AMENDMENTS TO HOUSE BILL NO. 1420

Sponsor: SENATOR BROWNE

Printer's No. 1527

Amend Bill, page 1, line 5, by striking out the period after "campaign" and inserting

; in public assistance, further providing for eligibility and for medical assistance payments for institutional care and providing for resident care and related costs and for pharmacy benefits manager audit and obligations; in the aged, further providing for LIFE program and providing for agency with choice; in children and youth, further providing for limits on reimbursements to counties; in nursing facility assessments, further providing for time periods; in managed care organization assessments, further providing for assessment amount; providing for innovative health care delivery models; abrogating regulations; and making a related repeal.

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

Section 2. Section 432(2)(vi) of the act is amended to read:

Section 432. Eligibility.--Except as hereinafter otherwise provided, and subject to the rules, regulations, and standards established by the department, both as to eligibility for assistance and as to its nature and extent, needy persons of the classes defined in clauses (1), (2), and (3) shall be eligible for assistance:

* * *

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

* * *

(vi) <u>The amounts of State supplemental assistance payments shall be as follows:</u>

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

Reorganization Act.

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

	Individual	Couple
Domiciliary Care Home	$634.30	$1,347.40
Personal Care Home	$639.30	$1,357.40

* * *

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

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

* * *

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

* * *

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

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

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

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

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

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

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

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

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

* * *

Section 4. The act is amended by adding sections to read:

Section 443.13. Resident Care and Related Costs.--(a) The following applies to a county and nonpublic nursing facility enrolled in the medical assistance program:

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

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

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

(A) Real estate taxes.

(B) Nursing facility assessment/HAI assessment.

(C) Depreciation.

(D) Interest on capital indebtedness.

(E) Rent on facility.

(F) Amortization capital costs.

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

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

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

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

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

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

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

(I) Real estate taxes.

(II) Nursing facility assessment/HAI assessment.

(III) Depreciation.

(IV) Interest on capital indebtedness.

(V) Rent on facility.

(VI) Amortization capital costs.

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

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

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

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

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

(ii) Determine the penalty amount as follows:

(A) Use the lesser of the following:

(I) Five.

(II) The difference under subparagraph (i).

(B) Multiply the lowest numeral under clause (A) by one hundredth (.01).

(C) Multiply the product under clause (B) by the county or nonpublic nursing facility's fee-for-service per diem payment rate as of June 30, 2022.

(D) Multiply the product under clause (C) by the total MA resident days of care on the facility's MA-11.

(3) A penalty imposed under this section shall be transmitted by the facility to the department for deposit in the Nursing Facility Quality Improvement Fund, established under subsection (c).

(4) The department shall enforce the penalty provisions under this subsection against full twelve-month cost reports with reporting periods that begin on or after January 1, 2023, after making the first payment of the increased county and nonpublic nursing facility rates, under both the fee-for-service program and the Community HealthChoices program, beginning January 1, 2023. If the first payment of the increased county and nonpublic nursing facility rates, including payments under both the fee-for-service program and the Community HealthChoices program, is after June 30, 2023, the enforcement of the penalty provisions of this subsection shall commence with the first full twelve-month cost report after payment of the increased county and nonpublic nursing facility rates.

(5) Paragraph (4) shall expire December 31, 2025.

(c) (1) The Nursing Facility Quality Improvement Fund is established as a separate fund in the State Treasury and shall be administered by the department.

(2) All interest earned from the investment or deposit of moneys accumulated in the fund shall be deposited into the fund for the same use.

(3) Moneys in the fund shall be expended by the department for the following purposes:

(i) To administer and enforce this section.

(ii) To provide funding for nursing facility quality improvement.

(d) The department may promulgate guidelines, as necessary, to implement this section. The guidelines shall be transmitted to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin. Prior to publication of the guidelines, the department shall consult interested parties. The guidelines under this section shall not be subject to:

(1) Sections 201, 202, 203, 204 and 205 of the act of July 31, 1968 (P.L.769, No.240), referred to as the Commonwealth Documents Law.

(2) Sections 204(b) and 301(10) of the act of October 15, 1980 (P.L.950, No.164), known as the "Commonwealth Attorneys Act."

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

"Regulatory Review Act."

(e) As used in this section, the following words and phrases shall have the meanings given to them in this subsection unless the context clearly indicates otherwise:

"HAI" means Hospital Acquired Infection.

"MA-11" means the Medical Assistance Financial and Statistical Report for Nursing Facilities and Services submitted to the department by either a county nursing facility or a nonpublic nursing facility for a twelve-month cost report period.

"Schedule C" means the computation and allocation of allowable costs schedule.

"Total MA resident days of care" means the Nursing Facility MA Fee-for-Service days of care and the Nursing Facility MA Community HealthChoices days of care, as reported on the MA-11.

Section 449.2. Pharmacy Benefits Manager Audit and Obligations.--(a) The Department of the Auditor General may conduct an audit and review of a pharmacy benefits manager that provides pharmacy benefits management to a medical assistance managed care organization under contract with the department. The Department of the Auditor General may review all previous audits completed by the department and shall have access to all documents it deems necessary to complete the review and audit.

(b) Information disclosed or produced by a pharmacy benefits manager or a medical assistance managed care organization for the use of the department or the Department of the Auditor General under this section shall not be subject to the act of February 14, 2008 (P.L.6, No.3), known as the "Right-to-Know Law."

(c) As used in this section, the following words and phrases shall have the meanings given to them in this subsection:

"Medical assistance managed care organization" means a Medicaid managed care organization as defined in section 1903(m)(1)(a) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396b(m)(1)(A)) that is a party to a Medicaid managed care contract with the department.

"Pharmacy benefits management" means any of the following:

(1) Procurement of prescription drugs at a negotiated contracted rate for distribution within this Commonwealth to covered individuals.

(2) Administration or management of prescription drug benefits provided by a covered entity for the benefit of covered individuals.

(3) Administration of pharmacy benefits, including:

(i) Operating a mail-service pharmacy.

(ii) Claims processing.

(iii) Managing a retail pharmacy network management.

(iv) Paying claims to pharmacies for prescription drugs dispensed to covered individuals by a retail, specialty or mail-order pharmacy.

(v) Developing and managing a clinical formulary,

utilization management and quality assurance programs.

(vi) Rebate contracting and administration.

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

(viii) Operating a disease management program.

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

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

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

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

(1) A description of the LIFE program.

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

(3) Contact information for LIFE providers.

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

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

* * *

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

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

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

Section 709.3. Limits on Reimbursements to Counties.--* * *

(f) Money appropriated for community-based family centers may not be considered as part of the base for calculation of a county's child welfare needs-based budget for a fiscal year.

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

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

Section 803-I. Assessment amount.

* * *

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

* * *

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

ARTICLE VIII-J

INNOVATIVE HEALTH CARE DELIVERY MODELS

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

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

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

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

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

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

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

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

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

"Catchment area" means the area surrounding an OED.

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

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

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

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

Section 10. Regulations are abrogated as follows:

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

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

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

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

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

(v) To the extent permitted under Federal law:

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

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

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

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

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

apply to individuals with symptoms of COVID-19:

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

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

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

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

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

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

Section 11. Repeals are as follows:

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

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

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

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

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