[62 Pa. Stat. and Cons. Stat. Ann. § 443.1.]

§ 443.1. Medical assistance payments for institutional care: Medical Assistance

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 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 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 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, 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, 2023, 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 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 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.

(iii) Notwithstanding subparagraph (i), the department 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 shall make enhanced capitation payments to medical assistance managed care organizations 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

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 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.

(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 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 payment methods and standards specified in paragraph (1.1)(ii). If the department 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 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 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, other than a behavioral health managed care organization that is a party to a medical assistance managed care contract with the department.

(1.6) Notwithstanding any other provision of law or departmental regulation to the contrary, the department 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. This cost in county homes shall be as specified by the regulations of the department 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;

(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 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 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 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

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 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 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 shall apply a revenue adjustment neutrality factor to county and nonpublic nursing facility payment rates so that the

estimated Statewide day-weighted average payment rate in effect for that fiscal year is limited to the amount permitted by the funds appropriated by the General Appropriation Act for the fiscal year. The revenue adjustment neutrality factor shall remain in effect until the sooner of June 30, 2022, 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 shall make quarterly medical assistance day-one incentive payments to qualified nonpublic nursing facilities. The department 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 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 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, 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 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, 2016-2017, 2018-2019 and 2019-2020, the department 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.

(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) The following shall apply:

(I) For fiscal years 2015-2016, 2016-2017 and 2018-2019, the State funds available for the nonpublic nursing facility medical assistance day-one incentive payments shall equal eight million dollars ($8,000,000).

(II) For fiscal years 2019-2020, the State funds available for the nonpublic nursing facility medical assistance day-one incentive payments shall equal sixteen million dollars ($16,000,000).

(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 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 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 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.

(iv) This subparagraph shall apply to any requests for approval of an increase in medical assistance certified beds pending or submitted on or after the effective date of this subparagraph. This subparagraph shall expire upon the department’s adoption of final regulations or June 30, 2012, whichever occurs first.