwealth agencies, such as child welfare and juvenile justice, mental health and mental retardation, the Department of Education or the Department of Aging. Finally, the Department rejected across-the-board provider fee reductions because reductions could cause some providers to discontinue participation in the MA program, which could potentially result in reduced access to needed services.

The Department also solicited and considered cost-containment recommendations submitted by the Medical Assistance Advisory Committee (MAAC) and its subcommittees as well as other advocacy organizations. Of the many suggested proposals, the Department had already implemented several and agreed to pursue others. None of the recommendations would, however, realize the necessary savings in the current fiscal year.

After reviewing the various options available to it, the Department concluded that the changes that would best achieve the goal of containing costs while continuing to make services available to the greatest number of MA recipients were to impose only a few service-specific limits, subject to exceptions in specified circumstances; modify copayments for brand name and generic drugs in the FFS delivery system; and permit its contracted MCOs to impose copayments up to those imposed by the Department in the FFS delivery system. The MCOs that provide services in the Department's voluntary and mandatory managed care programs have the option of imposing the same or lesser physical health service-specific limits. If the MCOs establish service limits, they must also establish an exceptions process. These limited changes to the MA Program will enable the Department to preserve the vital benefits to the greatest number of MA recipients in a fiscally responsible and cost-effective manner.

The Department informed providers and affected recipients of the benefit package and copayment changes, as well as the criteria and process for requesting exceptions to the limits, by individual notice mailed to each recipient household and each provider enrolled in the MA Program. Providers will receive additional information regarding the exception process by means of MA Bulletins and updates to provider handbooks. The Department will also issue paper vouchers to adult MA recipients, to be given to the provider during a visit that is subject to the 18-visit limit, as is the current procedure for adult GA recipients. MCOs that choose to exercise the option of imposing the same or fewer service-specific limits for some services or copayments for certain services will issue individual notice to their members, advising them of the specific benefit package changes and copayments, at least 30 days before the changes become effective. The MCOs will also notify their network providers of the changes they intend to implement.

Service-Specific Limits

The service-specific limits are designed to meet the medical needs of the vast majority of MA recipients. To protect its most vulnerable MA population, the Department imposed the service-specific limits only on adult MA and adult GA recipients, 21 years of age or older, excluding pregnant women. MA and GA recipients under 21 years of age are not affected by this final-omitted rulemaking and remain eligible for all medically necessary services. Likewise, pregnant recipients are not affected by this final-omitted rulemaking and remain eligible for all medically necessary services covered under the categorically needy and medically needy categories of MA and the categorically needy and medically needy only categories of GA.

The Department developed the service-specific limits mindful of the Federal requirement that the amount, duration and scope of each MA service must be sufficient to reasonably achieve its purpose. See 42 CFR 440.230(b) (relating to sufficiency of amount, duration, and scope). Specifically, the limits on inpatient medical rehabilitation and acute care hospital admissions are such that the majority of recipients will not be affected. For example, of

the approximately 760 adult MA and GA recipients in the MA FFS delivery system who were admitted to an inpatient medical rehabilitation hospital during SFY 2002-2003, 84.3% had only one admission. Similarly, of the approximately 3,774 adult GA recipients in the FFS delivery system who were admitted to an inpatient acute care hospital during SFY 2002-2003, 76.5% had only one admission.

The 18-visit limit on office and clinic visits, which has been in place for GA recipients since 1993 (see 22 Pa.B. 5995 (December 12, 1992)), will likewise not affect the majority of recipients. In the first instance, the limit applies only to specified procedures: evaluation and management and consultations by physicians, podiatrists, optometrists and certified registered nurse practitioners; general ophthalmologic services by ophthalmologists and optometrists; examination and manipulation services by chiropractors; and outpatient hospital clinic, independent medical clinic, rural health clinic and Federally qualified health center visits. Of the estimated 66,259 adult MA recipients who used practitioner and clinic visits in the MA FFS delivery system during SFY 2002-2003, 91.6% used 18 or fewer visits. Of the approximately 9,141 adult GA recipients who are currently subject to this limit and needed these services in the FFS delivery system during SFY 2002-2003, only 172 used more than 18 visits during the fiscal year; 98.1% used 18 or fewer visits.

In addition to the service-specific limits established by the Department in this final-omitted rulemaking, sections 2 and 3 of Act 42 imposed limits on inpatient and outpatient psychiatric services in the FFS delivery system, which the Department is also codifying through this final-omitted rulemaking. As with the service limits established by the Department, those enacted in Act 42 are also designed to meet the needs of the most recipients and to maintain the amount, duration and scope of the services to reasonably achieve their purpose.

For example, of the approximately 16,823 adult MA and GA recipients in the MA FFS delivery system who were admitted to a private inpatient psychiatric hospital or psychiatric unit during FY 2002-2003, 93.2% had stays of 30 or fewer days. Similarly, the vast majority of adult MA and GA recipients in the FFS delivery system had fewer than 5 hours of psychotherapy in an outpatient psychiatric clinic in a 30-day period: of the approximately 80,557 adult MA and GA recipients in the MA FFS delivery system who received psychotherapy during FY 2002-2003, 92.4% received 5 or fewer hours. Finally, of the estimated 4,967 adult MA and GA recipients in the FFS delivery system who received psychiatric partial hospitalization services during SFY 2002-2003, 91.3% received 540 or fewer hours.

The impact of the service-specific limits will be further ameliorated by the exceptions to the limits authorized by Act 42. Specifically, sections 443.3(b) and 454(c) of the code, as added by Act 42, authorize the Department to grant exceptions to allow payment for services beyond the established limits and specify the criteria that the Department will use to review exception requests. The Department has codified the exceptions process for both adult MA and adult GA recipients in § 1101.31(f) (relating to scope) to enable it to grant an exception when it determines that: the recipient has a serious chronic systemic illness or other serious health condition and denying the exception will jeopardize the recipient's life or result in the serious deterioration of the recipient's health; granting the exception is a cost-effective alternative for the MA Program; or granting the exception is necessary to comply with Federal law. The Department will apply the exceptions criteria in substantially the same way that it has applied the existing exceptions criteria for adult GA recipients.

To facilitate review of requests for exceptions to the service-specific limits, the Department will automate approval of several types of exception requests. For example, a request for an exception to the 18-visit service limit to visit a recipient's primary care practitioner (PCP) will be automatically approved. A request for an exception to the 18-visit service limit to visit a specialist on referral from a PCP will likewise be automatically approved. A request for an exception to the acute inpatient limit for adult GA recipients when the admission required care in an intensive care unit will also be automatically approved.

Copayments

The Department evaluated a broad range of potential copayment changes for recipients, which included both new copayments for services that do not currently have a copayment and increases to existing copayments. Rather than having to impose some of the more significant proposals under consideration, the Department is able to limit the copayment changes in the FFS delivery system to a nominal revision to copayments for brand name and generic drugs for MA and GA recipients 18 years of age and older. In addition, the Department is permitting MA MCOs to apply nominal copayments to recipients for the same services and up to the same amounts that are imposed in the FFS delivery system. MA and GA recipients who are under 18 years of age, pregnant or residents in an institution remain exempt from these copayment changes. The Department is making no other changes to recipient copayments.

The copayment for brand name drugs is increased from $1 for MA recipients and from $2 for GA recipients to $3 per prescription or refill for both MA and GA recipients. The copayment for generic drugs is reduced for GA recipients from $2 to $1 per prescription or refill and remains at $1 per prescription or refill for MA recipients. This nominal copayment revision supports the Department's general goal of encouraging the use of cost-effective generic drugs whenever appropriate while imposing limited additional liability on recipients.

DME

Act 42 amended section 443.6(b) of the code to raise the payment limit for DME and surgical supplies from $100 to $600 unless prior authorized by the Department and to permit rental of DME for 6 months rather than 3 months before PA is required. The original limits were enacted in 1978 and have not been amended since then. Act 42 amended the limits to account for increases in the cost of DME and medical supplies since 1978. Act 42 also authorizes the Department to continue to require PA for purchase of DME that costs less than $600 and rental of DME for fewer than 6 months.

Technical Amendments

The Department promulgated regulations published at 22 Pa.B. 5995 to establish a GA Basic Health Care package and to limit dental services for all recipients 21 years of age and older, to be effective on January 1, 1993. The GA Basic Health Care package established certain benefit limits, including a combined maximum of 18 practitioner and clinic visits per fiscal year; 3 prescriptions (including refills) per month in specific drug classes; 30 days of inpatient medical rehabilitation hospital per fiscal year; 30 days of inpatient drug and alcohol care per

fiscal year; 30 home health visits per fiscal year; emergency room care for emergency use only, and ambulance services for emergency transport only. The regulations also established criteria and procedures for requesting an exception to some of the limits.

After the regulations were promulgated but before the effective date, the regulations were enjoined on December 31, 1992, by the United States District Court for the Eastern District of Pennsylvania in *Felix v. Casey*, No. 92-CV-7376 (E. D. Pa.). Under the terms of a court-approved Stipulation of Settlement, the GA Basic Health Care package was modified to increase the prescription limit per month to six and to expand drug coverage to all classes of legend drugs included in the Department's Drug Reference File. Dental benefits were restored with certain limitations for all categories of recipients but limited to inpatient, short procedure unit and ambulatory surgical center settings for the medically needy categories of recipients. See 23 Pa.B. 4583 (September 25, 1993). These policies have been in place since July 1, 1993, and this final-omitted rulemaking amends §§ 1101.31(b) and (e) and 1149.21—1149.24.

Section 1101.31(e) is also amended to conform to a Notice of Rule Change published at 26 Pa.B. 2132 (May 4, 1996), which removed family planning clinic visits from the 18-visit limit on practitioner and clinic services in the GA Basic Health Care package.

Section 1101.31(d) is amended to eliminate the cross-reference to the categorically needy scope of benefits in § 1101.31(b) and restate the State Blind Pension (SBP) scope of benefits, § 1101.31(d). Because the changes to benefit limits and copayments that apply to the adult MA and GA populations do not apply to SBP recipients, the SBP benefit package must now be described separately. These amendments are purely technical in nature and do not alter the current scope of benefits for SBP recipients.

Finally, this final-omitted rulemaking adds § 1101.63(c) (relating to payment in full) to codify the $150 deductible per fiscal year that applies to adult GA recipients for ambulatory surgical center services and inpatient or outpatient hospital services, excluding laboratory and X-ray services, as currently specified in section 448 of the code.

Requirements

A. *Benefit limits, exceptions, copayments, and conditions for payment*. The final-omitted rulemaking amends the current scope of benefits for categorically and medically needy adult MA recipients and chronically and medically needy only adult GA recipients, codifies the exception criteria and process required under Act 42, amends copayment requirements and codifies conditions of payment for DME as follows:

1. *Practitioners' visits and clinic visits*. Section 1101.31(b)(2) is amended to provide that the Department will pay for up to a combined total of 18 office or home visits per SFY by practitioners and clinics for adult MA recipients.

2. *Inpatient medical rehabilitation hospital admissions*. Section 1101.31(b)(1) and (e)(1)(iv)(B) is amended to provide that the Department will pay for one admission to an inpatient rehabilitation hospital per SFY for both adult MA and adult GA recipients.

3. *Inpatient acute care hospital admissions*. Section 1101.31(e)(1)(iv)(A) is amended to provide that the Department will pay for one admission to an inpatient acute care hospital per SFY for adult GA recipients.

4. *Private inpatient psychiatric hospital care*. Sections 1101.31(b)(7) and (e)(1)(xii), 1151.2, 1151.21(b), 1151.22(b) and 1151.43(a) and (c) are amended to codify that the Department will pay for up to 30 days of inpatient care in a private psychiatric hospital or psychiatric unit per SFY, for both adult MA and adult GA recipients.

5. *Outpatient psychiatric clinic services*. Sections 1101.31(b)(11)(iii) and (e)(1)(xiii)(C) and 1153.53(a)(4) and (b) (relating to limitations on payment) are amended to codify that the Department will pay for psychotherapy provided by outpatient psychiatric clinics, up to 5 hours or 10 1/2 hour sessions every 30-consecutive-day period for both adult MA and adult GA recipients.

6. *Psychiatric partial hospitalization services*. Sections 1101.31(b)(3)(ii) and (e)(1)(viii)(B) and 1153.53(a)(1) and (b) are amended to codify that the Department will pay for psychiatric partial hospitalization, up to 540 hours per SFY, for both adult MA and adult GA recipients.

7. *Exceptions*. Section 1101.31(f) is added to codify the exceptions criteria enacted in Act 42 and to set forth the process for requesting an exception to a service-specific limit. Because the Department's application of the exceptions criteria will not be substantively different from application of the exceptions criteria currently in effect under § 1101.31 for GA recipients, these amendments also delete § 1101.31(e)(4)—(6) and consolidate the current GA exceptions process and the new exceptions process in § 1101.31(f), which applies to both adult MA and adult GA recipients.

8. *Copayments*. Section 1101.63(b)(2)(viii) and (ix) is amended to delete the exclusion of copayments by health maintenance organizations, to permit MCOs to apply nominal recipient copayments in the mandatory and voluntary managed care programs and to delete reference to health insuring organizations, which is an obsolete term. Section 1101.63(b)(5)(i) is amended to modify the copayment required of MA and GA recipients 18 years of age and older for brand name drugs to $3 per prescription and $3 per refill. Section 1101.63(b)(6)(i) is amended to modify the copayment required of MA and GA recipients 18 years of age and older for generic drugs to $1 per prescription and $1 per refill.

9. *Payment conditions for DME*. Section 1123.60(e) and (f) is amended to codify the payment conditions for DME specified in section 443.6(b) of the code, as amended by Act 42, to raise the payment limit for DME and surgical supplies to a maximum of $600 unless prior authorized by the Department and the rental of DME to 6 months before PA is required.

B. *Additional technical amendments*. Additional technical amendments in this final-omitted rulemaking are as follows:

1. *Scope of benefits for SBP recipients*. Section 1101.31(d) is amended to set forth the scope of benefits for SBP recipients and eliminate the cross-reference to the categorically needy scope of benefits in § 1101.31(b). This is purely a technical amendment. The scope of benefits for these recipients remains unchanged.

2. *Scope of benefits for GA chronically needy recipients*. Section 1101.31(e)(1) is amended to set forth the scope of benefits for GA chronically needy recipients; eliminate the cross-reference to the categorically needy scope of benefits in § 1101.31(b); codify the existing benefit limits on prescription drugs and dental services; and delete family planning clinic services from the 18-visit limit.

3. *Scope of benefits for MA medically needy and GA medically needy only recipients*. Section 1101.31(c) and

(e)(2) is amended to conform to Chapter 1143 (relating to podiatrists' services) to specify that podiatrists' services are included within the scope of benefits for these recipients.

4. *GA MA Deductible.* Section 1101.63(c) is added to codify the $150 deductible per fiscal year that applies to adult GA recipients for specified services, as required by section 448 of the code.

5. *Other technical amendments.* The Department is making various minor technical amendments throughout Chapters 1101, 1123, 1149, 1151 and 1153 to define and update terminology, as well as establish and update cross-references between Chapter 1101 and related service-specific chapters for the sole purpose of enhancing the clarity and readability of the regulations.

Affected Individuals and Organizations

Hospitals, including acute care and medical rehabilitation hospitals, private inpatient psychiatric hospitals and units of general hospitals, practitioners, outpatient psychiatric clinics and pharmacies that provide services to adult MA and GA recipients will be affected by the final-omitted rulemaking.

Adult MA and GA recipients except pregnant women who receive services in the FFS delivery system will be affected by the final-omitted rulemaking, which imposes limits on various inpatient and outpatient behavioral and physical health services and increases the copayment for brand name drugs while reducing or maintaining the copayment for generic drugs. Adult MA and GA recipients except pregnant women who receive services in the managed care delivery system could be affected by the final-omitted rulemaking because the MCOs are authorized to impose the physical health service limits and all copayments that are currently imposed in the FFS delivery system.

Accomplishments and Benefits

This final-omitted rulemaking makes limited changes to the MA Program that will enable the Department to preserve the vital benefits to the greatest number of MA recipients in a fiscally responsible and cost-effective manner. The service-specific limits are designed to meet the medical needs of the vast majority of MA recipients. The nominal copayment revisions support the Department's general goal of encouraging the use of cost-effective generic drugs whenever appropriate while imposing limited additional liability on recipients. By implementing these changes, the Department was able to avoid either the elimination of services or the termination of MA recipients from MA coverage.

Fiscal Impact

The revised benefit packages for adult MA and GA recipients will result in reduced payments for inpatient rehabilitation hospital admissions, inpatient acute care hospital admissions, private inpatient psychiatric hospital admissions, outpatient psychiatric clinic and psychiatric partial hospitalization services and practitioner and clinic visits. The Commonwealth expects to realize $104.727 million ($ 72.888 million in State funds) in savings in FY 2005-2006. The changes in copayments for brand name and generic drugs will result in savings of $ 6.517 million ($ 2.920 million in State funds) in FY 2005-2006.

Paperwork Requirements

There will be no new paperwork requirements as a result of the final-omitted rulemaking. Providers, practitioners and recipients will use the existing Program Exception process authorized in § 1150.63 (relating to waivers) to request exceptions to the service-specific limits.

Public Process

The Department discussed various proposed service-specific limits and copayment changes at meetings of the MAAC, as well as the Consumer and Fee-for-Service Delivery System Subcommittees of the MAAC, on an ongoing basis since February 24, 2005. Both issues were discussed at the MAAC meetings on February 24, 2005, March 24, 2005, April 28, 2005, and May 26, 2005; at the Consumer Subcommittee meetings on February 23, 2005, March 23, 2005, April 27, 2005, May 25, 2005, and June 22, 2005; and at the Fee-for-Service Delivery System Subcommittee meetings on February 14, 2005, and April 13, 2005. The Department distributed charts describing the various scope of benefit and copayment changes being considered, solicited input and alternative cost-containment strategies and responded to questions.

After Act 42 was enacted, the Department presented the final service-specific limits and copayment revisions at the MAAC meeting on July 28, 2005. The Department also presented a draft of the recipient notice, advising of the benefit package and copayment changes, to the Consumer Subcommittee of the MAAC for review and comment and revised the notice in response to comments received.

Regulatory Review Act

Under section 454 of the code, this final-omitted rulemaking is not subject to review under the Regulatory Review Act.

Findings

The Department finds that:

(1) Notice of proposed rulemaking is omitted in accordance with section 204(1)(iv) of the CDL and 1 Pa. Code § 7.4(1)(iv) because the regulation relates to Commonwealth grants and benefits.

(2) Adoption of this regulation in the manner provided by this order is necessary and appropriate for the administration and enforcement of the code.

Order

The Department, acting under the code, orders that:

(a) The regulations of the Department, 55 Pa. Code Chapters 1101, 1123, 1149, 1151 and 1153, are amended by amending §§ 1101.21, 1101.31, 1101.63, 1123.21, 1123.24, 1123.60, 1149.2, 1149.21, 1149.22, 1149.23, 1149.24, 1151.2, 1151.21, 1151.22, 1151.24, 1151.43, 1153.53 to read as set forth in Annex A.

(b) The Secretary of the Department shall submit this order and Annex A to the Office of General Counsel for approval as to legality and form as required by law.

(c) The Secretary of the Department shall certify and deposit this order and Annex A with the Legislative Reference Bureau as required by law.

(d) This order shall take effect on August 29, 2005.

ESTELLE B. RICHMAN,
Secretary

Fiscal Note: 14-500. No fiscal impact; (8) recommends adoption. Implementation of this rulemaking will generate savings to the General Fund beginning in Fiscal Year 2005-2006 of $75.8 million.

Annex A

TITLE 55. PUBLIC WELFARE

PART III. MEDICAL ASSISTANCE MANUAL

CHAPTER 1101. GENERAL PROVISIONS

DEFINITIONS

§ 1101.21. Definitions.

The following words and terms, when used in this part, have the following meanings, unless the context clearly indicates otherwise:

Adult—An MA recipient 21 years of age or older.

CRNP—Certified registered nurse practitioner.

Categorically needy—Aged, blind or disabled individuals or families and children who are otherwise eligible for Medicaid and who meet the financial eligibility requirements for TANF, SSI or an optional State supplement.

Complete medical history—A chronological medical record which includes, but is not limited to, major complaints, present medical history, past medical history, family history and social history.

County Assistance Offices or *CAOs*—The local offices of the Department that administer the MA Program on the local level. They determine recipient eligibility and perform other necessary MA functions such as prior authorization and client referral to a source of medical services.

Covered service—A benefit to which a MA recipient is entitled under the MA Program of the Commonwealth.

Department—The Department of Public Welfare of the Commonwealth or a subagency thereof.

Emergency situation—A condition in which immediate medical care is necessary to prevent the death or serious impairment of health of the individual.

Enroll—The act of becoming eligible to participate in the MA Program by completing the provider enrollment form, entering into or renewing as required a written provider agreement and meeting other participation requirements specified in this chapter and the appropriate separate chapters relating to each provider type.

EPSDT—Early and Periodic Screening, Diagnosis and Treatment Program.

FQHC—Federally qualified health center.

Factor—An individual or an organization, such as a service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold or transferred to the individual or organization for an added fee or a deduction of a portion of the accounts receivable.

GA—General Assistance—MA funded solely by State funds as authorized under Article IV of the Public Welfare Code (62 P. S. §§ 401—488).

General public—Payors other than Medicaid. The term includes other health insurance plans.

HHS—The United States Department of Health and Human Services or its successor agency, which is given responsibility for implementation of Title XIX of the Social Security Act.

MA—Medical Assistance.

Medicaid—Medical Assistance provided under a State Plan approved by HHS under Title XIX of the Social Security Act.

Medical facility—A licensed or approved hospital, skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, public clinic, shared health facility, rural health clinic, psychiatric clinic, pharmacy, laboratory, drug and alcohol clinic, partial hospitalization facility or family planning clinic.

Medically necessary—A service, item, procedure or level of care that is:

(i) Compensable under the MA Program.

(ii) Necessary to the proper treatment or management of an illness, injury or disability.

(iii) Prescribed, provided or ordered by an appropriate licensed practitioner in accordance with accepted standards of practice.

Medically needy—A term used to refer to aged, blind or disabled individuals or families and children who are otherwise eligible for Medicaid and whose income and resources are above the limits prescribed for the categorically needy but are within limits set under the Medicaid State Plan.

Noncompensable item—A service or supply a provider furnishes for which there is no provision for payment under this part.

Parent/caretaker—The person responsible for the care and control of an unemancipated minor child. This includes mother or father, grandmother or grandfather, stepmother or stepfather or another relative related by blood or marriage.

Postpartum period—The period beginning on the last day of the pregnancy and extending through the end of the month in which the 60-day period following termination of the pregnancy ends.

Practitioner—A medical doctor, doctor of osteopathy, dentist, optometrist, podiatrist, chiropractor or other medical professional licensed by the Commonwealth or by another state who is authorized to participate in the MA Program as a provider.

Prepayment review—Determination of the medical necessity of a service or item before payment is made to the provider. Prepayment review is performed after the service or item is provided and involves an examination of an invoice and related material, when appropriate. Prepayment review is not prior authorization.

Prior authorization—A procedure specifically required or authorized by this title wherein the delivery of an MA item or service is either conditioned upon or delayed by a prior determination by the Department or its agents or employees that an eligible MA recipient is eligible for a particular item or service or that there is medical necessity for a particular item or service or that a particular item or service is suitable to a particular recipient.

Professional Standards Review Organization or *PSRO*—An organization which HHS has charged with the responsibility for operating professional review systems to determine whether hospital services are medically necessary, provided appropriately, carried out on a timely basis and meet professional standards.

Program—The MA program of the Commonwealth.

Provider—An individual or medical facility which signs an agreement with the Department to participate in the MA program, including, but not limited to: licensed practitioners, pharmacies, hospitals, nursing homes, clinics, home health agencies and medical purveyors.

Public clinic—A health clinic operated by a Federal, State or local governmental agency.

Purveyor—A person other than a practitioner who, directly or indirectly, engages in the business of supplying to patients medical supplies, equipment or services for which reimbursement under the MA program is received, including, but not limited to: clinical laboratory services or supplies, X-ray laboratory services or supplies, inhalation therapy services or equipment, ambulance services, sick room supplies, physical therapy services or equipment, and orthopedic or surgical appliances or supplies.

Recipient—A person or family that is eligible for MA benefits.

School child—A child attending a kindergarten, elementary, grade or high school, either public or private.

Shared health facility—An entity other than a licensed or approved hospital facility, skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, rural health clinic, public clinic or Health Maintenance Organization in which:

(i) Medical services, either alone or together with support services, are provided at a single location.

(ii) Services are provided by three or more practitioners, two or more of whom are practicing within different professions.

(iii) Practitioners share any of the following: common waiting areas, examining rooms, equipment, supporting staff or records.

(iv) At least one practitioner receives payment on a fee for service basis.

(v) A provider receiving more than $30,000 in payment from the MA Program during the 12-month period prior to the date of the initial or renewal application of the shared health facility for registration in the MA Program.

State Blind Pension recipient—An individual 21 years of age or older who by virtue of meeting the requirements of Article V of the Public Welfare Code (62 P. S. §§ 501—515) is eligible for pension payments and payments made on his behalf for medical or other health care, with the exception of inpatient hospital care and post-hospital care in the home provided by a hospital. Payment for medical and health care is made solely from Commonwealth funds since these individuals do not meet the criteria for Federal funding of their medical care under Medicaid.

BENEFITS

§ 1101.31. Scope.

(a) *Scope.* The scope of benefits for which MA recipients are eligible differs according to recipients' categories of assistance, as described in this section.

(1) Recipients under 21 years of age are eligible for all medically necessary services.

(2) The benefit limits specified in subsections (b), (c), and (e) apply only to adults, with the exception of pregnant women, including throughout the postpartum period.

(3) Recipients shall exhaust other available medical resources prior to receiving MA benefits.

(b) *Categorically needy.* The categorically needy are eligible for all of the following benefits:

(1) Inpatient hospital services other than services in an institution for mental disease, as specified in Chapter 1163 (relating to inpatient hospital services), including one medical rehabilitation hospital admission per fiscal year.

(2) Up to a combined maximum of 18 clinic, office and home visits per fiscal year by physicians, podiatrists, optometrists, CRNPs, chiropractors, outpatient hospital clinics, independent medical clinics, rural health clinics, and FQHCs.

(3) Outpatient hospital services as follows:

(i) Short procedure unit services as specified in Chapter 1126 (relating to ambulatory surgical center services and hospital short procedure unit services).

(ii) Psychiatric partial hospitalization services as specified in Chapter 1153 (relating to outpatient psychiatric services) up to one hundred and eighty three-hour sessions, 540 total hours, per recipient per fiscal year.

(iii) Outpatient hospital clinic services as specified in Chapter 1221 (relating to clinic and emergency room services) and in paragraph (2).

(iv) Rural health clinic services and FQHC services as specified in Chapter 1129 (relating to rural health clinic services) and in paragraph (2).

(4) Laboratory and X-ray services as specified in Chapter 1243 (relating to outpatient laboratory services) and Chapter 1230 (relating to portable x-ray services).

(5) Nursing facility care as specified in Chapter 1181 (relating to nursing facility care) and Chapter 1187 (relating to nursing facility services).

(6) Intermediate care.

(7) Inpatient psychiatric care as specified in Chapter 1151 (relating to inpatient psychiatric services), up to 30 days per fiscal year.

(8) Physicians' services as specified in Chapter 1141 (relating to physicians' services) and in paragraph (2).

(9) Optometrists' services as specified in Chapter 1147 (relating to optometrists' services) and in paragraph (2).

(10) Home health care as specified in Chapter 1249 (relating to home health agency services).

(11) Clinic services as follows:

(i) Independent medical clinic services as specified in Chapter 1221 (relating to clinic and emergency room services) and in paragraph (2).

(ii) Ambulatory surgical center services as specified in Chapter 1126 (relating to ambulatory surgical center services and hospital short procedure unit services).

(iii) Psychiatric clinic services as specified in Chapter 1153 (relating to outpatient psychiatric services), including up to 5 hours or 10 one-half hour sessions of psychotherapy per recipient in a 30 consecutive day period.

(iv) Drug and alcohol clinic services, including methadone maintenance, as specified in Chapter 1223 (relating to outpatient drug and alcohol clinic services).

(12) Ambulance services as specified in Chapter 1245 (relating to ambulance transportation).

(13) Dental services as specified in Chapter 1149 (relating to dentists' services).

(14) Medical equipment, supplies, prostheses, orthoses and appliances as specified in Chapter 1123 (relating to medical supplies).

(15) EPSDT services, for recipients under 21 years of age as specified in Chapter 1241 (relating to early and periodic screening, diagnosis, and treatment program).

(16) Family planning services and supplies as specified in Chapter 1245 (relating to family planning clinic services).

(17) Drugs as specified in Chapter 1121 (relating to pharmaceutical services).

(18) Chiropractic services as specified in Chapter 1145 (relating to chiropractors' services) limited to the visits specified in paragraph (2).

(19) Podiatrists' services as specified in Chapter 1143 (relating to podiatrists' services) and in paragraph (2).

(20) CRNP services as specified in Chapter 1144 (relating to certified registered nurse practitioner services) and in paragraph (2).

(c) *Medically needy*. The medically needy are eligible for the benefits in subsection (b) with the exception of the following:

(1) Medical equipment, supplies, prostheses, orthoses and appliances.

(2) Drugs.

(d) *State Blind Pension*. State Blind Pension recipients are eligible for the following benefits:

(1) Outpatient hospital services as follows:

(i) Psychiatric partial hospitalization services as specified in Chapter 1153 up to 240 three-hour sessions, 720 total hours, per recipient in a 365 consecutive day period.

(ii) Rural health clinic services and FQHC services, as specified in Chapter 1129.

(2) Physicians' services as specified in Chapter 1141.

(3) Optometrists' services as specified in Chapter 1147.

(4) Home health care as specified in Chapter 1249.

(5) Clinic services as follows:

(i) Psychiatric clinic services as specified in Chapter 1153, including up to 7 hours or 14 one-half hour sessions of psychotherapy per recipient in a 30 consecutive day period.

(ii) Drug and alcohol clinic services, including methadone maintenance, as specified in Chapter 1223.

(6) Ambulance services as specified in Chapter 1245.

(7) Dental services as specified in Chapter 1149.

(8) Family planning services and supplies as specified in Chapter 1245.

(9) Drugs as specified in Chapter 1121.

(10) Chiropractors' services as specified in Chapter 1145.

(e) *GA recipients*. GA recipients are eligible for benefits as follows:

(1) GA chronically needy and nonmoney payment recipients are eligible for all of the following benefits:

(i) Up to a combined maximum of 18 clinic, office, and home visits per fiscal year by physicians, podiatrists, optometrists, CRNPs, chiropractors, outpatient hospital clinics, independent medical clinics, rural health clinics and FQHCs.

(ii) Home health care as specified in Chapter 1249, up to a maximum of 30 visits per fiscal year.

(iii) Legend and nonlegend drugs as specified in Chapter 1121 not to exceed a maximum of six prescriptions and refills per month.

(iv) Inpatient hospital services other than services in an institution for mental disease as specified in Chapter 1163, as follows:

(A) One acute care inpatient hospital admission per fiscal year.

(B) One medical rehabilitation hospital admission per fiscal year.

(C) Up to 30 days of drug and alcohol inpatient hospital care per fiscal year.

(v) Outpatient hospital services as follows:

(A) Short procedure unit services as specified in Chapter 1126.

(B) Psychiatric partial hospitalization services as specified in Chapter 1153, up to 180 three-hour sessions, 540 total hours, per recipient per fiscal year.

(C) Outpatient hospital clinic services as specified in Chapter 1221 and in subparagraph (i).

(D) Rural health clinic services and FQHC services as specified in Chapter 1129 and in subparagraph (i).

(vi) Ambulance services as specified in Chapter 1245, for medically necessary emergency transportation and transportation to a nonhospital drug and alcohol detoxification and rehabilitation facility from a hospital when a recipient presents to the hospital for inpatient drug and alcohol treatment and the hospital has determined that the required services are not medically necessary in an inpatient facility.

(vii) Emergency room care as specified in Chapter 1221, limited to emergency situations as defined in §§ 1101.21 and 1150.2 (relating to definitions; and definitions).

(viii) Laboratory and X-ray services as specified in Chapter 1243 and Chapter 1230.

(ix) Nursing facility care as specified in Chapter 1181 and Chapter 1187.

(x) Intermediate care.

(xi) Inpatient psychiatric care as specified in Chapter 1151, up to 30 days per fiscal year.

(xii) Clinic services as follows:

(A) Independent medical clinic services as specified in Chapter 1221 and in subparagraph (i).

(B) Ambulatory surgical center services as specified in Chapter 1126.

(C) Psychiatric clinic services as specified in Chapter 1153, including a total of 5 hours or 10 one-half hour sessions of psychotherapy per recipient in a 30 consecutive day period.

(D) Drug and alcohol clinic services, including methadone maintenance, as specified in Chapter 1223.

(xiii) Physicians' services as specified in Chapter 1141 and in subparagraph (i).

(xiv) Dental services as specified in Chapter 1149.

(xv) Podiatrists' services as specified in Chapter 1143 and in subparagraph (i).

(xvi) Chiropractic services as specified in Chapter 1145 limited to the visits specified in subparagraph (i)

(xvii) CRNP services as specified in Chapter 1144 and in subparagraph (i).

(xviii) Medical equipment, supplies, prostheses, orthoses and appliances as specified in Chapter 1123.

(xix) Family planning services and supplies as specified in Chapter 1225.

(2) GA medically needy only recipients are eligible for the benefits described in paragraph (1) of subsection (e), with the following exceptions:

(i) Medical equipment, supplies, prostheses, orthoses and appliances.

(ii) Drugs.

(3) The Department will inform recipients subject to the limits established in this subsection and medical service providers of these limits and the recipient's current usage of limited services. When the Department determines that a recipient's usage of services is likely to exceed the limits established by this subsection, it will review the case to determine whether the recipient should be referred to the Disability Advocacy Program.

(f) *Exceptions.*

(1) The Department is authorized to grant exceptions to the limits specified in subsections (b) and (e) when it determines that one of the following criteria applies:

(i) 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 serious deterioration of the health of the recipient.

(ii) Granting the exception is a cost-effective alternative for the MA Program.

(iii) Granting the exception is necessary in order to comply with Federal law.

(2) The process for requesting an exception is as follows:

(i) A recipient or a provider on behalf of a recipient may request an exception.

(ii) A request for an exception may be made to the Department in writing, by telephone, or by facsimile.

(iii) A request for an exception may be made prospectively, before the service has been delivered, or retrospectively, after the service has been delivered.

(iv) The Department will respond to a request for an exception no later than:

(A) For prospective exception requests, within 21 days after the Department receives the request.

(B) For prospective exception requests when the provider indicates an urgent need for quick response, within 48 hours after the Department receives the request.

(C) For retrospective exception requests, within 30 days after the Department receives the request.

(v) A retrospective request for an exception must be submitted no later than 60 days from the date the Department rejects the claim because the service is over the benefit limit. Retrospective exception requests made after 60 days from the claim rejection date will be denied.

(vi) Both the recipient and the provider will receive written notice of the approval or denial of the exception request. For prospective exception requests, if the provider or recipient is not notified of the decision within 21 days of the date the request is received, the exception will be automatically granted.

(vii) Departmental denials of requests for exception are subject to the right of appeal by the recipient in accordance with Chapter 275 (relating to appeal and fair hearing and administrative disqualification hearings).

(viii) A provider may not hold a recipient liable for payment for services rendered in excess of the limits established in subsections (b) and (e) unless both of the following conditions are met:

(A) The provider has requested an exception to the limit and the Department has denied the request.

(B) The provider informed the recipient before the service was rendered that the recipient is liable for the payment as specified in § 1101.63(a) (relating to payment in full) if the exception is not granted.

FEES AND PAYMENTS

§ 1101.63. Payment in full.

(a) *Supplementary payment for a compensable service.* A provider shall accept as payment in full, the amounts paid by the Department plus a copayment required to be paid by a recipient under subsection (b). A provider who seeks or accepts supplementary payment of another kind from the Department, the recipient or another person for a compensable service or item is required to return the supplementary payment. A provider may bill a MA recipient for a noncompensable service or item if the recipient is told before the service is rendered that the program does not cover it.

(b) *Copayments for MA services.*

(1) Recipients receiving services under the MA Program are responsible to pay the provider the applicable copayment amounts set forth in this subsection.

(2) The following services are excluded from the copayment requirement for all categories of recipients:

(i) Services furnished to individuals under 18 years of age.

(ii) Services and items furnished to pregnant women.

(iii) Services furnished to an individual who is a patient in a long term care facility or other medical institution as defined in 42 CFR 435.1009 (relating to definitions relating to institutional status) if the individual is required as a condition of receiving services in the institution, to spend all but a minimal amount of his income for medical care costs.

(iv) Services provided in an emergency situation as defined in § 1101.21 (relating to definitions).

(v) Laboratory services.

(vi) The professional component of diagnostic radiology, nuclear medicine, radiation therapy and medical diagnostic services, when the professional component is billed separately from the technical component.

(vii) Family planning services and supplies.

(viii) Home health agency services.

(ix) Psychiatric partial hospitalization program services.

(x) Services furnished by a funeral director.

(xi) Renal dialysis services.

(xii) Blood and blood products.

(xiii) Oxygen.

(xiv) Ostomy supplies.

(xv) Rental of durable medical equipment.

(xvi) Outpatient services when the MA fee is under $2.

(xvii) Medical examinations when requested by the Department.

(xviii) Screenings provided under the EPSDT Program.

(xix) More than one of a series of a specific allergy test provided in a 24-hour period.

(xx) Targeted case management services.

(3) The following services are excluded from the copayment requirement for categories of recipients except GA recipients age 21 to 65:

(i) Drugs, including immunizations, dispensed by a physician.

(ii) Specific drugs identified by the Department in the following categories:

(A) Antihypertensive agents.

(B) Antidiabetic agents.

(C) Anticonvulsants.

(D) Cardiovascular preparations.

(E) Antipsychotic agents, except those that are also schedule C-IV antianxiety agents.

(F) Antineoplastic agents.

(G) Antiglaucoma drugs.

(H) Antiparkinson drugs.

(I) Drugs whose only approved indication is the treatment of acquired immunodeficiency syndrome (AIDS).

(4) Except for the exclusions specified in paragraphs (2) and (3), each MA service furnished by a provider to an eligible recipient is subject to copayment requirements.

(5) The amount of the copayment, which is to be paid to providers by categories of recipients, except GA recipients, and which is deducted from the Commonwealth's MA fee to providers for each service, is as follows:

(i) For pharmacy services, drugs and over-the-counter medications:

(A) For recipients other than State Blind Pension recipients, $1 per prescription and $1 per refill for generic drugs.

(B) For recipients other than State Blind Pension recipients, $3 per prescription and $3 per refill for brand name drugs.

(C) For State Blind Pension recipients, $1 per prescription and $1 per refill for brand name drugs and generic drugs.

(ii) For inpatient hospital services, provided in a general hospital, rehabilitation hospital or private psychiatric hospital, the copayment is $3 per covered day of inpatient care, to an amount not to exceed $21 per admission.

(iii) For nonemergency services provided in a hospital emergency room, the copayment on the hospital support component is double the amount shown in subparagraph (vi), if an approved waiver exists from the United States Department of Health and Human Services. If an approved waiver does not exist, the copayment will follow the schedule shown in subparagraph (vi).

(iv) When the total component or only the technical component of the following services are billed, the copayment is $1:

(A) Diagnostic radiology.

(B) Nuclear medicine.

(C) Radiation therapy.

(D) Medical diagnostic services.

(v) For outpatient psychotherapy services, the copayment is 50¢ per unit of service.

(vi) For other services, the amount of the copayment is based on the MA fee for the service, using the following schedule:

(A) If the MA fee is $2 through $10, the copayment is 50¢.

(B) If the MA fee is $10.01 through $25, the copayment is $1.

(C) If the MA fee is $25.01 through $50, the copayment is $2.

(D) If the MA fee is $50.01 or more, the copayment is $3.

(6) The amount of the copayment, which is to be paid to providers by GA recipients age 21 to 65, and which is deducted from the Commonwealth's MA fee to providers for each service, is as follows:

(i) For prescription drugs:

(A) $1 per prescription and $1 per refill for generic drugs.

(B) $3 per prescription and $3 per refill for brand name drugs.

(ii) For inpatient hospital services, provided in a general hospital, rehabilitation hospital or private psychiatric hospital, the copayment is $6 per covered day of inpatient care, not to exceed $42 per admission.

(iii) When the total component or only the technical component of the following services are billed, the copayment is $2:

(A) Diagnostic radiology.

(B) Nuclear medicine.

(C) Radiation therapy.

(D) Medical diagnostic services.

(iv) For all other services, the amount of the copayment is based on the MA fee for the service, using the following schedule:

(A) If the MA fee is $2 through $10, the copayment is $1.

(B) If the MA fee is $10.01 through $25, the copayment is $2.

(C) If the MA fee is $25.01 through $50, the copayment is $4.

(D) If the MA fee is $50.01 or more, the copayment is $6.

(7) The Department calculates the amount of copayments paid by a recipient and reimburses GA recipients age 21 to 65 whose MA benefits are funded solely by State funds for copayments in excess of $180 in a 6-month period. The Department reimburses all other categories of recipients for copayments in excess of $90 in a 6-month period. This calculation is based on invoices paid by the MA Program and adjudicated between January through June and July through December of each year, which verify that the recipient paid the copayment.

(8) A provider participating in the program may not deny covered care or services to an eligible MA recipient because of the recipient's inability to pay the copayment amount. This paragraph does not change the fact that the

recipient is liable for the copayment, and it does not prevent the provider from attempting to collect the copayment amount. If a recipient believes that a provider has charged the recipient incorrectly, the recipient shall continue to pay copayments charged by that provider until the Department determines whether the copayment charges are correct.

(9) A provider may not waive the copayment requirement or compensate the recipient for the copayment amount.

(10) If a recipient is covered by a third-party resource and the provider is eligible for an additional payment from MA, the copayment required of the recipient may not exceed the amount of the MA payment for the item or service.

(c) *MA deductible.*

(1) A $150 deductible per fiscal year shall be applied to adult GA recipients for the following MA compensable services:

(i) Ambulatory surgical center services.

(ii) Inpatient hospital services.

(iii) Outpatient hospital services.

(2) Laboratory and x-ray services are excluded from the deductible requirement.

CHAPTER 1123. MEDICAL SUPPLIES
SCOPE OF BENEFITS

§ 1123.21. Scope of benefits for the categorically needy.

Categorically needy recipients are eligible for medically necessary medical supplies covered by the MA Program subject to the conditions and limitations of this chapter and Chapter 1101 (relating to general provisions). See § 1101.31(b) (relating to scope).

§ 1123.24. Scope of benefits for GA recipients.

GA recipients, age 21 to 65, are eligible for medically necessary basic health care benefits as defined in Chapter 1101 (relating to general provisions). See § 1101.31(e) (relating to scope).

PAYMENT FOR MEDICAL SUPPLIES

§ 1123.60. Limitations on payments.

(a) Under no circumstances may the provider be paid an amount that exceeds the price the provider currently charges the self-paying public.

(b) Payment will be made for either orthopedic shoes or orthotic devices but not both.

(c) Payment for orthopedic shoes and orthotic devices is subject to the following limitations:

(1) Four pairs of orthopedic shoes, either with or without an attached leg brace per year for those eligible recipients 20 years of age or younger.

(2) One pair of orthotic devices every 3 years for those eligible recipients 16 years of age or older. These are not compensable, however, if the recipient has received orthopedic shoes in the 365 days prior to provision of the orthotic device.

(3) Four pairs of orthotic devices every 3 years for those eligible recipients under 16 years of age. These are not compensable, however, if the recipient has received orthopedic shoes in the 365 days prior to provision of the orthotic device.

(d) Contact lenses are compensable only when prescribed as prostheses, that is, to replace the lens of the eye.

(e) Payment for durable medical equipment and surgical supplies is limited to a maximum of $600 unless prior authorized by the Department as specified in § 1101.67 (relating to prior authorization).

(f) Unless a shorter period is specified on the MA Program fee schedule, payment for rental of durable medical equipment is limited to 6 months after which time prior authorization is required from the Department as specified in § 1101.67.

(g) Payment for prescribed or ordered medical supplies shall be limited to those items in the MA program fee schedule.

(h) Only one eyeglass fitting fee will be paid per recipient per year.

(i) Prostheses and orthoses shall be prior authorized as specified in § 1101.67.

CHAPTER 1149. DENTISTS' SERVICES
GENERAL PROVISIONS

§ 1149.2. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Approved institution—A university, college or hospital whose dental school program is approved by the American Dental Association or a Canadian university whose dental school program is recognized by the American Dental Association.

Board certified or Board eligible orthodontist—A dentist who has successfully completed the full curriculum of advanced education in orthodontics at an approved institution or an orthodontic hospital residency program which is accredited by the Commission on Accreditation of Dental and Dental Auxiliary Education Programs of the American Dental Association.

Dental laboratory—A laboratory, comprised of dental technicians, and engaged in the business of constructing, altering, repairing or duplicating dentures, plates, partial plates, bridges, splints and orthodontic or prosthetic appliances.

Dental technician—An individual not licensed to practice dentistry in this Commonwealth but engaged in the business of constructing, altering, repairing or duplicating dentures, plates, partial plates, bridges, splints and orthodontic or prosthetic appliances from a prescription by a dentist.

Dentist—An individual licensed under the laws of the Commonwealth to practice dentistry within the scope of The Dental Law (63 P. S. §§ 120—130g).

Oral and maxillofacial surgeon—A dentist who limits his practice to the part of dental care which deals with the diagnosis, the surgical and adjunctive treatment of diseases, injuries and defects of the oral and maxillofacial region.

Pedodontist—A dentist who limits his practice to the diagnosis and treatment of conditions of the teeth and mouth in children.

SCOPE OF BENEFITS

§ 1149.21. Scope of benefits for the categorically needy.

Categorically needy adult recipients are eligible for all medically necessary dental services, subject to the condi-

tions and limitations established in this chapter, Chapters 1101 and 1150 (relating to general provisions; and MA Program payment policies) and the MA Program fee schedule. Categorically needy recipients under 21 years of age are eligible for all medically necessary dental services.

§ 1149.22. Scope of benefits for the medically needy.

Medically needy adult recipients are eligible for medically necessary dental services only when provided in an inpatient, ambulatory surgical center, or short procedure unit setting, and subject to the conditions and limitations established in this chapter and Chapters 1101 and 1150 (relating to general provisions; and MA Program payment policies) and the MA Program fee schedule. Medically needy recipients under 21 years of age are eligible for all medically necessary dental services.

§ 1149.23. Scope of benefits for State Blind Pension recipients.

(a) Except as noted in subsection (b), State Blind Pension recipients are eligible for all medically necessary dental services, subject to the conditions and limitations established in this chapter, Chapters 1101 and 1150 (relating to the general provisions; and MA Program payment policies) and the MA Program fee schedule.

(b) State Blind Pension recipients are not eligible for radiological services or inpatient dental services. State Blind Pension recipients are eligible for radiological services and inpatient surgical procedures and emergency dental services if they qualify as categorically needy or medically needy recipients.

§ 1149.24. Scope of benefits for GA recipients.

(a) GA chronically needy and nonmoney payment recipients, age 21 to 65, are eligible for medically necessary dental services subject to the conditions and limitations established in this chapter, Chapters 1101 and 1150 (relating to general provisions; and MA Program payment policies) and the MA Program fee schedule.

(b) GA medically needy only recipients, age 21 to 65, are eligible for medically necessary dental services only when provided in an inpatient, ambulatory surgical center, or short procedure unit setting, and subject to the conditions and limitations established in this chapter and Chapters 1101 and 1150 (relating to general provisions; and MA Program payment policies) and the MA Program fee schedule.

CHAPTER 1151. INPATIENT PSYCHIATRIC SERVICES
GENERAL PROVISIONS

§ 1151.2. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Acute psychiatric services—Psychiatric services rendered in response to a severe psychiatric condition requiring intervention to bring the patient's symptoms under control.

Certified day—A day of inpatient hospital care approved by the Department under this chapter.

Day of inpatient hospital care—Room, board and professional services furnished to a patient on a continuous 24-hour-a-day basis in a semiprivate room of a hospital. The term includes items and services ordinarily furnished by the hospital for the care and treatment of inpatients provided in an institution other than one maintained primarily for treatment and care of patients with tuberculosis.

Emergency admission—The unscheduled admission of a person with a severe mental disability who requires immediate treatment, to an inpatient psychiatric facility.

Fiscal year—A period of time beginning July 1 and ending June 30 of the following year.

General hospital—A facility licensed as a hospital under 28 Pa. Code Part IV, Subpart A (relating to general and special hospitals) which provides equipment and services primarily for inpatient care to persons who require treatment for injury, illness, disability or pregnancy. The term does not include public or private psychiatric hospitals, general nursing facilities, county-operated nursing facilities, intermediate care facilities for the mentally retarded or psychiatric transitional facilities.

Inpatient psychiatric facility—The term refers to private psychiatric hospitals and distinct part psychiatric units of general hospitals.

Patient pay amount—Income or assets that the CAO has determined to be available to a recipient to meet the cost of medical care. The recipient, not the MA Program, pays this amount toward the cost of care.

Private psychiatric hospital—An institution, other than a general hospital, not directly operated or controlled by the Department that is engaged in providing acute short-term psychiatric services on an inpatient basis.

Public psychiatric hospital—An institution, other than a general hospital, controlled, operated and funded directly by the Department and engaged in providing long-term and short-term inpatient psychiatric services for the diagnosis, treatment and care of individuals with mental diseases.

Recipient under 21 years of age—A recipient who is one of the following:

(i) Under 21 years of age.

(ii) Age 21 and was receiving inpatient psychiatric services in a psychiatric hospital the day preceding the date the recipient reached age 21. This recipient continues to be recognized as a recipient under 21 years of age until the earlier of the date the recipient either:

(A) No longer requires inpatient psychiatric facility services.

(B) Reaches age 22.

Therapeutic leave—A period of absence by a patient from the inpatient psychiatric facility directly related to the treatment of that patient's illness.

SCOPE OF BENEFITS

§ 1151.21. Scope of benefits for the categorically needy.

Categorically needy recipients under 21 years of age as defined in § 1151.2 (relating to definitions) or 65 years of age or older are eligible for medically necessary inpatient psychiatric services provided by a participating inpatient psychiatric facility, subject to this chapter and Chapter 1101 (relating to general provisions).

§ 1151.22. Scope of benefits for the medically needy.

Medically needy recipients under 21 years of age as defined in § 1151.2 (relating to definitions) or age 65 or older are eligible for medically necessary inpatient psychiatric services provided by a participating inpatient psy-

chiatric facility, subject to this chapter and Chapter 1101 (relating to general provisions).

§ 1151.24. Scope of benefits for GA recipients.

(a) GA recipients, age 21 to 65, are eligible for medically necessary inpatient psychiatric services as described in Chapter 1101 (relating to general provisions). See § 1101.31(e) (relating to scope).

(b) Inpatient psychiatric services are subject to this chapter and Chapter 1101 (relating to general provisions).

PAYMENT FOR INPATIENT PSYCHIATRIC SERVICES

§ 1151.43. Limitations on payment.

(a) For adult recipients, payment for inpatient psychiatric hospital services in a private psychiatric hospital or a distinct part of a psychiatric unit of a general hospital is limited to 30 days per fiscal year.

(b) A recipient is limited to two periods of therapeutic leave per calendar month. Neither of these periods of therapeutic leave may exceed 12 hours in a calendar day.

(c) The Department is authorized to grant an exception to the limits specified in subsection (a) as described in § 1101.31(f) (relating to scope).

CHAPTER 1153. OUTPATIENT PSYCHIATRIC SERVICES

PAYMENT FOR OUTPATIENT PSYCHIATRIC CLINIC AND OUTPATIENT PSYCHIATRIC PARTIAL HOSPITALIZATION SERVICES

§ 1153.53. Limitations on payment.

(a) Payment is subject to the following limitations:

(1) For recipients 21 years of age or older, 180 three-hour sessions, 540 total hours, of psychiatric partial hospitalization in a fiscal year per recipient, except for State Blind Pension recipients, for whom payment is limited to 240 3-hour sessions, 720 total hours, of psychiatric partial hospitalization in a consecutive 365-day period per recipient.

(2) At least 3 hours but no more than 6 hours of psychiatric partial hospitalization per 24-hour period.

(3) Two outpatient psychiatric evaluations in psychiatric clinics per patient per year.

(4) For recipients 21 years of age or older, a total of 5 hours or 10 one-half hour sessions of psychotherapy per recipient per 30-consecutive day period, except for State Blind Pension recipients, for whom payment is limited to a total of 7 hours or 14 one-half hour sessions of psychotherapy per recipient per 30-consecutive day period. This period begins on the first day that an eligible recipient receives an outpatient psychiatric clinic service listed in the MA Program Fee Schedule. Psychotherapy includes the total of individual, group, family, collateral family psychotherapy services and home visits provided per eligible recipient per 30-consecutive day period.

(5) Three psychiatric clinic medication visits per patient per 30-consecutive days in psychiatric outpatient clinics.

(6) One outpatient comprehensive diagnostic psychological evaluation or no more than $80 worth of individual psychological or intellectual evaluations in psychiatric clinics per patient per 365 consecutive days.

(7) The partial hospitalization fees listed in the MA Program Fee Schedule include payment for all services rendered to the patient during a psychiatric partial hospitalization session. Separate billings for individual services are not compensable.

(8) Partial hospitalization facilities licensed for adult programs will be reimbursed at the adult rate, regardless of the age of the client receiving treatment.

(9) Partial hospitalization facilities licensed as children and youth programs will be reimbursed at the child rate only when the client receiving treatment is 14 years of age or younger.

(10) Family psychotherapy and collateral family psychotherapy are compensable for only one person per session, regardless of the number of family members who participate in the session or the number of participants who are eligible for psychotherapy.

(11) Psychiatric clinic clozapine monitoring and evaluation visits are limited to five visits per patient per calendar month.

(12) Any combination of psychiatric clinic medication visits and psychiatric clinic clozapine monitoring and evaluation visits is limited to five per patient per calendar month.

(b) The Department is authorized to grant an exception to the limits specified in subsection (a)(1) and (4) as described in § 1101.31(f) (relating to scope).

[Pa.B. Doc. No. 05-1586. Filed for public inspection August 26, 2005, 9:00 a.m.]

DEPARTMENT OF PUBLIC WELFARE

[55 PA. CODE CH. 1121]

[Correction]

Pharmaceutical Services; Revisions to the State Maximum Allowable Cost for Pharmaceutical Services

Errors occurred in the document amending §§ 1121.2 and 1121.56 (relating to definitions; and drug cost determination), which appeared at 35 Pa.B. 4727, 4732 and 4733 (August 20, 2005). Amendments to those sections which appeared at 35 Pa.B. 4309 (August 6, 2005) were not incorporated. The correct version of those sections is as follows:

Annex A

TITLE 55. PUBLIC WELFARE

PART III. MEDICAL ASSISTANCE

CHAPTER 1121. PHARMACEUTICAL SERVICES

GENERAL PROVISIONS

§ 1121.2. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the content clearly indicates otherwise:

AWP—The average wholesale price listed for a drug in one or more available Nationally recognized pricing services.

Brand name—A registered trade name commonly used to identify a drug.

CMS—The Centers for Medicare and Medicaid Services.

CMS multisource drug—A multisource drug identified by CMS for which FFP is limited under 42 CFR 447.331—447.333 (relating to drugs: aggregate upper limits of payment; upper limits for multiple source drugs; state plan requirements, findings and assurances).

Compounded prescription—A prescription that is prepared in the pharmacy by combining two or more ingredients and involves the weighing of at least one solid ingredient which shall be a compensable item or a legend drug in a therapeutic amount.

DESI drug—A drug product for which Federal Financial Participation FFP is not available under 42 CFR 441.25 (relating to less than effective drugs).

EAC—Estimated Acquisition Cost—As defined in 42 CFR 447.301 (relating to definitions).

Experimental drug—A drug or product currently being investigated under licensure by the FDA to determine its safety and effectiveness.

FDA—Food and Drug Administration.

FFP—Federal financial participation.

Federal upper limit—The per unit amount set for a multisource drug which is established by CMS under 42 CFR 447.332.

Generic drug—A drug that is "A-rated" by the FDA as therapeutically equivalent to the counterpart brand name drug.

Legend drug—A drug or product that under Federal law or State law can be dispensed only upon the order of a physician.

Licensed prescriber—A person currently licensed under the law of a state to order medication.

Multisource drug—A drug marketed or sold by two or more manufacturers or labelers or a drug marketed or sold by the same manufacturer or labeler under two or more different proprietary names or both under a proprietary name and without such a name.

Nonlegend drug—A drug or product that can be purchased without a prescription.

OBRA '90—The Omnibus Budget Reconciliation Act of 1990 (Pub. L. No. 101-508, 104 Stat. 1388).

Pricing service—A third-party source that compiles and provides drug-specific information needed to maintain the drug reference file under this chapter.

State MAC—The maximum allowable cost established for a multisource drug.

Usual and customary charge—The pharmacy's lowest net charge an MA recipient would pay for a prescription as a non-Medicaid patient at the time of dispensing for the same quantity and strength of a particular drug or product, including applicable discounts, such as special rates to nursing home residents, senior citizens, or other discounts extended to a particular group of patients. This lowest net price does not apply to special in-store rates or discounts extended to charitable organizations, religious groups, store employees and their families, nonprofit organizations, members of the medical profession or other similar non-Medicaid groups.

WAC—Wholesale Acquisition Cost—The manufacturer's list price for a drug to wholesalers or direct purchasers in the United States as listed in one or more available Nationally recognized pricing services.

PAYMENT FOR PHARMACEUTICAL SERVICES

§ 1121.56. Drug cost determination.

(a) The Department will base its drug cost for compensable legend and nonlegend drugs on the lower of:

(1) The EAC established by the Department.

(i) For brand name drugs, the EAC is established by the Department as one of the following:

(A) The lowest WAC listed for the drug in available Nationally recognized pricing services, plus 7%.

(B) If WAC data are not available from a Nationally recognized pricing service, the lowest AWP listed for the drug in available Nationally recognized pricing services, minus 14%.

(C) If both WAC and AWP cost data are available for the drug from a Nationally recognized pricing service, the lower of the two amounts.

(ii) For generic drugs, the EAC is established by the Department as one of the following:

(A) The lowest WAC listed for the drug in available Nationally recognized pricing services, plus 66%.

(B) If WAC data are not available from a Nationally recognized pricing service, the lowest AWP listed for the drug in available Nationally recognized pricing services, minus 25%.

(C) If both WAC and AWP cost data are available for the drug from a Nationally recognized pricing service, the lower of the two amounts.

(2) The State MAC established by the Department.

(b) The Department will update the EAC for individual drugs on a monthly basis as it appears in available Nationally recognized pricing services.

(c) CMS establishes lists that identify and set Federal upper limits for CMS multisource drugs and provides the listing of these drugs and revisions to the list to the Department through Medicaid manual transmittals on a periodic basis.

(d) The Department will determine the State MAC by one of the following methods:

(1) For multisource drugs, the Department will set the State MAC at the lower of the following:

(i) The upper payment limit established by the CMS.

(ii) Provided that the generic product is available at the price established by the Department from at least two wholesalers:

(A) If the generic product is available from more than one manufacturer, the base price of 150% of the lowest acquisition cost for the generic product, unless 150% of the lowest acquisition cost is not at least 120% of the second lowest acquisition cost, in which case the base price will be set at 120% of the second lowest acquisition cost.

(B) If the generic product is available from only one manufacturer, the base price is 120% of the acquisition cost for the generic product.

(2) For disposable insulin syringes, the Department will set the State MAC at the amount listed in the MA Program Fee Schedule.

(e) The Department will update the State MAC:

(1) If the State MAC for a multisource drug is set at the Federal upper payment limit established by CMS, the

Department will apply the Federal upper limits for CMS multisource drugs to be effective on the date established by CMS and will describe the update to each pharmacy enrolled in the MA Program when it is available.

(2) The Department will apply the price for all other State MAC multisource drugs every 3 months, and will distribute the update to each pharmacy enrolled in the MA Program.

(f) With the exception of the HCFA multisource drugs, the Department will make further additions to the list of State MAC drugs after consultation with the Medical Assistance Advisory Committee as to whether the application of a State MAC is cost effective to the Department for a particular multisource drug. The Department will add the HCFA multisource drugs to the State MAC list effective as of the effective date established by HCFA.

(g) With the exception of disposable insulin syringes, the State MAC does not apply if the conditions are met as described in § 1121.53(b)(1) and (2) (relating to limitations on payment).

(h) The most common package size for the purposes of determining the product cost is one of the following:

(1) For capsules, tablets and liquids available in breakable package sizes:

(i) The listed package size if only one package size is listed.

(ii) The 100 or pint package size if more than one package size is listed.

(iii) The next smaller package size from the 100 or pint size, excluding a drug company's unit-dose package size, if more than one package size is listed other than the 100 or pint package size.

(iv) The package size closest to the 100 or pint package size, excluding a drug company's unit-dose package size, if the next smaller package is the unit-dose package size.

(2) The listed package size for all dosage forms available for all nonlegend drug products.

(3) The smallest package size for all dosage forms available in nonbreakable packages.

[Pa.B. Doc. No. 05-1561. Filed for public inspection August 19, 2005, 9:00 a.m.]

Title 58—RECREATION

GAME COMMISSION

[58 PA. CODE CH. 135]

Lands and Buildings

To effectively manage the wildlife resources of this Commonwealth, the Game Commission (Commission), at its June 28, 2005, meeting, adopted an amendment to § 135.107 (relating to Middle Creek Wildlife Management Area) to permit the Director to designate dates for deer hunting outside of the established seasons and bag limits in the Middle Creek Wildlife Management Area and eliminate redundant language.

The final-form rulemaking will have no adverse impact on the wildlife resources of this Commonwealth.

The authority for the final-form rulemaking is 34 Pa.C.S. (relating to Game and Wildlife Code) (code).

Notice of proposed rulemaking was published at 35 Pa.B. 3229 (June 4, 2005).

1. *Purpose and Authority*

Section 137.107 allows special deer hunts to take place on controlled areas of the Middle Creek Wildlife Management Area. However, hunters are required to apply for and receive a permit prior to taking part in these special hunts. Under § 135.161(2) (relating to Commission-owned or leased), these special hunts are currently required to be held in conformity with established seasons and bag limits.

The Commission has recently identified a trend indicating that, in addition to the properly permitted hunters who are authorized to hunt inside of these controlled areas, a heavy concentration of hunters tend to surround the boundary lines of these areas hoping to harvest deer as they go to and from the Middle Creek Wildlife Management Area. The combination of increased deer movement and the high concentration of hunters in and around these controlled areas poses a significant safety concern. To address this safety concern, the Commission has amended § 135.107 to allow the Director to designate dates for the special deer hunts in the Middle Creek Wildlife Management Area to take place outside of the established seasons and bag limits. This amendment should help dilute the heavy concentration of hunters in and around the Middle Creek Wildlife Management Area during established deer hunting seasons.

Section 135.107(b)(4) and (c)(4) contained the language "or a designee." The creation of this language was intended to allow the Director to designate another individual the authority to suspend special hunts and cancel the remaining permits when an adequate number of game animals had been harvested. However, after additional review of the definition of "Director" in section 102 of the code (relating to definitions), it is apparent that the term "designee" is already covered by the definition. Therefore, the Commission has adopted the amendment to § 135.107(b)(4) and (c)(4) by eliminating the "or a designee" language in these provisions since it is redundant and unnecessary.

Section 322(c)(2) of the code (relating to powers and duties of commission) specifically empowers the Commission to "Remove protection, declare an open season or increase, reduce or close a season." Section 322(c)(6) of the code specifically empowers the Commission to "Limit the number of hunters or furtakers in any designated area . . . ." Section 322(c)(10) of the code specifically empowers the Commission to "Manage and develop its lands and waters . . . as it considers advisable and, by proper action and proceedings, enact and enforce regulations to insure the prudent and proper use of these lands." Section 721(a) of the code (relating to control of property) provides "The administration of all lands and waters owned, leased or otherwise controlled by the commission shall be under the sole control of the Director, and the commission shall promulgate regulations . . . for its use and protection as necessary to properly manage these lands or waters." Section 2102(a) of the code (relating to regulations) provides that "The commission shall promulgate such regulations as it deems necessary and appropriate concerning game or wildlife and hunting or furtaking in this Commonwealth, including regulations relating to the protection, preservation and management of game or wildlife and game or wildlife habitat, permitting or prohibiting hunting or furtaking, the ways, manner, methods and means of hunting or furtaking, and the health and safety of persons who hunt or take wildlife or may be in the

vicinity of persons who hunt or take game or wildlife in this Commonwealth." The amendment to § 135.107 was adopted under this authority.

2. *Regulatory Requirements*

The final-form rulemaking will permit the Director to designate dates for deer hunting outside of the established seasons and bag limits in the Middle Creek Wildlife Management Area and will eliminates redundant language.

3. *Persons Affected*

Persons wishing to take part in any special game hunts that take place on controlled areas of the Middle Creek Wildlife Management Area may be affected by the final-form rulemaking.

4. *Comment and Response Summary*

There were no official comments received regarding this final-form rulemaking.

5. *Cost and Paperwork Requirements*

The final-form rulemaking should not result in additional cost or paperwork.

6. *Effective Date*

The final-form rulemaking will be effective upon publication in the *Pennsylvania Bulletin* and will remain in effect until changed by the Commission.

7. *Contact Person*

For further information regarding the final-form rulemaking, contact Michael A. Dubaich, Director, Bureau of Law Enforcement, 2001 Elmerton Avenue, Harrisburg, PA 17110-9797, (717) 783-6526.

Findings

The Commission finds that:

(1) Public notice of intention to adopt the administrative amendment adopted by this order has been given under sections 201 and 202 of the act of July 31, 1968 (P. L. 769, No. 240) (45 P. S. §§ 1201 and 1202) and the regulations thereunder, 1 Pa. Code §§ 7.1 and 7.2.

(2) The adoption of the amendment of the Commission in the manner provided in this order is necessary and appropriate for the administration and enforcement of the authorizing statute.

Order

The Commission, acting under authorizing statute, orders that:

(a) The regulations of the Commission, 58 Pa. Code Chapter 135, are amended by amending § 135.107 to read as set forth at 35 Pa.B. 3229.

(b) The Executive Director of the Commission shall certify this order and 35 Pa.B. 3229 and deposit them with the Legislative Reference Bureau as required by law.

(c) This order shall become effective upon final-form publication in the *Pennsylvania Bulletin*.

VERNON R. ROSS,
Executive Director

Fiscal Note: Fiscal Note 48-210 remains valid for the final adoption of the subject regulation.

[Pa.B. Doc. No. 05-1587. Filed for public inspection August 26, 2005, 9:00 a.m.]

GAME COMMISSION
[58 PA. CODE CH. 141]
Hunting and Trapping

To effectively manage the wildlife resources of this Commonwealth, the Game Commission (Commission), at its June 28, 2005, meeting, adopted an amendment to Chapter 141, Appendix G (relating to hunting hours) to reflect the annual change in days and subsequent hunting times for the 2005-2006 hunting license year.

The final-form rulemaking will have no adverse impact on the wildlife resources of this Commonwealth.

The authority for the final-form rulemaking is 34 Pa.C.S. (relating to Game and Wildlife Code) (code).

Notice of proposed rulemaking was published at 35 Pa.B. 3230 (June 4, 2005).

1. *Purpose and Authority*

Each year there is a shift in calendar days for each month. As a result of this occurrence, the table of hunting hours in Appendix G must be amended and updated on an annual basis to reflect the upcoming year's accurate dates and hours for legal hunting. Towards this end, the Commission amended Appendix G by updating the table of hunting hours to accurately reflect the dates and hours of legal hunting for the 2005-2006 hunting year.

Section 322(c)(1) of the code (relating to powers and duties of commission) specifically empowers the Commission to "fix seasons, daily shooting or taking hours, and any modification thereof, and daily, season and possession limits for any species of game or wildlife." Section 2102(a) of the code (relating to regulations) provides that "The Commission shall promulgate such regulations as it deems necessary and appropriate concerning game or wildlife and hunting or furtaking in this Commonwealth . . . ." The amendment to Appendix G was adopted under this authority.

2. *Regulatory Requirements*

The final-form rulemaking amends Appendix G to update the table of hunting hours to accurately reflect the dates and hours of legal hunting for the 2005-2006 hunting year.

3. *Persons Affected*

Persons wishing to hunt or trap within this Commonwealth will be affected by the final-form rulemaking.

4. *Comment and Response Summary*

There were no official comments received regarding this final-form rulemaking.

5. *Cost and Paperwork Requirements*

The final-form rulemaking should not result in additional cost or paperwork.

6. *Effective Date*

The final-form rulemaking will be effective upon publication in the *Pennsylvania Bulletin* and will remain in effect until changed by the Commission.

7. *Contact Person*

For further information regarding the final-form rulemaking, contact Michael A. Dubaich, Director, Bureau of Law Enforcement, 2001 Elmerton Avenue, Harrisburg, PA 17110-9797, (717) 783-6526.

Findings

The Commission finds that:

(1) Public notice of intention to adopt the administrative amendment adopted by this order has been given under sections 201 and 202 of the act of July 31, 1968 (P. L. 769, No. 240) (45 P. S. §§ 1201 and 1202) and the regulations thereunder, 1 Pa. Code §§ 7.1 and 7.2.

(2) The adoption of the amendment of the Commission in the manner provided in this order is necessary and appropriate for the administration and enforcement of the authorizing statute.

Order

The Commission, acting under authorizing statute, orders that:

(a) The regulations of the Commission, 58 Pa. Code Chapter 141, are amended by amending Appendix G to read as set forth at 35 Pa.B. 3230.

(b) The Executive Director of the Commission shall certify this order and 35 Pa.B. 3230 and deposit them with the Legislative Reference Bureau as required by law.

(c) This order shall become effective upon final-form publication in the *Pennsylvania Bulletin*.

VERNON R. ROSS,
Executive Director

Fiscal Note: Fiscal Note 48-211 remains valid for the final adoption of the subject regulation.

[Pa.B. Doc. No. 05-1588. Filed for public inspection August 26, 2005, 9:00 a.m.]

GAME COMMISSION
[58 PA. CODE CH. 143]
Hunting and Furtaker Licenses

To effectively manage the wildlife resources of this Commonwealth, the Game Commission (Commission), at its June 28, 2005, meeting, adopted amendments to §§ 143.201 and 143.203 (relating to purpose and scope; and drawing) to correct language recognizing the different classifications of elk licenses available and to make drawing requirements for the different classifications of the elk license more consistent.

The final-form rulemaking will have no adverse impact on the wildlife resources of this Commonwealth.

The authority for the final-form rulemaking is 34 Pa.C.S. (relating to Game and Wildlife Code) (code).

Notice of proposed rulemaking was published at 35 Pa.B. 3231 (June 4, 2005).

1. *Purpose and Authority*

Since the creation of the elk license a short time ago, only two classifications of the elk license have been available, the antlered and the antlerless elk license. In an effort to promote and increase elk hunter success within this Commonwealth, the Commission has added a third classification to the elk license. This new classification entitles the holder of the license to harvest either an antlered or antlerless elk. This means that the hunter may choose which sex of elk is harvested according to factors such as preference, availability, weather conditions, and the like.

The new antlered and/or antlerless elk license classification should be available to elk hunters in the near future. However, before this new classification of elk license can be sold, the Commission must amend §§ 143.201 and 143.203 to correct language recognizing the different classifications of elk licenses available and also to make the drawing requirements for the different classifications of the elk license more consistent. Formerly, § 143.201 only recognizes that the Commission will establish a quantity of tags for antlered and antlerless elk. Since the new classification of elk license permits either antlered or antlerless elk to be harvested, the Commission is adopting this language by inserting "/or" to recognize all classifications of the elk license now currently available.

Currently, § 143.203 only restricted successful applicants issued an "antlered elk license" from applying for another elk license for 5 license years. Due to the fact that the new classification of elk license entitles the holder to harvest either an antlered or antlerless elk, the Commission has adopted the amendment to § 143.203 to restrict successful applicants issued any license entitling them to take an antlered elk from applying for another elk license for 5 license years. This amendment should maintain a certain level of fairness in the lottery drawing process for all applicants.

Section 2705(15) of the code (relating to classes of licenses) provides that "To ensure sound management of Pennsylvania's wild elk population, the commission may promulgate regulations to establish a limited number of licenses." Section 2722(g) of the code (relating to authorized license-issuing agents) directs the Commission to adopt regulations for the administration, control and performance of license issuing activities. Section 2102(a) of the code (relating to regulations) provides that "The commission shall promulgate such regulations as it deems necessary and appropriate concerning game or wildlife and hunting or furtaking in this Commonwealth, including regulations relating to the protection, preservation and management of game or wildlife . . . in this Commonwealth." The amendments to §§ 143.201 and 143.203 were adopted under this authority.

2. *Regulatory Requirements*

The final-form rulemaking will correct language referring to the different classifications of the elk license available to hunters by adding the language "/or" and also makes the drawing requirements for the different classifications of the elk license more consistent by prohibiting all applicants successfully drawn for any elk license entitling them to take an antlered elk from reapplying for another elk license for 5 license years.

3. *Persons Affected*

Persons wishing to apply for an elk license entitling them to harvest an antlered or an antlerless elk within this Commonwealth will be affected by the final-form rulemaking.

4. *Comment and Response Summary*

There were no official comments received regarding this final-form rulemaking.

5. *Cost and Paperwork Requirements*

The final-form rulemaking should not result in additional cost or paperwork.

6. *Effective Date*

The final-form rulemaking will be effective upon publication in the *Pennsylvania Bulletin* and will remain in effect until changed by the Commission.

7. *Contact Person*

For further information regarding the final-form rulemaking, contact Michael A. Dubaich, Director, Bureau of Law Enforcement, 2001 Elmerton Avenue, Harrisburg, PA 17110-9797, (717) 783-6526.

Findings

The Commission finds that:

(1) Public notice of intention to adopt the administrative amendments adopted by this order has been given under sections 201 and 202 of the act of July 31, 1968 (P. L. 769, No. 240) (45 P. S. §§ 1201 and 1202) and the regulations thereunder, 1 Pa. Code §§ 7.1 and 7.2.

(2) The adoption of the amendments of the Commission in the manner provided in this order is necessary and appropriate for the administration and enforcement of the authorizing statute.

Order

The Commission, acting under authorizing statute, orders that:

(a) The regulations of the Commission, 58 Pa. Code Chapter 143, are amended by amending §§ 143.201 and 143.203 to read as set forth at 35 Pa.B. 3231.

(b) The Executive Director of the Commission shall certify this order and 35 Pa.B. 3231 and deposit them with the Legislative Reference Bureau as required by law.

(c) This order shall become effective upon final-form publication in the *Pennsylvania Bulletin*.

VERNON R. ROSS,
Executive Director

Fiscal Note: Fiscal Note 48-208 remains valid for the final adoption of the subject regulations.

[Pa.B. Doc. No. 05-1589. Filed for public inspection August 26, 2005, 9:00 a.m.]

PENNSYLVANIA GAMING CONTROL BOARD
[58 PA. CODE CHS. 407 AND 423]
Amendments to Temporary Regulations

Under the Pennsylvania Gaming Control Board's (Board) Resolution No. 2005-3 REG, entitled Adoption of Temporary Regulations, dated June 16, 2005, the Board has the authority to amend the temporary regulations, adopted on June 16, 2005, as it deems necessary in accordance with the purpose of the act of July 5, 2004 (P. L. 572, No. 71) (Act 71) and to further the intent of Act 71. Therefore, the Board has decided to make editorial changes to the temporary regulations, dated June 16, 2005, as deposited with the Legislative Reference Bureau (Bureau) and published at 35 Pa.B. 4045 (July 16, 2005).

Therefore, the Board has deposited with the Bureau amendments to §§ 407.1, 423.2 and 423.4 (relating to case files; application processing; and incomplete applications). The amendments are effective as of August 17, 2005.

(*Editor's Note:* The temporary regulations of the Board, 58 Pa. Code Chapters 407 and 423, are amended by amending §§ 407.1, 423.2 and 423.4 to read as set forth in Annex A, with ellipses referring to the existing text of the regulations.)

THOMAS A. DECKER,
Chairperson

Fiscal Note: 125-3. No fiscal impact; (8) recommends adoption.

Annex A

TITLE 58. RECREATION

PART VII. GAMING CONTROL BOARD

Subpart A. GENERAL PROVISIONS

CHAPTER 407. PUBLIC ACCESS TO BOARD RECORDS

§ 407.1. Case files.

(a) *Records.* Formal records in proceedings before the Board shall contain a file for nonconfidential records and a file for confidential records.

* * * * *

Subpart B. LICENSING, REGISTERING AND PERMITTING

CHAPTER 423. APPLICATIONS

§ 423.2. Application processing.

* * * * *

(c) An application submitted under this part and all information obtained by the Board relating to the application shall be part of the evidentiary record of the licensing proceeding. The Board's decision to issue or deny a license shall be based solely on the evidentiary record before the Board.

§ 423.4. Incomplete applications.

* * * * *

(c) Refusal to provide information as requested by the Board, the Bureau, its designees or agents or the Pennsylvania State Police shall result in the immediate denial of a license or permit.

[Pa.B. Doc. No. 05-1590. Filed for public inspection August 26, 2005, 9:00 a.m.]
