REGULATORY ANALYSIS FORM
FINAL-FORM AND FINAL-OMITTED RULEMAKING

Regulatory Analysis Form

(1) Agency Department of Public Welfare	This space for use by IRRC
(2) I.D. Number (Governor's Office Use)	IRRC Number: 2615

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INDEPENDENT REGULATORY REVIEW COMMISSION

(3) Short Title
Inpatient Hospital Services

(4) PA Code Cite 55 Pa.Code Ch. 1163	(5) Agency Contacts & Telephone Numbers Primary Contact: Donald Yearsley 772 6147 Secondary Contact: Leesa Allen 705 8308
(6) Type of Rule Making (Check One) _____ Proposed Rule Making _____ Final Order Adopting Regulation _x_ Final Order, Proposed Rule Making Omitted	(7) Is a 120-Day Emergency Certification Attached? (To be used only for emergency-certified regulations.) _x_ No _____ Yes: By the Attorney General _____ Yes: By the Governor

(8) Briefly explain the regulation in clear and nontechnical language.
Respond in complete sentences.
The purpose of this regulation is to limit the Department's payment of Medicare cost-sharing amounts for inpatient hospital services rendered to dual eligible Medical Assistance recipients in the same manner as the Department's payments of Medicare cost-sharing payments for all other services.

(9) State the statutory authority for the regulation and any relevant state or federal court decisions.
The Department of Public Welfare adopts these amendments pursuant to §§ 201 443.1 of the Public Welfare Code (62 P.S. §§ 201 and 443.1).

(10) Is the regulation mandated by any federal or state law or court order, or federal regulation? If yes, cite the specific law, case or regulation, and any deadlines for action.
No. Instead, this is an option available to the states pursuant to the Balanced Budget

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Act. (42 U.S.C.A. § 1396a(n)(2).

(11) Explain the compelling public interest that justifies the regulation. What is the problem it addresses?
This regulation is needed to enable the Department to realize substantial cost savings and to make the Department's Medicare cost-sharing payment policies uniform for all providers and services.

(12) State the public health, safety, environmental or general welfare risks associated with non-regulation.
None.

(13) Describe who will benefit from the regulation. (Quantify the benefits as completely as possible and approximate the number of people who will benefit.)
Adoption of these amendments will enable the Department to both realize substantial cost savings and to makes its Medicare cost-sharing payment policies uniform for all providers and services.

(14) Describe who will be adversely affected by the regulation. (Quantify the adverse effects as completely as possible and approximate the number of people who will be adversely affected.)
No one will be adversely affected by the regulation.

(15) List the persons, groups or entities that will be required to comply with the regulation. (Approximate the number of people who will be required to comply.)
Acute care general hospitals enrolled as providers in the MA program.

(16) Describe the communications with and input from the public in the development and drafting of the regulation. List the persons and/or groups who were involved, if applicable.
The Department of Public Welfare has engaged in public outreach through which the Department has already notified affected parties of the promulgation of these amendments and has solicited and received input from the hospital industry and other interested persons. Specifically, the Department met with the Hospital Association of Pennsylvania on May 10, 2007.

(17) Provide a specific estimate of the costs and/or savings to the regulated community associated with compliance, including any legal, accounting or consulting procedures that may be required.
There are no new costs or savings to the regulated community associated with compliance with this regulation. No new legal, accounting or consultant procedures are required.

(18) Provide a specific estimate of the costs and/or savings to local governments associated with compliance, including any legal, accounting or consulting procedures that may be required.
There are no new costs or savings to local governments associated with compliance with this regulation. No new legal, accounting or consultant procedures are required.

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(19) Provide a specific estimate of the costs and/or savings to state government associated with the implementation of the regulation, including any legal, accounting, or consulting procedures that may be required.

The Commonwealth anticipates annual savings of $30.000 million ($13.753 million in State funds) beginning in Fiscal Year 2007-2008, as the result of these amendments.

Linda L Luckhering 5-17-07

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(20) In the table below, provide an estimate of the fiscal savings and costs associated with implementation and compliance for the regulated community, local government, and state government for the current year and five subsequent years.

	Current FY Year	FY +1 Year	FY +2 Year	FY +3 Year	FY +4 Year	FY +5 Year
SAVINGS:						
Regulated Community						
Local Government						
State Government MA- Inpatient	$0.000	$(13.753 M)	$(13.753 M)	$(13.753 M)	$(13.753 M)	$(13.753M)
Total Savings						
COSTS:						
Regulated Community						
Local Government						
State Government						
Total Costs						
REVENUE LOSSES:						
Regulated Community						
Local Government						
State Government						
Total Revenue Losses						

(20a) Explain how the cost estimates listed above were derived.
Due to the time lag between discharge and payment, no fiscal impact is anticipated in Fiscal Year 2006-2007. Annual Medical Assistance-Inpatient savings, beginning in Fiscal Year 2007-2008, are based on inpatient paid claims history for the dual eligible population for the period January 1, 2006 through December 31, 2006, and assume a savings based on a percentage of the identified payments.

Linda L Shelley 5-17-07

Regulatory Analysis Form

(20b) Provide the past three year expenditure history for programs affected by the regulation.

Program	FY -3	FY -2	FY -1	Current FY
MA-Inpatient	$411.042 M	$531.785 M	$474.693 M	$456.879 M
			-	

(21) Using the cost-benefit information provided above, explain how the benefits of the regulation outweigh the adverse effects and costs.
The Commonwealth anticipates savings of $30.000 Million ($13.753 in state funds) in Fiscal Year 2007-2008 as a result of these amendments.

(22) Describe the nonregulatory alternatives considered and the costs associated with those alternatives. Provide the reasons for their dismissal.
Nonregulatory methods were not considered.

(23) Describe alternative regulatory schemes considered and the costs associated with those schemes. Provide the reasons for their dismissal.
No alternative regulatory schemes were considered.

(24) Are there any provisions that are more stringent than federal standards? If yes, identify the specific provisions and the compelling Pennsylvania interest that demands stronger regulation.
This regulation is not more stringent than Federal standards.

(25) How does this regulation compare with those of other states? Will the regulation put Pennsylvania at a competitive disadvantage with other states?
Other states have the option to limit cost-sharing in the same manner as Pennsylvania. This does not put Pennsylvania at a competitive disadvantage.

(26) Will the regulation affect existing or proposed regulations of the promulgating agency or other state agencies? If yes, explain and provide specific citations.
This regulation does not affect existing or proposed regulations of the Department or

Regulatory Analysis Form
another state agency.
(27) Will any public hearings or informational meetings be scheduled? Please provide the dates, times, and locations, if available. The Department will continue to meet with affected individuals and organizations to discuss the application and effectiveness of this regulation.
(28) Will the regulation change existing reporting, record keeping, or other paperwork requirements? Describe the changes and attach copies of forms or reports that will be required as a result of implementation, if available. No new reports, forms, recordkeeping or paperwork are required by this regulation.
(29) Please list any special provisions that have been developed to meet the particular needs of affected groups or persons including, but not limited to, minorities, elderly, small businesses, and farmers. There are no special provisions relating to these groups.
(30) What is the anticipated effective date of the regulation; the date by which compliance with the regulation will be required; and the date by which any required permits, licenses or other approvals must be obtained? The regulation will take effect immediately and apply to inpatient hospital services with discharge dates on or after July 1, 2007.
(31) Provide the schedule for continual review of the regulation. The Department of Public Welfare will continue to review the regulation on an ongoing basis.

CDL-1

FACE SHEET
FOR FILING DOCUMENTS
WITH THE LEGISLATIVE REFERENCE BUREAU

(Pursuant to Commonwealth Documents Law)

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Copy below is hereby approved as to form and legality. Attorney General	Copy below is hereby certified to be a true and correct copy of a document issued, prescribed or promulgated by:	Copy below is hereby approved as to Form and legality. Executive or Independent Agencies.
By: _____ (Deputy Attorney General)	DEPARTMENT OF PUBLIC WELFARE (Agency)	By: _____ Andrew C. Clark JUN 5 2007
_____ Date of Approval	LEGAL COUNSEL: Mary Francis Gabrielli	Date of Approval
	DOCUMENT/FISCAL NOTE NO. 14-511	(Deputy General Counsel) (~~Chief Counsel, Independent Agency~~) (~~Strike inapplicable title~~)
☐ Check if applicable Copy not approved. Objections attached.	DATE OF ADOPTION: _____ BY: Estelle B. Richman TITLE: SECRETARY OF PUBLIC WELFARE (Executive Officer, Chairman or Secretary)	☐ Check if applicable. No Attorney General approval or objection within 30 days after submission.

NOTICE OF FINAL-OMITTED RULEMAKING WITHOUT PUBLICATION
AS PROPOSED

DEPARTMENT OF PUBLIC WELFARE

OFFICE OF MEDICAL ASSISTANCE PROGRAMS

[55 Pa.Code Chapter 1163]

Inpatient Hospital Services

Statutory Authority

The Department of Public Welfare (DPW or the Department) by this order adopts amendments to Chapter 1163, as set forth in Annex A. These amendments are adopted pursuant to §§ 201 and 443.1 of the Public Welfare Code (62 P.S. §§ 201 and 443.1).

Omission of Proposed Rulemaking

The Department is omitting notice of proposed rulemaking in accordance with § 204(1)(iv) and (3) of the act of July 31, 1968 (P.L. 769, No. 240) (CDL) (45 P.S. § 1204(1)(iv) and (3)), and 1 Pa.Code § 7.4(1)(iv) and (3) because:

- The Department finds that publication of these amendments as proposed rulemaking is contrary to the public interest. The primary purpose of these amendments is limit the Department's payment of Medicare cost-sharing amounts for inpatient hospital services rendered to dual eligible Medical Assistance (MA) recipients. Adoption of these amendments by final rulemaking will enable the Department to both realize substantial cost-savings and to make its Medicare cost-sharing payment policies uniform for all providers and services.

- The Department finds that notice of proposed rulemaking is, under the circumstances, impracticable and unnecessary. As described below, the Department has engaged in public outreach through which the Department has already notified affected parties of the promulgation of these amendments, and has solicited and received input from the

hospital industry and other interested persons. The Department has given careful consideration to this public input in developing these regulations. The Department believes that publishing notice of proposed rulemaking is not likely to result in additional comments that are substantially different than those already received and considered in developing the regulations.

- These regulations relate to reimbursement for inpatient hospital services under the MA Program, which is a Commonwealth grant or benefit.

Purpose

The purpose of this rulemaking is to limit the Department's payment of Medicare cost-sharing amounts for inpatient hospital services rendered to dual eligible MA recipients in the same manner as the Department's payments of Medicare cost-sharing payments for all other services.

Background

Under the Medicare Program, Medicare beneficiaries receive coverage of inpatient hospital services, skilled nursing facility services and hospice services through Medicare Part A, and coverage of physician services, hospital outpatient services and certain other outpatient services through Medicare Part B. Medicare beneficiaries participate in the costs of both their Medicare Part A and Part B services by paying deductibles and coinsurance payments. These payments are generally referred to as "cost sharing."

Some Medicare beneficiaries are also eligible for Medical Assistance under the Commonwealth's MA Program. Other Medicare beneficiaries, known as Qualified Medicare Beneficiaries (QMBs), are not eligible for the full scope of MA benefits but, because of their income, cannot afford to pay Medicare cost-sharing payments. Under Federal law, the Department has paid Medicare cost-sharing amounts for both dual eligible recipients and QMBs; however, historically those payments were subject to certain conditions. Immediately prior to 1994, the Department paid Medicare cost-sharing amounts only if the applicable MA fee or payment for the service exceeded the Medicare payment amount received by the provider. In such instances, the Department reimbursed Medicare cost-sharing amounts up to the difference between the MA fee or payment and the Medicare payment amount. For example, if the Medicare approved payment amount for a service equaled $100 and the beneficiary's Medicare coinsurance amount equaled 20% or $20, the provider would receive payment of $80 from Medicare. If the MA fee for the same service equaled $90, the Department would pay $10 of the $20 coinsurance.

In 1994, the United States Court of Appeals for the Third Circuit ruled in Pennsylvania Medical Society v. Snider, 29 F.3d 886 (3rd Cir. 1994) (PMS) that the Department was obligated to pay providers for the full cost sharing amounts, including coinsurance and deductibles, for QMBs. The Department amended the Commonwealth's Title XIX State Plan and its payment policies to comply with the Court's ruling. The Department, however, made no change in any of its regulations. To the extent the regulations prescribed cost-sharing payment

different than Federal law, as construed by the Third Circuit in PMS, the Department considered the regulations superseded.

Thereafter, Congress amended Title XIX of the Social Security Act at § 1902(n), as part of the Balance Budget Act of 1997 ("BBA"), P.L. 105-33, § 4714(a), to state, in pertinent part, that:

> [A] State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for Medicare cost-sharing to the extent that payment under title XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this [title XIX] for such service if provided to an eligible recipient other than a Medicare beneficiary.

42 U.S.C.A. § 1396a(n)(2) (relating to state plans for medical assistance).

The BBA authorized, but did not require, states to limit payments for cost-sharing amounts as the Department had prior to PMS. Following enactment of the BBA, the Department took the necessary steps, including the submission of a new state plan amendment (SPA 97-08), to reinstate the payment policies that had been amended following PMS. Because the Department had not amended its regulations as a result of PMS, the Department did not issue new regulations or amendments to its regulations in response to the BBA.

Although SPA 97-08 amended those portions of the State Plan that had been changed after PMS, it did not amend the methods and standards for establishing payment rates for inpatient hospital services set forth in the Commonwealth's approved Title XIX State Plan. Nor did it alter the manner in which MA payments for such services are calculated under the Department's regulations, including payments relating to inpatient services to dual eligible recipients and QMBs. Rather the SPA indicated that MA fees and payments would be determined and limited in accordance with the provisions of the State Plan and implementing Department regulations for the service.

Since 1984, the Department's regulations, 55 Pa. Code § 1163.66 (relating to third-party liability), have specified a different MA payment for Medicare cost-sharing amounts for inpatient hospital services than other services. Instead of comparing the Medicare payment received by the provider with the applicable MA payment, Section 1163.66 requires a comparison of the Medicare cost-sharing amount with the applicable MA DRG payment for the hospitalization and, if less, provides for a payment up to the DRG amount less any other resources available for the inpatient services. If the above example involved inpatient hospital services, and the beneficiary had no other third party resources, the MA payment under Section 1163.66 would be $20. Now, the Department has determined that it is appropriate to amend its regulations to limit cost-sharing payments for inpatient services to conform its payment policies to those used for all other services.

Requirements

This rulemaking amends 55 Pa. Code § 1163.66 (relating to third-party liability) to limit MA payment of cost sharing related to inpatient hospital services to hospital inpatients who are MA recipients covered on a primary basis by Medicare Part A. As a result of the amendment, the Department will make an MA payment for Medicare cost-sharing amounts only if the applicable DRG payment, including any outlier payment, for the hospitalization exceeds the Medicare payment amount received by the provider. In such instances, the Department will reimburse Medicare cost-sharing amounts up to the difference between the applicable DRG payment, including any outlier payment, and the Medicare payment amount. The total MA payment combined with the amount paid by Medicare Part A, exclusive of cost sharing, and any amounts paid by other available resources will be no greater than the applicable DRG payment amount, including any outlier payment, that would be made under the Department's DRG regulations and approved State Plan for inpatient hospital services if the MA recipient were not also eligible for coverage under Medicare Part A. As further limitations, no co-payment or deductible, if any, will be paid in excess of the applicable DRG or per diem amounts that would be due under the fee-for-service MA Program or in excess of the maximum cost-sharing amounts. This requirement will apply to inpatient hospital services with discharge dates on or after July 1, 2007.

Affected Individuals and Organizations

Acute care general hospitals enrolled as providers in the MA Program.

Accomplishments and Benefits

Adoption of these amendments by final rulemaking will enable the Department to both realize substantial cost-savings and to make its Medicare cost-sharing payment policies uniform for all providers and services.

Fiscal Impact

The revised payment policies for inpatient hospital services rendered to dual eligible Medical Assistance recipients will result in reduced payments to hospitals enrolled in the Medical Assistance Program. The Commonwealth anticipates savings of $30.000 million ($13.753 million in State funds) in Fiscal Year 2007-2008, as the result of these amendments.

Public Comment

Although this regulation is being adopted without publication as proposed rulemaking, interested persons are invited to submit written comments, suggestions or objections regarding the regulation to the Department at the following address: Department of Public Welfare, Office of Medical Assistance Programs, Attention: Regulations Coordinator, c/o Deputy Secretary's Office, Room 515 Health and Welfare Building, Harrisburg, Pennsylvania 17102. Comments will be reviewed and considered for any subsequent revision of the regulation.

Persons with a disability who require an auxiliary aid or service may submit comments by using the AT&T Relay Service at 1-800-654-5984 (TDD users) or 1-800-654-5988 (voice users).

Regulatory Review Act

Under § 5.1(c) of the Regulatory Review Act (71 P.S. § 745.5a(c), on JUN 05 2007 the Department submitted a copy of this regulation, with proposed rulemaking omitted, to the Independent Regulatory Review Commission (IRRC) and to the Chairpersons of the House Committee on Health and Human Services and the Senate Committee on Public Health and Welfare. On the same date, the regulation was submitted to the Office of the Attorney General for review and approval pursuant to the Commonwealth Attorneys Act.

In accordance with § 5.1 (j.1) and (j.2) of the Regulatory Review Act, this regulation was [deemed] approved by the Committees on . The IRRC met on and approved the regulation.

In addition to submitting the final-omit rulemaking, the Department has provided IRCC and the Committees with a copy of a Regulatory Analysis Form prepared by the Department. A copy of this form is available to the public upon request.

Order

The Department finds:

(a) Notice of proposed rulemaking is omitted in accordance with § 204(1)(iv) and (3) of the Commonwealth Documents Law (45 P.S. §

1204(1)(iv) and (3)) and 1 Pa.Code § 7.4(1)(iv) and (3) because this rulemaking relates to Commonwealth grants and benefits.

(b) That the adoption of this regulation in the manner provided by this Order is necessary and appropriate for the administration and enforcement of the Public Welfare Code.

(c) That any delay in the effective date of this rulemaking would be impracticable, unnecessary and contrary to the public interest since it would significantly reduce the cost-savings associated with this change and would continue to maintain a disparate payment policy for inpatient hospital providers.

The Department acting pursuant to 62 P.S. §§ 201 and 443.1 orders:

(a) The regulation of the Department is amended to read as set forth in Annex A of this Order.

(b) The Secretary of the Department shall submit this Order and Annex A to the Offices of General Counsel and Attorney General for approval as to legality and form as required by law.

(c) The Secretary of the Department shall certify and deposit this Order and Annex A with the Legislative Reference Bureau as required by law.

(d) This Order shall take effect immediately and apply to inpatient hospital services with discharge dates on or after July 1, 2007.

ANNEX A

Title 55. Public Welfare

Part III. Medical Assistance Manual

Chapter 1163. Inpatient Hospital Services

Subchapter A. Acute Care General Hospitals Under the Prospective Payment System

* * * * *

Payment for Hospital Services

* * * * *

§ 1163.66. Third-party liability.

(a) Hospitals shall utilize the available third-party resources for services a recipient receives while in the hospital. Medicare lifetime reserve days are considered available resources.

(b) If expected payment by a third party resource is not realized, the hospital may bill the MA Program.

(c) If the hospital receives reimbursement from a third-party subsequent to payment from the Department, the hospital shall repay the Department by submitting a claim adjustment.

(d) If a recipient or the legal representative of a recipient requests a copy of the hospital invoice, the hospital shall submit a copy of the invoice and the request to

the Bureau of Claim Settlement, MA Recovery Unit, at the address specified in the Provider Handbook. The Bureau of Claim Settlement forwards the requested copy to the requestor and takes follow-up action necessary to ensure the repayment of MA expenditures.

(e) For a hospitalization with a discharge date on or after July 1, 2007, [If] if a recipient is entitled to Medicare Part A benefits, the Department will not pay any deductible and coinsurance amounts if the Medicare payment exceeds the applicable DRG payment, including any outlier payments. If the Medicare payment is less than the applicable DRG payment including any outlier payments, the Department pays [the lesser of:

(1) The amount of the] Medicare deductible and coinsurance amounts to the extent that the Department's payment, the Medicare payment and [minus] any other resources available to the recipient for the hospital inpatient care combined do not exceed the applicable DRG payment, including any outlier payments. The Department will not pay more than the maximum deductible and coinsurance amounts.

[(2) The DRG payment rate less other resources available to the recipient for inpatient hospital care.]

(f) Except as specified in subsection (g), if a recipient is entitled to hospital insurance benefits other than Medicare Part A, the Department pays the applicable DRG payment rate minus the insurer's liability amount and other

resources available to the recipient for hospital care, including any Medicare Part B payment.

(g) If the resources available to a recipient for inpatient hospital care equal or exceed the Department's applicable DRG payment rate, the Department makes no payment for the hospital care.

(h) The hospital shall utilize resources available through Medicare Part B for those services provided in the hospital that are covered and approved for payment by Medicare.

* * * * *

TRANSMITTAL SHEET FOR REGULATIONS SUBJECT TO THE REGULATORY REVIEW ACT

Please sign all three copies and return one copy to:
Kim Kaufman
14th Floor, Harristown II
IRRC

I.D. NUMBER: 14-511

SUBJECT: INPATIENT HOSPITAL SERVICES

AGENCY: DEPARTMENT OF PUBLIC WELFARE

TYPE OF REGULATION

Proposed Regulation

Final Regulation

X Final Regulation with Notice of Proposed Rulemaking Omitted

120-day Emergency Certification of the Attorney General

120-day Emergency Certification of the Governor

Delivery of Tolled Regulation
a. With Revisions b. Without Revisions

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FILING OF REGULATION

DATE	SIGNATURE	DESIGNATION
6/5/07	Karen Shaffer	HOUSE COMMITTEE ON HEALTH & HUMAN SERVICES
6/5/07	N Thompson	
6/5/07	Lauren Paler	SENATE COMMITTEE ON PUBLIC HEALTH & WELFARE
6/5/07	Kristen Kauffman	
6/5/07	Kathy Cooper	INDEPENDENT REGULATORY REVIEW COMMISSION
6-5-07		ATTORNEY GENERAL (for Final Omitted only)
		~~LEGISLATIVE REFERENCE BUREAU (for Proposed only)~~

June 5, 2007