PRINTER'S NO. 1684

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, TOOHIL, EVERETT, SAYLOR, FRITZ, RYAN, DAY, WHEELAND, CUTLER AND MOUL, MAY 9, 2017

REFERRED TO COMMITTEE ON HEALTH, MAY 9, 2017

AN ACT

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

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

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

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

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

* * *

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

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

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

Office of Independent Medicaid Director, except as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

(v) The [department] Office of Independent Medicaid Director shall make enhanced capitation payments to medical assistance managed care organizations if necessary exclusively for the purpose of making supplemental payments to hospitals in order to promote continued access to quality care for medical assistance recipients. Medical assistance managed care organizations shall use the enhanced capitation payments received pursuant to this section solely for the purpose of making supplemental payments to hospitals and shall provide documentation to the [department] Office of Independent Medicaid Director certifying that all funds received in this manner are used in accordance with this section. The supplemental payments to hospitals made pursuant to this subsection are in lieu of increased or additional payments for inpatient acute care services from medical assistance managed care organizations resulting from the [department's] Office of Independent Medicaid Director's implementation of payments under paragraph (1.1)(ii). Medical assistance managed care organizations shall in no event be obligated under this section to make supplemental or other additional payments to hospitals that exceed the enhanced capitation payments made to the medical assistance managed care organization under this section. Medical assistance managed care organizations shall not be required to advance the supplemental payments to hospitals authorized by this subsection and shall only make the supplemental payments to hospitals once medical

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

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

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

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

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

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

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

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

in place on June 30, 2010.

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

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

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

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

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

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

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

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

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

(ii) "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] Office of Independent Medicaid Director, other than a behavioral health managed care organization that is a party to a medical assistance managed care contract with the [department] Office of Independent Medicaid Director.

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

and for mothers' obstetrical delivery.

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

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

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

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

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

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

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

(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] Office of Independent Medicaid Director'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:

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

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

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

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

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

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

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

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

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

(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] Office of Independent Medicaid Director 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, 2019, 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

observation services shall be specified in a medical assistance bulletin.

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

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

(i) Psychiatric outpatient clinic services not to exceed

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

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

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

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

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

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

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

(1) Section 205 of the Commonwealth Documents Law.

(2) Section 204(b) 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."

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

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

* * *

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

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

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

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

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

* * *

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

ARTICLE IV-A

OFFICE OF INDEPENDENT MEDICAID DIRECTOR

Section 401-A. Declaration of purpose.

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

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

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

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

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

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

Section 402-A. Definitions.

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

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

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

Section 403-A. Office of Independent Medicaid Director.

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

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

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

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

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

the Appropriations Committee of the House of Representatives.

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

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

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

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

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

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

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

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

(i) The name of the nominee.

(ii) The effective date of the appointment.

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

(iv) The residence of the nominee.

(v) A clause providing that the nominee is submitted

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

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

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

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

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

Section 405-A. Powers and duties of director.

The director shall have the following powers and duties:

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

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

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

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

(ii) Value-based purchasing.

(iii) The use of evidence-based programs.

(iv) Performance incentives for exceeding outcomes.

(v) Uniformed coordination of services.

(vi) Cost containment provisions.

(vii) Maximizing the amount of Federal funds.

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

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

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

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

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

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

(ii) Changes that will be implemented by the

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

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

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

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

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

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

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

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

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

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

(13) Developing and implementing policies to address

excessive utilization of health care services.

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

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

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

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

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

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

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

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

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

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

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

Section 407-A. Use of funds.

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

Section 408-A. Legislative oversight powers.

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

Section 409-A. Duties of Commonwealth agencies.

The following shall apply:

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

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

Section 410-A. Construction.

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

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

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

immediately, whichever is later.