STATEMENTS OF POLICY

Title 4—ADMINISTRATION

PART II. EXECUTIVE BOARD

[4 PA. CODE CH. 9]

Reorganization of the Department of Aging and Department of Public Welfare

The Executive Board approved a reorganization of the Department of Aging and Department of Public Welfare effective October 7, 2008.

The organization charts at 38 Pa.B. 5965—5968 (November 1, 2008) are published at the request of the Joint Committee on Documents under 1 Pa. Code § 3.1(a)(9) (relating to contents of code).

(*Editor's Note*: The Joint Committee on Documents has found organization charts to be general and permanent in nature. This document meets the criteria of 45 Pa.C.S. § 702(7) (relating to contents of *Pennsylvania Code*) as a document general and permanent in nature which shall be codified in the *Pennsylvania Code*.)

[Pa.B. Doc. No. 08-1968. Filed for public inspection October 31, 2008, 9:00 a.m.]

PART II. EXECUTIVE BOARD

[4 PA. CODE CH. 9]

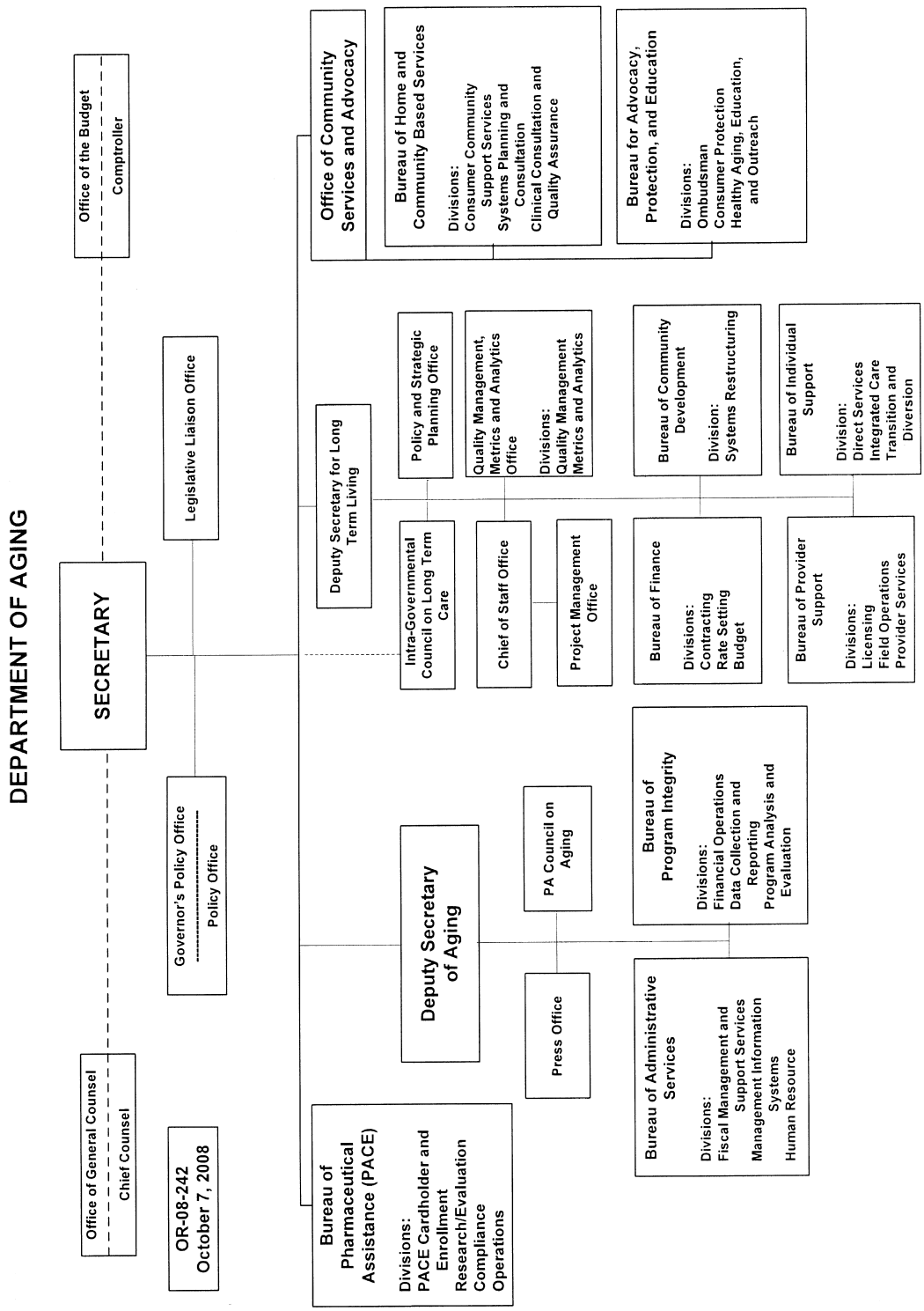
Reorganization of the Department of Labor and Industry

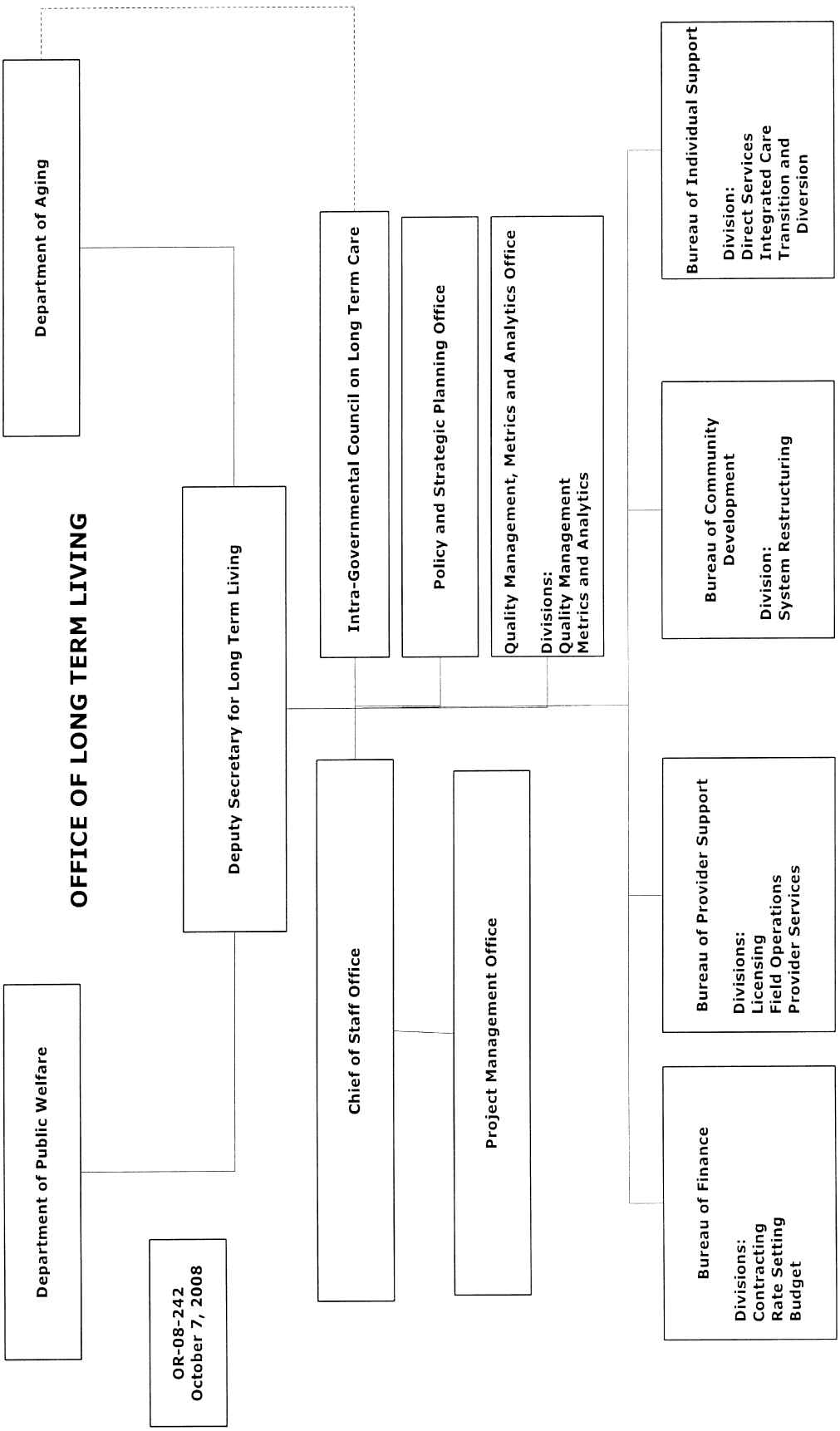
The Executive Board approved a reorganization of the Department of Labor and Industry effective October 7, 2008.

The organization chart at 38 Pa.B. 5969 (November 1, 2008) is published at the request of the Joint Committee on Documents under 1 Pa. Code § 3.1(a)(9) (relating to contents of code).

(*Editor's Note*: The Joint Committee on Documents has found organization charts to be general and permanent in nature. This document meets the criteria of 45 Pa.C.S. § 702(7) (relating to contents of *Pennsylvania Code*) as a document general and permanent in nature which shall be codified in the *Pennsylvania Code*.)

[Pa.B. Doc. No. 08-1969. Filed for public inspection October 31, 2008, 9:00 a.m.]


DEPARTMENT OF AGING
SECRETARY
Office of the Budget
Comptroller
Office of General Counsel
Chief Counsel
Legislative Liaison Office
Governor's Policy Office
Policy Office
OR-08-242
October 7, 2008
Office of Community Services and Advocacy
Bureau of Home and Community Based Services
Divisions:
Consumer Community Support Services
Systems Planning and Consultation
Clinical Consultation and Quality Assurance
Bureau for Advocacy, Protection, and Education
Divisions:
Ombudsman
Consumer Protection
Healthy Aging, Education, and Outreach
Deputy Secretary for Long Term Living
Policy and Strategic Planning Office
Quality Management, Metrics and Analytics Office
Divisions:
Quality Management
Metrics and Analytics
Bureau of Community Development
Division:
Systems Restructuring
Bureau of Individual Support
Division:
Direct Services
Integrated Care
Transition and Diversion
Intra-Governmental Council on Long Term Care
Chief of Staff Office
Project Management Office
Bureau of Finance
Divisions:
Contracting
Rate Setting
Budget
Bureau of Provider Support
Divisions:
Licensing
Field Operations
Provider Services
Bureau of Pharmaceutical Assistance (PACE)
Divisions:
PACE Cardholder and Enrollment
Research/Evaluation
Compliance
Operations
Deputy Secretary of Aging
PA Council on Aging
Press Office
Bureau of Program Integrity
Divisions:
Financial Operations
Data Collection and Reporting
Program Analysis and Evaluation
Bureau of Administrative Services
Divisions:
Fiscal Management and Support Services
Management Information Systems
Human Resource


OFFICE OF LONG TERM LIVING
Department of Aging
Department of Public Welfare
Deputy Secretary for Long Term Living
Intra-Governmental Council on Long Term Care
Policy and Strategic Planning Office
Quality Management, Metrics and Analytics Office
Divisions:
Quality Management
Metrics and Analytics
Chief of Staff Office
Project Management Office
Bureau of Individual Support
Division:
Direct Services
Integrated Care
Transition and
Diversion
Bureau of Community
Development
Division:
System Restructuring
Bureau of Provider Support
Divisions:
Licensing
Field Operations
Provider Services
Bureau of Finance
Divisions:
Contracting
Rate Setting
Budget
OR-08-242
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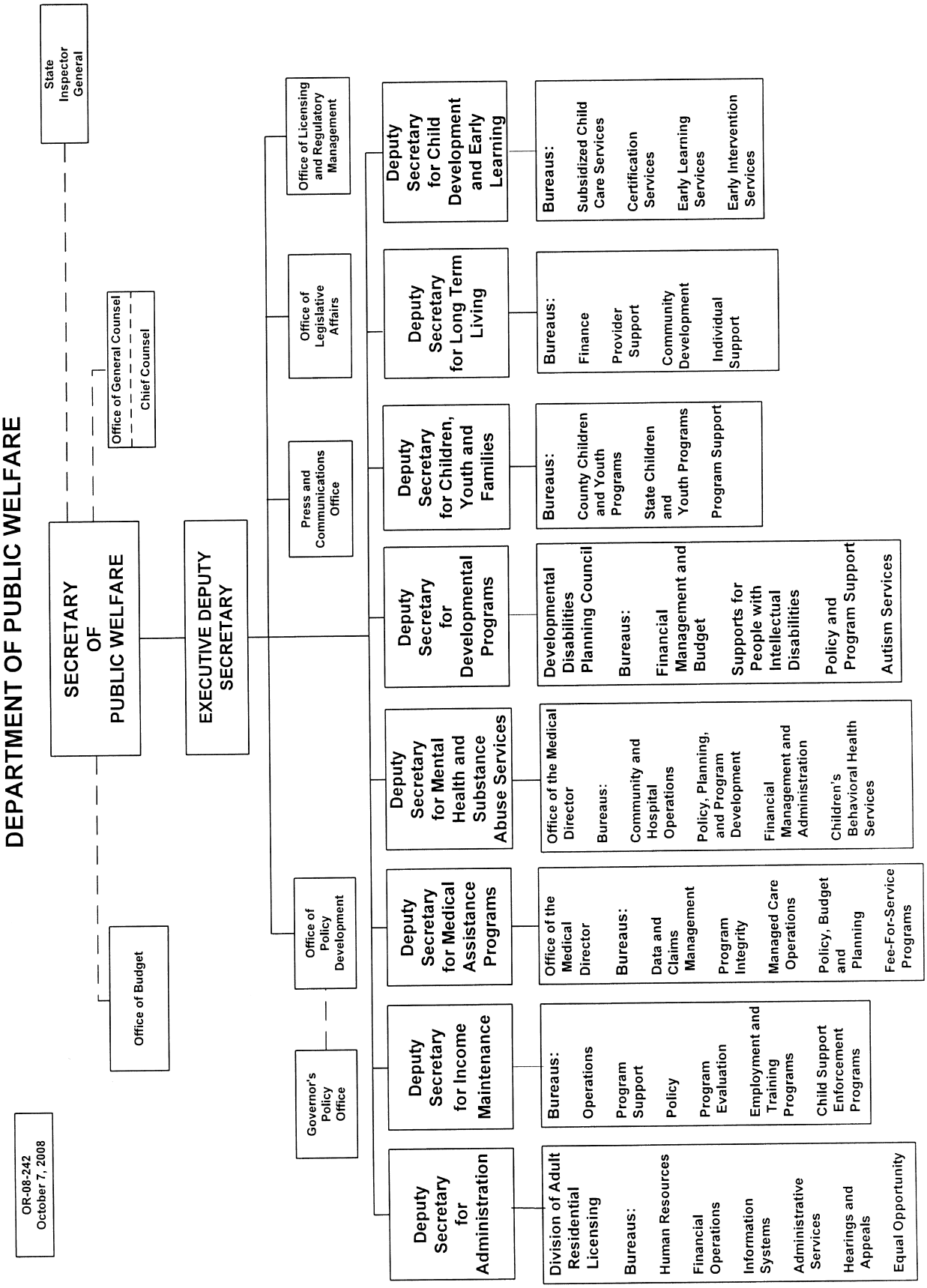
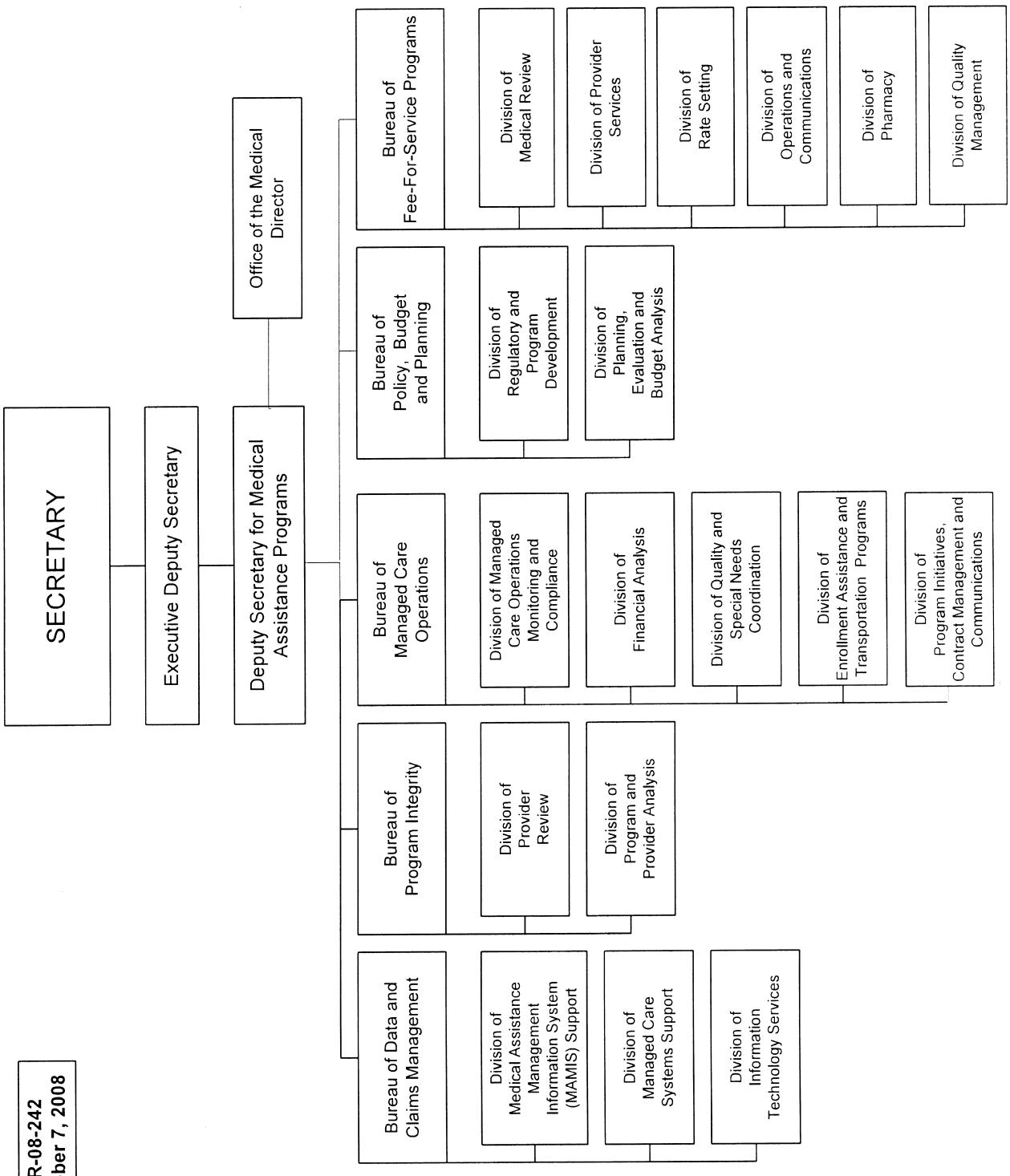

DEPARTMENT OF PUBLIC WELFARE
OR-08-242
October 7, 2008
SECRETARY OF PUBLIC WELFARE
State Inspector General
Office of General Counsel
Chief Counsel
Office of Budget
EXECUTIVE DEPUTY SECRETARY
Governor's Policy Office
Office of Policy Development
Press and Communications Office
Office of Legislative Affairs
Office of Licensing and Regulatory Management
Deputy Secretary for Administration
Division of Adult Residential Licensing
Bureaus:
Human Resources
Financial Operations
Information Systems
Administrative Services
Hearings and Appeals
Equal Opportunity
Deputy Secretary for Income Maintenance
Bureaus:
Operations
Program Support
Policy
Program Evaluation
Employment and Training Programs
Child Support Enforcement Programs
Deputy Secretary for Medical Assistance Programs
Office of the Medical Director
Bureaus:
Data and Claims Management
Program Integrity
Managed Care Operations
Policy, Budget and Planning
Fee-For-Service Programs
Deputy Secretary for Mental Health and Substance Abuse Services
Office of the Medical Director
Bureaus:
Community and Hospital Operations
Policy, Planning, and Program Development
Financial Management and Administration
Children's Behavioral Health Services
Deputy Secretary for Developmental Programs
Developmental Disabilities Planning Council
Bureaus:
Financial Management and Budget
Supports for People with Intellectual Disabilities
Policy and Program Support
Autism Services
Deputy Secretary for Children, Youth and Families
Bureaus:
County Children and Youth Programs
State Children and Youth Programs
Program Support
Deputy Secretary for Long Term Living
Bureaus:
Finance
Provider Support
Community Development
Individual Support
Deputy Secretary for Child Development and Early Learning
Bureaus:
Subsidized Child Care Services
Certification Services
Early Learning Services
Early Intervention Services

DEPARTMENT OF PUBLIC WELFARE
DEPUTY SECRETARY FOR MEDICAL ASSISTANCE PROGRAMS



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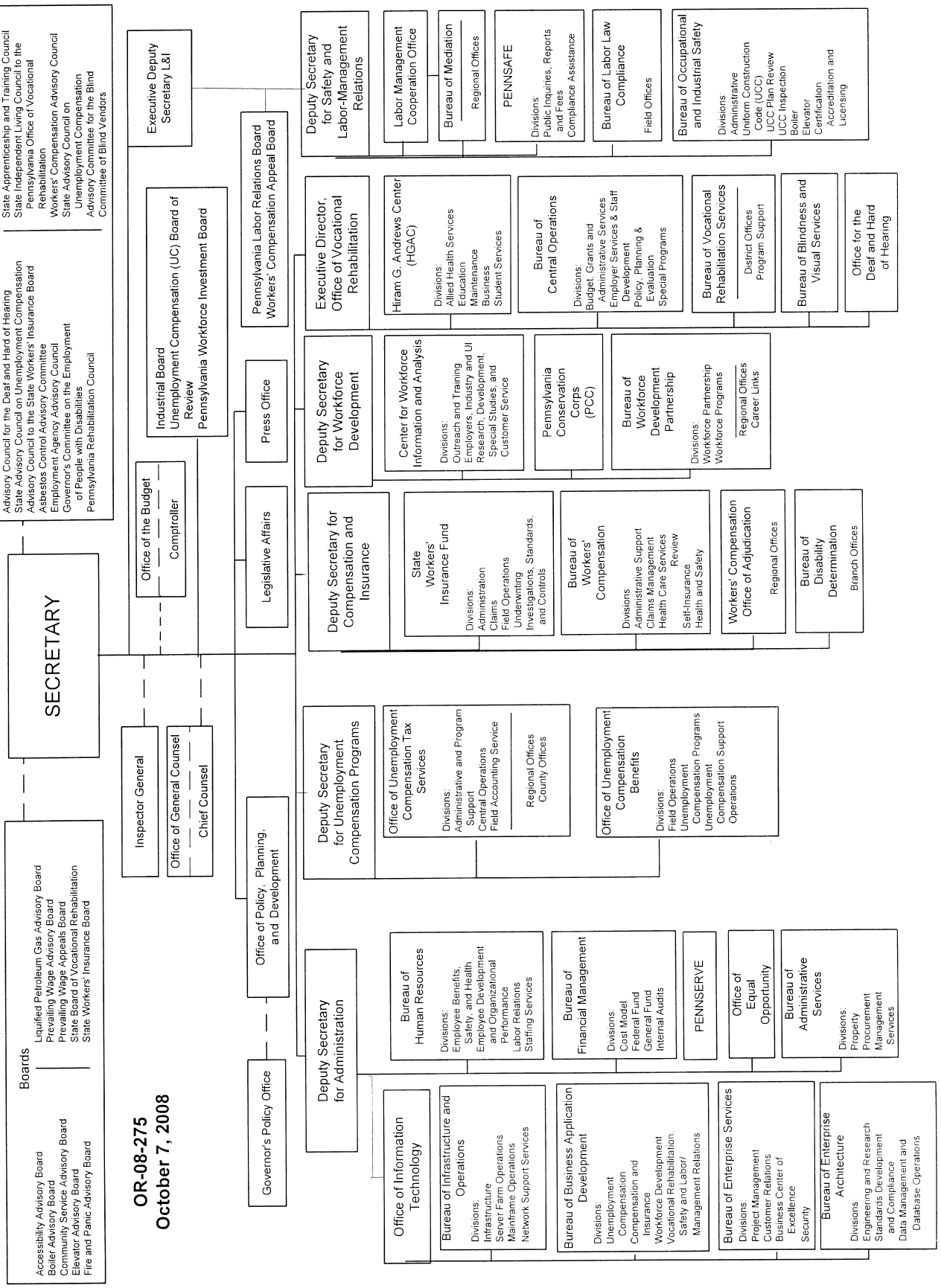
October 7, 2008


DEPARTMENT OF LABOR AND INDUSTRY
OR-08-275
October 7, 2008
SECRETARY
Boards
Accessibility Advisory Board
Boiler Advisory Board
Community Service Advisory Board
Elevator Advisory Board
Fire and Panic Advisory Board
Liquified Petroleum Gas Advisory Board
Prevailing Wage Advisory Board
Prevailing Wage Appeals Board
State Board of Vocational Rehabilitation
State Workers' Insurance Board
Councils/Committees
Advisory Council for the Deaf and Hard of Hearing
State Advisory Council on Unemployment Compensation
Advisory Council to the State Workers' Insurance Board
Asbestos Control Advisory Committee
Employment Agency Advisory Council
Governor's Committee on the Employment of People with Disabilities
Pennsylvania Rehabilitation Council
State Apprenticeship and Training Council
State Independent Living Council to the Pennsylvania Office of Vocational Rehabilitation
Workers' Compensation Advisory Council
State Advisory Council on Unemployment Compensation
Advisory Committee for the Blind
Committee of Blind Vendors
Inspector General
Office of General Counsel
Chief Counsel
Office of the Budget
Comptroller
Industrial Board
Unemployment Compensation (UC) Board of Review
Pennsylvania Workforce Investment Board
Executive Deputy Secretary L&I
Pennsylvania Labor Relations Board
Workers' Compensation Appeal Board
Governor's Policy Office
Office of Policy, Planning, and Development
Legislative Affairs
Press Office
Deputy Secretary for Administration
Office of Information Technology
Bureau of Infrastructure and Operations
Divisions:
Infrastructure
Server Farm Operations
Mainframe Operations
Network Support Services
Bureau of Business Application Development
Divisions:
Unemployment Compensation and Insurance
Workforce Development
Vocational Rehabilitation, Safety and Labor/ Management Relations
Bureau of Enterprise Services
Divisions:
Project Management
Customer Relations
Business Center of Excellence
Security
Bureau of Enterprise Architecture
Divisions:
Engineering and Research
Standards Development and Compliance
Data Management and Database Operations
Bureau of Human Resources
Divisions:
Employee Benefits, Safety, and Health
Employee Development and Organizational Performance
Labor Relations
Staffing Services
Bureau of Financial Management
Divisions:
Cost Model
Federal Fund
General Fund
Internal Audits
PENNSERVE
Office of Equal Opportunity
Bureau of Administrative Services
Divisions:
Property
Procurement
Management Services
Deputy Secretary for Unemployment Compensation Programs
Office of Unemployment Compensation Tax Services
Divisions:
Administrative and Program Support
Central Operations
Field Accounting Service
Regional Offices
County Offices
Office of Unemployment Compensation Benefits
Divisions:
Field Operations
Unemployment Compensation Programs
Unemployment Compensation Support Operations
Deputy Secretary for Compensation and Insurance
State Workers' Insurance Fund
Divisions:
Administration
Claims
Field Operations
Underwriting
Investigations, Standards, and Controls
Bureau of Workers' Compensation
Divisions:
Administrative Support
Claims Management
Health Care Services Review
Self-Insurance Health and Safety
Workers' Compensation Office of Adjudication
Regional Offices
Bureau of Disability Determination
Branch Offices
Deputy Secretary for Workforce Development
Center for Workforce Information and Analysis
Divisions:
Outreach and Training
Employers, Industry and UI Research, Development, Special Studies, and Customer Service
Pennsylvania Conservation Corps (PCC)
Bureau of Workforce Development Partnership
Divisions:
Workforce Partnership
Workforce Programs
Regional Offices
Career Links
Deputy Secretary for Safety and Labor-Management Relations
Labor Management Cooperation Office
Bureau of Mediation
Regional Offices
PENNSAFE
Divisions:
Public Inquiries, Reports and Fees
Compliance Assistance
Bureau of Labor Law Compliance
Field Offices
Bureau of Occupational and Industrial Safety
Divisions:
Administrative
Uniform Construction Code (UCC)
UCC Plan Review
UCC Inspection
Boiler
Elevator
Certification
Accreditation and Licensing
Executive Director, Office of Vocational Rehabilitation
Hiram G. Andrews Center (HGAC)
Divisions:
Allied Health Services
Education
Maintenance
Business
Student Services
Bureau of Central Operations
Divisions:
Budget, Grants and Administrative Services
Employer Services & Staff Development
Policy, Planning & Evaluation
Special Programs
Bureau of Vocational Rehabilitation Services
District Offices
Program Support
Bureau of Blindness and Visual Services
Office for the Deaf and Hard of Hearing

Title 55—PUBLIC WELFARE

DEPARTMENT OF PUBLIC WELFARE

[55 PA. CODE CH. 259]

Implementation of Third-Party Liability Provisions of Act 2008-44

Scope

This statement of policy applies to claims by the Department of Public Welfare (Department) for reimbursement of Medical Assistance (MA) from moneys owed by third parties on tort claims brought by MA recipients.

Purpose

The purpose of this statement of policy is to state how the Department will interpret and apply sections 1409 and 1409.1 of the Public Welfare Code (code) (62 P. S. §§ 1409 and 1409.1) to tort claims involving MA recipients.

Background

The Commonwealth participates in the Federal Medicaid Program established under Title XIX of the Social Security Act (42 U.S.C.A. §§ 1396—1396v). The Commonwealth's Medicaid program is called Medical Assistance (MA). Section 1902(a)(25) of the Social Security Act requires the Department to operate a program to recover the costs of MA expenditures from liable third parties. Section 1409 of the code (42 U.S.C.A. § 1396a(a)(25)), implements these provisions by giving the Department the option of suing tortfeasors separately or asserting a claim against money owed by third parties in tort claims brought by MA recipients. Section 1912 of the Social Security Act (42 U.S.C.A. § 1396k), requires MA recipients to assign to the state the right to payment for medical care from any third party. Section 1404(b) of the code (62 P. S. § 1404(b)) implements the assignment under State law.

In *Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268, 126 S.Ct. 1752 (2006) (Ahlborn), the United States Supreme Court held that states could only assert claims on that portion of a tort recovery that represents the assigned right to payment for medical care from third parties. States are prohibited from asserting Medicaid claims against that portion of a tort recovery that represents other types of damages such as lost wages, pain and suffering, and other nonmedical damages when proceeding under the assignment.

On July 4, 2008, Governor Rendell signed Act 2008-44 (Act 44) into law. Act 44 makes significant changes in MA third-party liability procedures. The new law enacts section 1409.1 of the code to implement the *Ahlborn* decision by statute and it amends section 1409 of the code to establish procedures under which MA recipients can exclude recovery of medical expenses paid by MA from their tort claims. The legislation also extends the statute of limitations for the recovery of medical expenses paid by MA on behalf of minors, thus allowing parents to recover the medical expenses after the statute of limitations on other parental claims has expired. This change effectively overrules the Superior Court's decision in *Bowmaster v. Clair*, 933 A.2d 86 (Pa. Super. 2007). Finally, the law extends the statute of limitations for the Department to pursue third parties and insurers, and gives the Department civil money penalty authority to enforce the law.

Discussion

This statement of policy explains how the Department will interpret and apply certain changes in the law made by Act 44. This statement of policy also explains the duty of MA beneficiaries to cooperate with the Department's efforts to obtain reimbursement from third parties. The term "beneficiary" includes both adult and minor recipients of MA.

Section 259.2 (relating to claims against moneys for which third parties are liable as a result of a tort claim allocation of tort proceeds in actions filed before September 2, 2008—statement of policy) will now apply only to lawsuits filed prior to September 2, 2008. As required by Federal law, the Department will continue to apply the *Ahlborn* decision to lawsuits filed prior to September 2, 2008, even though the statutory requirement implementing *Ahlborn* in section 1409.1 of the code does not apply to those cases. In addition, a technical change was made to § 259.2 to add subsection (d) to clarify that the Department's Bureau of Hearings and Appeals has jurisdiction to determine the amount of the Department's claim against settlements under the existing regulation in 55 Pa. Code § 275.1(a)(4)(ii)(F) (relating to policy) when a court does not adjudicate the claim.

Section 259.3 (relating to claims against moneys for which third parties are liable as a result of a tort claim—allocation of tort proceeds in actions filed on or after September 2, 2008—statement of policy) explains how the Department will apply the amendments made by Act 44. This section applies to lawsuits filed on or after September 2, 2008. In accordance with section 1409.1 of the code and *Ahlborn*, the Department will only recover from that portion of a tort recovery which represents payment for medical care by the third party. The beneficiary is in exclusive possession of information as to whether a tort recovery included all damages. Accordingly, the beneficiary has the burden of informing the Department that a claim must be limited under *Ahlborn* and showing that not all medical expenses paid by MA were recovered.

Act 44 establishes a procedure for MA recipients to exclude medical expenses paid by MA from the damages claimed in a court case. Section 259.3(b) explains the consequences of the decision. If a beneficiary decides not to pursue medical expenses paid by MA, then the Department will intervene in the case or sue separately if it is cost-effective to do so. *Ahlborn* does not limit the Department's recovery when it sues a third party directly using its independent statutory authority to recover MA under section 1409(b)(1) of the code. Beneficiaries who elect not to recover medical expenses paid by MA as part of their claim forfeit the right to have the Department's claim reduced on account of their attorneys' fees and costs, even if the Department benefits indirectly from their efforts. The beneficiary may not attempt to recover medical expenses paid by MA in the past, or those medical expenses that will be paid by MA in the future. Notice of settlement must still be provided to the Department under section 1409(b)(5)(iv) of the code notwithstanding the election. An election not to recover medical expenses paid by MA can be revoked by the beneficiary only with the express written consent of the Department since it is expected that the Department will incur costs to retain counsel and intervene following the election. The beneficiary cannot settle or release the Department's claims against third parties or insurers.

Act 44 places new obligations upon insurers and third parties. These obligations are similar to those imposed by

Congress upon insurers and third parties with respect to the Medicare program in the Medicare, Medicaid and SCHIP Extension Act of 2007, Pub. L. No.110-173. Liability insurance companies must now establish a direct relationship with the Department's Division of Third-Party Liability and provide the Department with both notice of suit and notice of settlement in any case when they have information indicating that the claimant received MA. This information will often come from plaintiff's counsel and may also be present in medical and provider records that are reviewed as part of the insurer's claim adjudication process. Section 1409(c) of the code authorizes the Department to impose civil money penalties upon insurers that do not comply with these requirements or who make distributions to beneficiaries in cases when the Department has an interest without insuring payment of the Department's claim. The Department has established a safe harbor provision in § 259.3(e) and has specified those actions that can be taken by third parties and insurers to shield themselves from potential liability to the Department.

Section 259.3(f) and (g) specify what identifying information must be included in notices that are provided to the Department. Subsection (f) is similar to existing requirements in § 259.2(c)(6).

Act 44 requires that a notice of election to not recover MA be given so that the Department has sufficient time to intervene and prosecute the claim itself. Section 259.3(h) specifies when notice of an election to not recover MA will be considered unreasonable. Notice is not reasonable if it is given after the close of discovery. Notice of a settlement that occurs prior to the close of discovery is not reasonable if the Department is not given 30 days to intervene in the case before the settlement agreement is executed.

Section 259.3(h) provides that the Bureau of Hearings and Appeals has jurisdiction to determine the amount of the Department's claim against a settlement under the existing regulation in § 275.1(a)(4)(ii)(F),when a court does not adjudicate the claim.

Act 44 does not expressly provide procedures for cases that are settled without litigation. Section 259.4 (relating to settlements without litigation—statement of policy) explains how the Department will apply *Ahlborn* to settlements that occur without litigation. The Department will assume that a settlement includes medical expenses paid by MA unless certain circumstances apply. In a case involving a minor or incapacitated individual, the court order approving the settlement may adjudicate the Department's claim. If agreement cannot be reached with the Department regarding the amount of its claim against a settlement, then the beneficiary can obtain an *Ahlborn* allocation determination by filing an appeal to the Bureau of Hearings and Appeals.

Section 259.4(b) specifies the circumstances when the Department will not assert a claim against a settlement that is settled without litigation. The Department will not assert a claim in a settlement involving a minor or incapacitated person, when the court order approving the settlement expressly adjudicates the Department's claim after reasonable notice and an opportunity to be heard. The Department will not assert a claim when the beneficiary is legally incapable of recovering the medical expenses paid by MA. Finally, the Department will not assert a claim against a settlement when both the Department and the settling party have been provided advance notice that the beneficiary's claim does not include medical expenses paid by MA. The Department will consider a failure to provide it with reasonable notice that a claim does not include medical expenses paid by MA to be a violation of section 1408(a)(1) of the code, and may impose a civil money penalty or establish an overpayment of MA. Notice is not reasonable if it is given less than 30 days prior to execution of a settlement agreement. Section 259.4 applies to all pending claims.

Beneficiaries are required to cooperate with the Department's efforts to secure reimbursement as a condition of eligibility for MA. 42 U.S.C.A. § 1396k(a)(1)(B)(ii). The Department's interpretation of the cooperation requirement is explained at § 259.5 (relating to cooperation in obtaining payment from third-party—statement of policy). Cooperation includes identifying liable third parties, providing information to the Department, disclosing that a claim has been filed against an insurer or third party, not opposing the Department's efforts to intervene in the case, consenting to reasonable extensions of time requested by the Department's counsel, supplying litigation documents, and providing testimony in support of the Department's claim. The cooperation requirement also requires beneficiaries to disclose to tort defendants that they are not recovering medical expenses that have been paid by MA or will be paid by MA in the future. The cooperation requirement precludes beneficiaries from interfering with the Department's collection efforts by, for example, signing an indemnification agreement under which the beneficiary will pay the tort defendant if the Department pursues its claim. Finally, the Department may request that a beneficiary include medical expenses paid by MA in his claim under the cooperation requirement. If a beneficiary violates the cooperation requirement, the Department may terminate or deny MA benefits, and may establish an overpayment against the client for MA benefits received after the date of noncooperation. Section 259.5 applies to all pending claims.

Section 259.6 (relating to civil money penalties—statement of policy) describes the civil money penalties that the Department may impose for violations of section 1409 of the code and failing to disclose information regarding third-party liability to the Department as required under section 1408(a)(1) of the code. Section 259.6(c) identifies those persons who are required to disclose information to the Department and § 259.6(d) defines what constitutes a willful violation of the law. The Bureau of Hearings and Appeals has jurisdiction to hear appeals relating to civil money penalties. Section 259.6 applies to pending cases.

Effective Date

This statement of policy is effective immediately upon publication in the *Pennsylvania Bulletin*.

Contact

Comments and questions regarding this statement of policy should be directed to the Division of Third-Party Liability, Department of Public Welfare, P. O. Box 8486, Harrisburg, PA 17105-8486, (717) 772-6604.

ESTELLE B. RICHMAN,
Secretary

(*Editor's Note*: Title 55 of the Pa. Code is amended by amending a statement of policy in § 259.2 and adding statements of policy in §§ 259.3—259.6 to read as set forth in Annex A.)

Fiscal Note: 14-BUL-078. No fiscal impact; (8) recommends adoption.

Annex A

TITLE 55. PUBLIC WELFARE

PART II. PUBLIC ASSISTANCE MANUAL

Subpart G. RESTITUTION AND REIMBURSEMENT

CHAPTER 259. THIRD-PARTY LIABILITY

§ 259.2. Claims against moneys for which third parties are liable as a result of a tort claim allocation of tort proceeds in actions filed before September 2, 2008—statement of policy.

(a) With respect to claims asserted by the MA Program against moneys owed by third parties as a result of tort claims asserted by a beneficiary of MA benefits, the Department will only recover from that portion of a tort recovery which represents payment for medical care by the third party. The term "beneficiary" includes both present and former recipients of MA benefits, and includes individuals receiving benefits through an MA managed care organization.

(b) In determining the portion of a tort recovery that represents payment for medical care by a third party, the Department will apply the following interpretations:

(1) Unless the Department intervenes in a lawsuit or sues separately, beneficiaries, including beneficiaries who are minors, are vested with the right to recover injury related medical expenses paid by the MA Program as part of their cause of action for other damages, and absent an express court order to the contrary are deemed to recover medical expenses as part of any tort recovery.

(2) In the absence of a court order allocating tort proceeds among categories of damages, 1/2 of the net proceeds are allocated by law to be available to repay injury-related MA expenses. The amount of net proceeds is computed by deducting from the gross proceeds the attorney's fees, litigation costs and medical expenses relating to the injury that were paid for by the beneficiary prior to the settlement of the injured beneficary's action or claim.

(3) If the beneficiary or other party seeks to obtain a court order limiting the portion of the tort recovery from which MA reimbursement may be paid to an amount less than 1/2 of net proceeds, or excluding amounts paid by the MA Program from the recovery, the Department shall be given fair notice and an opportunity to protect its interest.

(4) Failure to provide the Department with fair notice and an opportunity to protect its interest, prior to obtaining a court order limiting the portion of a tort recovery from which MA reimbursement may be paid, constitutes a violation of section 1408(a)(1) of the Public Welfare Code (62 P. S. § 1408(a)(1)).

(5) The Department is not bound by a private agreement between the parties to a tort claim regarding allocation of the proceeds.

(6) The Department's claims against third parties for reimbursement of MA cannot be released by a beneficiary without the Department's express consent in writing.

(c) The following procedures provide the Department with fair notice and an opportunity to protect its interest prior to entry of an order subject to subsection (b)(3):

(1) In a case when the beneficiary seeks to exclude injury-related medical expenses paid by the MA Program from the recovery, the beneficiary shall compy with the notice of suit requirements in section 1409(b)(5) of the Public Welfare Code (62 P. S. § 1409(b)(5)) and include a statement that the beneficiary will seek to exclude moneys paid by the MA Program from any recovery.

(2) In a case when the beneficiary seeks an allocation of tort proceeds by the court or a trier of fact, the beneficiary shall provide the Department with reasonable advance notice and opportunity to intervene in the case prior to the determination.

(3) In a case when the beneficary seeks a court order limiting the portion of the tort settlement from which MA reimbursement may be paid to an amount less that 1/2 of the net proceeds of any settlement, the beneficiary shall provide the Department with reasonable advance notice of settlement before it becomes binding.

(4) In a case when a motion is to eliminate medical expenses paid by MA from the case, the moving party shall provide the Department with reasonable advance notice and an opportunity to intervene in the case prior to adjudication of the motion.

(5) Thirty days advance notice is considered reasonable advance notice under this subsection.

(6) Notices must be in writing and sent by certified or registered mail to the Division of Third-Party Liability, Department of Public Welfare, P. O. Box 8486, Harrisburg, PA 17105 and include the following information:

(i) The name of the beneficiary.

(ii) The beneficiary's MA identification number, if known.

(iii) The beneficiary's date of birth.

(iv) The name of the beneficiary's attorney, if applicable.

(v) The insurance carriers, if applicable.

(vi) The date and specific injuries giving rise to the claim.

(vii) The court and docket number in which the claim is pending, if applicable.

(d) If a court does not adjudicate the amount of the Department's claim against a settlement, the Bureau of Hearings and Appeals has jurisdiction to hear and determine an appeal by a beneficiary contesting the amount of the Department's claim.

§ 259.3. Claims against moneys for which third-parties are liable as a result of a tort claim—allocation of tort proceeds in actions filed on or after September 2, 2008—statement of policy.

(a) With respect to claims asserted by the MA Program against moneys owed by third parties as a result of tort claims asserted by a beneficiary of MA benefits, the Department will only recover from that portion of a tort recovery which represents payment for medical care by the third party. The beneficiary has the burden of informing the Department that its claim must be limited under this subsection and showing not all medical expenses paid by MA were recovered. For purposes of this section, the term "beneficiary" includes both present and former adult and minor recipients of MA benefits, and includes individuals receiving benefits through an MA managed care organization.

(b) If a beneficiary elects not to recover expenses for which medical assistance is provided under section 1409(b)(5) of the Public Welfare Code (62 P. S. § 1409(b)(5)) then:

(1) The Department will pursue its claim directly against the liable third-party or insurer if it is cost-effective to do so.

(2) The Department will not reduce its claim on account of attorney fees or costs incurred by the beneficiary regardless of any indirect benefit that the Department receives from the beneficiary's prosecution of his claim.

(3) The beneficiary is prohibited from attempting to recover past or future medical expenses that will be paid by MA.

(4) Notice of settlement under section 1409(b)(5)(iv) of the Public Welfare Code shall be provided to the Department.

(5) The election not to recover expenses paid by MA may be revoked by the beneficiary only with the consent of the Department in writing.

(6) The beneficiary shall disclose to the liable third-party or insurer that the beneficiary has elected not to recover expenses paid by MA and that the third-party or insurer will remain liable to the Department on the claim.

(7) The beneficiary shall cooperate with the Department's efforts to obtain payment of medical care from any liable third-party or insurer as a condition of eligibility for MA in accordance with § 259.5 (relating to cooperation in obtaining payment from third-parties—statement of policy)

(c) A beneficiary may not settle or release the Department's claims against third parties or insurers without the Department's consent.

(d) The Department may impose a $5,000 civil money penalty for a violation of the notice requirements of section 1409(b)(5) of the Public Welfare Code or the distribution requirements of section 1409(b)(9) of the Public Welfare Code. A separate penalty may be imposed for each violation of the law. In determining whether to assess a civil money penalty against a third party or insurer for violating the statutory requirements, the Department will deem a third party or insurer to have information indicating that a beneficiary received medical assistance if the beneficiary's MA status is shown in records received by the third party or insurer.

(e) The Department will not impose or pursue liability under section 1409(b)(9) of the Public Welfare Code against a third-party or insurer for the distribution of settlement proceeds on a claim by a beneficiary if an insurer or third-party has complied with one or more of the following requirements:

(1) The insurer resolves the Department's claim with the Department and makes direct payment to the Department.

(2) The insurer or third-party requires the beneficiary to satisfy the Department's claim and makes the Department a payee on the settlement draft so that the Department's endorsement is required to negotiate the draft.

(3) The insurer obtains a statement from the Division of Third-Party Liability that the Department has no claim against the settlement.

(f) Notices to the Department under sections 1409 and 1409.1 of the Public Welfare Code (62 P. S. §§ 1409 and 1409.1) must be in writing and sent by certified or registered mail to the Division of Third-Party Liability, Department of Public Welfare, P. O. Box 8486, Harrisburg, PA 17105 and include the following information:

(1) The name of the beneficiary.

(2) The beneficiary's MA identification number, if known.

(3) The beneficiary's date of birth.

(4) The name of the beneficiary's attorney, if applicable.

(5) The insurance carriers and claim numbers, if applicable.

(6) The date and specific injuries giving rise to the claim.

(7) The court and docket number in which the claim is pending.

(8) The filing date of the lawsuit or claim.

(9) The close of discovery date.

(g) A notice of election to exclude medical expenses paid by MA from a claim that is made within 30 days of filing the complaint must contain a copy of the complaint. A notice of election to exclude medical expenses paid by MA from a claim that is made more than 30 days after the filing of the complaint must contain a copy of the complaint and the docket entries in the case.

(h) A notice of election to exclude medical expenses paid by MA is not reasonable if it is given after the close of discovery in a case, or in the event of a settlement prior to the close of discovery, it is given less than 30 days prior to the date the settlement agreement is fully executed.

(i) If a court does not adjudicate the amount of the Department's claim against a settlement, the Bureau of Hearings and Appeals has jurisdiction to hear and determine an appeal by a beneficiary contesting the amount of the Department's claim.

§ 259.4. Settlements without litigation—statement of policy.

(a) With respect to claims asserted by the MA Program against moneys owed by third-parties as a result of tort claims asserted by a beneficiary of MA benefits, the Department will only recover from that portion of a tort settlement which represents payment for medical care by the third party. The beneficiary has the burden of informing the Department that its claim must be limited under this subsection and showing not all medical expenses paid by MA were recovered. For purposes of this section, the term "beneficiary" includes both present and former adult and minor recipients of MA benefits, and includes individuals receiving benefits through an MA managed care organization.

(b) If a beneficiary settles a tort claim without litigation, the settlement includes medical expenses paid by MA unless one of the following applies:

(1) The case involves a minor or incapacitated individual and a court enters an order expressly adjudicating the Department's claim after the Department has been given notice and an opportunity to be heard.

(2) The beneficiary is legally incapable of recovering the medical expenses paid by MA.

(3) The beneficiary notifies both the Department and the third party or insurer that the beneficiary's claim does not include medical expenses paid by MA prior to settling the claim.

(c) A beneficiary may not settle or release the Department's claims against third parties or insurers without the Department's written consent.

(d) The failure to provide reasonable notice to the Department that a claim does not include recovery of medical expenses paid by MA constitutes a violation of section 1408(a)(1) of the Public Welfare Code (62 P. S. § 1408(a)(1)). Notice is not reasonable if it is given less than 30 days prior to the date a settlement agreement is fully executed.

(e) The Bureau of Hearings and Appeals has jurisdiction to hear and determine an appeal by a beneficiary contesting the amount of the Department's claim against a settlement.

§ 259.5. Cooperation in obtaining payment from third parties—statement of policy.

(a) A beneficiary has a duty to cooperate with the Department in obtaining payment from third parties and insurers as a condition of eligibility for MA.

(b) If a beneficiary does not cooperate with the Department's efforts to obtain payment of medical care from any third party or insurer, then the Department will determine the beneficiary to be ineligible for MA and pursue an overpayment of MA received after the date of noncooperation. The Department is not limited to recovering from the medical portion of a tort recovery when an overpayment is established.

(c) Cooperation with the Department's efforts to obtain payment of medical care from any third party or insurer includes the following:

(1) Disclosing to the Department that a claim was filed against an insurer or third party.

(2) Identifying and providing information to assist the Department in pursuing a third party who may be liable to pay for medical care and services.

(3) Consenting to the Department's intervention into the beneficiary's pending lawsuit.

(4) Consenting to a reasonable extension of time requested by Department counsel in the case.

(5) Providing Department counsel copies of discovery documents and legal papers filed in the lawsuit upon request.

(6) Disclosing to the liable third party or insurer that the beneficiary has elected not to pursue recovery of expenses paid by MA and the third party or insurer will remain liable to the Department on the claim.

(7) Not agreeing to indemnify or release the liable third party or insurer from the Department's claims.

(8) Providing testimony and evidence in support of the Department's claim.

(9) Providing notices required under section 1409(b)(5) of the Public Welfare Code (62 P. S. § 1409(b)(5) in compliance with this section.

(10) Including medical expenses paid by MA in a claim or lawsuit if requested to do so by the Department.

(11) Taking any other action requested by the Department that is necessary to pursue a claim against a third party.

§ 259.6. Civil money penalties—statement of policy.

(a) The Department may impose a civil money penalty of up to $5,000 per violation upon a person who willfully fails to comply with the obligations imposed under section 1409 of the Public Welfare Code (62 P. S. § 1409).

(b) The Department may impose a civil money penalty of up to $1,000 per violation upon a person who willfully fails to disclose a material fact regarding third party liability for a beneficiary's injuries.

(c) Persons who are required to disclose information regarding third-party liability to the Department include the beneficiary, any representative of the beneficiary, and any liable third-party or insurer in possession of that information.

(d) "Willfully" means that the person acted intentionally in the sense that the person intended to do the act and was aware of what the person was doing. Proof of evil motive or intent or knowledge that the person's conduct violated the law is not required.

(e) The Bureau of Hearings and Appeals has jurisdiction to hear appeals from the assessment of civil money penalties by the Department.

[Pa.B. Doc. No. 08-1970. Filed for public inspection October 31, 2008, 9:00 a.m.]

[55 PA. CODE CH. 1187]
Nursing Facility Services

Statutory Authority

The Department of Public Welfare (Department) under the authority of section 443.1(8) of the Public Welfare Code (code) (62 P. S. § 443.1(8)), intends to revise the statement of policy in 55 Pa. Code § 1187.21a (relating to nursing facility exception requests—statement of policy) as set forth in Annex A.

Scope

This proposed statement of policy applies to county, general, hospital-based and special rehabilitation nursing facilities that are enrolled, or applying for enrollment in the Medical Assistance (MA) Program.

Purpose

The purpose of this proposed statement of policy is to provide nursing facilities and other interested persons with notice of the guidelines that the Department intends to use in exercising its existing statutory and regulatory discretion to manage the enrollment and participation of nursing facilities as providers in the MA program.

Background

The Department is the "Single State Agency" responsible for the administration of the MA Program. See 62 P. S. § 201(1) regarding State participation in cooperative Federal programs. As the Single State Agency, the Department must operate the MA Program in compliance with Federal law. Federal law requires, among other things, that the Department administer the MA Program in a manner that assures that "care and services [are] provided in a manner consistent with simplicity of administration and the best interests of recipients," and in a manner that safeguards against the unnecessary utilization of services and that assures that MA payments are consistent with efficiency, economy and quality of services. See 42 U.S.C.A. § 1396a(a)(23) and (30)(A) (relating to state plans for medical assistance). Additionally, Federal law requires that the Department administer the MA Program so as to avoid the unjustified institutional isolation of persons with disabilities. *Olmstead v. L.C.*, 527 U.S. 581, 597 (1999).

To ensure compliance with applicable Federal requirements, and acting under its authority under section

201(2) and (3) of the code and regulations in §§ 1101.42(a) and 1101.77(b)(1) (relating to prerequisites for participation and enforcement actions by the Department), the Department issued a series of statements of policy relating to certain provider participation culminating in a 1998 statement of policy (SOP). See 28 Pa.B. 138 (January 10, 1998), codified in §§ 1101.42b, 1101.77a and 1187.21a (relating to certificate of need requirements for participation—statement of policy; terminationfor covenience and best interests of the Department—statement of policy; and nursing facility exception requests—statement of policy). the SOPs, the Department announced both the general policies relating to the participation of nursing facilities, and the specific guidelines that it intended to consider in future adjudications involving nursing facility participation in the MA Program. In adopting and applying these policies and guidelines, the Department's overarching goal was, and remains, to promote the efficient operation of the MA Program in a manner, consistent with the best interests of recipients, that avoids the unjustified institutional isolation of persons with disabilities. The SOPs provide the means for the Department to manage and control the publicly-funded long-term living system in this Commonwealth so as to reduce the MA Program's continued reliance on institutional nursing services and encourage the increased access to and use of home and community-based (HCB) services.

Approximately 10 years after the SOPs were issued, Commonwealth Court determined in *Eastwood Nursing & Rehabilitation Center v. Department of Public Welfare*, 910 A.2d 134, 148 (2006), that the SOPs were invalid because they imposed binding norms but had not been duly promulgated as regulations. The Court also determined that the SOPs reference to the "best interests of the Department" was inconsistent with the Federal requirement that the Department adopt "safeguards to assure that care and services 'will be provided in a manner consistent with . . . the best interests of the recipient.' " [1] *Id.*, at 149.

The General Assembly responded to *Eastwood* by enacting the act of June 30, 2007 (P. L. 33, No. 16) (Act 16). Act 16 amended the Public Welfare Code to require, among other things, private or public nursing facilities to seek and obtain advance written approval from the Department to enroll in the MA Program or to increase their existing certified bed complement if already enrolled in the MA Program. See section 1 of Act 16 (62 P. S. § 443.1(8)). Act 16 also directed the Department to publish proposed regulations by July 1, 2009, setting forth the process and criteria it intends to use to review and act on requests by nursing facilities for approval to enroll in the MA Program or increase their bed capacity. *Id.* It further specified that, pending the adoption of final regulations or until September 30, 2011, (whichever comes first), the Department must review pending and future requests for enrollment or expansion in accordance with the process and guidelines contained in the statements of policy published at 28 Pa.B. 138 (SOPs). *Id.*

Act 16 also authorized the Department to "publish amendments to the statement of policy if the department determines that changes to the process and guidelines for reviewing and responding to requests for approval of increases in MA-certified beds will facilitate access to medically necessary nursing facility services or are required to assure that long-term living care and services under the MA program will be provided in a manner consistent with applicable Federal and State law, including Title XIX of the Social Security Act." See section 1 of Act 16. Before the Department adopts amendments to the SOP, however, Act 16 requires that the Department solicit public comments for 30 days.

This proposed statement of policy announces the Department's intent to amend the existing § 1187.21a published at 28 Pa.B. 138. In proposing these amendments, the Department's intent is to clarify the language of the SOP to address the Federal law concerns identified by the *Eastwood* court and to streamline the process and guidelines used in conducting reviews thereunder so as to facilitate MA recipients' continued access to medically necessary nursing facility services. The revisions are identified and discussed in greater detail as follows.

Discussion

Best Interests of MA Recipients

Since the SOPs were first issued in 1998, the Department's paramount consideration in reviewing nursing facility enrollment and expansion requests has been the best interests of MA-recipients. As noted previously, the Department issued the SOPs to promote the growth in HCB services, which consumers prefer, while ensuring that MA recipients have adequate access to medically necessary nursing facility services. Consistent with the SOPs intended objective, the Department has reviewed nursing facility requests on a case-by-case basis without any presumption as to whether the requests should be approved or denied. In determining whether to approve the enrollment of a new nursing facility provider or an increase in the MA-certified bed capacity of an existing nursing facility provider, the Department has examined occupancy rates, the availability of HCB services, and specific information relating to the needs of MA recipients, including whether MA recipients had adequate access to care in the service area proposed by the provider seeking expansion or enrollment in the MA Program.

To better reflect how the Department has applied and will continue to apply the SOPs in reviewing requests to enroll and expand, the Department is proposing to revise its guidelines to clarify how the occupancy rates and other information that may be relevant to whether MA recipients have adequate access to care and to explicitly state that it will consider whether a project is necessary to address the special needs of individual MA recipients that may exceed the needs of the general MA nursing facility population. See § 1187.21a(h)(1)(iii).

Obsolete Certificate of Need (CON) Provisions

The issuance of the SOPs were prompted by the sunset of the Commonwealth's CON process on December 19, 1996. See 28 Pa.B. 138, 139. The SOPs, however, were not intended to, nor did they, reinstitute the CON process. Nonetheless, the Department recognized that certain providers might not have completed nursing facility projects under CONs issued shortly before December of 1996. Therefore, the Department included separate guidelines for CON holders that reasonably relied on a CON and substantially implemented its project within the time frames required by the CON (see 28 Pa.B. 143 and 55 Pa. Code § 1187.21a(f)). The Department also specified that CON holders should submit requests for enrollment or expansion no later than April 13, 1998, to be considered under these separate guidelines. Since more than 10

[1] The statutory provision on which the *Eastwood* Court relied in making this determination states that A State plan for medical assistance must—

(19) provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients.

42 U.S.C. § 1396a(a)(19)

years has elapsed, the Department has determined that separate guidelines for CON holders are no longer required, and is proposing to delete the guideline from the SOP.

Outdated Bed Need Projections

When the Department issued the SOP in 1998, it attached "Appendix C" as one of the many factors it would consider in evaluating nursing facility enrollment and expansion requests. See 28 Pa.B. at 145, Appendix C. Appendix C was developed by the Department of Health, and contained nursing home bed need projections by counties through the year 2000. Since these projections have not been updated since they were issued, the Department has determined they are obsolete. Additionally, because the projections relate to the community at large, and do not adequately take into account either the increasing availability of HCB services or the current occupancy rates in MA-participating nursing facilities, the Department has concluded that they are no longer relevant in assessing the merits of requests made under the SOP. The Department is proposing to delete Appendix C.

New Bed Transfer Provisions

The nursing facility associations have recommended that the Department include guidelines in the SOP that would apply to requests to increase the number of MA-certified beds of a nursing facility simultaneous with a decrease of an equal or greater number of MA-certified beds in another nursing facility. Upon careful consideration of this recommendation, the Department agrees that there may be circumstances when allowing owners to adjust the MA-certified beds at their nursing facilities may facilitate access to medically necessary nursing facility services for MA recipients but not impede the Department's ability to administer long-term living care and services under the MA program in an efficient and economic manner that is consistent with applicable Federal and State law. Therefore, the Department is proposing to include new provisions in the SOP that will provide for separate guidelines and expedited reviews of bed transfer requests when certain conditions are present.

Because the Department wants the benefit of additional public input on the subject of bed transfers during the regulatory review process, the Department intends to limit application of these new SOP provisions to requests involving nursing facilities owned or controlled by the same legal entity and located in the same county. Requests that do not meet the conditions for consideration under these new provisions will not be automatically denied. Rather, they will be evaluated under the process and guidelines applicable to other bed requests.

Guideline

The proposed amendments to the statement of policy are contained in Annex A.

Effective Date

The statement of policy will be effective upon publication of the final statement of policy in the *Pennsylvania Bulletin*.

Comments

Interested persons are invited to submit written comments regarding this proposed statement of policy to the Department. Comments and questions regarding the proposed statement of policy should be directed to the Department of Public Welfare, Office of Long-Term Living, Bureau of Policy and Strategic Planning, Gail Weidman, P. O. Box 2675, Harrisburg, PA 17105. Comments received within 30 days will be reviewed and considered in the development of the final statement of policy. Persons with a disability who require an auxiliary aid or service may submit comments using the AT&T Relay Services at (800) 654-5984 (TDD users) or (800) 654-5988 (voice users).

ESTELLE B. RICHMAN,
Secretary

Fiscal Note: 14-BUL-077. No fiscal impact; (8) recommends adoption.

Annex A

TITLE 55. PUBLIC WELFARE

PART III. MEDICAL ASSISTANCE MANUAL

CHAPTER 1187. NURSING FACILITY SERVICES

Subchapter C. NURSING FACILITY PARTICIPATION

§ 1187.21a. Nursing facility **[exception requests] participation review process and guidelines**—statement of policy.

(a) *Scope.* This section applies to applicants **[and providers]** as defined in subsection (i).

(b) *Purpose.* The purpose of this section is to **[provide nursing facilities and other interested persons with notice of] describe the process and** the guidelines that the Department **[intends to] will** use **[in exercising its discretion regarding enrollment and participation of nursing facilities as providers in the MA Program] to review and respond to bed requests under section 443.1(8) of the Public Welfare Code (62 P. S. § 443.1(8))**.

(c) *Policy regarding enrollment and expansion.*

(1) **[** ***General.***

(i) The Department, possessing the authority to regulate nursing facility participation in the MA Program, has discretion to refuse to enter into provider agreements with applicants and to terminate provider agreements with participating providers to protect and advance the best interests of the Department.

(ii) The Department has determined that, in most instances, the current complement of nursing facilities participating in the MA Program results in an adequate supply of nursing facility beds for persons who qualify for MA nursing facility services, and, therefore, in most instances, increasing the number of MA-certified nursing facility beds through the enrollment of new providers or the expansion of existing providers is not in the Department's best interests.

(iii) The Department has determined that, because in most instances an increase in the number of MA-certified beds is not in the Department's best interests, if an applicant or a provider desires to cause an increase, it is appropriate to require the applicant or provider to request the Department's prior approval and to bear the burden of demonstrating that, under the circumstances, an increase in the number of MA-certified beds is in the Department's best interests and that the applicant or provider should be allowed to provide those beds.

(2) ***Policy regarding enrollment of applicants.***

(i) Except as noted in subparagraph (ii), when the Department receives an exception request from an applicant which, if granted by the Department, would cause a currently unenrolled nursing facility to become an enrolled MA provider of nursing facility services, the Department will, in the exercise of its discretion under § 1101.42(a) (relating to prerequisite for participation), deny that exception request.

(ii) The Department will make an exception to the policy in subparagraph (i) if, after considering the applicant's exception request in accordance with subsection (f) or (g), the Department determines that the applicant has demonstrated that its enrollment as an MA provider of nursing facility services is in the best interests of the Department.

(3) ***Policy regarding expansion of providers.***

(i) Except as noted in subparagraph (ii), the Department will, in the exercise of its discretion under § 1101.77(b)(1) (relating to nursing facility exception requests—statement of policy), terminate the enrollment of a provider that undertakes to increase the number of licensed and MA-certified beds at its nursing facility and, further, will terminate the direct or indirect participation of that provider in the MA Program, and may suspend payments to that provider.

(ii) The Department will make an exception to the policy in subparagraph (i) if, after considering the provider's exception request in accordance with subsection (f) or (g), the Department determines that the provider has demonstrated that an increase in the number of the provider's licensed and MA-certified beds is in the Department's best interests.]

Before an applicant increases the number of MA-certified beds in an existing MA nursing facility or the number of MA-certified beds in the MA Program, the applicant shall submit a bed request to the Department and obtain the Department's advance written approval.

(2) The Department will review bed requests on a case-by-case basis in accordance with the guidelines in subsection (g) or (h).

(d) *Submission* ***[and content of exception] of bed*** *requests.*

(1) An applicant **[or provider may make an exception request by submitting] shall submit** an original and two copies of its **bed** request to the Department at the following address:

Department of Public Welfare
[Bureau of Long Term Care Programs]
Office of Long Term Living
P. O. Box 2675
Harrisburg, PA 17105-2675
ATTN: MA/LTC Participation Review **[Unit]**

(2) **[Except as otherwise provided in subsection (f), an] An** applicant **[or provider should] shall** submit its **[exception] bed** request to the Department prior to beginning construction of the **[new or additional nursing facility beds that will be the subject of its request] applicant's proposed project**.

(e) ***Contents of bed requests.***

[(3)] (1) When an applicant submits **[an exception] a bed** request **[to enroll as an MA provider, or a provider submits an exception request to expand the number of licensed and MA-certified beds at its nursing facility]**, the Department has no obligation to independently seek out any information on the question of whether the circumstances of that applicant **[or provider]** are such that **[an exception] the applicant's bed request** should be **[made] approved**. To the contrary, **[if an applicant or provider believes an exception should be made,]** the applicant **[or provider]** should submit to the Department **whatever** information that the applicant **[or provider believes to be] believes is** relevant to **or supports** its **bed** request **[to enroll or expand]**.

[(4) If an applicant or provider submits an exception request to the Department, the Department may base its decision solely upon the information supplied by the applicant or provider. The Department may request or consider additional information other than the information provided by the applicant or provider, including any public comments received on the exception request, and the information specified in subsections (f) and (g).] (2) The Department recommends that a bed request include the information specified in paragraphs (3) and (4). If a bed request does not include the recommended information, the Department will not automatically deny the bed request, but the Department may independently seek and consider the information in determining how to respond to the bed request.

[(5) To enable the Department to fully evaluate an exception request, the Department suggests that an exception request include the following information:] (3) An applicant's bed request should include the following information:

(i) An overview of the **applicant's proposed** project which **[explains how it addresses the Department's goal to develop a fuller array of long-term care supports and services to meet the needs of its MA population and why it meets, or is needed to meet, the nursing facility service needs of the community] includes a description of the population and primary service area the applicant intends to serve**.

(ii) A narrative and supporting documentation, if any, addressing each guideline in subsection **[(f) or]** (g) **or (h)** and indexed to identify which guideline is being addressed.

(iii) **[If the applicant or provider possesses a Certificate of Need (CON) and is seeking an exception under subsection (f), copies of the CON application.**

(iv)] Copies of any feasibility or market studies and financial projections prepared for the project, including any studies or projections identifying project costs, sources of project funds, projected revenue sources by payor type, including assumptions used and expected occupancy rates by payor type.

[(v) A list of owners and related parties/entities involved in the project.]

(iv) A list identifying the names and addresses of the owners of the applicant and the owners of the proposed project and any related parties or entities involved in the project and, for each person included on the list, a description of the person's involvement with the project and the information specified in paragraph (4).

[(vi)] (v) Independent audited financial statements, if any, of the applicant **[and provider,]** and owners or parent corporation, if any, of the applicant **[or provider]** for the most recent year prior to the fiscal year in which the **[exception] bed** request is filed.

[(vii)] (vi) Other information that the **[provider] applicant** believes to be relevant.

[(6) The Department requests that the] (4) An applicant **[or provider] should** specify **[in its narrative and supporting documentation relating to suitability under subsections (f)(10) and (g)(2),]** whether or not any of the following applies, and, if so, **[that]** the applicant **[or provider] should** attach copies of all documents relating to the applicable action, including notices, orders**[,]** or sanction letters, received from the **[Health Care Financing Administration] Federal Centers for Medicare and Medicaid Services** or any state Medicaid, survey or licensing agency:

(i) Whether the applicant**[, provider]** or any owner **of the applicant or proposed project** is currently precluded from participating in the Medicare Program or any state Medicaid Program.

(ii) Whether the applicant**[, provider]** or any owner **of the applicant or the proposed project** owned, operated or managed a nursing facility, at any time during the **[period specified in subsection (f)(10) or (g)(2)] 3-year period preceding the date of the bed request** and one of the following applies:

* * * * *

[(e)] (f) *Consideration of* **[** ***exception*** **]** ***bed*** *requests.*

(1) **[Applicants or providers that possess a CON or letter of nonreviewability for their new or additional beds dated on or before December 18, 1996, may submit an exception request (if they have not already done so) under the guidelines in subsection (f), if the exception request is submitted by April 13, 1998. The Department will process and consider requests involving CONs or letters of nonreviewability as they are received. The Department will consider requests not submitted within this 90-day period under the guidelines in subsections (e)(2)—(5) and (g).**

(2) The] Subject to paragraph (6), the Department will consider **[all other exception requests under subsection (g)] bed requests, other than bed transfer requests, submitted on or after July 1, 2008,** biannually in two groups as follows:

(i) Group One will consist of **[exception] bed** requests **other than bed transfer requests** received January 1 through June 30. The Department will use its best efforts to issue decisions on Group One **[exception requests]** by the following December 31.

(ii) Group Two will consist of **[exception] bed** requests **other than bed transfer requests** received from July 1 through December 31. The Department will use its best efforts to issue decisions on Group Two **[exception requests]** by the following June 30.

[(3) Applicants or providers that submitted exception requests received by the Department between December 1996 through June 30, 1997 (Group One-1997) will be permitted until February 11, 1998, to submit additional information relating to their exception requests. The Department will use its best efforts to issue decisions on Group One-1997 by March 31, 1998.

(4) Following the close of each 6-month request period, the Department will publish a notice in the *Pennsylvania Bulletin* listing the exception requests included in the Group under consideration. For a 30-day period following publication of the notice in the *Pennsylvania Bulletin*, the Department will make copies of the requests in that Group available for review by the public during regular business hours, and will accept written comments related to the requests in the Group.

(5) The Department may expedite its review and act on an individual request before the target date.]

(2) The Department will use its best efforts to issue decisions on any bed requests, other than bed transfer requests, that were submitted prior to and pending with the Department on June 30, 2008, by _____(*Editor's Note*: The blank refers to a date 120 days following the date of publication of the final statement of policy in the *Pennsylvania Bulletin.)*.

(3) The Department will use its best efforts to issue decisions on any bed transfer requests that were submitted prior to _____ Editor's Note: The blank refers to the effective date of publication of the final statement of policy in the *Pennsylvania Bulletin* by _____ (Editor's Note: The blank refers to a date 60 days after the effective date of publication of the final statement of policy in the *Pennsylvania Bulletin*.).

(4) The Department will consider bed transfer requests submitted on or after _____(Editor's Note: The blank refers to the effective date of publication of the final statement of policy in the *Pennsylvania Bulletin*.) in the order in which they are received. Subject to paragraph (6), the Department will issue decisions on those requests on an ongoing basis following the expiration of the public comment period set forth in paragraph (5)(ii).

(5) *Public process.*

(i) *Bed requests, other than bed transfer requests.* Following the close of each 6-month request period, the Department will make available on the Office of Long Term Living (OLTL) web site a listing of the bed requests, other than bed transfer requests, included in the group under consideration. For a 30-day period following the date that the notice is posted on the web site, the Department will make copies of the requests in that group available for review by the public during regular business hours, and will accept written comments related to the requests in the group.

(A) The Group One listing will be made available on the OLTL web site on or before January 31.

(B) The Group Two listing will be made available on the OLTL web site on or before July 31.

(ii) *Bed transfer requests.* No later than 15 calendar days following the last day of each calendar month, the Department will make available on the OLTL web site a listing of the bed transfer requests received by the Department during that calendar month. For a 15-day period following the date that the notice is posted on the web site, the Department will make copies of the bed transfer requests that are listed in the notice for that calendar month available for review by the public during regular business hours, and will accept written comments related to the bed transfer requests.

(6) If an applicant demonstrates good cause, the Department may expedite its review and respond to a bed request before the target date; provided that the Department will not respond prior to the close of the applicable public comment period specified in paragraph (5)(i) and (ii).

(7) In reviewing an applicant's bed request, the Department will consider the information provided by the applicant and any public comments received on the request. In addition, the Department may consider information contained in the Department's books and records or obtained from persons other than the applicant that is relevant to the applicant's bed request including:

(i) The information specified in subsection (e)(3) and (4).

(ii) Data relating to the overall occupancy rates of MA nursing facilities in the applicant's primary service area and the county in which the applicant's proposed project is located.

(iii) Data relating to the admission rates for day-one MA eligible persons and the MA occupancy rates of MA nursing facilities in the applicant's primary service area and the county in which the applicant's proposed project is located.

(iv) Data relating to the availability of home and community based services in the applicant's primary service area and the county in which the applicant's proposed project is located.

(v) Data relating to the demographics of the applicant's primary service area and the county in which the applicant's proposed project is located.

(vi) Data relating to the admission and discharge practices of the applicant and of MA nursing facilities in the applicant's primary service area and the county in which the applicant's proposed project is located.

(vii) Data relating to the applicant's suitability as a provider of nursing facility services.

(viii) Data relating to the availability of specialized medical services the applicant is proposing to provide in the applicant's primary service area and the county in which the applicant's proposed project is located.

[(f) *Consideration of exception requests made by applicants and providers possessing CON or letters of nonreviewability dated on or before December 18, 1996.* In considering whether an applicant or provider has demonstrated that an increase in the number of MA-certified beds is in the Department's best interests, the Department will use the following guidelines and will consider the following information in evaluating the request:

(1) Whether the applicant or provider possesses a CON or letter of nonreviewability dated on or before December 18, 1996, authorizing the construction of new or additional nursing facility beds.

(2) Whether the Department of Health has issued a license to the applicant or provider authorizing it to operate the new or additional beds.

(3) If the applicant's or provider's CON or letter of nonreviewability was issued within 24 months of the date of its written notice to the Department, whether the applicant or provider demonstrates to the satisfaction of the Department that it is implementing its approved project in accordance with the substantial implementation timetable included in its approved CON application or, if not, whether there is good cause for the delay.

(4) If the applicant's or provider's CON or letter of nonreviewability was issued more than 24 months before the date of its written notice to the Department, whether the applicant or provider demonstrates to the satisfaction of the Department that it has substantially implemented its project as defined in 28 Pa. Code § 401.2 (relating to definitions), as effective December 18, 1996, or, if not, whether there is good cause for the failure.

(5) Whether the applicant or provider demonstrates to the satisfaction of the Department that, in determining that its project was economically and financially feasible, it presumed that it would participate in the MA Program and render services to MA recipients.

(6) For an applicant that possesses a CON for the new beds, whether the applicant will agree to provide written assurances to the Department that it will serve at least that percentage of MA recipients specified in its CON application, and that it will admit day-one MA recipients on a first-come/first-served basis as necessary to achieve and maintain that MA percentage on an ongoing basis.

(7) For a provider that is seeking to expand its number of licensed and certified beds under a CON, whether the provider will agree to provide written assurances to the Department that it will serve at least that percentage of MA recipients specified in its CON application, and that it will admit day-one MA recipients on a first-come/first served basis as necessary to achieve and maintain that MA occupancy percentage.

(8) For a provider that is seeking to expand its number of licensed and certified beds under a letter of nonreviewability, whether the provider will agree to provide written assurances to the Department that it will serve at least that percentage of MA recipients necessary to achieve an MA occupancy rate equal to its MA occupancy rate percentage in effect during the most recent 12-month fiscal period ending prior to its written request to the Department, and that it will admit day-one MA recipients on a first-come/first served basis as necessary to achieve and maintain that MA occupancy percentage.

(9) Whether the applicant or provider will agree to provide written assurances to the Department that the construction of its new or additional beds will be economically and financially feasible without the receipt of MA capital component payments and that it is not entitled to MA capital component payments related to the new or additional beds.

(10) Whether the applicant or provider has demonstrated suitability for enrollment or expansion. In determining whether an applicant or provider is suitable, the Department will consider the record of licensure and Medicaid and Medicare Program participation of the applicant, provider and any owner of the applicant or provider subsequent to the issuance date of the CON or letter of nonreviewability.]

(g) *Guidelines for evaluation of* **[** ***all other exception requests*** **]** ***bed transfer requests.*** **[Except for those exception requests reviewed under subsection (f), the Department will use the following guidelines and will consider the following information in evaluating an exception request.] The Department will use the following guidelines to evaluate bed transfer requests:**

(1) Whether the nursing facility that will increase its MA-certified beds (receiving facility) and the nursing facility that will decrease its MA-certified beds (surrendering facility) admit MA day-one recipients.

(2) Whether the decrease in beds at the surrendering facility will result in access barriers to nursing facility services for MA recipients. For purposes of this determination, the Department will examine, among other things, the MA occupancy rates both at the surrendering facility and at the receiving facility.

(3) Whether the increase in beds at the receiving facility will improve access to nursing facility services for MA recipients. For purposes of this determination, the Department will examine, among other things, the MA occupancy rates both at the surrendering facility and at the receiving facility.

(4) Whether the proposed project will result in a change in peer group under Chapter 1187 (relating to nursing facility services) for the surrendering or receiving facility and, if so, whether the change will have a negative or positive effect on the MA Program or on MA recipients.

(5) Whether the surrendering facility received capital component payments for the closed beds.

(6) Whether during the 3 year period preceding the date of the bed transfer request, the applicant, the receiving facility, the surrendering facility or any other nursing facility where the applicant is the owner, has been precluded from participation in the MA Program or in the Medicare Program; has been subject to the imposition of licensing or MA or Medicare certification sanctions or remedies; or has operated under a Corporate Integrity Agreement with the Department or the Federal government.

(h) ***Guidelines for evaluation of bed requests other than bed transfer requests.*** **The Department will use the following guidelines in evaluating any bed request that is not a bed transfer request:**

(1) *MA Program's need for additional nursing facility beds.* The Department will determine whether **[the MA Program needs]** additional **MA-certified** nursing facility beds **are needed** in the applicant's **[or provider's]** primary service area and **the county in which the applicant's proposed project is located to facilitate MA recipients' access to medically necessary nursing facility services or to assure that MA long-term living care and services will be provided in a manner consistent with applicable Federal and State law, including Title XIX of the Social Security Act (42 U.S.C.A. §§ 1396—1396v) and**, if so, whether the applicant **[or provider]** has demonstrated to the Department's satisfaction that it will meet that **[MA Program]** need. **[The] In making these determinations, the** Department will **review and** consider **[information as may be provided by the applicant or provider to show that a need for additional MA-certified nursing facility beds exists in the applicant's or provider's primary service area. The Department regards]** the following **[information as relevant to the determination of MA Program need]**:

(i) **[The extent to which MA recipients have access to nursing facility services in the applicant's or provider's primary service area] The existing size and utilization of the MA-certified bed capacity in the applicant's primary service area and the county in which the applicant's proposed project is located**.

(ii) The extent to which **MA recipients, including** day-one MA recipients **[and technology-dependent MA recipients]** have access to **[nursing facility beds] the existing MA-certified bed capacity** in the applicant's **[or provider's]** primary service area **and the county in which the applicant's proposed project is located, and whether there are systemic barriers that prevent MA recipients from accessing that bed capacity**.

(iii) **[Whether, and to what extent (expressed as a percentage of MA occupancy), the applicant or provider is willing and able to admit and serve day-one eligible MA recipients.**

(iv) Whether the applicant or provider is willing and able to admit and serve technology-dependent MA recipients.

(v) Whether there are any alternatives to an increase in the number of MA-certified nursing facility beds, such as an increase in home and community-based services, that would be less costly, more efficient or more appropriate in meeting any MA Program need.

(vi) Except for those exception requests involving nursing facility beds licensed prior to March 31, 1997, whether there is a need for additional nursing facility beds in the applicant's or provider's primary service area. In determining whether such a bed need exists, the Department will consider whether, and to what extent, the applicant's or provider's primary service area involves a county with bed shortages or surpluses, as set forth in Appendix C. Occupancy rates in the applicant's and provider's primary service area are also relevant to this determination.]

Whether the applicant is willing and able to admit and serve MA recipients having specialized medical needs and the extent to which MA recipients needing specialized medical services proposed by the applicant have access to the existing MA-certified bed capacity in the applicant's primary service area and the county in which the applicant's proposed project is located, and whether there are systemic barriers that prevent MA recipients with specialized medical needs from accessing that bed capacity.

(iv) Whether, and to what extent (expressed as a percentage of MA occupancy), the applicant is willing and able to admit and serve day-one eligible MA recipients.

(v) Whether there are any alternatives to an increase in the number of MA-certified nursing facility beds, such as an increase in home and community-based services, that would be less costly, more efficient or more appropriate in assuring that long-term living care and services will be provided under the MA Program in a manner consistent with applicable Federal and State law.

(vi) Whether, and how, the applicant's proposed project would affect the Department's goal to rebalance the Commonwealth's publicly-funded long-term living system in order to create a fuller array of service options for MA recipients.

(2) *Suitability.* The Department will determine whether the **[applicant or provider has demonstrated suitability for enrollment or expansion. In determining whether an applicant or provider is suitable, the Department will consider the]** record of licensure and Medicaid and Medicare Program participation of the applicant**[, provider]** and any owner of the applicant or **[provider beginning 3 years prior to the date of the exception request] the applicant's proposed project during the 3-year period preceding the date of the applicant's bed request demonstrates the applicant's suitability to increase the number of MA-certified nursing facility beds in the MA Program**.

(3) *Economic and financial feasibility without MA capital component payments.* **[If an applicant's new beds or the provider's additional beds will be ineligible for capital cost reimbursement under § 1187.113(a) (relating to capital component payment limitation), the] The** Department will consider whether the applicant **[or provider]** will agree to provide written assurances to the Department that the construction of its new or additional beds will be economically and financially feasible without the receipt of MA capital component payments and that it is not entitled to MA capital component payments related to the new or additional beds.

(4) *Employment of welfare and* **[*Medical Assistance*]** ***MA*** *recipients.* The Department will consider whether an applicant **[or provider]** will commit to employ welfare or **[medical assistance] MA** recipients in its new or expanded facility.

[(h)] (i) *Time lines for completion of approved projects.* **[Applicants or providers who are granted exceptions] An applicant whose bed request is approved** shall provide written assurances to the Department that the **[construction of the new or additional beds] applicant's project** will be completed in sufficient time so that the beds may be licensed, certified and available for occupancy within 3 years from the date the Department approves the applicant's **[or provider's enrollment or expansion, or] bed request, or by** another date as may be specified by the applicant **[or provider]** and agreed to by the Department.

[(i)] (j) *Definitions.* For purposes of this section, the following words and terms, have the following meanings, unless the context clearly indicates otherwise:

Applicant—A person who submits a **bed** request to the Department **[which, if granted, would cause a nursing facility not presently enrolled in the MA Program to become a participating provider of nursing facility services to MA Program recipients]**.

***Bed request*—A request by an applicant for the Department's approval to increase the number of MA-certified beds in a county or nonpublic nursing facility or to increase the number of MA-certified beds in the MA Program either by increasing the number of beds in an existing MA nursing facility or by enrolling a new MA nursing facility.**

***Bed transfer request*—A bed request in which all of the following conditions apply:**

(i) The applicant seeks the Department's approval to increase the number of MA-certified beds in a county or nonpublic nursing facility.

(ii) The applicant represents that, if the Department approves the applicant's request, the same number of MA-certified nursing facility beds at a different nursing facility will be simultaneously decertified and permanently closed.

(iii) The same person is an owner of the nursing facilities.

(iv) The nursing facilities are located in the same county.

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[*Exception request*—A request by an applicant to enroll in the MA Program as a nursing facility provider or, in the case of an MA nursing facility provider, to expand its licensed and MA-certified bed capacity.]

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***Specialized medical services*—Services not routinely provided in a nursing facility. These services may include, services needed by an individual who requires a respirator for survival, has severe dementia or traumatic brain injury.**

[*Technology-dependent*—In need of a respirator for survival.]

(*Editor's Note*: The Department is proposing to delete Appendix C which appears in 55 Pa. Code pages 1187-83—1187-86 (serial pages (332529) to (332532).)

Appendix C. [Reserved].

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