

AMENDMENTS TO HOUSE BILL NO. 1420

Sponsor: SENATOR BROWNE

Printer's No. 1527

1 Amend Bill, page 1, line 5, by striking out the period after
2 "campaign" and inserting
3 ; in public assistance, further providing for eligibility and
4 for medical assistance payments for institutional care and
5 providing for resident care and related costs and for
6 pharmacy benefits manager audit and obligations; in the aged,
7 further providing for LIFE program and providing for agency
8 with choice; in children and youth, further providing for
9 limits on reimbursements to counties; in nursing facility
10 assessments, further providing for time periods; in managed
11 care organization assessments, further providing for
12 assessment amount; providing for innovative health care
13 delivery models; abrogating regulations; and making a related
14 repeal.

15 Amend Bill, page 3, by inserting between lines 7 and 8

16 Section 2. Section 432(2)(vi) of the act is amended to read:
17 Section 432. Eligibility.--Except as hereinafter otherwise
18 provided, and subject to the rules, regulations, and standards
19 established by the department, both as to eligibility for
20 assistance and as to its nature and extent, needy persons of the
21 classes defined in clauses (1), (2), and (3) shall be eligible
22 for assistance:

23 * * *

24 (2) Persons who are eligible for State supplemental
25 assistance.

26 * * *

27 (vi) The amounts of State supplemental assistance payments
28 shall be as follows:

29 (A) After the amounts of assistance payments have been
30 determined by the department with the approval of the Governor
31 and General Assembly, the amounts of assistance payments shall
32 not be increased, except under clause (B), without the approval
33 of the General Assembly in accordance with the procedure
34 established by the act of April 7, 1955 (P.L.23, No.8) known as
35 the "Reorganization Act of 1955," and a message to the General
36 Assembly from the Governor for the purposes of executing such
37 function shall be transmitted as in other cases under the

1 Reorganization Act.

2 (B) Beginning in State fiscal year 2022-2023, the monthly
3 State supplemental assistance amounts for residents of a
4 domiciliary care home, as defined in section 2202-A of the act
5 of April 9, 1929 (P.L.177, No.175), known as "The Administrative
6 Code of 1929," or a personal care home as defined in section
7 1001 shall be as follows:

	<u>Individual</u>	<u>Couple</u>
8 <u>Domiciliary Care Home</u>	<u>\$634.30</u>	<u>\$1,347.40</u>
9 <u>Personal Care Home</u>	<u>\$639.30</u>	<u>\$1,357.40</u>
10 * * *		

11
12 Section 3. Section 443.1(7)(iv) of the act is amended and
13 the paragraph is amended by adding a subparagraph to read:

14 Section 443.1. Medical Assistance Payments for Institutional
15 Care.--The following medical assistance payments shall be made
16 on behalf of eligible persons whose institutional care is
17 prescribed by physicians:

18 * * *

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

27 * * *

28 (iv) Subject to Federal approval of such amendments as may
29 be necessary to the Commonwealth's approved Title XIX State
30 Plan, for each fiscal year beginning on or after July 1, 2011,
31 the department shall apply a revenue adjustment neutrality
32 factor to county and nonpublic nursing facility payment rates so
33 that the estimated Statewide day-weighted average payment rate
34 in effect for that fiscal year is limited to the amount
35 permitted by the funds appropriated by the General Appropriation
36 Act for the fiscal year. The revenue adjustment neutrality
37 factor shall remain in effect until the sooner of June 30,
38 [2022] 2026, or the date on which a new rate-setting methodology
39 for medical assistance nursing facility services which replaces
40 the rate-setting methodology codified in 55 Pa. Code Chs. 1187
41 (relating to nursing facility services) and 1189 (relating to
42 county nursing facility services) takes effect.

43 (iv.1) Notwithstanding subparagraph (ii) and subject to
44 Federal approval as may be necessary, the following shall apply
45 to nonpublic and county nursing facility payment rates, to the
46 extent funds are appropriated for the purpose of rate increases
47 for increased direct resident care requirements and resident
48 care and related costs:

49 (A) Beginning January 1, 2023, the department shall make
50 capitation payments to medical assistance Community
51 HealthChoices managed care organizations that include amounts

1 exclusively for the purpose of making payments to nonpublic
2 nursing facilities and county nursing facilities as provided
3 under clause (B) (I).

4 (B) The department shall adopt a minimum payment rate for
5 payments for services rendered to medical assistance recipients
6 under the Community HealthChoices program, effective with dates
7 of service of January 1, 2023, through December 31, 2025, as
8 follows:

9 (I) Community HealthChoices managed care organizations shall
10 apply no less than the minimum payment rate to make payments to
11 nonpublic nursing facilities and county nursing facilities for
12 services rendered to medical assistance recipients under the
13 Community HealthChoices program.

14 (II) The minimum payment rate shall be greater than or equal
15 to the following amounts:

16 (a) For nonpublic nursing facilities, the nursing facility
17 case-mix rates calculated in accordance with 55 Pa. Code Ch.
18 1187 (relating to nursing facility services) and the
19 Commonwealth's approved Title XIX State Plan in effect for the
20 dates of service.

21 (b) For county nursing facilities, the county nursing
22 facility rates in accordance with 55 Pa. Code Ch. 1189 (relating
23 to county nursing facility services) and the Commonwealth's
24 approved Title XIX State Plan in effect for the dates of
25 service.

26 * * *

27 Section 4. The act is amended by adding sections to read:
28 Section 443.13. Resident Care and Related Costs.--(a) The
29 following applies to a county and nonpublic nursing facility
30 enrolled in the medical assistance program:

31 (1) The county or nonpublic nursing facility shall
32 demonstrate on its submitted MA-11 that seventy percent of its
33 total costs, as reported by the facility, are resident care
34 costs or other resident-related costs under 55 Pa. Code §
35 1187.51(e) (1) and (2) (relating to scope).

36 (2) Except as provided under paragraph (3), the department
37 shall use the following methodology to determine the facility's
38 compliance with paragraph (1):

39 (i) Add the facility's unallocated Total Net Operating Costs
40 reported as total expenses on the facility's Schedule C of the
41 MA-11, plus the following capital costs reported by the facility
42 on its Schedule C, to determine the facility's total costs:

43 (A) Real estate taxes.

44 (B) Nursing facility assessment/HAI assessment.

45 (C) Depreciation.

46 (D) Interest on capital indebtedness.

47 (E) Rent on facility.

48 (F) Amortization capital costs.

49 (ii) Add the facility's unallocated Total Resident Care
50 Costs reported as total expenses on the facility's Schedule C
51 and the unallocated Total Other Resident Related Costs reported

1 as total expenses on the facility's Schedule C to determine the
2 facility's total resident cost of care.

3 (iii) Divide the facility's total resident cost of care
4 under subparagraph (ii) by the facility's total costs under
5 subparagraph (i) to determine the percentage of total costs
6 related to resident care costs and other resident-related costs.

7 (3) When a county or nonpublic nursing facility is
8 affiliated with a continuing care retirement community, the
9 following shall apply:

10 (i) The facility shall submit a supplemental cost report
11 form apportioning the capital costs related to the nursing
12 facility, in a form and manner as prescribed by the department.

13 (ii) The department shall use the following methodology to
14 determine the facility's compliance with paragraph (1):

15 (A) Add the facility's unallocated Total Net Operating Costs
16 reported as total expenses on the facility's Schedule C of the
17 MA-11, plus the following capital costs, reported by the
18 facility on its supplemental cost report form under subparagraph
19 (i), to determine the facility's total costs:

20 (I) Real estate taxes.

21 (II) Nursing facility assessment/HAI assessment.

22 (III) Depreciation.

23 (IV) Interest on capital indebtedness.

24 (V) Rent on facility.

25 (VI) Amortization capital costs.

26 (B) Add the facility's unallocated Total Resident Care Costs
27 reported as total expenses on the facility's Schedule C and the
28 unallocated Total Other Resident Related Costs reported as total
29 expenses on the facility's Schedule C to determine the
30 facility's total resident cost of care.

31 (C) Divide the facility's total resident cost of care under
32 clause (B) by the facility's total costs under clause (A) to
33 determine the percentage of total costs related to resident care
34 and other resident-related costs.

35 (b) (1) If in any twelve-month cost-reporting period a
36 county or nonpublic nursing facility enrolled in the medical
37 assistance program fails to meet the resident care percentage
38 under subsection (a)(1), the department may impose a penalty on
39 the facility up to the difference between the seventy percent of
40 total costs requirement under paragraph (2) and the percentage
41 spent by the facility on resident care costs or other resident-
42 related costs, but no more than five percent.

43 (2) The formula for determining the maximum penalty amount
44 is as follows:

45 (i) Determine the percentage difference from the seventy
46 percent resident care requirement by subtracting the percentage
47 of total costs related to resident care and other resident-
48 related costs under subsection (a)(2)(iii) or (3)(ii)(C) from
49 seventy percent.

50 (ii) Determine the penalty amount as follows:

51 (A) Use the lesser of the following:

1 (I) Five.
2 (II) The difference under subparagraph (i).
3 (B) Multiply the lowest numeral under clause (A) by one
4 hundredth (.01).
5 (C) Multiply the product under clause (B) by the county or
6 nonpublic nursing facility's fee-for-service per diem payment
7 rate as of June 30, 2022.
8 (D) Multiply the product under clause (C) by the total MA
9 resident days of care on the facility's MA-11.
10 (3) A penalty imposed under this section shall be
11 transmitted by the facility to the department for deposit in the
12 Nursing Facility Quality Improvement Fund, established under
13 subsection (c).
14 (4) The department shall enforce the penalty provisions
15 under this subsection against full twelve-month cost reports
16 with reporting periods that begin on or after January 1, 2023,
17 after making the first payment of the increased county and
18 nonpublic nursing facility rates, under both the fee-for-service
19 program and the Community HealthChoices program, beginning
20 January 1, 2023. If the first payment of the increased county
21 and nonpublic nursing facility rates, including payments under
22 both the fee-for-service program and the Community HealthChoices
23 program, is after June 30, 2023, the enforcement of the penalty
24 provisions of this subsection shall commence with the first full
25 twelve-month cost report after payment of the increased county
26 and nonpublic nursing facility rates.
27 (5) Paragraph (4) shall expire December 31, 2025.
28 (c) (1) The Nursing Facility Quality Improvement Fund is
29 established as a separate fund in the State Treasury and shall
30 be administered by the department.
31 (2) All interest earned from the investment or deposit of
32 moneys accumulated in the fund shall be deposited into the fund
33 for the same use.
34 (3) Moneys in the fund shall be expended by the department
35 for the following purposes:
36 (i) To administer and enforce this section.
37 (ii) To provide funding for nursing facility quality
38 improvement.
39 (d) The department may promulgate guidelines, as necessary,
40 to implement this section. The guidelines shall be transmitted
41 to the Legislative Reference Bureau for publication in the
42 Pennsylvania Bulletin. Prior to publication of the guidelines,
43 the department shall consult interested parties. The guidelines
44 under this section shall not be subject to:
45 (1) Sections 201, 202, 203, 204 and 205 of the act of July
46 31, 1968 (P.L.769, No.240), referred to as the Commonwealth
47 Documents Law.
48 (2) Sections 204(b) and 301(10) of the act of October 15,
49 1980 (P.L.950, No.164), known as the "Commonwealth Attorneys
50 Act."
51 (3) The act of June 25, 1982 (P.L.633, No.181), known as the

1 "Regulatory Review Act."
2 (e) As used in this section, the following words and phrases
3 shall have the meanings given to them in this subsection unless
4 the context clearly indicates otherwise:
5 "HAI" means Hospital Acquired Infection.
6 "MA-11" means the Medical Assistance Financial and
7 Statistical Report for Nursing Facilities and Services submitted
8 to the department by either a county nursing facility or a
9 nonpublic nursing facility for a twelve-month cost report
10 period.
11 "Schedule C" means the computation and allocation of
12 allowable costs schedule.
13 "Total MA resident days of care" means the Nursing Facility
14 MA Fee-for-Service days of care and the Nursing Facility MA
15 Community HealthChoices days of care, as reported on the MA-11.
16 Section 449.2. Pharmacy Benefits Manager Audit and
17 Obligations.--(a) The Department of the Auditor General may
18 conduct an audit and review of a pharmacy benefits manager that
19 provides pharmacy benefits management to a medical assistance
20 managed care organization under contract with the department.
21 The Department of the Auditor General may review all previous
22 audits completed by the department and shall have access to all
23 documents it deems necessary to complete the review and audit.
24 (b) Information disclosed or produced by a pharmacy benefits
25 manager or a medical assistance managed care organization for
26 the use of the department or the Department of the Auditor
27 General under this section shall not be subject to the act of
28 February 14, 2008 (P.L.6, No.3), known as the "Right-to-Know
29 Law."
30 (c) As used in this section, the following words and phrases
31 shall have the meanings given to them in this subsection:
32 "Medical assistance managed care organization" means a
33 Medicaid managed care organization as defined in section 1903(m)
34 (1)(a) of the Social Security Act (49 Stat. 620, 42 U.S.C. §
35 1396b(m)(1)(A)) that is a party to a Medicaid managed care
36 contract with the department.
37 "Pharmacy benefits management" means any of the following:
38 (1) Procurement of prescription drugs at a negotiated
39 contracted rate for distribution within this Commonwealth to
40 covered individuals.
41 (2) Administration or management of prescription drug
42 benefits provided by a covered entity for the benefit of covered
43 individuals.
44 (3) Administration of pharmacy benefits, including:
45 (i) Operating a mail-service pharmacy.
46 (ii) Claims processing.
47 (iii) Managing a retail pharmacy network management.
48 (iv) Paying claims to pharmacies for prescription drugs
49 dispensed to covered individuals by a retail, specialty or mail-
50 order pharmacy.
51 (v) Developing and managing a clinical formulary,

1 utilization management and quality assurance programs.

2 (vi) Rebate contracting and administration.

3 (vii) Managing a patient compliance, therapeutic
4 intervention and generic substitution program.

5 (viii) Operating a disease management program.

6 (ix) Setting pharmacy reimbursement pricing and
7 methodologies, including maximum allowable cost, and determining
8 single or multiple source drugs.

9 "Pharmacy benefits manager" means a person, business or other
10 entity that performs pharmacy benefits management. The term
11 shall include an affiliated ownership of a medical assistance
12 managed care organization that performs pharmacy benefits
13 management.

14 Section 5. Section 602(a), (b) and (c) of the act are
15 amended to read:

16 Section 602. LIFE Program.--(a) Informational materials and
17 department correspondence used by the department and the
18 Independent Enrollment Broker to educate or notify an eligible
19 individual about long-term care services and supports, including
20 an individual's rights, responsibilities and choice of managed
21 care organization to cover long-term care services and supports,
22 shall include the following:

23 (1) A description of the LIFE program.

24 (2) A statement that an eligible individual has the option
25 to enroll in the LIFE program or a managed care organization
26 under the Community Health Choices Program.

27 (3) Contact information for LIFE providers.

28 (b) The department shall continue to provide training to the
29 Independent Enrollment Broker on the LIFE program through the
30 Independent Enrollment Broker LIFE module to better educate the
31 Independent Enrollment Broker and to require that the LIFE
32 program is offered equally to eligible individuals.

33 (c) At the end of each quarter, the department shall issue a
34 report to the chairperson and minority chairperson of the Health
35 and Human Services Committee of the Senate and the chairperson
36 and minority chairperson of the Human Services Committee of the
37 House of Representatives that tracks by county the enrollment of
38 eligible individuals in long-term care service programs by the
39 Independent Enrollment Broker, including managed care
40 organizations and LIFE programs. The report shall also include
41 documentation of compliance with subsections (a) and (b).

42 * * *

43 Section 6. The act is amended by adding a section to read:

44 Section 603. Agency with Choice.--The department shall not
45 administer or contract with a single Statewide entity to
46 administer the Agency with Choice Financial Management Services
47 model of service delivery to beneficiaries of programs
48 administered by the Office of Long-Term Living for at least
49 twelve months following the effective date of this section.

50 Section 7. Section 709.3 of the act is amended by adding a
51 subsection to read:

1 Section 709.3. Limits on Reimbursements to Counties.--* * *
2 (f) Money appropriated for community-based family centers
3 may not be considered as part of the base for calculation of a
4 county's child welfare needs-based budget for a fiscal year.

5 Section 8. Sections 815-A and 803-I(b) of the act are
6 amended to read:

7 Section 815-A. Time periods.--The assessment authorized in
8 this article shall be imposed July 1, 2003, through June 30,
9 [2022] 2026.

10 Section 803-I. Assessment amount.

11 * * *

12 (b) Fixed fee.--[Beginning July 1, 2016, and ending June 30,
13 2020] Except as provided under subsections (c) and (d), the
14 managed care organization shall be assessed a fixed fee of
15 [\$13.48] \$24.95 for each unduplicated member for each month the
16 member is enrolled for any period of time with the managed care
17 organization beginning July 1, 2020, and ending June 30, 2025.

18 * * *

19 Section 9. The act is amended by adding an article to read:

20 ARTICLE VIII-J

21 INNOVATIVE HEALTH CARE DELIVERY MODELS

22 Section 801-J. Required criteria for operation of OED.

23 (a) Requirements of an OED.--An eligible provider location
24 for Medical Assistance reimbursement that intends to operate an
25 OED shall meet the following criteria:

26 (1) The main licensed hospital of an OED shall offer
27 general acute care services.

28 (2) The OED shall be included as an outpatient location
29 under the license of the hospital and located within a
30 thirty-five-mile radius of the main licensed hospital.

31 (3) At the time the OED begins operating, the OED shall
32 have a catchment area that is no less than thirty-five miles
33 of travel distance established by roadways to a main licensed
34 hospital or a campus that offers emergency services and is
35 not under common legal ownership with the OED or another OED
36 that is not under common legal ownership.

37 (4) The hospital shall continue to meet the statutory
38 definition of a "hospital" as defined in section 802.1 of the
39 act of July 19, 1979 (P.L.130, No.48), known as the "Health
40 Care Facilities Act."

41 (5) The hospital, including the OED, shall maintain full
42 or substantial compliance with the provisions of 28 Pa. Code
43 Pt. IV Subpt. B (relating to general and special hospitals).

44 (b) Definitions.--As used in this section, the following
45 words and phrases shall have the meanings given to them in this
46 subsection unless the context clearly indicates otherwise:

47 "Campus" means a clinical facility that offers inpatient
48 services and is included under the license of the main licensed
49 hospital but not located on the grounds of the main licensed
50 hospital.

51 "Catchment area" means the area surrounding an OED.

1 "Hospital" means the main licensed hospital, its campuses and
2 outpatient locations, under common legal ownership.

3 "Main licensed hospital of the OED" means the location where
4 a hospital license is held.

5 "Outpatient emergency department" or "OED" means an
6 outpatient location of a hospital under common legal ownership
7 that offers emergency services and is not located on the grounds
8 of the main licensed hospital.

9 "Outpatient location" means a location offering only
10 outpatient services that are included under the license of a
11 main licensed hospital but not located on the grounds of the
12 main licensed hospital.

13 Section 10. Regulations are abrogated as follows:

14 (1) The following provisions of 55 Pa. Code are
15 abrogated:

16 (i) Section 1153.14(1) (relating to noncovered
17 services).

18 (ii) Section 1223.14(2) (relating to noncovered
19 services).

20 (iii) Section 5230.55(c) (relating to supervision)
21 to the extent that it requires a face-to-face meeting.

22 (iv) Section 1121.53(c) (relating to limitations on
23 payment) to the extent that payment for prescriptions is
24 limited to a 34-day supply or 100 units.

25 (v) To the extent permitted under Federal law:

26 (A) Section 1123.2 (relating to definitions) to
27 the extent that the definition of "shoe inserts"
28 limits the prescriptions for an orthotic device to a
29 prescription from a physician.

30 (B) Section 1249.52(a)(1) (relating to payment
31 conditions for various services) and section
32 1249.53(a)(1) (relating to payment conditions for
33 skilled nursing care) to the extent that home health
34 services are only covered and reimbursable under the
35 medical assistance program if a physician orders the
36 services and establishes the plan of treatment.

37 (C) Section 1249.54(a)(3) (relating to payment
38 conditions for home health aide services) to the
39 extent that a home health aide service is only
40 covered and reimbursable under the medical assistance
41 program if a physician establishes the written plan
42 of treatment and, if skilled care is not required,
43 certifies that the personal care services are
44 medically necessary.

45 (D) Section 1249.55(a) (relating to payment
46 conditions for medical supplies) to the extent
47 supplies may only be reimbursed if prescribed by a
48 physician.

49 (2) The following provisions of 55 Pa. Code, relating to
50 physician or certified registered nurse practitioner
51 notification requirements, are abrogated to the extent they

1 apply to individuals with symptoms of COVID-19:

2 (i) Section 3270.137 (relating to children with
3 symptoms of disease).

4 (ii) Section 3270.153 (relating to facility persons
5 with symptoms of disease).

6 (iii) Section 3280.137 (relating to children with
7 symptoms of disease).

8 (iv) Section 3280.153 (relating to facility persons
9 with symptoms of disease).

10 (v) Section 3290.137 (relating to children with
11 symptoms of disease).

12 (vi) Section 3290.153 (relating to facility persons
13 with symptoms of disease).

14 Section 11. Repeals are as follows:

15 (1) The General Assembly declares that the repeal under
16 paragraph (2) is necessary to effectuate the amendment of
17 section 803-I(b) of the act.

18 (2) Section 1601-O of the act of April 9, 1929 (P.L.343,
19 No.176), known as The Fiscal Code, is repealed.

20 Section 12. The amendment of section 803-I(b) of the act is
21 a continuation of section 1601-O of the act of April 9, 1929
22 (P.L.343, No.176), known as The Fiscal Code. Except as otherwise
23 provided in the amendment of section 803-I(b) of the act, all
24 activities initiated under section 1601-O of The Fiscal Code
25 shall continue and remain in full force and effect and may be
26 completed under the amendment of section 803-I(b) of the act.
27 Orders, regulations, rules and decisions which were made under
28 section 1601-O of The Fiscal Code and which are in effect on the
29 effective date of this section shall remain in full force and
30 effect until revoked, vacated or modified under the amendment of
31 section 803-I(b) of the act. Contracts, obligations and
32 collective bargaining agreements entered into under section
33 1601-O of The Fiscal Code are not affected nor impaired by the
34 repeal of section 1601-O of The Fiscal Code.

35 Section 13. The amendment of sections 443.1(7)(iv) and 815-A
36 of the act shall apply retroactive to June 29, 2022.

37 Amend Bill, page 3, line 8, by striking out "2" and inserting

38 14