

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1354 Session of 2017

INTRODUCED BY GROVE, MCGINNIS, BARRAR, ORTITAY, WARD, PICKETT, PHILLIPS-HILL, DUSH, NELSON, SCHEMEL, HENNESSEY, O'NEILL, TOOHL, EVERETT, SAYLOR, FRITZ, RYAN, DAY, WHEELAND, CUTLER AND MOUL, MAY 9, 2017

REFERRED TO COMMITTEE ON HEALTH, MAY 9, 2017

AN ACT

1 Amending the act of June 13, 1967 (P.L.31, No.21), entitled "An
 2 act to consolidate, editorially revise, and codify the public
 3 welfare laws of the Commonwealth," in public assistance,
 4 further providing for income for the community spouse, for
 5 medical assistance payments for institutional care, for
 6 medical assistance payments for home health care, for other
 7 medical assistance payments and for medical assistance
 8 benefit packages and coverage, copayments, premiums and
 9 rates; and providing for the Office of Independent Medicaid
 10 Director.

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

13 Section 1. Section 441.7(a) of the act of June 13, 1967
 14 (P.L.31, No.21), known as the Human Services Code, is amended to
 15 read:

16 Section 441.7. Income for the Community Spouse.--(a) When a
 17 community spouse has income below the monthly maintenance needs
 18 allowance as determined under the [department's] regulations
 19 [and] adopted by the Office of Independent Medicaid Director for
 20 the Commonwealth approved State plan under Title XIX of the
 21 Social Security Act (49 Stat. 620, 42 U.S.C. § 1396 et seq.),

1 the institutionalized spouse may transfer additional resources
2 to the community spouse only in accordance with this section.

3 * * *

4 Section 2. Section 443.1 of the act, amended December 28,
5 2015 (P.L.500, No.92) and July 8, 2016 (P.L.480, No.76), is
6 amended to read:

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

11 (1) Payments as determined by the [department] Office of
12 Independent Medicaid Director for inpatient hospital care
13 consistent with Title XIX of the Social Security Act (49 Stat.
14 620, 42 U.S.C. § 1396 et seq.). To be eligible for such
15 payments, a hospital must be qualified to participate under
16 Title XIX of the Social Security Act and have entered into a
17 written agreement with the [department] Office of Independent
18 Medicaid Director regarding matters designated by the secretary
19 as necessary to efficient administration, such as hospital
20 utilization, maintenance of proper cost accounting records and
21 access to patients' records. Such efficient administration shall
22 require the [department] Office of Independent Medicaid Director
23 to permit participating hospitals to utilize the same fiscal
24 intermediary for this Title XIX program as such hospitals use
25 for the Title XVIII program.

26 (1.1) Subject to section 813-G, for inpatient hospital
27 services provided during a fiscal year in which an assessment is
28 imposed under Article VIII-G, payments under the medical
29 assistance fee-for-service program shall be determined in
30 accordance with the [department's] regulations adopted by the

1 Office of Independent Medicaid Director, except as follows:

2 (i) If the Commonwealth's approved Title XIX State Plan for
3 inpatient hospital services in effect for the period of July 1,
4 2010, through June 30, 2018, specifies a methodology for
5 calculating payments that is different from the department's
6 regulations or authorizes additional payments not specified in
7 the department's regulations, such as inpatient disproportionate
8 share payments and direct medical education payments, the
9 department shall follow the methodology or make the additional
10 payments as specified in the approved Title XIX State Plan.

11 (ii) Subject to Federal approval of an amendment to the
12 Commonwealth's approved Title XIX State Plan, in making medical
13 assistance fee-for-service payments to acute care hospitals for
14 inpatient services provided on or after July 1, 2010, the
15 [department] Office of Independent Medicaid Director shall use
16 payment methods and standards that provide for all of the
17 following:

18 (A) Use of the All Patient Refined-Diagnosis Related Group
19 (APR/DRG) system for the classification of inpatient stays into
20 DRGs.

21 (B) Calculation of base DRG rates, based upon a Statewide
22 average cost, which are adjusted to account for a hospital's
23 regional labor costs, teaching status, capital and medical
24 assistance patient levels and such other factors as the
25 [department] Office of Independent Medicaid Director determines
26 may significantly impact the costs that a hospital incurs in
27 delivering inpatient services and which may be adjusted based on
28 the assessment revenue collected under Article VIII-G.

29 (C) Adjustments to payments for outlier cases where the
30 costs of the inpatient stays either exceed or are below cost

1 thresholds established by the [department] Office of
2 Independent Medicaid Director.

3 (iii) Notwithstanding subparagraph (i), the [department]
4 Office of Independent Medicaid Director may make additional
5 changes to its payment methods and standards for inpatient
6 hospital services consistent with Title XIX of the Social
7 Security Act, including changes to supplemental payments
8 currently authorized in the State plan based on the availability
9 of Federal and State funds.

10 (1.2) Subject to section 813-G, for inpatient acute care
11 hospital services provided under the physical health medical
12 assistance managed care program during State fiscal year 2010-
13 2011, the following shall apply:

14 (i) For inpatient hospital services provided under a
15 participation agreement between an inpatient acute care hospital
16 and a medical assistance managed care organization in effect as
17 of June 30, 2010, the medical assistance managed care
18 organization shall pay, and the hospital shall accept as payment
19 in full, amounts determined in accordance with the payment terms
20 and rate methodology specified in the agreement and in effect as
21 of June 30, 2010, during the term of that participation
22 agreement. If a participation agreement in effect as of June 30,
23 2010, uses the [department] fee for service DRG rate methodology
24 in determining payment amounts, the medical assistance managed
25 care organization shall pay, and the hospital shall accept as
26 payment in full, amounts determined in accordance with the fee
27 for service payment methodology in effect as of June 30, 2010,
28 including, without limitation, continuation of the same grouper,
29 outlier methodology, base rates and relative weights, during the
30 term of that participation agreement.

1 (ii) Nothing in subparagraph (i) shall prohibit payment
2 rates for inpatient acute care hospital services provided under
3 a participation agreement to change from the rates in effect as
4 of June 30, 2010, if the change in payment rates is authorized
5 by the terms of the participation agreement between the
6 inpatient acute care hospital and the medical assistance managed
7 care organization. For purposes of this act, any contract
8 provision that provides that payment rates and changes to
9 payment rates shall be calculated based upon the department's
10 fee for service DRG payment methodology shall be interpreted to
11 mean the [department's] fee for service medical assistance DRG
12 methodology in place on June 30, 2010.

13 (iii) If a participation agreement between a hospital and a
14 medical assistance managed care organization terminates during a
15 fiscal year in which an assessment is imposed under Article
16 VIII-G prior to the expiration of the term of the participation
17 agreement, payment for services, other than emergency services,
18 covered by the medical assistance managed care organization and
19 rendered by the hospital shall be made at the rate in effect as
20 of the termination date, as adjusted in accordance with
21 subparagraphs (i) and (ii), during the period in which the
22 participation agreement would have been in effect had the
23 agreement not terminated. The hospital shall receive the
24 supplemental payment in accordance with subparagraph (v).

25 (iv) If a hospital and a medical assistance managed care
26 organization do not have a participation agreement in effect as
27 of June 30, 2010, the medical assistance managed care
28 organization shall pay, and the hospital shall accept as payment
29 in full, for services, other than emergency services, covered by
30 the medical assistance managed care organization and rendered

1 during a fiscal year in which an assessment is imposed under
2 Article VIII-G, an amount equal to the rates payable for the
3 services by the medical assistance fee for service program as of
4 June 30, 2010. The hospital shall receive the supplemental
5 payment in accordance with subparagraph (v).

6 (v) The [department] Office of Independent Medicaid
7 Director shall make enhanced capitation payments to medical
8 assistance managed care organizations if necessary exclusively
9 for the purpose of making supplemental payments to hospitals in
10 order to promote continued access to quality care for medical
11 assistance recipients. Medical assistance managed care
12 organizations shall use the enhanced capitation payments
13 received pursuant to this section solely for the purpose of
14 making supplemental payments to hospitals and shall provide
15 documentation to the [department] Office of Independent Medicaid
16 Director certifying that all funds received in this manner are
17 used in accordance with this section. The supplemental payments
18 to hospitals made pursuant to this subsection are in lieu of
19 increased or additional payments for inpatient acute care
20 services from medical assistance managed care organizations
21 resulting from the [department's] Office of Independent Medicaid
22 Director's implementation of payments under paragraph (1.1)(ii).
23 Medical assistance managed care organizations shall in no event
24 be obligated under this section to make supplemental or other
25 additional payments to hospitals that exceed the enhanced
26 capitation payments made to the medical assistance managed care
27 organization under this section. Medical assistance managed care
28 organizations shall not be required to advance the supplemental
29 payments to hospitals authorized by this subsection and shall
30 only make the supplemental payments to hospitals once medical

1 assistance managed care organizations have received the enhanced
2 capitation payments from the [department] Office of Independent
3 Medicaid Director.

4 (vi) Nothing in this subsection shall prohibit an inpatient
5 acute care hospital and a medical assistance managed care
6 organization from executing a new participation agreement or
7 amending an existing participation agreement on or after July 1,
8 2010, in which they agree to payment terms that would result in
9 payments that are different than the payments determined in
10 accordance with subparagraphs (i), (ii), (iii) and (iv).

11 (1.3) Subject to section 813-G, the [department] Office of
12 Independent Medicaid Director may adjust its capitation payments
13 to medical assistance managed care organizations under the
14 physical health medical assistance managed care program during
15 State fiscal year 2011-2012 to provide additional funds for
16 inpatient hospital services to mitigate the impact, if any, to
17 the managed care organizations that may result from the changes
18 to the [department's] Office of Independent Medicaid Director's
19 payment methods and standards specified in paragraph (1.1)(ii).
20 If the [department] Office of Independent Medicaid Director
21 adjusts a medical assistance managed care organization's
22 capitation payments pursuant to this paragraph, the following
23 shall apply:

24 (i) The medical assistance managed care organization shall
25 provide documentation to the [department] Office of Independent
26 Medicaid Director identifying how the additional funds received
27 pursuant to this subsection were used by the medical assistance
28 managed care organization.

29 (ii) If the medical assistance managed care organization
30 uses all of the additional funds received pursuant to this

1 subsection to make additional payments to hospitals, the
2 following shall apply:

3 (A) For inpatient hospital services provided under a
4 participation agreement between an inpatient acute care hospital
5 and the medical assistance managed care organization in effect
6 as of June 30, 2010, the medical assistance managed care
7 organization shall pay, and the hospital shall accept as payment
8 in full, amounts determined in accordance with the payment terms
9 and rate methodology specified in the agreement and in effect as
10 of June 30, 2010, during the term of that participation
11 agreement. If a participation agreement in effect as of June 30,
12 2010, uses the [department] fee-for-service DRG rate methodology
13 in determining payment amounts, the medical assistance managed
14 care organization shall pay, and the hospital shall accept as
15 payment in full, amounts determined in accordance with the fee-
16 for-service payment methodology in effect as of June 30, 2010,
17 including, without limitation, continuation of the same grouper,
18 outlier methodology, base rates and relative weights during the
19 term of that participation agreement.

20 (B) Nothing in clause (A) shall prohibit payment rates for
21 inpatient acute care hospital services provided under a
22 participation agreement to change from the rates in effect as of
23 June 30, 2010, if the change in payment rates is authorized by
24 the terms of the participation agreement between the inpatient
25 acute care hospital and the medical assistance managed care
26 organization. For purposes of this act, any contract provision
27 that provides that payment rates and changes to payment rates
28 shall be calculated based upon the [department's] fee-for-
29 service DRG payment methodology shall be interpreted to mean the
30 department's fee-for-service medical assistance DRG methodology

1 in place on June 30, 2010.

2 (C) For an out-of-network inpatient discharge of a recipient
3 enrolled in a medical assistance managed care organization that
4 occurs in State fiscal year 2011-2012, the medical assistance
5 managed care organization shall pay, and the hospital shall
6 accept as payment in full, the amount that the [department's]
7 fee-for-service program would have paid for the discharge if the
8 recipient were enrolled in the [department's] fee-for-service
9 program and the discharge occurred on June 30, 2010.

10 (D) Nothing in this subparagraph shall prohibit an inpatient
11 acute care hospital and a medical assistance managed care
12 organization from executing a new participation agreement or
13 amending an existing participation agreement on or after July 1,
14 2010, in which they agree to payment terms that would result in
15 payments that are different from the payments determined in
16 accordance with clauses (A), (B) and (C).

17 (1.4) Subject to section 813-G, for inpatient hospital
18 services provided under the physical health medical assistance
19 managed care program during State fiscal years 2012-2013, 2013-
20 2014, 2014-2015, 2015-2016, 2016-2017 and 2017-2018, the
21 following shall apply:

22 (A) The [department] Office of Independent Medicaid Director
23 may adjust its capitation payments to medical assistance managed
24 care organizations to provide additional funds for inpatient and
25 outpatient hospital services.

26 (B) For an out-of-network inpatient discharge of a recipient
27 enrolled in a medical assistance managed care organization that
28 occurs in State fiscal year 2012-2013, 2013-2014, 2014-2015,
29 2015-2016, 2016-2017 and 2017-2018, the medical assistance
30 managed care organization shall pay, and the hospital shall

1 accept as payment in full, the amount that the [department's]
2 fee-for-service program would have paid for the discharge if the
3 recipient was enrolled in the [department's] fee-for-service
4 program.

5 (C) Nothing in this paragraph shall prohibit an inpatient
6 acute care hospital and a medical assistance managed care
7 organization from executing a new participation agreement or
8 amending an existing participation agreement on or after July 1,
9 2013.

10 (1.5) As used in paragraphs (1.2), (1.3) and (1.4), the
11 following terms shall have the following meanings:

12 (i) "Emergency services" means emergency services as defined
13 in section 1932(b) of the Social Security Act (49 Stat. 620, 42
14 U.S.C. § 1396u-2(b)(2)(B)). The term shall not include
15 poststabilization care services as defined in 42 CFR 438.114(a)
16 (1) (relating to emergency and poststabilization services).

17 (ii) "Medical assistance managed care organization" means a
18 Medicaid managed care organization as defined in section 1903(m)
19 (1)(a) of the Social Security Act (49 Stat. 620, 42 U.S.C. §
20 1396b(m)(1)(a)) that is a party to a Medicaid managed care
21 contract with the [department] Office of Independent Medicaid
22 Director, other than a behavioral health managed care
23 organization that is a party to a medical assistance managed
24 care contract with the [department] Office of Independent
25 Medicaid Director.

26 (1.6) Notwithstanding any other provision of law or
27 departmental regulation to the contrary, the [department] Office
28 of Independent Medicaid Director shall make separate fee-for-
29 service APR/DRG payments for medically necessary inpatient acute
30 care general hospital services provided for normal newborn care

1 and for mothers' obstetrical delivery.

2 (2) The cost of skilled nursing and intermediate nursing
3 care in State-owned geriatric centers, institutions for the
4 mentally retarded, institutions for the mentally ill, and the
5 cost of skilled and intermediate nursing care provided prior to
6 June 30, 2004, in county homes which meet the State and Federal
7 requirements for participation under Title XIX of the Social
8 Security Act and which are approved by the [department] Office
9 of Independent Medicaid Director. This cost in county homes
10 shall be as specified by the regulations of the [department]
11 Officer of Independent Medicaid Director adopted under Title XIX
12 of the Social Security Act and certified to the department by
13 the Auditor General; elsewhere the cost shall be determined by
14 the [department] Office of Independent Medicaid Director;

15 (3) Rates on a cost-related basis established by the
16 department for skilled nursing home or intermediate care in a
17 non-public nursing home, when furnished by a nursing home
18 licensed or approved by the department and qualified to
19 participate under Title XIX of the Social Security Act and
20 provided prior to June 30, 2004;

21 (4) Payments as determined by the department for inpatient
22 psychiatric care consistent with Title XIX of the Social
23 Security Act. To be eligible for such payments, a hospital must
24 be qualified to participate under Title XIX of the Social
25 Security Act and have entered into a written agreement with the
26 department regarding matters designated by the secretary as
27 necessary to efficient administration, such as hospital
28 utilization, maintenance of proper cost accounting records and
29 access to patients' records. Care in a private mental hospital
30 provided under the fee for service delivery system shall be

1 limited to thirty days in any fiscal year for recipients aged
2 twenty-one years or older who are eligible for medical
3 assistance under Title XIX of the Social Security Act and for
4 recipients aged twenty-one years or older who are eligible for
5 general assistance-related medical assistance. Exceptions to the
6 thirty-day limit may be granted under section 443.3. Only
7 persons aged twenty-one years or under and aged sixty-five years
8 or older shall be eligible for care in a public mental hospital.
9 This cost shall be as specified by regulations of the
10 [department] Office of Independent Medicaid Director adopted
11 under Title XIX of the Social Security Act and certified to the
12 department by the Auditor General for county and non-public
13 institutions;

14 (5) After June 30, 2004, and before June 30, 2007, payments
15 to county and nonpublic nursing facilities enrolled in the
16 medical assistance program as providers of nursing facility
17 services shall be calculated and made as specified in the
18 [department's] regulations in effect on July 1, 2003, except
19 that if the Commonwealth's approved Title XIX State Plan for
20 nursing facility services in effect for the period of July 1,
21 2004, through June 30, 2007, specifies a methodology for
22 calculating county and nonpublic nursing facility payment rates
23 that is different than the department's regulations in effect on
24 July 1, 2003, the [department] Office of Independent Medicaid
25 Director shall follow the methodology in the Federally approved
26 Title XIX State plan.

27 (6) For public nursing home care provided on or after July
28 1, 2005, the [department] Office of Independent Medicaid
29 Director may recognize the costs incurred by county nursing
30 facilities to provide services to eligible persons as medical

1 assistance program expenditures to the extent the costs qualify
2 for Federal matching funds and so long as the costs are
3 allowable as determined by the department and reported and
4 certified by the county nursing facilities in a form and manner
5 specified by the department. Expenditures reported and certified
6 by county nursing facilities shall be subject to periodic review
7 and verification by the department or the Auditor General.
8 Notwithstanding this paragraph, county nursing facilities shall
9 be paid based upon rates determined in accordance with
10 paragraphs (5) and (7).

11 (7) After June 30, 2007, payments to county and nonpublic
12 nursing facilities enrolled in the medical assistance program as
13 providers of nursing facility services shall be determined in
14 accordance with the methodologies for establishing payment rates
15 for county and nonpublic nursing facilities specified in the
16 [department's] Office of Independent Medicaid Director's
17 regulations and the Commonwealth's approved Title XIX State Plan
18 for nursing facility services in effect after June 30, 2007. The
19 following shall apply:

20 (i) For the fiscal year 2007-2008, the [department] Office
21 of Independent Medicaid Director shall apply a revenue
22 adjustment neutrality factor and make adjustments to county and
23 nonpublic nursing facility payment rates for medical assistance
24 nursing facility services. The revenue adjustment factor shall
25 limit the estimated aggregate increase in the Statewide day-
26 weighted average payment rate over the three-year period
27 commencing July 1, 2005, and ending June 30, 2008, from the
28 Statewide day-weighted average payment rate for medical
29 assistance nursing facility services in fiscal year 2004-2005 to
30 6.912% plus any percentage rate of increase permitted by the

1 amount of funds appropriated for nursing facility services in
2 the General Appropriation Act of 2007. Application of the
3 revenue adjustment neutrality factor shall be subject to Federal
4 approval of any amendments as may be necessary to the
5 Commonwealth's approved Title XIX State Plan for nursing
6 facility services.

7 (ii) The [department] Office of Independent Medicaid
8 Director may make additional changes to its methodologies for
9 establishing payment rates for county and nonpublic nursing
10 facilities enrolled in the medical assistance program consistent
11 with Title XIX of the Social Security Act, except that if during
12 a fiscal year an assessment is implemented under Article VIII-A,
13 the department shall not make a change under this subparagraph
14 unless it adopts regulations as provided under section 814-A.

15 (iii) Subject to Federal approval of such amendments as may
16 be necessary to the Commonwealth's approved Title XIX State
17 Plan, the department shall do all of the following:

18 (A) For each fiscal year between July 1, 2008, and June 30,
19 2011, the department shall apply a revenue adjustment neutrality
20 factor to county and nonpublic nursing facility payment rates.
21 For each such fiscal year, the revenue adjustment neutrality
22 factor shall limit the estimated aggregate increase in the
23 Statewide day-weighted average payment rate so that the
24 aggregate percentage rate of increase for the period that begins
25 on July 1, 2005, and ends on the last day of the fiscal year is
26 limited to the amount permitted by the funds appropriated by the
27 General Appropriations Act for those fiscal years.

28 (B) In calculating rates for nonpublic nursing facilities
29 for fiscal year 2008-2009, the department shall continue to
30 include costs incurred by county nursing facilities in the rate-

1 setting database, as specified in the department's regulations
2 in effect on July 1, 2007.

3 (C) The department shall propose regulations that phase out
4 the use of county nursing facility costs as an input in the
5 process of setting payment rates of nonpublic nursing
6 facilities. The final regulations shall be effective July 1,
7 2009, and shall phase out the use of these costs in rate-setting
8 over a period of three rate years, beginning fiscal year 2009-
9 2010 and ending on June 30, 2012.

10 (D) The department shall propose regulations that establish
11 minimum occupancy requirements as a condition for bed-hold
12 payments. The final regulations shall be effective July 1, 2009,
13 and shall phase in these requirements over a period of two rate
14 years, beginning fiscal year 2009-2010.

15 (iv) Subject to Federal approval of such amendments as may
16 be necessary to the Commonwealth's approved Title XIX State
17 Plan, for each fiscal year beginning on or after July 1, 2011,
18 the [department] Office of Independent Medicaid Director shall
19 apply a revenue adjustment neutrality factor to county and
20 nonpublic nursing facility payment rates so that the estimated
21 Statewide day-weighted average payment rate in effect for that
22 fiscal year is limited to the amount permitted by the funds
23 appropriated by the General Appropriation Act for the fiscal
24 year. The revenue adjustment neutrality factor shall remain in
25 effect until the sooner of June 30, 2019, or the date on which a
26 new rate-setting methodology for medical assistance nursing
27 facility services which replaces the rate-setting methodology
28 codified in 55 Pa. Code Chs. 1187 (relating to nursing facility
29 services) and 1189 (relating to county nursing facility
30 services) takes effect.

1 (v) Subject to Federal approval of such amendments as may be
2 necessary to the Commonwealth's approved Title XIX State Plan,
3 for fiscal year 2013-2014, the [department] Office of
4 Independent Medicaid Director shall make quarterly medical
5 assistance day-one incentive payments to qualified nonpublic
6 nursing facilities. The [department] Office of Independent
7 Medicaid Director shall determine the nonpublic nursing
8 facilities that qualify for the quarterly medical assistance
9 day-one incentive payments and calculate the payments using the
10 total Pennsylvania medical assistance (PA MA) days and total
11 resident days as reported by nonpublic nursing facilities under
12 Article VIII-A. The [department's] Office of Independent
13 Medicaid Director's determination and calculations under this
14 subparagraph shall be based on the nursing facility assessment
15 quarterly resident day reporting forms available on October 31,
16 January 31, April 30 and July 31. The [department] Office of
17 Independent Medicaid Director shall not retroactively revise a
18 medical assistance day-one incentive payment amount based on a
19 nursing facility's late submission or revision of its report
20 after these dates. The [department] Office of Independent
21 Medicaid Director, however, may recoup payments based on an
22 audit of a nursing facility's report. The following shall apply:

23 (A) A nonpublic nursing facility shall meet all of the
24 following criteria to qualify for a medical assistance day-one
25 incentive payment:

26 (I) The nursing facility shall have an overall occupancy
27 rate of at least 85% during the resident day quarter. For
28 purposes of determining a nursing facility's overall occupancy
29 rate, a nursing facility's total resident days, as reported by
30 the facility under Article VIII-A, shall be divided by the

1 product of the facility's licensed bed capacity, at the end of
2 the quarter, multiplied by the number of calendar days in the
3 quarter.

4 (II) The nursing facility shall have a medical assistance
5 occupancy rate of at least 65% during the resident day quarter.
6 For purposes of determining a nursing facility's medical
7 assistance occupancy rate, the nursing facility's total PA MA
8 days shall be divided by the nursing facility's total resident
9 days, as reported by the facility under Article VIII-A.

10 (III) The nursing facility shall be a nonpublic nursing
11 facility for a full resident day quarter prior to the applicable
12 quarterly reporting due dates of October 31, January 31, April
13 30 and July 31.

14 (B) The [department] Office of Independent Medicaid
15 Director shall calculate a qualified nonpublic nursing
16 facility's medical assistance day-one incentive quarterly
17 payment as follows:

18 (I) The total funds appropriated for payments under this
19 subparagraph shall be divided by four.

20 (II) To establish the quarterly per diem rate, the amount
21 under subclause (I) shall be divided by the total PA MA days, as
22 reported by all qualifying nonpublic nursing facilities under
23 Article VIII-A.

24 (III) To determine a qualifying nonpublic nursing facility's
25 quarterly medical assistance day-one incentive payment, the
26 quarterly per diem rate shall be multiplied by a nonpublic
27 nursing facility's total PA MA days, as reported by the facility
28 under Article VIII-A.

29 (C) For fiscal year 2013-2014, the State funds available for
30 the nonpublic nursing facility medical assistance day-one

1 incentive payments shall equal eight million dollars
2 (\$8,000,000).

3 (vi) Subject to Federal approval of such amendments as may
4 be necessary to the Commonwealth's approved Title XIX State
5 Plan, for fiscal years 2015-2016 and 2016-2017, the [department]
6 Office of Independent Medicaid Director shall make up to four
7 medical assistance day-one incentive payments to qualified
8 nonpublic nursing facilities. The department shall determine the
9 nonpublic nursing facilities that qualify for the medical
10 assistance day-one incentive payments and calculate the payments
11 using the total Pennsylvania medical assistance (PA MA) days and
12 total resident days as reported by nonpublic nursing facilities
13 under Article VIII-A. The department's determination and
14 calculations under this subparagraph shall be based on the
15 nursing facility assessment quarterly resident day reporting
16 forms, as determined by the department. The department shall not
17 retroactively revise a medical assistance day-one incentive
18 payment amount based on a nursing facility's late submission or
19 revision of the department's report after the dates designated
20 by the department. The department, however, may recoup payments
21 based on an audit of a nursing facility's report. The following
22 shall apply:

23 (A) A nonpublic nursing facility shall meet all of the
24 following criteria to qualify for a medical assistance day-one
25 incentive payment:

26 (I) The nursing facility shall have an overall occupancy
27 rate of at least eighty-five percent during the resident day
28 quarter. For purposes of determining a nursing facility's
29 overall occupancy rate, a nursing facility's total resident
30 days, as reported by the facility under Article VIII-A, shall be

1 divided by the product of the facility's licensed bed capacity,
2 at the end of the quarter, multiplied by the number of calendar
3 days in the quarter.

4 (II) The nursing facility shall have a medical assistance
5 occupancy rate of at least sixty-five percent during the
6 resident day quarter. For purposes of determining a nursing
7 facility's medical assistance occupancy rate, the nursing
8 facility's total PA MA days shall be divided by the nursing
9 facility's total resident days, as reported by the facility
10 under Article VIII-A.

11 (III) The nursing facility shall be a nonpublic nursing
12 facility for a full resident day quarter prior to the applicable
13 quarterly reporting due dates, as determined by the department.

14 (B) The department shall calculate a qualified nonpublic
15 nursing facility's medical assistance day-one incentive payment
16 as follows:

17 (I) The total funds appropriated for payments under this
18 subparagraph shall be divided by the number of payments, as
19 determined by the department.

20 (II) To establish the per diem rate for a payment, the
21 amount under subclause (I) shall be divided by the total PA MA
22 days, as reported by all qualifying nonpublic nursing facilities
23 under Article VIII-A for that payment.

24 (III) To determine a qualifying nonpublic nursing facility's
25 medical assistance day-one incentive payment, the per diem rate
26 calculated for the payment shall be multiplied by a nonpublic
27 nursing facility's total PA MA days, as reported by the facility
28 under Article VIII-A for the payment.

29 (C) For fiscal years 2015-2016 and 2016-2017, the State
30 funds available for the nonpublic nursing facility medical

1 assistance day-one incentive payments shall equal eight million
2 dollars (\$8,000,000).

3 (8) As a condition of participation in the medical
4 assistance program, before any county or nonpublic nursing
5 facility increases the number of medical assistance certified
6 beds in its facility or in the medical assistance program,
7 whether as a result of an increase in beds in an existing
8 facility or the enrollment of a new provider, the facility must
9 seek and obtain advance written approval of the increase in
10 certified beds from the department. The following shall apply:

11 (i) Before July 1, 2009, the department shall propose
12 regulations that would establish the process and criteria to be
13 used to review and respond to requests for increases in medical
14 assistance certified beds, including whether an increase in the
15 number of certified beds is necessary to assure that long-term
16 living care and services under the medical assistance program
17 will be provided in a manner consistent with applicable Federal
18 and State law, including Title XIX of the Social Security Act.

19 (ii) Pending adoption of regulations, a nursing facility's
20 request for advance written approval for an increase in medical
21 assistance certified beds shall be submitted and reviewed in
22 accordance with the process and guidelines contained in the
23 statement of policy published in 28 Pa.B. 138.

24 (iii) The [department] Office of Independent Medicaid
25 Director may publish amendments to the statement of policy if
26 the department determines that changes to the process and
27 guidelines for reviewing and responding to requests for approval
28 of increases in medical assistance certified beds will
29 facilitate access to medically necessary nursing facility
30 services or are required to assure that long-term living care

1 and services under the medical assistance program will be
2 provided in a manner consistent with applicable Federal and
3 State law, including Title XIX of the Social Security Act. The
4 [department] Office of Independent Medicaid Director shall
5 publish the proposed amendments in the Pennsylvania Bulletin and
6 solicit public comments for thirty days. After consideration of
7 the comments it receives, the [department] Office of
8 Independent Medicaid Director may proceed to adopt the
9 amendments by publishing an amended statement of policy in the
10 Pennsylvania Bulletin which shall include its responses to the
11 public comments that it received concerning the proposed
12 amendments.

13 Section 3. Section 443.2 of the act is amended to read:

14 Section 443.2. Medical Assistance Payments for Home Health
15 Care.--The following medical assistance payments shall be made
16 in behalf of eligible persons whose care in the home has been
17 prescribed by a physician, chiropractor or podiatrist:

18 (1) Rates established by the [department] Office of
19 Independent Medicaid Director for post-hospital home care, as
20 specified by regulations of the [department] Office of
21 Independent Medicaid Director adopted under Title XIX of the
22 Federal Social Security Act for not more than one hundred eighty
23 days following a period of hospitalization, if such care is
24 related to the reason the person was hospitalized and if given
25 by a hospital as comprehensive, hospital type care in a
26 patient's home;

27 (2) Rates established by the [department] Office of
28 Independent Medicaid Director for home health care services if
29 such services are furnished by a voluntary or governmental
30 health agency.

1 Section 4. Section 443.3 of the act, amended December 28,
2 2015 (P.L.500, No.92), is amended to read:

3 Section 443.3. Other Medical Assistance Payments.--(a)
4 Payments on behalf of eligible persons shall be made for other
5 services, as follows:

6 (1) Rates established by the [department] Office of
7 Independent Medicaid Director for outpatient services as
8 specified by regulations of the department adopted under Title
9 XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396
10 et seq.) consisting of preventive, diagnostic, therapeutic,
11 rehabilitative or palliative services; furnished by or under the
12 direction of a physician, chiropractor or podiatrist, by a
13 hospital or outpatient clinic which qualifies to participate
14 under Title XIX of the Social Security Act, to a patient to whom
15 such hospital or outpatient clinic does not furnish room, board
16 and professional services on a continuous, twenty-four hour a
17 day basis.

18 (1.1) Rates established by the [department] Office of
19 Independent Medicaid Director for observation services provided
20 by or furnished under the direction of a physician and furnished
21 by a hospital. Payment for observation services shall be made in
22 an amount specified by the [department] Office of Independent
23 Medicaid Director by notice in the Pennsylvania Bulletin and
24 shall be effective for dates of service on or after July 1,
25 2016. Payment for observation services shall be subject to
26 conditions specified in the [department's] Office of Independent
27 Medicaid Director regulations, including regulations adopted by
28 the [department] Office of Independent Medicaid Director to
29 implement this paragraph. Pending adoption of regulations
30 implementing this paragraph, the conditions for payment of

1 observation services shall be specified in a medical assistance
2 bulletin.

3 (2) Rates established by the [department] Office of
4 Independent Medicaid Director for (i) other laboratory and X-ray
5 services prescribed by a physician, chiropractor or podiatrist
6 and furnished by a facility other than a hospital which is
7 qualified to participate under Title XIX of the Social Security
8 Act, (ii) physician's services consisting of professional care
9 by a physician, chiropractor or podiatrist in his office, the
10 patient's home, a hospital, a nursing facility or elsewhere,
11 (iii) the first three pints of whole blood, (iv) remedial eye
12 care, as provided in Article VIII consisting of medical or
13 surgical care and aids and services and other vision care
14 provided by a physician skilled in diseases of the eye or by an
15 optometrist which are not otherwise available under this
16 Article, (v) special medical services for school children, as
17 provided in the Public School Code of 1949, consisting of
18 medical, dental, vision care provided by a physician skilled in
19 diseases of the eye or by an optometrist or surgical care and
20 aids and services which are not otherwise available under this
21 article.

22 (3) Notwithstanding any other provision of law, for
23 recipients aged twenty-one years or older receiving services
24 under the fee for service delivery system who are eligible for
25 medical assistance under Title XIX of the Social Security Act
26 and for recipients aged twenty-one years or older receiving
27 services under the fee-for-service delivery system who are
28 eligible for general assistance-related categories of medical
29 assistance, the following medically necessary services:

30 (i) Psychiatric outpatient clinic services not to exceed

1 five hours or ten one-half-hour sessions per thirty consecutive
2 day period.

3 (ii) Psychiatric partial hospitalization not to exceed five
4 hundred forty hours per fiscal year.

5 (b) The [department] Office of Independent Medicaid Director
6 may grant exceptions to the limits specified in this section,
7 section 443.1(4) or the department's regulations when any of the
8 following circumstances applies:

9 (1) The [department] Office of Independent Medicaid Director
10 determines that the recipient has a serious chronic systemic
11 illness or other serious health condition and denial of the
12 exception will jeopardize the life of or result in the rapid,
13 serious deterioration of the health of the recipient.

14 (2) The [department] Office of Independent Medicaid Director
15 determines that granting a specific exception to a limit is a
16 cost-effective alternative for the medical assistance program.

17 (3) The [department] Office of Independent Medicaid Director
18 determines that granting an exception to a limit is necessary in
19 order to comply with Federal law.

20 (c) The [Secretary of Public Welfare] Office of Independent
21 Medicaid Director shall promulgate regulations pursuant to
22 section 204(1)(iv) of the act of July 31, 1968 (P.L.769,
23 No.240), referred to as the Commonwealth Documents Law, to
24 implement this section. Notwithstanding any other provision of
25 law, the promulgation of regulations under this subsection
26 shall, until December 31, 2005, be exempt from all of the
27 following:

28 (1) Section 205 of the Commonwealth Documents Law.

29 (2) Section 204(b) of the act of October 15, 1980 (P.L.950,
30 No.164), known as the "Commonwealth Attorneys Act."

1 (3) The act of June 25, 1982 (P.L.633, No.181), known as the
2 "Regulatory Review Act."

3 Section 5. Section 454(a) and (c) of the act are amended to
4 read:

5 Section 454. Medical Assistance Benefit Packages; Coverage,
6 Copayments, Premiums and Rates.--(a) Notwithstanding any other
7 provision of law to the contrary, the [department] Office of
8 Independent Medicaid Director shall promulgate regulations as
9 provided in subsection (b) to establish provider payment rates;
10 the benefit packages and any copayments for adults eligible for
11 medical assistance under Title XIX of the Social Security Act
12 (49 Stat 620, 42 U.S.C. § 1396 et seq.) and adults eligible for
13 medical assistance in general assistance-related categories; and
14 the premium or copayment requirements for disabled children
15 whose family income is above two hundred percent of the Federal
16 poverty income limit. Subject to such Federal approval as may be
17 necessary, the regulations shall authorize and describe the
18 available benefit packages and any copayments and premiums,
19 except that the [department] Office of Independent Medicaid
20 Director shall set forth the copayment and premium schedule for
21 disabled children whose family income is above two hundred
22 percent of the Federal poverty income limit by publishing a
23 notice in the Pennsylvania Bulletin. The [department] Office of
24 Independent Medicaid Director may adjust such copayments and
25 premiums for disabled children by notice published in the
26 Pennsylvania Bulletin. The regulations shall also specify the
27 effective date for provider payment rates.

28 * * *

29 (c) The [department] Office of Independent Medicaid Director
30 is authorized to grant exceptions to any limits specified in the

1 benefit packages adopted under this section or when any of the
2 following circumstances applies:

3 (1) The [department] Office of Independent Medicaid Director
4 determines the recipient has a serious chronic systemic illness
5 or other serious health condition and denial of the exception
6 will jeopardize the life of or result in the rapid, serious
7 deterioration of the health of the recipient.

8 (2) The [department] Office of Independent Medicaid Director
9 determines that granting a specific exception to a limit is a
10 cost-effective alternative for the medical assistance program.

11 (3) The department determines that granting an exception to
12 a limit is necessary in order to comply with Federal law.

13 * * *

14 Section 6. The act is amended by adding an article to read:

15 ARTICLE IV-A

16 OFFICE OF INDEPENDENT MEDICAID DIRECTOR

17 Section 401-A. Declaration of purpose.

18 The General Assembly finds and declares that the intent of
19 this article is to ensure that the Commonwealth's current
20 Medicaid programs provide all of the following:

21 (1) Budget stability and predictability through defined
22 outcomes, performance and accountability.

23 (2) A balance of quality, patient satisfaction,
24 financial measures and self-sufficiency.

25 (3) The most efficient and cost-effective services,
26 administrative systems and structures.

27 (4) A sustainable and uniform delivery system across the
28 Commonwealth's departments and agencies.

29 (5) Services are offered to assist recipients attain
30 independence or self-care.

1 Section 402-A. Definitions.

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

5 "Director." The Director of the Office of Independent
6 Medicaid Director.

7 "Medicaid program." A State program or funding source which
8 is connected, whether by funding or approval, to the Centers for
9 Medicare and Medicaid Services of the United States Department
10 of Health and Human Services.

11 Section 403-A. Office of Independent Medicaid Director.

12 The Office of Independent Medicaid Director is established
13 within the department for budgetary purposes.

14 Section 404-A. Director of the Office of Independent Medicaid
15 Director.

16 (a) Appointment.--The Governor shall appoint the Director of
17 the Office of Independent Medicaid Director from the list
18 submitted by the Selection and Organization Committee under
19 subsection (c) for a term of six years and subject to
20 confirmation by the Senate. The initial term of office for the
21 director shall commence upon confirmation by the Senate and
22 shall expire June 30, 2022. After June 30, 2022, the term of
23 office for the director shall be four years and shall commence
24 on July 1 after the date of confirmation.

25 (b) Committee.--The Selection and Organization Committee is
26 established for the purpose of comprising a list of potential
27 nominees for director. The committee shall consist of the
28 following:

29 (1) The chair and minority chair of the Appropriations
30 Committee of the Senate and the chair and minority chair of

1 the Appropriations Committee of the House of Representatives.

2 (2) The Majority Leader and the Minority Leader of the
3 Senate and the Majority Leader and the Minority Leader of the
4 House of Representatives.

5 (3) The President pro tempore of the Senate and the
6 Speaker of the House of Representatives.

7 (5) The chair and minority chair of the Health and Human
8 Services Committee of the Senate.

9 (6) The chair and minority chair of the Health Committee
10 of the House of Representatives.

11 (c) Nomination.--The following shall apply:

12 (1) The Selection and Organization Committee shall
13 submit no more than three potential nominees to the Governor
14 within 30 days of a vacancy.

15 (2) The Governor shall submit a nominee from the list
16 submitted under paragraph (1) for director to the Senate for
17 confirmation no later than May 1 of the year when the term of
18 office expires.

19 (3) If the Governor fails to submit a nominee under
20 paragraph (2) by May 1 of the year when the term of office
21 expires, the President pro tempore of the Senate and the
22 Speaker of the House of Representatives shall jointly submit
23 a nominee to the Senate on or before May 15 of the same year
24 by resolution. The resolution shall include all of the
25 following:

26 (i) The name of the nominee.

27 (ii) The effective date of the appointment.

28 (iii) The date of expiration of the term of office.

29 (iv) The residence of the nominee.

30 (v) A clause providing that the nominee is submitted

1 upon joint recommendation of the President pro tempore of
2 the Senate and the Speaker of the House of
3 Representatives.

4 (4) If a nominee for director is not confirmed within 30
5 days of submission to the Senate, a new nominee for director
6 shall be submitted to the Senate.

7 (d) Vacancy.--The following shall apply if the position of
8 director is vacant:

9 (1) If the vacancy occurs before the director's term of
10 office expires, the Governor shall submit a nominee from the
11 list submitted by the Selection and Organization Committee
12 under subsection (c) for director to the Senate no later than
13 60 days after the vacancy occurs.

14 (2) If the vacancy occurs when the General Assembly is
15 not in session, the Governor shall appoint an acting director
16 to serve the remainder of the unexpired term. An acting
17 director may not serve for more than three months without
18 confirmation by the Senate.

19 Section 405-A. Powers and duties of director.

20 The director shall have the following powers and duties:

21 (1) Administering Medicaid programs in a manner in which
22 the total expenditures, net of agency receipts, do not exceed
23 the authorized budget for the Medicaid programs.

24 (2) Employing clerical and professional staff for the
25 Office of Independent Medicaid Director, including
26 consultants, actuaries and legal counsel, for the purpose of
27 administering Medicaid programs. The director may offer
28 employment contracts for specified terms and set compensation
29 for the employees, which may include performance-based
30 bonuses based on meeting budget or other targets.

1 (3) Notwithstanding any other provisions of law,
2 entering into and managing contracts for the administration
3 of Medicaid programs, which shall include all of the
4 following:

5 (i) Expected outcomes to improve the health and
6 well-being of residents of this Commonwealth.

7 (ii) Value-based purchasing.

8 (iii) The use of evidence-based programs.

9 (iv) Performance incentives for exceeding outcomes.

10 (v) Uniformed coordination of services.

11 (vi) Cost containment provisions.

12 (vii) Maximizing the amount of Federal funds.

13 (4) Establishing and adjusting all components of
14 Medicaid programs within the appropriated and allocated
15 budget.

16 (5) Adopting rules and regulations relating to Medicaid
17 programs in accordance with Executive Order 1996-1.

18 (6) Developing mid-year budget correction plans and
19 strategies and taking mid-year budget corrective actions as
20 necessary to keep Medicaid programs within budget.

21 (7) Approving or disapproving and overseeing all
22 expenditures to be allocated to Medicaid programs.

23 (8) Developing and providing to the Office of the
24 Budget, the Appropriations Committee of the Senate and the
25 Appropriations Committee of the House of Representatives by
26 January 1, 2018, and each year thereafter, the following
27 information about Medicaid programs:

28 (i) A detailed four-year forecast of expected
29 changes to enrollment growth and enrollment demographics.

30 (ii) Changes that will be implemented by the

1 department in order to stay within the existing budget
2 based on the next fiscal year's forecasted enrollment
3 growth and enrollment demographics.

4 (iii) The cost to maintain the current level of
5 services based on the next fiscal year's forecasted
6 enrollment growth and enrollment demographics.

7 (9) Creating a publicly accessible Internet website for
8 the Office of Independent Medicaid Director and updating the
9 website on at least a monthly basis with the following
10 information about the Medicaid programs:

11 (i) Enrollment by Medicaid program aid category by
12 county.

13 (ii) Per member, per month spending by category of
14 service.

15 (iii) Spending and receipts by fund, including a
16 detailed variance analysis.

17 (iv) A comparison of the figures specified under
18 subparagraphs (i), (ii) and (iii) to the amounts
19 forecasted and budgeted for the corresponding time
20 period.

21 (10) Developing performance measures and outcomes for
22 programs under the director's jurisdiction and programs which
23 are billed against Medicaid programs.

24 (11) Making recommendations to the Governor and the
25 General Assembly to streamline programs to provide better
26 services for residents of this Commonwealth at a lower cost
27 to taxpayers.

28 (12) Serving at the pleasure of the residents of this
29 Commonwealth in an independent manner.

30 (13) Developing and implementing policies to address

1 excessive utilization of health care services.

2 (14) Ensuring that services are coordinated throughout
3 Commonwealth agencies, including physical health, behavioral
4 health, long-term services and supports and third-party
5 insurances.

6 Section 406-A. Amendments to State plan for Medicaid programs.

7 (a) Amendments.--The director may take all necessary action
8 to amend the State plan for Medicaid programs in order to keep
9 Medicaid programs within the certified budget, including State
10 plan amendments, waivers and waiver amendments.

11 (b) Submission.--An amendment to the State plan for Medicaid
12 programs shall be submitted by the director in accordance with
13 the following:

14 (1) A law of this Commonwealth mandating that the
15 director submit an amendment to the State plan for Medicaid
16 programs.

17 (2) A law of this Commonwealth which changes Medicaid
18 programs and requires approval from the Federal Government.

19 (3) A change in Federal law which requires an amendment
20 to the State plan for Medicaid programs.

21 (4) An order of a court of competent jurisdiction if the
22 amendment to the State plan for Medicaid programs is
23 necessary to implement the order.

24 (5) In a manner as required to maintain Federal funding
25 for Medicaid programs.

26 (c) Notice.--No less than 30 days before submitting an
27 amendment to the State plan for Medicaid programs to the Federal
28 Government, the director shall post the amendment on the Office
29 of Independent Medicaid Director's publicly accessible Internet
30 website and notify the members of the General Assembly and the

1 Independent Fiscal Office that the amendment has been posted.
2 The notice requirement under this subsection shall not apply to
3 a draft or proposed amendment submitted to the Federal
4 Government for comments and not for approval.

5 Section 407-A. Use of funds.

6 The Office of Independent Medicaid Director shall use
7 encumbered funds appropriated to the department to implement
8 this article.

9 Section 408-A. Legislative oversight powers.

10 The Appropriations Committee of the Senate and the
11 Appropriations Committee of House of Representatives, while in
12 discharge of official duties, shall have access to any document
13 and may compel the attendance of an employee or secure any
14 evidence.

15 Section 409-A. Duties of Commonwealth agencies.

16 The following shall apply:

17 (1) A Commonwealth agency shall not interfere with the
18 duties of the director or withhold information requested by
19 the director.

20 (2) A Commonwealth agency shall coordinate with the
21 director to ensure the residents of this Commonwealth have a
22 continuity of care.

23 Section 410-A. Construction.

24 Nothing in this article shall be construed to limit the
25 budget authority of the Office of the Budget under Article VI of
26 the act of April 9, 1929 (P.L.177, No.175), known as The
27 Administrative Code of 1929.

28 Section 7. All acts and parts of acts are repealed insofar
29 as they are inconsistent with this act.

30 Section 8. This act shall take effect July 1, 2017, or

1 immediately, whichever is later.