RULES AND REGULATIONS

Title 55—PUBLIC WELFARE

DEPARTMENT OF PUBLIC WELFARE

[55 PA. CODE CH. 165]

Road to Economic Self-Sufficiency Through Employment and Training (RESET) Program; Revisions to the Special Allowance for Supportive Services Requirements

The Department of Public Welfare (Department) amends Chapter 165 (relating to Road to Economic Self-Sufficiency Through Employment and Training (RESET) Program) to read as set forth in Annex A under the authority in sections 201(2), 403(b), 403.1, 405, 405.1, 405.1A, 405.3, 408(c) and 432 of the Public Welfare Code (code) (62 P. S. §§ 201(2), 403(b), 403.1, 405, 405.1, 405.1A, 405.3, 408(c) and 432), as amended by the act of June 30, 2011, (P. L. 89, No. 22) (Act 22).

Omission of Proposed Rulemaking

Act 22 added several new provisions to the code, including sections 403.1 and 405.1A. Section 403.1(a) of the code authorizes the Department to promulgate final-omitted regulations under section 204(1)(iv) of the act of July 31, 1968 (P. L. 769, No. 240) (45 P. S. § 1204(1)(iv)), known as the Commonwealth Documents Law (CDL), to establish standards for determining eligibility and the nature and extent of assistance, modify existing benefits and establish benefit limits, among other things. Section 204(1)(iv) of the CDL authorizes an agency to omit or modify notice of proposed rulemaking when the regulation relates to Commonwealth grants or benefits.

Final-omitted rulemaking under section 403.1 of the code is expressly exempted from the Regulatory Review Act (71 P. S. §§ 745.1—745.12), section 205 of the CDL (45 P. S. § 1205) and section 204(b) of the Commonwealth Attorneys Act (71 P. S. § 732-204(b)). Section 403.1(c) of the code provides that the Department shall take action specified in subsection (a) as may be necessary to ensure that expenditures for State Fiscal Year (FY) 2011-2012 for assistance programs administered by the Department do not exceed the aggregate amount appropriated for programs by the General Appropriations Act of 2011.

Section 405.1A of the code provides that by January 1, 2012, the Department shall further reduce annual and lifetime limits for the Road to Economic Self-sufficiency Through Employment and Training (RESET) program, including moving and transportation expenses, by up to 25%, or eliminate special allowances from the program. Section 405.1A of the code also directs the Department to utilize the procedures outlined in section 403.1 of the code to effect these changes to the RESET program.

The Department is amending Chapter 165 in accordance with sections 403.1 and 405.1A of the code. These amendments relate to cash assistance, Supplemental Nutrition Assistance Program (SNAP) benefits and special allowances for supportive services, which are Commonwealth grants and benefits. The final-omitted rulemaking establishes standards for determining eligibility and the nature and extent of assistance, modifies existing benefits and establishes benefit limits.

Purpose

This final-omitted rulemaking eliminates several types of special allowances, combines public and private transportation related special allowances into one category and reduces the maximum combined annual limit for transportation from $3,000 to $1,500. This final-omitted rulemaking also eliminates the motor vehicle insurance special allowance. In addition, the lifetime limit for other work, education and training-related allowances is reduced from $2,000 to $1,000.

This final-omitted rulemaking further specifies that the Department will not authorize a special allowance for a service or item that has been paid for or obtained prior to requesting the special allowance, unless required under Federal law. In addition, the individual shall provide verification within the time frame specified on the Agreement of Mutual Responsibility or Employment Development Plan. This verification must document that the special allowance was actually used to obtain the service or item requested.

This final-omitted rulemaking also amends Chapter 165 to specify the types of special allowances for supportive services that may be issued for individuals who apply for or receive SNAP-only benefits. This final-omitted rulemaking specifies that SNAP-only applicants or recipients whose educational or training-related expenses are being met prior to participation in a SNAP employment and training program or activity are not eligible to receive special allowances for supportive services. This means that SNAP-only applicants or recipients who are participating in an education or training program or activity prior to participation in the Department's SNAP employment and training program are not eligible for special allowances for education or training-related expenses, including books, fees or equipment.

These amendments meet the statutory requirement in section 405.1A of the code to further reduce annual and lifetime limits, as directed, for the RESET program. These amendments also meet the requirements in section 403.1 of the code, including the requirement in subsection (c) that the changes are necessary to ensure that expenditures for State FY 2011-2012 for assistance programs administered by the Department do not exceed the aggregate amount appropriated for programs by the General Appropriations Act of 2011.

This final-omitted rulemaking also eliminates two bases for good cause for failure to comply with RESET requirements: allowing an individual to end employment that is sporadic; and allowing an individual to reject a job offer that would result in the loss of income. This final-omitted rulemaking also deletes the "benefit of the doubt" language in § 165.52(b) (relating to good cause), which had directed caseworkers to give recipients the benefit of the doubt when determining good cause for failure to comply with work or work-related requirements. Finally, this final-omitted rulemaking adds a new provision stating that the Department may request verification from the individual regarding good cause and clarifies in § 165.52(a) that the good cause provisions apply as permitted by Federal law. Like the special allowance amendments, these good cause amendments are consistent with the requirements in section 403.1 of the code, including the requirement in subsection (c) that the changes are necessary to ensure that expenditures for State FY 2011-2012 for assistance programs administered by the Department do not exceed the aggregate amount appropriated by the General Appropriations Act of 2011.

Background

In 2010, the Department amended Chapter 165 by establishing new annual and lifetime limits, creating six categories of special allowances for supportive services and enhancing program integrity. See 40 Pa.B. 6665 (November 20, 2010). As a result of State budget constraints and to comply with Act 22 requirements, the Department is again amending Chapter 165 by combining public and private transportation special allowances into one transportation category, reducing the maximum combined annual limit for transportation from $3,000 to $1,500, deleting the motor vehicle insurance special allowance category and reducing the lifetime limit for other work, education and training special allowances from $2,000 to $1,000.

The Department is also eliminating certain special allowances for supportive services for SNAP-only participants consistent with sections 403.1 and 405.1A of the code and based on guidance from the United States Department of Agriculture, Food and Nutrition Services (FNS). In that guidance, FNS explained that special allowances for moving and relocation costs to accept employment, motor vehicle-related expenses, motor vehicle purchase, vehicle insurance, personal computers, union dues and professional fees are generally not permissible payments under 7 CFR 273.7 (relating to work provisions). This final-omitted rulemaking therefore deletes these special allowances for SNAP-only participants, except that union dues are permissible to the extent required under Federal law. In other Federal guidance, FNS has advised that payments for education or training-related expenses are not permissible SNAP payments under 7 CFR 273.7 when these expenses are being met prior to participation in a SNAP employment and training program. See Administrative Notice 48-2010 (August 24, 2010).

Chapter 165 currently provides a list of examples of good cause for failure to comply with RESET requirements, which include ending employment that is sporadic and rejecting employment that would result in a net loss of income. In this final-omitted rulemaking, the Department is deleting these two examples because deleting them is consistent with the legislative "work first" approach in section 405.1(a.1) of the code, which includes establishing a work history and maximizing economic independence through employment. It is also consistent with the explicit statutory requirement in section 405.1(a.2) of the code that as a condition of eligibility, the individual shall "accept any offer of employment." The Department is also deleting the "benefit of the doubt" language in § 165.52(b) because it has determined that this policy tends to diminish the recipient's burden to establish good cause. To further strengthen the Department's good cause policy, a provision has been added to subsection (b) in which the Department may request verification from an individual when determining good cause.

Affected Individuals and Organizations

This final-omitted rulemaking affects cash assistance and SNAP-only applicants and recipients.

Accomplishments and Benefits

As required under Act 22, the Department is conserving resources to ensure that the expenditures for State FY 2011-2012 for assistance programs administered by the Department do not exceed the aggregate amount appropriated for the program by the General Appropriations Act of 2011. This final-omitted rulemaking also complies with the directive in section 405.1A of the code to reduce special allowances for supportive services, including moving and transportation expenses, by up to 25%, or to eliminate special allowances from the program.

Fiscal Impact

The Commonwealth will realize an estimated savings of $1.029 million ($0.244 in State funds) in State FY 2011-2012.

Paperwork Requirements

There are no new paperwork requirements under this final-omitted rulemaking.

Public Comment

Although this regulation is being adopted without publication as proposed rulemaking, the Department decided to post a draft regulation on the Department's web site on February 24, 2012, with a 15-day comment period. The Department invited interested persons to submit written comments regarding the regulation to the Department. The Department received 17 comments from 9 commentators. The Department also discussed the Act 22 regulations and responded to questions at the House Health Committee hearing on March 8, 2012.

The Department considered the comments received in response to the draft regulation. After careful deliberation, the Department decided to maintain the following draft changes to § 165.52: (1) addition of the phrase "[a]s permitted by Federal law" in subsection (a); (2) deletion of the current text in subsection (a)(10) and (11), regarding ending employment that is sporadic and rejecting employment that would result in a net loss of income; and (3) deletion of the "benefit of the doubt" language in subsection (b). The Department also added a provision stating that the Department may request verification of good cause. Because transportation-related good cause will remain intact, the Department no longer needs to amend §§ 165.51 and 165.61 (relating to compliance review; and sanctions). As a result, the Department removed those draft changes from this final-form rulemaking. For the following reasons, the Department has decided to maintain the remaining policies and procedures in the draft regulations.

Discussion of Comments and Major Changes

Following is a summary of the major comments received following publication of the draft regulation and the Department's response to those comments.

Comment

Several commentators stated that the Department did not allow sufficient time for review and comment of the regulations. In addition, commentators requested the public comment period be extended an additional 30 days due to the policy changes and the volume of regulations.

Response

The Department engaged in a transparent public process through which the Department solicited and received numerous comments and input from stakeholders and other interested parties.

As previously mentioned, the Department posted the draft regulation on the Department's web site on February 24, 2012. The Department invited interested persons to submit written comments, on or before March 9, 2012, regarding the regulation to the Department. In addition, the Department's Regulatory Agenda announced the Act 22 regulations at 42 Pa.B. 879, 894 (February 11, 2012).

As a final-omitted rulemaking under Act 22, the Department was not required to have a public comment process. However, to encourage transparency and public input the Department provided an opportunity for comment by posting the draft regulation on the Department's web site. This public comment process provided sufficient opportunity for interested parties to submit comments, as supported by the number of comments that were submitted.

As previously mentioned, the Department removed the draft changes in §§ 165.51 and 165.61 regarding transportation-related good cause. The Department will, however, follow through on its plan to add "[a]s permitted by Federal law" to § 165.52(a) and to delete § 165.52(a)(10) and (11). The Department is also deleting the "benefit of the doubt" language in § 165.52(b) and adding a provision stating that the Department may request verification of good cause. The Department decided to keep the remaining amendments in this final-omitted rulemaking for the reasons stated elsewhere in this preamble.

Faced with a budgetary crisis, the Department undertook this final-omitted rulemaking to ensure that its State expenditures for FY 2011-2012 would not exceed its appropriations. To accomplish that task, the Department is refining some of its policies and procedures, changes that are entirely consistent with Federal and State law. Many changes are simply refinements of current policy, such as those involving verification and those required under Federal SNAP law and guidance.

To continue to provide special allowances to the greatest number of recipients, the Department revised certain special allowance limits in Appendix A (relating to work and work-related special allowances). The authority in Act 22 to amend special allowances and related limits is clear and two-fold: (1) the authority as directed by the General Assembly in section 405.1A of the code; and (2) the authority as permitted by the General Assembly in section 403.1 of the code. Together, these sections provide the legal bases for the Chapter 165 amendments, including those in Appendix A. With the removal of the draft amendments regarding transportation-related good cause and the related draft amendments involving penalties, the remaining policy and procedural changes are relatively modest, conform to the General Assembly's intent under Act 22 and are specifically designed to ensure the integrity of the Department's RESET program.

Comment

Commentators suggested that the Department has not complied with section 405.1A of the act because this final-omitted rulemaking will be promulgated after January 1, 2012. Section 405.1A of the code provides that "no later than January 1, 2012, the department shall further reduce annual and lifetime limits for the RESET program, including moving and transportations expenses, by up to twenty-five percent, or eliminate any special allowances from the program."

Response

As previously stated, the Department's statutory authority to promulgate this regulation is twofold, existing under sections 403.1 and 405.1A of the code. Although section 405.1A of the code directs the Department to reduce annual and lifetime limits for the RESET program, section 403.1 of the code also authorizes the Department to establish regulations to establish standards for determining eligibility and the nature and extent of assistance and modify benefit limits, which plainly include making revisions and additional reductions to special allowances for cost savings or cost containment purposes. Under section 403.1(e) of the code, the Department has until June 30, 2012, to promulgate this final-omitted rulemaking.

Comment

Commentators also stated that the Department did not comply with Act 22 by reducing annual and lifetime limits by more than 25%.

Response

As previously explained, the Department's statutory authority to promulgate this final-omitted rulemaking is not limited to section 405.1A of the code. Section 405.1A of the code directs the Department to reduce annual and lifetime limits for the RESET program by up to 25% or to eliminate special allowances, but section 403.1 of the code authorizes the Department to establish regulations to establish standards for determining eligibility and the nature and extent of assistance and modify benefit limits. This authority includes making revisions and additional reductions to special allowances for cost savings or cost containment purposes. Section 405.1A of the code does not preclude discretionary revisions.

Comment

Several commentators expressed concern about the proposed reduction or elimination of annual and lifetime limits. Commentators asserted that the reductions in lifetime limits on transportation, education and training allowances undermine the ability of parents to work or participate in welfare to work programs. One commentator also expressed concern that the regulatory amendments will place financial burdens on women and their families when salaries and supports are shrinking. The commentator stated that the safety net is important and worthy of support by the government and taxpayers. Commentators also asserted that the elimination of allowances for car insurance payments means that parents will be faced with the choice of not going to work, their welfare to work programs or driving without car insurance.

Response

The need to apply a fiscally responsible approach in offering supportive services for special allowances related to employment and training, as well as the General Assembly's directive to reduce or eliminate at least some special allowances necessitated at least some changes in benefits. Despite these changes, the Department will continue to provide many supports for employment and training-related needs and also promote personal responsibility and self-sufficiency. Even with these changes, the Department's special allowance program will continue to effectively serve the needs of the vast majority of the recipient population. The safety net will remain intact for the greatest number of eligible recipients, which will help to alleviate the additional financial burden they would have without it.

The annual limit for all types of transportation special allowances for supportive services will be reduced to $1,500. In addition, the work, education and training related special allowances have been limited to actual cost up to $1,000 in a lifetime. These reductions will help to ensure that limited funding is available to a greater number of participants.

In addition, a review of the Department's data warehouse revealed that the educational assistance received by individuals from grants, loans and scholarships is

usually adequate to cover educational expenses and that an additional payment for the service or item would often be a duplication of employment and training-related supports.

Finally, the Department deleted the special allowance for motor vehicle insurance since it is the least frequently issued special allowance based on the Department's data warehouse figures and statistics for 2012. Eliminating this special allowance will, therefore, not affect many individuals. Although the few that would benefit from it will experience the change, the Department had to make some difficult budgetary decisions to continue to support the greatest number of needy individuals.

Comment

Commentators claimed that SNAP special allowance limitations based on FNS guidance lacks sufficient authority for these regulatory amendments.

Response

The Department regulates SNAP-only special allowances based on FNS regulations and guidance. To maximize its compliance with Federal law and related FNS guidance and to minimize the possibility of Federal disallowance based on noncompliance with Federal law, the Department is prudently exercising its authority to revise its regulations to ensure consistency with Federal law and the guidance interpreting the law.

Comment

Senator Kitchen expressed concern that the draft regulation states that a nonwillful failure to comply with RESET requirements due to transportation-related reasons results in ineligibility for the family. The plain text meaning of this draft regulation indicates that if, for example, a TANF parent is late because of a flat tire or traffic delays then the whole family would be deemed ineligible. The enforcement of a provision such as this appears harsh and unforgiving. Changing the standard from willful to unwillful places a burden on individuals who are attempting to become self-sufficient and also appears to conflict with the code.

Response

After careful consideration, the Department has decided to withdraw this proposal and will not, therefore, amend §§ 165.51 and 165.61.

Comment

Senator Kitchen and commentators also commented that the nonwillful failure to comply with RESET requirements due to transportation-related reasons conflicts with the statutory provisions of the code. The code contains a detailed statutory scheme under section 405.1(a.2) and section 432.3 (62 P. S. § 432.3) that defines what happens if a Temporary Assistance for Needy Families (TANF) parent is noncompliant with RESET requirements. Commentators also asserted that the rulemaking ignores the distinction between pre- and post-24-month sanctions.

Response

After careful consideration, the Department decided to not to amend the transportation-related examples of good cause in the existing regulations. Consequently, the Department determined that it will also not amend §§ 165.51 and 165.61.

Comment

Commentators commented on the deletion of certain good cause exceptions in § 165.52(a)(10), (11) and (14). Commentators asserted that the eliminations of certain good cause exceptions are unnecessarily harsh, undermine self-sufficiency and justification has not been provided. In addition, commentators requested the Department retain the "benefit of the doubt" language in § 165.52(b).

Response

After careful consideration, the Department decided to restore the minor transgression language in subsection (b) of the final-omitted rulemaking. The Department, however, decided to proceed with the draft amendments to the good cause provisions. The Department is maintaining the addition of the "[a]s permitted by Federal law" language and the deletion of subsection (a)(10) and (11). In addition, the "benefit of the doubt" language is also being deleted with a new provision being added which states that the Department may request verification of good cause.

These amendments are consistent with the legislative intent of the RESET program to promote "work first" as the overarching goal based on the premise that establishing a work history is critical to economic self-sufficiency. Establishing a work history includes accepting even temporary or sporadic employment or a job that nets less income than the cash assistance grant and is consistent with the legislative intent in section 405.1(a.1) of the code and the explicit statutory requirement in section 405.1(a.2) of the code that as a condition of eligibility, the individual shall "accept any offer of employment." As stated earlier, the Department is deleting the "benefit of the doubt" language because this diminishes the recipient's burden to establish good cause. To underscore the recipient's burden to establish good cause, the Department added a provision that the Department may request verification from the individual when determining good cause. These amendments are reasonable, advance the "work first" goal of RESET and are expected to yield cost savings as recipients further establish their work histories, maximize their earnings and rely less on public assistance.

Comment

Commentators claimed that eligibility for special allowances is not determined within the time frames required under § 165.45 (relating to time frames for authorization of special allowances for supportive services). Therefore, recipients have to borrow money for employment and training expenses. Commentators commented that special allowances should not be barred from being reimbursed due to untimely eligibility determinations. Commentators also state that this delay inappropriately rewards staff for stalling on special allowance requests by reducing their workload if they neglect the requests long enough.

Response

The Department disagrees with the assertion that welfare offices often exceed the time frames for authorizing special allowances. Recipients shall provide necessary verification to establish their eligibility for special allowances, which sometimes delays the process. The intent of this regulatory amendment under § 165.44 (relating to verification for special allowances for supportive services) is not to withhold legitimate special allowances for eligible recipients. Rather, the intent is to prohibit reimbursement if the need for the special allowance no longer exists, unless Federal law requires it.

Regulatory Review Act

Under section 403.1 of the code, this final-omitted rulemaking is not subject to review under the Regulatory Review Act.

Findings

The Department finds that:

(1) Notice of proposed rulemaking is omitted in accordance with section 204(1)(iv) of the CDL and 1 Pa. Code § 7.4(1) (iv) because the final-omitted rulemaking relates to Commonwealth grants and benefits.

(2) Adoption of this final-omitted rulemaking in the manner provided by this order is necessary and appropriate for the administration and enforcement of the code.

Order

The Department, acting under the code, orders that:

(a) The regulations of the Department, 55 Pa. Code Chapter 165, are amended by amending §§ 165.1, 165.41, 165.44, 165.46 and 165.52 and Appendix A to read as set forth in Annex A.

(b) The Secretary of the Department shall submit this order and Annex A to the Office of General Counsel 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 upon final publication in the *Pennsylvania Bulletin*.

GARY D. ALEXANDER,
Secretary

Fiscal Note: 14-526. No fiscal impact; (8) recommends adoption.

Annex A

TITLE 55. PUBLIC WELFARE

PART II. PUBLIC ASSISTANCE MANUAL

Subpart C. ELIGIBILITY REQUIREMENTS

CHAPTER 165. ROAD TO ECONOMIC SELF-SUFFICIENCY THROUGH EMPLOYMENT AND TRAINING (RESET) PROGRAM

GENERAL RESET PROVISIONS

§ 165.1. General.

(a) A recipient who is not exempt shall participate in and comply with RESET, including meeting hourly and other work and work-related requirements as specified on the AMR or EDP, unless the recipient establishes good cause. An exempt individual may volunteer to participate in an approved work or work-related activity. The Department will inform an applicant and recipient of the rights, responsibilities and services and benefits available to RESET participants. The Department or its agent will assess the recipient's ability to meet RESET participation requirements after consultation with the recipient.

(b) The Department will provide RESET participants with case management and special allowances for supportive services as required to help them become self-sufficient. The Department will authorize special allowances for supportive services for the least costly item or service which is available and practical considering the location and hours of scheduled employment or training, and the location of the participant's residence in relation to the provider of the item or service. In addition, the Department will provide participants with or refer them to work or work-related activities designed to break the cycle of welfare dependency. To the extent it deems possible, the Department will identify and promote resources in the public and private sectors that may assist participants to prepare for and obtain employment they may realistically be expected to obtain.

(c) Nothing in this chapter shall be interpreted as requiring the Department to develop or to offer or to continue to offer employment, education, training, work-related activities or work experience programs.

(d) This chapter applies to applicants and recipients of TANF and GA cash assistance. Sections 165.1, 165.2, 165.31(d), 165.41—165.46, 165.52, 165.71, 165.81, 165.91 and Appendix A also apply to SNAP only participants defined in § 165.2 (relating to definitions) as permitted by Federal law. For SNAP only participants, a special allowance for supportive services may be authorized as determined by the Department only up to the employment start date, with the following exception. SNAP only participants may receive special allowances for supportive services not to exceed the types and time frames permitted by Federal law.

(e) The Department may provide for additional supportive services to the extent required by an approved work, work-related or educational program under a written agreement with the Department.

SPECIAL ALLOWANCES FOR SUPPORTIVE SERVICES

§ 165.41. Eligibility for special allowances for supportive services.

(a) A participant may receive special allowances for supportive services, as specified in this chapter, to enable the individual to participate in an approved work or work-related activity for the number of hours as specified on the AMR or EDP. Supportive services will be provided if required by the individual to participate in an approved work or work-related activity.

(b) A special allowance for supportive services is made only to the extent that the item or service is not available from another public or non-profit source at no cost to the individual, and cannot be met by educational assistance. The activity may not be secondary education or an equivalent level of vocational or technical training, unless the individual is pregnant or a custodial parent.

(c) The Department will inform the individual, orally and in writing, of the availability of special allowances for supportive services at application, redetermination, recertification and whenever the AMR or EDP is developed or revised.

(d) The Department will assist the participant to obtain supportive services required to participate in approved work or work-related activities as specified on an AMR or EDP, with one exception. Supportive services are not available for a SNAP only participant to maintain current employment, except as provided in § 165.1(d) (relating to general).

(e) Except as otherwise restricted in this chapter, special allowances for supportive services may be granted up to the maximum amount and frequency established by the Department in Appendix A (relating to work and work-related special allowances).

(f) The Department will not pay for education or training-related expenses for a SNAP only participant when these expenses are being met prior to participation in a SNAP employment and training program.

§ 165.44. Verification for special allowances for supportive services.

(a) *Verification needed to authorize special allowances for supportive services.*

(1) Before authorizing the special allowance for supportive services, the Department will determine the following:

(i) Whether the supportive service requested is required to enable the participant to engage in an approved work or work-related activity.

(ii) The expected charge for the service or item requested.

(iii) The date the service or item is needed by the participant.

(iv) The date that payment for the service or item is required under the provider's usual payment policy or practice.

(v) The Department will not pay for or provide a special allowance for items and services already paid for or obtained unless required under Federal law.

(2) Verification, including collateral contact, that the special allowances for supportive services is required will be provided prior to authorization.

(3) Acceptable verification consists of collateral contacts, written statements or completed Departmental forms, obtained from sources such as employers, prospective employers, school officials, employment and training providers or providers of supportive services. If collateral contacts are used, the information will be documented in the participant's file.

(4) The Department will use collateral contacts whenever necessary to ensure that payment is made in advance of the date that payment is required.

(b) *Verification needed for reoccurring and nonrecurring special allowances for supportive services.*

(1) The individual's eligibility for a special allowance for a supportive service is reviewed monthly, or more often if expenses are likely to change, at each redetermination or recertification, whenever a change in employment or training is reported by the individual or the employment and training provider, and whenever the AMR or EDP is revised.

(i) A participant shall verify the actual costs incurred by the participant for the supportive service and the participant's attendance at the approved work or work-related activity. The Department may require that the participant or provider of the supportive service, or both, verify that the participant received the approved special allowance for supportive services and that the provider received payment for the amount the participant was eligible to receive.

(ii) When verification provided indicates a change in eligibility, payment of the special allowance to the participant shall be reduced, terminated or increased, as appropriate, upon issuance of a confirming notice to the participant, in accordance with § 133.4(c) (relating to procedures).

(iii) The individual shall provide verification of expenditure of the special allowance within the time frame specified on the AMR or EDP.

(2) The Department will process an overpayment referral to recover a special allowance for supportive services to the extent of the misuse in accordance with § 165.91 (relating to restitution) and Chapter 255 (relating to restitution). Circumstances for which a referral may be appropriate include the following:

(i) The participant was ineligible for cash assistance or SNAP only benefits in the month the Department issued a special allowance for supportive services.

(ii) The participant did not use the special allowance for supportive services for its intended purpose.

(iii) The actual cost of the supportive service was less than the estimated cost of the service.

(iv) The participant provided falsified or erroneous documentation to obtain a special allowance for supportive services.

(v) The participant received a reoccurring special allowance for supportive services when the need no longer existed.

(vi) The participant or provider of supportive services, or both, did not provide verification, such as a receipt, that the supportive services requested were obtained using the special allowance payment.

(vii) The participant did not participate in or comply with RESET, including meeting hourly and other work and work-related requirements as specified on the AMR or EDP.

§ 165.46. Types of special allowances for supportive services.

(a) *Transportation and related expenses.* The Department will pay for transportation and related expenses required for an individual to engage in approved work or work-related activities up to the maximum allowance established in Appendix A (relating to work or work-related special allowances). Transportation-related allowances are provided for the least costly type of transportation which is available and practical considering the location and hours of scheduled approved work or work-related activity, the participant's physical condition and the need to transport children to a child care provider. Transportation-related allowances are not provided if the activity is secondary education or an equivalent level of vocational or technical training unless the individual is pregnant or a custodial parent.

(1) *Public transportation.* Public transportation-related allowances are provided for costs incurred for transportation provided by bus, subway, commuter rail, taxi, paratransit or other recognized modes of transportation.

(i) An allowance for public transportation is the actual cost to the participant up to the maximum amount established by the Department in Appendix A.

(ii) Verification of the need and the cost of transportation is required.

(2) *Private transportation.* Private transportation-related allowances are provided for costs incurred for transportation provided by privately owned vehicles, ride sharing and car or van pools.

(i) An allowance for private transportation provided by a vehicle owned by the participant is the mileage rate established by the Department in Appendix A and the actual cost of parking and highway or bridge tolls up to the maximum amount established by the Department in Appendix A.

(ii) An allowance for transportation provided by a volunteer driver or if the participant is permitted to use another person's vehicle is the mileage rate established by the Department in Appendix A and the actual cost of parking and highway or bridge tolls up to the maximum amount established by the Department in Appendix A.

(iii) An allowance provided for transportation by a car or van pool is the participant's proportionate share of the cost up to the maximum amount established by the Department in Appendix A. If the participant's share is a flat fee, the payment is the actual fee up to the maximum amount established by the Department in Appendix A.

(3) *Motor vehicle purchase or repair.* When there is no other type of practical transportation available or other available transportation is more expensive, a special allowance may be authorized toward the purchase, down payment or repair of a motor vehicle for an individual to participate in an approved work or work-related activity.

(i) The maximum total allowance toward a motor vehicle purchase, down payment and repair is limited to the rate and frequency established by the Department in Appendix A.

(ii) Preexpenditure approval is required.

(4) *Motor vehicle-related expenses.* The cost of a driver's license, State inspection fee, emission control inspection fee, license plates and vehicle registration fee may be authorized for a participant if they are required for participation in an approved work or work-related activity.

(i) Payment is made for actual cost up to the maximum allowance and frequency established by the Department in Appendix A.

(ii) Preexpenditure approval is required.

(b) *Other expenses related to approved work and work-related activities.* Special allowances may be authorized for other items related to participation in approved work or work-related activities. Preexpenditure approval is required. The maximum allowances for these items are subject to the rates and frequencies established by the Department in Appendix A.

(1) *Clothing.* The Department may refer a participant to other public or nonprofit sources that provide clothing and grooming items at no cost. If these sources are not available or do not have appropriate clothing or other required items, the Department may authorize a special allowance for supportive services for clothing and grooming items required to participate in an approved work or work-related activity.

(2) *Tools and other equipment.* A special allowance may be authorized for tools and other equipment which an employer, education, employment or training provider requires for participation in an approved work or work-related activity but which are not provided by the employer, education, employment or training provider and are not available under Federal, State or other educational grants.

(3) *Books and supplies.* A special allowance may be authorized for books and supplies that an employer or employment and training provider requires for a participant to participate in an approved work or work-related activity if these items are not provided by the employer or training provider and are not available under Federal, State or other educational grants.

(4) *Fees.* A special allowance for supportive services may be authorized for a fee to take a test such as a high school equivalency test, a test that is a prerequisite for employment or for registration or enrollment fees required for an individual to enter an approved work or work-related activity. Tuition is not construed to be a fee.

(5) *Union dues and professional fees.* If payment of union dues or professional fees is a condition of employment, a special allowance for supportive services may be authorized to participants who receive TANF or GA cash assistance for the initial fee only and for the period up to the date of the participant's first pay. A special allowance for supportive services may not be issued to pay for reoccurring fees, such as license fees, even if they are necessary for the individual to maintain employment.

COMPLIANCE REVIEW AND GOOD CAUSE

§ 165.52. Good cause.

(a) As permitted by Federal law, good cause includes the following circumstances beyond the individual's control:

(1) The job was beyond the capacity of the individual.

(2) The individual reasonably attempted and is unable to secure or to maintain transportation.

(3) The individual reasonably attempted and cannot secure or maintain appropriate child care, as defined in § 165.2 (relating to definitions), or appropriate adult care for an incapacitated adult living in the same home, within a reasonable distance from the individual's home, as defined in § 165.2.

(4) The working conditions are substandard; that is, the place of employment is not free of recognized hazards that are causing or are likely to cause death or serious physical harm, or the wages paid are below the minimum wage if applicable for that type of employment or are below the prevailing wage normally paid in the community for that specific kind of employment.

(5) The individual establishes a basis for a claim of discrimination by an employer or fellow employees based on age, race, sex, color, handicap, religious beliefs, national origin or political beliefs or other unlawful discrimination.

(6) The individual leaves a job in connection with patterns of employment in which workers frequently move from one employer to another, such as migrant farm labor, construction work or temporary work through an agency. Even though employment at the new site has not actually started, leaving the previous employment shall be considered good cause it if is part of the pattern of that type of employment.

(7) Personal illness or illness of another household or family member.

(8) A personal emergency.

(9) The individual failed to receive notice at least 2 days prior to the date of a scheduled RESET activity.

(10) The individual was placed in an education or training activity that was beyond the capacity of the individual to complete, and the individual is willing to participate in another activity better suited to the individual's needs and aptitudes.

(11) A required employment and training activity conflicts with scheduled hours of employment or a job interview.

(12) The location of a RESET site or job is more than 2 hours round-trip by reasonably available public or private transportation from the individual's residence.

(13) The individual is claiming to be exempt from RESET participation requirements under § 165.21 (relating to exemptions from RESET participation requirements) and is cooperating in an attempt to provide verification of exemption.

(b) In determining good cause, the worker will consider all the facts and circumstances, especially if the transgression is relatively minor (such as reporting to a component a few minutes late) or isolated in nature (such as forgetting to keep an appointment, despite good overall attendance). The Department may request verification from the individual when determining good cause. Even after the CAO has made a preliminary determination of the lack of good cause, an individual may offer evidence of good cause to avoid sanction.

(c) The Department may grant good cause for up to 6 months to an individual, when strict application of any RESET participation requirement would not promote an individual's approved plan for self-sufficiency, as recorded on the AMR, and would make it more difficult for the individual to fulfill the plan. Examples of good cause for not strictly complying with a RESET participation requirement include:

(1) Hours that an individual is participating in an approved education or training activity which began during the first 24 months of receipt of cash assistance, if the total hours of instruction, lab time and work or work-related activity, whichever applies, equals at least 20 hours per week.

(2) Hours that an individual is participating in an internship, student teaching, or practicum assignment required as part of an approved education or training curriculum, if the individual is maintaining satisfactory progress as determined by the school or training agency, and the total hours of this activity and work or work-related activity, whichever applies, equals at least 20 hours per week.

(d) The Department may also grant good cause to a pregnant or parenting individual under 22 years of age who is enrolled in high school or attending a minimum 20-hour per week GED program, until the individual graduates from high school, receives a GED or reaches 22 years of age, whichever occurs first.

APPENDIX A

WORK AND WORK-RELATED SPECIAL ALLOWANCES

Type of Allowance	*Frequency TANF or GA*	*SNAP Only*	*Maximum Allowance*
TRANSPORTATION RELATED ALLOWANCES			—actual cost up to $1,500 annually except for moving/relocation costs to accept employment
Transportation Public	—as required for job interviews, work or work-related activities	—as required for job interviews, work or work-related activities	
—bus —subway —commuter rail —taxi —paratransit	—for employment, may be authorized for the period up to the date of the first pay	—for employment, may be authorized for the period up to the start date	
Transportation Private	—as required for job interviews, work or work-related activities	—as required for job interviews, work or work-related activities	—mileage reimbursement rate will be set by the Department by notice not to exceed Commonwealth reimbursement rate for actual cost of gasoline, plus the actual cost of parking and highway and bridge tolls
—privately-owned vehicle —volunteer car and driver	—for employment, may be authorized for the period up to the date of the first pay	—for employment, may be authorized for the period up to the start date	
Transportation Car or van pool	—as required for work or work-related activities	—as required for work or work-related activities	
	—for employment, may be authorized for the period up to the date of the first pay	—for employment, may be authorized for the period up to the start date	
Moving/relocation costs to accept employment	—to accept a verified offer of gainful, permanent employment	Not permitted.	—actual cost up to $200
	—no more than once in a 12-month period		

Type of Allowance	*Frequency TANF or GA*	*SNAP Only*	*Maximum Allowance*
Motor Vehicle Repair	—as required for work or work-related activities	—as required for work or work-related activities or if required to accept employment	
Motor Vehicle-Related Expenses —driver's license —State inspection fee —emission control inspection fee —license plates —vehicle registration fee	—as required for work or work-related activities	Not permitted.	
MOTOR VEHICLE PURCHASE	—as required for work or work-related activities	Not permitted.	—actual cost for one vehicle up to $1,500 in a lifetime.
CLOTHING	—as required for work or work-related activities	—as required for work or work-related activities or if required to accept employment	—required clothing or actual cost of clothing up to $150 annually
WORK, EDUCATION AND TRAINING-RELATED ALLOWANCES			—actual cost up to $1,000 a lifetime
Tools and Equipment	—as required for work or work-related activities	—as required for work or work-related activities or if required to accept employment Personal computers and related hardware or software are not permitted.	
Books and Supplies	—as required for work or work-related activities	—as required for work or work-related activities	
Fees	—as required for work or work-related activities	—as required for work-or work-related activities or if required to accept employment	
Union Dues/ Professional Fees	—may be authorized for the period up to date of first pay	Not permitted, unless required under Federal law.	

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DEPARTMENT OF PUBLIC WELFARE

[55 PA. CODE CHS. 168 AND 3041]

Subsidized Child Care Hearings, Overpayments and Absence Changes

The Department of Public Welfare (Department) amends Chapters 168 and 3041 (relating to child care; and subsidized child care eligibility) to read set forth in Annex A under the authority in sections 201(2), 403(b) and 403.1 of the Public Welfare Code (code) (62 P. S. §§ 201(2), 403(b) and 403.1), as amended by the act of June 30, 2011 (P. L. 89, No. 22) (Act 22).

Omission of Proposed Rulemaking

Act 22 amended the code and added several new provisions. Specifically, Act 22 added section 403.1 of the code. Section 403.1(a)(1) of the code authorizes the Department to promulgate final-omitted regulations to establish standards for determining eligibility and the nature and extent of assistance. The basis for the final-omitted regulation is section 204(1)(iv) of the act of July 31, 1968 (P. L. 769, No. 240) (45 P. S. § 1204(1)(iv)), known as the Commonwealth Documents Law (CDL), which authorizes an agency to omit or modify notice of proposed rulemaking when the regulation relates to Commonwealth grants or benefits. See section 403.1(d) of the code. Child care subsidy is a Commonwealth benefit. In addition, until June 30, 2012, section 403.1 of the code expressly exempts certain regulations under the Regulatory Review Act (71 P. S. §§ 745.1—745.12), section 205 of the CDL (45 P. S. § 1205) and section 204(b) of the Commonwealth Attorneys Act (71 P. S. § 732-204(b)).

The Department is amending Chapters 168 and 3041 in accordance with section 403.1 of the code because this final-omitted rulemaking pertains to establishing standards for determining eligibility and the nature and extent of assistance. In addition, this final-omitted rulemaking implements section 403.1(c) of Act 22. As provided in section 403.1(c) of the code, the Department is permitted to exercise its rulemaking authority granted under section 403.1(a) of the code as may be necessary to ensure that expenditures for State Fiscal Year (FY) 2011-2012 for assistance programs administered by the Department do not exceed the aggregate amount appropriated for the

program by the General Appropriations Act of 2011. Specifically, this final-omitted rulemaking will save $463,000 in State FY 2011-2012.

Purpose

The purpose of this final-omitted rulemaking is to amend the number of days of consecutive absences of a child allowed before the eligibility agency shall send an adverse action notice to a parent or caretaker. Reducing the allowable number of consecutive days of absence from 10 days to 5 days will result in cost-savings. For example, if a child cannot return to care because of a lengthy illness, the child care subsidy can be suspended during this time and eligibility can continue for up to 90 days.

In addition, the number of days of child care that will be paid if a parent or caretaker involuntarily loses work, begins a strike or graduates from or completes education or training will be reduced to 30 days. The parent will continue to have 30 additional days of eligibility, however subsidy will be suspended and payment will not be made to the provider. The additional 30 days of eligibility, for which child care subsidy is not paid, allows the parent or caretaker an additional 30 days to begin another work or training activity and not have to be placed at the bottom of the waiting list.

This final-omitted rulemaking will also deem the parent or caretaker responsible to pay the child care provider for any absences beyond the total number of absences allowed. Section 3041.18(b) (relating to attendance) specifies that a child is expected to attend child care on all days for which the parent or caretaker has established a need. Setting a standard for a total number of allowable absences and imposing consequences for exceeding the standard encourages the parent or caretaker to use the days of child care requested or report a change in the number of days needed. If a child has more than one enrollment in a day, a child is considered absent only once if the child is absent from more than one provider on the same day. The requirement to pay for absences does not apply to a parent or caretaker who is receiving subsidized child care under the Supplemental Nutrition Assistance Program (SNAP) employment and training program. In addition, suspended days will not count towards the total number of absent days.

Also, this final-omitted rulemaking amends the requirements for the Head Start expansion program to make certain that a child enrolled in the Head Start expansion program remains eligible as long as the parent or caretaker meets the criteria under § 3041.51 (relating to Head Start expansion program) and the child remains enrolled in Head Start. To be eligible for the Head Start expansion program, a family shall verify eligibility each time a child in the family applies for the Head Start expansion program. In addition, the amendment states that children in the Head Start expansion program remain eligible even if other family members become ineligible. Families with children not enrolled in the Head Start expansion program, but receiving subsidized child care, shall still meet the eligibility requirements.

Finally, this final-omitted rulemaking amends the regulations concerning the collection of overpayments. Specifically, the collection of overpayments in cases of suspected fraud will be delayed until the Office of Inspector General (OIG) completes its investigation. Overpayments involving fraud will be collected in conjunction with the OIG. This will allow the Department to determine whether the eligibility agency, OIG or the court is best suited to collect the overpayments.

Requirements

§ 168.72. Determining monthly child care costs

This section is amended to state that child care costs include a charge for up to 5 consecutive days on which the child was not in attendance, instead of 10 consecutive days.

This section is also amended by adding subsection (b). Subsection (b) states that if a child is absent more than 25 days during the State's fiscal year, the parent or caretaker will be responsible to pay the provider for each day a child is absent beginning with the 26th day of absence. The parent or caretaker will be required to pay the provider's verified published daily rate for each day of absence over the allowed number. A parent or caretaker who receives subsidized child care through the SNAP employment and training program, however, will not be required to pay for absent days that exceed the allowable number.

The Department posted a draft regulation on the Department's web site on February 24, 2012, with a 15-day comment period. The draft regulation included 20 allowable absences for the child if the parent or caretaker worked or trained less than 25 hours and 30 allowable absences if the parent or caretaker worked or trained 25 hours or more. As provided in more detail as follows, this subsection was revised to provide for 25 allowable absences based on the public comments received. The draft regulation was also revised to clarify that a child is considered absent only once during an enrollment day.

§ 3041.19. Absence

Subsection (a) is amended to decrease the number of consecutive days of absence allowed before the eligibility agency sends an adverse action notice. The amended regulation states that the adverse action notice shall be sent after 5 consecutive days of absence instead of 10 consecutive days of absence.

Subsection (c) has been added to this section. If a child is absent more than 25 days during the State's fiscal year, the parent or caretaker will be responsible to pay the provider for each day a child is absent beginning with the 26th day of absence. The parent or caretaker will be required to pay the provider's verified published daily rate for each day of absence over the allowed number. Suspended days of service as specified in § 3041.21 (relating to subsidy suspension) are not considered days of absence.

Subsection (c) was also revised after public comment. The draft regulation included 20 allowable absences for the child if the parent or caretaker worked or trained less than 25 hours and 30 allowable absences if the parent or caretaker worked or trained more than 25 hours. Based on the comments received, this subsection was revised to provide 25 allowable absences. The draft regulation was also revised to clarify that a child is considered absent only once during an enrollment day.

§ 3041.20. Subsidy continuation during breaks in work, education or training

This section has been amended to state that a family's eligibility and payment for subsidized child care continues for 30 calendar days from the date of an involuntary loss of work, the date a strike begins or the date the parent graduates from or completes education or training. On day 31, the child care subsidy will be suspended and the family's eligibility will continue for an additional 30 days. The additional 30 days of eligibility, for which child care subsidy is not paid, allows the parent or caretaker an

additional 30 days to begin another work or training activity and not have to be placed at the bottom of the waiting list. The regulation previously allowed the family to be eligible and payment to be issued for 60 days.

§ 3041.21. Subsidy suspension

This section is amended to decrease the number of days of consecutive absences before subsidy can be suspended for up to 90 days for a child who meets specific criteria. The number of days of consecutive absence have decreased from 10 days to 5 days, which aligns with the change made to § 3041.19 (relating to absence). The criterion to qualify for subsidy suspension has not changed.

§ 3041.51. Head Start expansion program

Subsection (b) is amended to state that the parent or caretaker shall meet the eligibility requirements in subsection (f) each time a child in the family applies for the Head Start expansion program. An addition was also made to subsection (f) to include the need to verify income eligibility as specified in § 3041.41 (relating to financial eligibility) each time a child in the family applies for the Head Start expansion program.

Subsection (c) is amended to state that the eligibility agency will verify with the Head Start program that the child is enrolled in a Head Start program that meets Federal and State Head Start standards.

Under the amended regulation, the eligibility agency will not be permitted to complete a partial redetermination or redetermination on a child who is enrolled in the Head Start expansion program until a child is no longer enrolled in the Head Start program. The eligibility agency will conduct a partial redetermination or redetermination if the family has additional children who are not enrolled in Head Start, but receive subsidized child care.

A child enrolled in the Head Start expansion program is not subject to partial redetermination or redetermination regulation in subsection (i). Eligibility for a child enrolled in the Head Start expansion program is unrelated to the eligibility of other children in the family who are not enrolled in the Head Start expansion program and receive subsidized child care. Eligibility for a child enrolled in the Head Start expansion program shall continue as specified in subsections (a)—(k).

§ 3041.167. Notice of overpayment

Subsection (b)(5) is amended by adding the language "except in cases of suspected fraud." The addition of this language rescinds the requirement to include the repayment methods in the notice of overpayment when the overpayment is due to suspected fraud.

§ 3041.182. Eligibility agency responsibilities regarding overpayment

This section specifies that cases of suspected provider fraud will be referred to the OIG.

§ 3041.183. Delaying recoupment

This section is amended to delay recoupment for cases referred to the OIG for suspected fraud until the investigation is complete. It also establishes that the method of recoupment in cases of suspected fraud will be determined in conjunction with the OIG.

§ 3041.186. Collection

This section is amended by adding the requirement that the collection of overpayments in cases of suspected fraud shall be done in conjunction with the OIG. When the OIG has determined fraud, in an active case, the eligibility agency shall determine the collection method in conjunction with the OIG.

§ 3041.188. Collection for a family whose child is no longer in care

This section is amended by adding the requirement that the collection of overpayments in cases of suspected fraud shall be done in conjunction with the OIG. When the OIG has determined fraud, in a case when the child is no longer in care, the eligibility agency shall determine the collection method in conjunction with the OIG.

§ 3041.189. Disqualification

This section is amended by adding an additional criteria when a parent or caretaker is disqualified from participating in the subsidized child care program. If the parent or caretaker agrees to be disqualified by signing an administrative disqualification hearing waiver, the parent or caretaker will be disqualified.

Affected Individuals and Organizations

Parents and caretakers who receive subsidized child care are affected by this final-omitted rulemaking. If a parent or caretaker's child has five consecutive absences, the child care subsidy will be suspended. In addition, parents and caretakers will be required to pay for absences over a specified amount in a fiscal year. Parents and caretakers are also required to meet eligibility requirements each time a child in the family applies for the Head Start expansion program.

In addition, providers and eligibility agencies are affected by this final-omitted rulemaking. Providers are required to notify the eligibility agency when a child is absent for 5 consecutive days. Eligibility agencies are required to verify enrollment directly with the Head Start expansion program. In addition, eligibility agencies are required to track the number of absences for each child receiving subsidized child care to determine if a child exceeds the allotted number of absences. Finally, eligibility agencies are required to refer all suspected cases of fraud to the OIG.

Accomplishments and Benefits

This final-omitted rulemaking implements section 403.1 of the code. As provided in Act 22, this final-omitted rulemaking will help the Department's efforts to conserve resources to ensure that the expenditures for State FY 2011-2012 for assistance programs administered by the Department do not exceed the aggregate amount appropriated for assistance programs by the General Appropriations Act of 2011.

Fiscal Impact

The Commonwealth will realize an estimated savings of $463,000 in State FY 2011-2012.

Paperwork Requirements

There are new paperwork requirements under the final-omitted rulemaking. Under the amended regulation, when applying for the Head Start expansion program, the parent or caretaker will be required to verify that the eligibility requirements are met for subsidized child care each time a child in the family applies for the Head Start expansion program. Verification will include income eligibility.

The eligibility agency is required to conduct partial redeterminations or redeterminations if the family has additional children who are not enrolled in Head Start,

but receive subsidized child care. The number of redeterminations will increase under the amended regulation.

In addition, the eligibility agency will need to track the number of absences for each child receiving subsidized child care to determine if a child exceeds 25 absences.

Public Comment

Although this rulemaking is being adopted without publication as proposed rulemaking, the Department posted a draft regulation on the Department's web site on February 24, 2012, with a 15-day comment period. The Department invited interested persons to submit written comments regarding the draft regulation to the Department. The Department received 48 comments. The Department also discussed the Act 22 regulations and responded to questions at the House Health Committee hearing on March 8, 2012.

The Department considered the comments received in response to the draft regulation. For the following reasons, the Department has decided to revise the regulations concerning the number of absences allowed before a parent or caretaker is deemed responsible to pay the provider if additional absences occur. The regulations were also revised to clarify that a child is considered absent only once during an enrollment day.

Discussion of Comments

Following is a summary of the major comments received within the public comment period following publication of the draft regulation and the Department's response to the comments.

Comment

Several commentators stated that the Department did not allow sufficient time for review and comment of the regulations. In addition, commentators requested the public comment period be extended an additional 30 days due to the policy changes and the volume of regulations.

Response

The Department engaged in a transparent public process through which the Department solicited and received numerous comments and input from stakeholders and other interested parties. As previously mentioned, the Department posted the draft regulation on the Department's web site on February 24, 2012. The Department invited interested persons to submit written comments, on or before March 9, 2012, regarding the draft regulation to the Department. In addition, the Department's Regulatory Agenda announced the Act 22 regulations at 42 Pa.B. 879, 893 (February 11, 2012).

As a final-omitted regulation under Act 22, the Department was not required to have a public comment process. However, to encourage transparency and public input, the Department provided an opportunity for comment by posting the draft regulation on the Department's web site. This public comment process provided sufficient opportunity for interested parties to submit comments, as supported by the number of comments that were submitted. Therefore, the Department is not extending the public comment period.

Comment

Comments were received both in support and opposition of the regulation regarding consecutive days of absence changing from 10 days to 5 days. Comments varied from supporting the 5 days of absence to opposing the reduction because illness can last longer or the absences will be difficult to track.

Response

The Department is maintaining the policy to reduce the allowable number of consecutive days of absence from 10 days to 5 days as provided in the draft regulations. This amendment will ensure that a child care subsidy is only provided on a limited basis to children who are not in child care.

Comment

Comments were received both in support and opposition to capping the number of absences allowed before a parent or caretaker is responsible to pay the provider for additional absences. Recommendations included making the number of absences the same regardless of the number of hours a parent or caretaker works or trains and adding exceptions for illness or hospitalization.

Response

Based on the comments received, the Department revised the regulation to allow a child to be absent a total of 25 enrollment days in a fiscal year before the parent is responsible for paying the provider for additional absent days, regardless of how many hours the parent or caretaker is working or training. Originally, the regulation differentiated the number of absences allowed according to the number of hours the parent or caretaker worked or trained—20 enrollment days if the parent or caretaker worked or trained less than 25 hours and 30 enrollment days if the parent or caretaker worked or trained 25 hours or more.

Due to varying training and work schedules, the Department revised § 168.72 (relating to determining monthly child care costs) and § 3041.19 to align the number of paid absences in a year. If a child's absences exceed 25 total enrollment days in the State's fiscal year, the parent or caretaker is responsible to pay to the provider the provider's verified published daily rate for each day of absence starting with the 26th day of absence. In addition, the Department clarified that a child is considered absent only once during an enrollment day.

Comment

Comments were received both in support and opposition of the regulation involving the time frames for eligibility and suspension when there is an involuntary loss of work, strike completes education or training. Comments varied from supporting the payment of child care subsidy only up to 30 days to opposing the reduction from 60 days due to the current economic climate and the difficulties with finding a job.

Response

The Department is maintaining the policy that 30 days of child care subsidy will be paid after a parent or caretaker involuntarily loses work, begins a strike or graduates or completes education or training. After 30 days, the child care subsidy will end. The family's eligibility, however, will remain for an additional 30 days in the event another job is found during that time. This change ensures that child care subsidy is only provided for children who need child care, while still allowing a grace period for the parent or caretaker to find another job.

Comment

Comments were received both in support and opposition to the regulatory amendment concerning disqualification and overpayments. Commentators suggested the regulations be revised to contain protections against

abuse of the hearing waiver process. In addition, commentators suggested the regulations be revised to specify the collection method in cases of suspected fraud.

Response

The Department is maintaining the policy concerning the disqualification hearing waiver and also the collection of overpayments in cases of suspected fraud. If a parent or caretaker agrees to be disqualified by signing an administrative waiver, the parent or caretaker will be disqualified. The collection of overpayments in cases of suspected fraud will be delayed until the OIG completes its investigation. Overpayments involving fraud will be collected in conjunction with the OIG. This change will allow the Department to determine whether the eligibility agency, OIG or the court is best suited to collect overpayments. Further, delaying recoupment in cases of suspected fraud will allow a thorough investigation to take place.

Comment

Commentators submitted recommendations concerning special eligibility for children enrolled in Head Start. These recommendations included requiring redeterminations for children enrolled in Head Start who receive subsidized child care, developing clear notification regarding sibling rules and providing sufficient time between notification and discontinuation of subsidy.

Response

The Department is maintaining the policy that to be eligible for the Head Start expansion program, a family shall verify eligibility each time a child in the family applies for the Head Start expansion program. Prior to amendment, the regulations only required parents and caretakers to report a job loss. Under the regulatory amendment, parents and caretakers will be required to continue to meet eligibility requirements.

Regulatory Review Act

Under section 403.1 of the code, this final-omitted rulemaking is not subject to the Regulatory Review Act.

Findings

The Department finds that:

(1) Notice of proposed rulemaking is omitted in accordance with section 204(1)(iv) of the CDL, 1 Pa. Code § 7.4(1)(iv) and section 403.1(d) of the code because the regulations relates to Commonwealth grants and benefits.

(2) Adoption of this final-omitted rulemaking in the manner provided by this order is necessary and appropriate for the administration and enforcement of the code.

Order

The Department, acting under the code, orders that:

(a) The regulations of the Department, 55 Pa. Code Chapters 168 and 3041, are amended by amending §§ 168.72, 3041.19—3041.21, 3041.51, 3041.167, 3041.182, 3041.183, 3041.186, 3041.188 and 3041.189 to read as set forth in Annex A.

(b) The Secretary of the Department shall submit this order and Annex A to the Offices of General Counsel 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 upon publication in the *Pennsylvania Bulletin*.

GARY D. ALEXANDER,
Secretary

Fiscal Note: 14-532. No fiscal impact; (8) recommends adoption.

Annex A

TITLE 55. PUBLIC WELFARE

PART II. PUBLIC ASSISTANCE MANUAL

Subpart C. ELIGIBILITY REQUIREMENTS

CHAPTER 168. CHILD CARE PAYMENT DETERMINATION

§ 168.72. Determining monthly child care costs.

(a) Child care costs include the following:

(1) A charge for child care during the hours of the work-related activity, including travel time and sleeptime.

(2) A charge for up to 5 consecutive days on which the child was not in attendance.

(3) A charge for transporting the child to or from care if the charge is included as part of the normal child care charge and not levied as a separate charge.

(b) If a child's absences exceed 25 total enrollment days in the State's fiscal year, the parent or caretaker is responsible to pay to the provider the provider's verified published daily rate for each day of absence starting with the 26th day of absence. A child is considered absent only once during an enrollment day. A parent or caretaker who receives subsidized child care under the Supplemental Nutrition Assistance Program employment and training program is not be required to pay for absences under this subsection.

PART V. CHILDREN, YOUTH AND FAMILIES MANUAL

Subpart B. ELIGIBILITY FOR SERVICES

CHAPTER 3041. SUBSIDIZED CHILD CARE ELIGIBILITY

GENERAL REQUIREMENTS AND BENEFITS

§ 3041.19. Absence.

(a) Upon notification from the provider that a child has been absent more than 5 consecutive days for which the child is scheduled to attend child care, not including days of a child's illness, injury or impairment that precludes a child from attending child care, or other reason as specified in § 3041.21 (relating to subsidy suspension), the eligibility agency shall send the parent or caretaker an adverse action notice terminating the child's eligibility and payment to the provider.

(b) The notice shall inform the parent or caretaker of the following:

(1) The parent or caretaker shall report to the eligibility agency the date of the child's return to care.

(2) Payment will not be terminated if the child returns to care by the date set forth on the notice.

(3) If the child does not return to care by the date set forth on the notice and there are no grounds for subsidy suspension, the child's subsidy will be terminated effective the date set forth on the notice.

(c) If a child's absences exceed 25 total enrollment days in the State's fiscal year, the parent or caretaker is

responsible to pay to the provider the provider's verified published daily rate for each day of absence starting with the 26th day of absence. A child is considered absent only once during an enrollment day. Suspended days of service as specified in § 3041.21 are not considered days of absence.

§ 3041.20. Subsidy continuation during breaks in work, education or training.

A family's eligibility and payment for subsidized child care continues for and during the following:

(1) Thirty calendar days from the date of an involuntary loss of work, the date a strike begins or the date the parent graduates from or completes education or training. On day 31, the child care subsidy will be suspended and the family's eligibility will continue for an additional 30 days.

(2) A total of 84 calendar days from the first day of family leave, including maternity leave, as defined under the Family and Medical Leave Act of 1993 (29 U.S.C.A. §§ 2601—2654), provided there is a need for child care.

(3) Regularly scheduled breaks in work or breaks in education or training, if the regularly scheduled break is less than 31 calendar days.

§ 3041.21. Subsidy suspension.

(a) If a child is unable to attend child care for more than 5 consecutive days for which the child is scheduled to attend care, subsidy shall be suspended for up to 90 calendar days in the following circumstances:

(1) The child is visiting the noncustodial parent or caretaker.

(2) The child is ill or hospitalized, preventing the child from participating in child care.

(3) The child is absent because of family illness or emergency.

(4) The child remains at home with his parent or caretaker during family leave.

(5) The provider is closed because of failure to meet certification or registration requirements.

(6) The parent or caretaker needs to locate another provider because the current provider cannot meet the parent's or caretaker's child care needs.

(7) The parent or caretaker is on maternity or family leave, as defined under the Family and Medical Leave Act of 1993 (29 U.S.C.A. §§ 2601—2654).

(8) A parent or caretaker has a break in work, education or training that exceeds 30 calendar days but does not continue beyond 90 calendar days.

(b) The child is no longer eligible for subsidy payment or service if the child continues to be absent following 90 calendar days of suspension.

SPECIAL ELIGIBILITY PROGRAMS

§ 3041.51. Head Start expansion program.

(a) Head Start is a Federally-funded program designed to prepare at-risk children, 3 years of age or older but under 5 years of age, for school success. A Head Start expansion program is a program that combines the Head Start program with the subsidized child care program.

(b) A child who is enrolled in a Head Start program, whose parent or caretaker needs extended hours or days of child care beyond the hours or days provided by the Head Start program to work, is eligible for subsidized child care under this section, if the parent or caretaker meets the eligibility requirements for subsidized child care as specified in subsection (f), each time a child in the family applies for the Head Start expansion program.

(c) The eligibility agency shall verify with the Head Start program that the child is enrolled in a Head Start program that meets Federal and State Head Start standards.

(d) If a child in the family as specified in § 3041.31 (relating to family size) is enrolled in the Head Start expansion program, the family co-payment is based on family size and income. If additional children in the family are enrolled in subsidized child care, the family co-payment is based on family size and income.

(e) If extended hours or days of care are provided beyond the Head Start program hours or days, the extended hours and days of care shall be provided by a facility that has a certificate of compliance or registration by the Department as a child day care facility.

(f) Upon program entry and continuation in the Head Start expansion program, a parent or caretaker shall meet the following conditions:

(1) Verification of a minimum of 20 hours of work per week as specified in § 3041.43 (relating to work, education and training) each time a child in the family applies for the Head Start expansion program.

(2) Verification that extended hours and days of child care are needed to work as specified in subsection (b).

(3) Verification of income eligibility for subsidized child care as specified in § 3041.41 (relating to financial eligibility) each time a child in the family applies for the Head Start expansion program.

(4) Compliance with the waiting list conditions specified in § 3041.133 (relating to waiting list).

(5) Payment of the co-payment as specified in § 3041.101 (relating to general co-payment requirements).

(6) Report loss of work within 10 calendar days following the date work ended as specified in § 3041.127(b) (relating to parent and caretaker report of change).

(7) Report when a child is no longer enrolled in Head Start within 10 calendar days following the date the Head Start enrollment ended.

(g) Subsidy for a child receiving care under this section may be suspended during summer school breaks.

(h) A parent or caretaker whose child receives subsidized child care and is enrolled in a Head Start program is not required to report changes in circumstances during the period of the child's Head Start enrollment, unless the parent or caretaker loses work. If the parent or caretaker involuntarily loses work, the family remains eligible for the Head Start expansion program for up to 60 calendar days following the loss of work. If the parent or caretaker is unemployed for more than 60 calendar days, the family is ineligible for subsidized child care.

(i) The eligibility agency may not complete a partial redetermination or redetermination on a child enrolled in the Head Start expansion program until the Head Start program, the parent or caretaker or a reliable source confirmed by the eligibility agency reports to the eligibility agency that a child is no longer enrolled in the Head Start program.

(j) The eligibility agency shall conduct a partial redetermination or redetermination as specified in §§ 3041.129 and 3041.130 (relating to partial determination based on

reported changes; and redetermination of eligibility) if the family has additional children who are not enrolled in Head Start but receive subsidized child care.

(k) A child enrolled in the Head Start expansion program is not subject to partial redetermination or redetermination requirements as specified in subsection (i). Eligibility for a child enrolled in the Head Start expansion program is unrelated to the eligibility of other children in the family who are not enrolled in the Head Start expansion program and receive subsidized child care. Eligibility for a child enrolled in the Head Start expansion program shall continue as specified in this section.

NOTIFICATION AND RIGHT TO APPEAL

§ 3041.167. Notice of overpayment.

(a) The eligibility agency shall notify the parent or caretaker in writing of an overpayment.

(b) The notice of overpayment must include the following:

(1) The reason for the overpayment as specified in § 3041.181 (relating to overpayment).

(2) The period of the overpayment.

(3) The amount of the overpayment.

(4) An explanation of how the overpayment was calculated.

(5) The repayment methods as specified in § 3041.186 (relating to collection) except in cases of suspected fraud.

(6) The right of the parent or caretaker to appeal the decision on the overpayment and how to appeal as specified in §§ 3041.162 and 3041.171 (relating to notice of right to appeal; and appealable actions).

OVERPAYMENT AND DISQUALIFICATION

§ 3041.182. Eligibility agency responsibilities regarding overpayment.

(a) The eligibility agency shall inform a parent or caretaker who files an appeal and requests subsidy continuation pending appeal, that if the hearing decision is in favor of the eligibility agency or the Department, the parent or caretaker shall reimburse the amount of the overpayment unless the hearing officer determines a hardship.

(b) The eligibility agency shall pursue possible overpayments in active and closed cases, including those that were voluntarily closed.

(c) The following are the responsibilities of the eligibility agency when exploring possible overpayments:

(1) Determination of whether the overpayment is the result of one of the conditions specified in § 3041.181 (relating to overpayment).

(2) Written assurance that the methods of exploring overpayments are appropriate to the particular situation and to the different eligibility factors.

(3) Assurance that the methods of exploring overpayments do not infringe on the civil liberties of individuals or interfere with the due process of law.

(4) Investigation of a credible complaint that a parent or caretaker is erroneously receiving subsidized child care.

(5) Identification and documentation of the causes of the overpayment.

(6) Computation of the amount of the overpayment.

(7) Referral of suspected fraud cases to the Office of Inspector General.

(8) Submission of an overpayment notice to the parent or caretaker as specified in § 3041.167 (relating to notice of overpayment).

(d) The eligibility agency shall refer all cases of suspected provider fraud to the Office of Inspector General.

§ 3041.183. Delaying recoupment.

(a) Recoupment shall be delayed until after a hearing decision, if the family files an appeal of the overpayment decision no later than 10 calendar days after the date the written notice is postmarked or hand-delivered to the parent or caretaker by the eligibility agency.

(b) Recoupment shall be delayed for cases referred to the Office of Inspector General for suspected fraud until the investigation is complete.

(c) The method of recoupment in cases of suspected fraud will be determined in conjunction with the Office of Inspector General.

§ 3041.186. Collection.

(a) The eligibility agency shall collect the total amount of the overpayment from a family whose child continues to receive subsidized child care when the eligibility agency identifies an overpayment as specified in § 3041.182 (relating to eligibility agency responsibilities regarding overpayment).

(b) If the Department, eligibility agency or other entity identifies an overpayment unrelated to fraud, subject to repayment as specified in § 3041.181 (relating to overpayment), related to a family whose child continues to receive subsidized child care, the eligibility agency shall:

(1) Notify the parent or caretaker by a letter that a repayment is required, the amount of the repayment and the following repayment options:

(i) A one-time payment of the full amount owed.

(ii) A one-time partial payment and an increase in the co-payment to be paid until repayment is complete.

(iii) An increase in the co-payment until the repayment is complete.

(2) Automatically implement an increase to the co-payment until the repayment is complete when the parent or caretaker does not select an option as specified in paragraph (1) no later than 10 calendar days following the date of the letter.

(3) Notify the parent or caretaker by a second letter of failure to choose a repayment option as specified in paragraph (1), the amount of the increased co-payment and the number of weeks the increased co-payment will continue.

(c) When the Office of Inspector General has determined fraud in an active case, the eligibility agency shall determine collection methods in conjunction with the Office of Inspector General.

§ 3041.188. Collection for a family whose child is no longer in care.

(a) The eligibility agency shall collect the total amount of the overpayment as specified in § 3041.182 (relating to eligibility agency responsibilities regarding overpayment) from a family whose child is no longer receiving subsi-

dized child care if the eligibility agency identifies an overpayment.

(b) If the Department, eligibility agency or other entity identifies an overpayment unrelated to fraud, for a family whose child is no longer receiving subsidized child care, the eligibility agency shall:

(1) Notify the Department of the subsidy termination date, the amount of the overpayment recouped and the amount outstanding. The Department will notify the parent or caretaker by letter of the overpayment, the amount of the outstanding overpayment and that repayment is required in either a single payment or under a payment plan agreeable to the parent or caretaker and the eligibility agency. The letter must state that the parent or caretaker has 10 calendar days to respond to the Department indicating agreement or disagreement and indicating the choice of a repayment method.

(2) Send a second letter that repeats the information contained in the letter specified in paragraph (1) when the Department notifies the eligibility agency that the parent or caretaker failed to respond. The second letter must also request a response from the parent or caretaker no later than 10 calendar days following the date of the letter.

(c) When the Office of Inspector General has determined fraud in a case when the child is no longer in care, the eligibility agency shall determine the collection methods in conjunction with the Office of Inspector General.

(d) The Department may institute civil legal proceedings when the parent or caretaker fails to respond to the second letter.

§ 3041.189. Disqualification.

(a) The parent or caretaker is disqualified from participating in the subsidized child care program if one of the following applies:

(1) A Federal or State court finds the parent or caretaker guilty of fraud in applying for or receiving subsidized child care.

(2) A hearing officer determines that the parent or caretaker committed fraud pursuant to the procedures and standards in Chapter 275 (relating to appeal and fair hearing and administrative disqualification hearings).

(3) The parent or caretaker signs a disqualification consent agreement as part of a court's deferred adjudication process.

(4) The parent or caretaker agrees to be disqualified by signing an administrative disqualification hearing waiver.

(b) Upon disqualification under subsection (a), a parent or caretaker and eligible children in the parent's or caretaker's family shall be prohibited from participation in the subsidized child care program:

(1) For 6 months from the date of the first conviction, hearing decision or determination.

(2) For 12 months from the second conviction, hearing decision or determination.

(3) Permanently from the date of the third conviction, hearing decision or determination.

(c) A parent or caretaker may not be granted a hearing on a court conviction or administrative disqualification hearing decision that led to the disqualification.

[Pa.B. Doc. No. 12-643. Filed for public inspection April 13, 2012, 9:00 a.m.]

DEPARTMENT OF PUBLIC WELFARE

[55 PA. CODE CH. 299]

Supplemental Security Income Program and State Supplementary Payment Program; State Supplementary Payment Levels

The Department of Public Welfare (Department) amends Chapter 299 (relating to Supplemental Security Income Program and State Supplementary Payment Program) to read as set forth in Annex A under the authority in sections 201(2), 403(b), 403.1 and 432(2) of the Public Welfare Code (code) (62 P. S. §§ 201(2), 403(b), 403.1 and 432(2)), as amended by the act of June 30, 2011 (P. L. 89, No. 22) (Act 22).

Omission of Proposed Rulemaking

Act 22 amended the code and added several new provisions. Specifically, Act 22 added section 403.1 to the code. Section 403.1(a)(1) and (3), (c) and (d) of the code authorizes the Department to promulgate final-omitted regulations to establish standards for the nature and extent of assistance and also to modify existing benefits and to establish benefit limits.

The basis for this final-omitted rulemaking is section 204(1)(iv) of the act of July 31, 1968 (P. L. 769, No. 240) (45 P. S. § 1204(1)(iv)), known as the Commonwealth Documents Law (CDL), which authorizes an agency to omit or modify notice of proposed rulemaking when the regulation relates to Commonwealth grants or benefits. The State Supplementary Payment (SSP) is a Commonwealth benefit. Section 403.1 of the code provides additional authority for this final-omitted rulemaking. Until June 30, 2012, section 403.1(d) of the code expressly exempts certain regulations from under the Regulatory Review Act (71 P. S. §§ 745.1—745.12), section 205 of the CDL (45 P. S. § 1205) and section 204(b) of the Commonwealth Attorneys Act (71 P. S. § 732-204(b)).

The Department is amending § 299.37 (relating to optional SSP levels) in accordance with section 403.1 of the code because this final-omitted rulemaking pertains to the nature and extent of assistance and benefit limits.

This final-omitted rulemaking also implements section 403.1(c) of the code which requires that rulemaking under Act 22 be necessary to ensure that expenditures for State Fiscal Year (FY) 2011-2012 for assistance programs administered by the Department do not exceed the aggregate amount appropriated for the program by the General Appropriations Act of 2011. The amount appropriated for State supplemental grants for FY 2011-2012 is $150,029,000.

Purpose

The purpose of this final-omitted rulemaking is to codify the SSP levels in § 299.37 and to rescind Appendix A. Previously, the SSP levels were codified in Appendix A.

Background

The Social Security Administration (SSA) established Supplemental Security Income (SSI) payment amounts as

a National minimum assistance standard. These payment amounts do not take into account variations in the cost of living throughout the country and the special needs of certain individuals. States have the option to provide additional assistance through the SSP program to address these differences.

The Commonwealth opted to provide the SSP to eligible individuals. SSI recipients receive an SSI payment from the SSA and also an SSP benefit from the Commonwealth. Certain other individuals who do not receive SSI, however, may still qualify for SSP.

Previously, the Department reduced the SSP payment levels by publishing a notice at 40 Pa.B. 479 (January 16, 2010). These SSP payment rates were reduced under the authority of § 299.37. This section provided that revisions to SSP payment levels will be published as a notice in the *Pennsylvania Bulletin*.

The authority of the Department to change the SSP payment levels by notice rather than by regulation is currently being challenged in Commonwealth Court. Although the Department is confident that its arguments in support of the existing regulation are strong, the purpose of this final-omitted rulemaking is to mitigate the uncertainty associated with that, as with any litigation. This final-omitted rulemaking sets the level of SSP payments at their current levels, places those levels in § 299.37, deletes the language authorizing that subsequent changes to payment levels will be by publication of a notice in the *Pennsylvania Bulletin* and rescinds Appendix A. With these amendments, the Department considered the four factors in section 432(2)(iii) of the code:

(1) The funds certified by the Budget Secretary as available for State supplemental assistance.

(2) Pertinent Federal legislation and regulation.

(3) The cost-of-living.

(4) The number of persons who may be eligible.

For the first and fourth statutory factors, the Department considered the funds certified as available for SSP for FY 2011-2012, which was set at $150,029,000. See Appropriation Act 2011-1A. Under the FY 2011-2012 budget, the allocation is projected to be sufficient to cover the costs incurred for the monthly average SSP population of 380,000 individuals. If the SSP population continues to increase to 390,214 individuals for FY 2012-2013 (as projected in the current budget), SSP funding could fall short without a commensurate increase in the SSP appropriation.

For the second statutory factor, the Department considered pertinent Federal statutes and regulations, which include 20 CFR 416.2001, 416.2015, 416.2030, 416.2035 and 416.2095—416.2099. The Department's SSP payment levels in this final-omitted rulemaking comport with Federal pass-along (maintenance of effort) provisions which require states to maintain certain minimum SSP payment levels. The purpose of the pass-along requirement is to ensure that recipients, not states, benefit from Federal SSI payment increases by requiring minimum SSP payment thresholds that states must not fall below notwithstanding SSI payment increases. The penalty for noncompliance with this requirement is loss of Federal funding for Medicaid. See 20 CFR 416.2096 (relating to basic pass-along rules).

For the third statutory factor, the Department considered cost-of-living, taking into account the fact that inflation rates continue to be relatively low and are expected to remain stable for the foreseeable future. When considering cost-of-living, the Department also kept in mind that higher SSP payment levels could threaten to deplete available SSP funds for eligible individuals.

Finally, as previously noted, the number of individuals who may qualify for SSP has continued to increase. In FY 2009-2010, approximately 359,300 recipients received SSP. The number of SSP recipients increased in FY 2010-2011 to approximately 369,917. This number is anticipated to rise to approximately 390,214 individuals for FY 2012-2013.

Requirements

In this final-omitted rulemaking, the Department is codifying the SSP payment levels in § 299.37 and rescinding Appendix A. This final-omitted rulemaking also deletes references to Appendix A in §§ 299.11 and 299.36 (relating to mandatory and optional SSPs; and eligibility requirements for SSP-only). The Department replaces these references with a citation to § 299.37.

Affected Individuals and Organizations

This final-omitted rulemaking affects approximately 380,000 individuals who receive or are anticipated to receive the optional SSP.

Accomplishments and Benefits

This final-omitted rulemaking implements section 403.1(a)(1) and (3), (c) and (d) of Act 22. As provided in Act 22, the Department is conserving resources to ensure that the expenditures for State FY 2011-2012 for assistance programs administered by the Department do not exceed the aggregate amount appropriated for the program by the General Appropriations Act of 2011.

Fiscal Impact

The Commonwealth will realize an estimated savings of $21,147,890 in State FY 2011-2012.

Paperwork Requirements

There are no new paperwork requirements under the final-omitted rulemaking.

Public Comment

Although this regulation is being adopted without publication as proposed rulemaking, the Department posted a draft regulation on the Department's web site on February 24, 2012, with a 15-day comment period. The Department invited interested persons to submit written comments regarding the regulation to the Department. The Department did not receive public comments regarding this final-omitted rulemaking following the posting of the draft regulation. The Department also discussed the Act 22 regulations and responded to questions at the House Health Committee hearing on March 8, 2012.

Although the Department did not receive comments in response to the draft regulation, the Department did receive a comment from Community Legal Services (CLS) and Community Justice Project (CJP) prior to the posting of the draft regulation. In addition, the Department received general comments regarding the promulgation of regulations under Act 22.

Discussion of Comments

Comment

In response to the Department's Regulatory Agenda published at 42 Pa.B. 879, 894 (February 11, 2012), CLS and CJP commented that the Department is not in compliance with section 432(2)(iii) of the code in establishing the amount of the SSP by not considering all four of the following statutory criteria: "the funds certified by the Budget Secretary as available for State supplemental

assistance, pertinent Federal legislation and regulations, the cost-of-living and the number of persons who may be eligible."

Response

As previously stated, the Department considered the four factors under section 432(2)(iii) of the code in establishing the SSP levels.

Comment

Several commentators stated that the Department did not allow sufficient time for review and comment of the regulations. In addition, commentators requested the public comment period be extended an additional 30 days due to the policy changes and the volume of regulations.

Response

The Department engaged in a transparent public process through which the Department solicited and received numerous comments and input from stakeholders and other interested parties. As previously mentioned, the Department posted the draft regulation on the Department's web site on February 24, 2012. The Department invited interested persons to submit written comments, on or before March 9, 2012, regarding the regulation to the Department. In addition, the Department's Regulatory Agenda announced the Act 22 regulations at 42 Pa.B. 879, 894.

As a final-omitted rulemaking under Act 22, the Department was not required to have a public comment process. However, to encourage transparency and public input, the Department provided an opportunity for comment by posting the draft regulation on the Department's web site. This public comment process provided sufficient opportunity for interested parties to submit comments. Therefore, the Department is not extending the public comment period.

Regulatory Review Act

Under section 403.1 of the code, this final-omitted rulemaking is not subject to the Regulatory Review Act.

Findings

The Department finds that:

(1) Notice of proposed rulemaking is omitted in accordance with section 204(1)(iv) of the CDL, 1 Pa. Code § 7.4(1)(iv) and section 403.1(d) of the code because the regulations relate to Commonwealth grants and benefits.

(2) Adoption of this final-omitted rulemaking in the manner provided by this order is necessary and appropriate for the administration and enforcement of the code.

Order

The Department acting under the code, orders that:

(a) The regulations of the Department, 55 Pa. Code Chapter 299, are amending by amending §§ 299.11, 299.36 and 299.37 and by deleting Appendix A to read as set forth in Annex A, with ellipses referring to the existing text of the regulations.

(b) The Secretary of the Department shall submit this order and Annex A to the Offices of General Counsel 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 July 1, 2011, in accordance with section 403.1(e) of the code.

GARY D. ALEXANDER,
Secretary

Fiscal Note: 14-525. No fiscal impact. This action is expected to save $21.148 million in FY 2011-12; (8) recommends adoption.

Annex A

TITLE 55. PUBLIC WELFARE

PART II. PUBLIC ASSISTANCE MANUAL

Subpart I. OTHER INCOME MAINTENANCE PROGRAMS

CHAPTER 299. SUPPLEMENTAL SECURITY INCOME PROGRAM AND STATE SUPPLEMENTARY PAYMENT PROGRAM

TYPES OF SSP

§ 299.11. Mandatory and optional SSPs.

The two types of SSPs are as follows:

(1) *Mandatory SSP.* A mandatory SSP is provided to an eligible individual or couple under 20 CFR 416.2050 (relating to mandatory minimum state supplementation).

(2) *Optional SSP.* An individual or couple not eligible for the mandatory SSP may receive an optional SSP, as specified in § 299.37 (relating to optional SSP levels). Eligibility requirements for the optional SSP are set forth in §§ 299.21, 299.22 and 299.31—299.36.

GENERAL PROVISIONS FOR STATE-ADMINISTERED OPTIONAL SSP

§ 299.36. Eligibility requirements for SSP-only.

(a) *Eligibility requirements.* The Commonwealth will administer and pay an optional SSP to an individual or a couple as follows:

(1) *Categories.* The individual or couple may be eligible for SSP-Only if the individual or each member of the couple is one of the following:

(i) Aged—65 years of age or older.

(ii) Blind under 20 CFR Part 416, Subpart I (relating to determining disability and blindness).

(iii) Disabled under 20 CFR Part 416, Subpart I.

(2) *Additional requirements.* In addition to paragraph (1), the individual or each member of the couple shall:

(i) Meet the residency requirements under § 147.23 (relating to requirements).

(ii) Be a United States citizen or a qualified alien under 20 CFR Part 416, Subpart P (relating to residence and citizenship). A qualified alien shall meet the eligibility requirements under section 401 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C.A. § 1612) regarding limited eligibility of qualified aliens for certain Federal programs.

(iii) Meet SSI resource requirements under 20 CFR Part 416, Subpart L (relating to resources and exclusions).

(iv) Meet income requirements under 20 CFR Part 416, Subpart K (relating to income) except that:

(A) Countable income must be less than the combined total of the FBR and the maximum allowable SSP for the eligible individual or couple.

(B) Countable income is adjusted dollar for dollar against the appropriate SSP amount in § 299.37 (relating to optional SSP levels), plus the FBR.

(v) Meet enumeration requirements under § 155.2 (relating to general).

(vi) Meet redetermination requirements under 20 CFR 416.204 (relating to redeterminations of SSI eligibility).

(vii) Cooperate in verifying all eligibility requirements including age, residence, citizenship, employment, income and resources as specified under § 201.4 (relating to procedures).

(viii) Consent to the disclosure of information that is in the possession of third parties and necessary for the SSP eligibility determination.

* * * * *

§ 299.37. Optional SSP levels.

The SSP levels are as follows:

	Individual	*Couple*
Residing in an Independent Living Arrangement	$22.10	$33.30
Residing in the Household of Another	$25.53	$38.44
Residing in a Domiciliary Care Home	$434.30	$947.40
Residing in a Personal Care Home	$439.30	$957.40

APPENDIX A.
(Reserved)

[Pa.B. Doc. No. 12-644. Filed for public inspection April 13, 2012, 9:00 a.m.]

DEPARTMENT OF PUBLIC WELFARE

[55 PA. CODE CH. 1101]

Amendments to Copayment Regulations

The Department of Public Welfare (Department) amends Chapter 1101 (relating to general provisions) to read as set forth in Annex A under the authority of sections 201(2), 403(b) and 403.1 of the Public Welfare Code (code) (62 P. S. §§ 201(2), 403(b) and 403.1), as amended by the act of June 30, 2011 (P. L. 89, No. 22) (Act 22).

Omission of Proposed Rulemaking

On July 1, 2011, the General Assembly enacted Act 22, which amended the code. Act 22 added several new provisions to the code, including section 403.1. Section 403.1(a)(1) and (3) of the code authorizes the Department to promulgate final omitted regulations under section 204(1)(iv) of the act of July 31, 1968 (P. L. 769, No. 240) (45 P. S. § 1204(1)(iv)), known as the Commonwealth Documents Law (CDL), to establish rules, regulations, procedures and standards for the nature and extent of assistance and to modify existing benefits. Section 204(1) of the CDL authorizes an agency to omit or modify notice of proposed rulemaking when a regulation relates to Commonwealth grants or benefits. The Medical Assistance (MA) Program is a Commonwealth grant program through which eligible recipients receive coverage of certain health care benefits. In addition, to ensure that the Department's expenditures for State Fiscal Year (FY) 2011-2012 do not exceed the aggregate amount appropriated by the General Assembly, section 403.1(d) of the code expressly exempts these regulations from the Regulatory Review Act (71 P. S. §§ 745.1—745.12), section 205 of the CDL (45 P. S. § 1205) and section 204(b) of the Commonwealth Attorneys Act (71 P. S. § 732-204(b)).

The Department is amending § 1101.63(b) (relating to payment in full) in accordance with section 403.1(a)(1) and (3) of the code because this final-omitted rulemaking pertains to the nature and extent of assistance and benefits for the MA Program. Further, consistent with section 403.1(c) of the code, this final-omitted rulemaking is necessary to ensure that expenditures for State FY 2011-2012 for assistance programs administered by the Department do not exceed the aggregate amount appropriated for the program by the General Appropriations Act of 2011.

Purpose

The purpose of this final-omitted rulemaking is to amend § 1101.63 to: 1) eliminate recipient copayment reimbursements; 2) update the sliding-scale MA copayment amount and provide that the Department may, by publication of a notice in the *Pennsylvania Bulletin*, adjust these copayments amounts; and 3) make technical amendments to Chapter 1101 to codify certain Federally mandated copayment exclusions and to clarify existing MA copayment policies.

Background

The Department administers the MA Program under Title XIX of the Social Security Act (act) (42 U.S.C.A. §§ 1396—1396w-5) for low-income individuals, pregnant women, infants and children, and individuals who are aged, blind or disabled. In addition, the Department administers an MA program for General Assistance (GA) MA recipients, principally single adults, which is funded solely by State funds and is not mandated by the Federal government. Both MA programs provide a continuum of physical and behavioral health services, including long-term care, inpatient hospital, pharmacy, outpatient services such as physician, podiatric, medical and psychiatric clinics, chiropractic services and dental services, and medical supplies and durable medical equipment to approximately 2.1 million eligible MA recipients.

In an effort to address the current budget constraints, the Department has taken steps to implement a series of initiatives aimed at reducing costs while still providing needed care to MA recipients, including limiting pharmacy benefits for recipients 21 years of age and older to six prescriptions for drugs per calendar month and by limiting certain dental benefits for recipients 21 years of age and older. Despite these and other cost saving efforts, the Department was compelled to identify additional ways to achieve the necessary cost savings. After reviewing various options, the Department determined that modifying the recipient copayment obligations will produce savings with the least impact on services and care provided to MA recipients.

The Department implemented nominal copayment requirements for certain nonexempt MA recipients in September 1983. At that time, the Department also implemented a reimbursement process for MA recipients other than GA recipients for copayments paid in excess of $90 in a 6-month period. In January 1993, the copayment reimbursement process was expanded to apply to GA recipients who pay copayments in excess of $180 in a 6-month period. Although this copayment reimbursement was intended to limit the potential adverse fiscal impact of the copayment requirement, it prevents the Depart-

ment from maximizing the potential cost savings available to the MA Program through application of MA recipient copayments. As a result, the Department will eliminate the copayment reimbursement provision in § 1101.63(b)(7) with this final-omitted rulemaking.

Until 2006, Federal Medicaid regulations permitted nominal sliding scale copayments ranging from $0.50 to $3 depending on the amount the Commonwealth pays for the service. The Department's MA sliding scale copayments for MA recipients, other than GA recipients, have remained fixed at these amounts for many years. For State-funded GA recipients, the Department applies twice the nominal copayments applicable to other MA recipients. The Deficit Reduction Act of 2005 (DRA) (Pub. L. No. 109-171) and implementing regulations increased the maximum Medicaid nominal sliding copayment amounts each year, beginning in 2006, by the annual percentage increase in the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) for the period September to September ending in the preceding calendar year and rounded to the next higher 5 cent increment. See section 1916(a)(3) and (b)(3) of the Social Security Act (42 U.S.C.A. § 1396o(a)(3) and (b)(3)) and 42 CFR 447.54 (relating to maximum allowable and nominal charges). The Department has not increased the copayment amount as permitted by Federal law. In an effort to meet current budgetary objectives, the Department is updating the MA sliding scale copayment amounts for MA recipients, other than GA recipients, to reflect the current CPI-U adjustments and may, through publication of a notice in the *Pennsylvania Bulletin*, update the sliding scale copayment amounts on a recurring basis to account for future CPI-U adjustments, as permitted by the DRA. The Department may also update the sliding scale copayment amounts for GA MA recipients, which will continue to be twice the amounts applied to MA recipients other than GA recipients, consistent with current MA copayment policy for these populations.

Technical Amendments

The Department is making several technical corrections to § 1101.63(b). These technical corrections do not represent changes to the Department's current MA copayment policies. The technical corrections reflect and clarify copayment exclusions that have been in effect under the MA Program, based upon Federal Medicaid requirements and MA copayment policies, but have not yet been incorporated into Chapter 1101. These technical corrections are as follows:

• Exclude from MA copayments services provided to individuals who are eligible under the Breast and Cervical Cancer Prevention and Treatment (BCCPT) Program and individuals, regardless of age, who qualify for benefits under Title IV-B Foster Care and Title IV-E Foster Care and Adoption Assistance, as mandated under the DRA. The Department adopted this mandate effective March 31, 2006, and notified providers by way of MA Bulletin 99-06-12, "Change to copayment requirements for recipients eligible under the Breast and Cervical Cancer Prevention and Treatment Program and Titles IV-B & IV-E Foster Care and Adoption Assistance," issued December 10, 2006.

• Exclude tobacco cessation counseling services from MA copayments. In September, 2006, the Department excluded these services to remove perceived barriers to accessing this MA covered service that helps recipients quit smoking.

• Exclude from MA copayments services for recipients residing in personal care homes (PCH) and domiciliary care homes (DCH). In October 2007, the Department amended the Medicaid State Plan to exclude PCH and DCH residents from MA copayments, as most of these individuals receive Supplemental Security Income (SSI) and contribute all but a minimal amount of the SSI income to the costs of the PCH or DCH care.

• Exclude from MA copayments services for recipients in hospice care. This is a Federal Medicaid requirement that has been in effect under the MA Program for many years, but is not currently identified in MA copayment regulations.

• Clarify that the exclusion of pregnant women from copayment requirements extends throughout the woman's postpartum period, consistent with 42 CFR 447.53(b)(2) (relating to applicability; specification; multiple charges). The inadvertent omission of the postpartum period language in the Department's current MA copayment regulation has led to some confusion for MA enrolled providers regarding the full scope of this exclusion.

• Specify that intermediate care facilities (ICF/MR) or other related conditions (ICF/ORC) are facilities that meet the criteria for the copayment exclusion for institutionalized individuals. Institutionalized recipients are excluded from copayment requirements under 42 CFR 447.53(b)(3) if the institutionalized individuals are, as a condition of receiving services in the institution, required to spend all but a minimal amount of their income for medical services. Within the Commonwealth's MA Program, ICF/MRs and ICF/ORCs are facilities that meet the criteria for this copayment exclusion. The Department's current MA copayment regulation does not explicitly identify ICF/MRs and ICF/ORCs, which has resulted in confusion for MA providers regarding applicability of the exclusion to residents of these facilities.

Additionally, the Department is renumbering the copayment regulations.

Therefore, with this final-omitted rulemaking, the Department is amending § 1101.63(b)(2) to codify and clarify the scope and applicability of these copayment exclusions. The technical amendments do not impose new or additional copayment exclusions and reflect the manner in which these copayment exclusions are currently applied in the MA Program.

Public Process

The Department published an advance public notice at 42 Pa.B 1001 (February 18, 2012) announcing its intent to amend the copayment provisions under Chapter 1101. The Department invited interested persons to comment. In addition, the Department discussed these copayment amendments with the Medical Assistance Advisory Committee on February 23, 2012.

The Department also posted the draft regulation on the Department's web site on February 24, 2012, with a 15-day comment period. The Department again invited interested persons to submit written comments regarding the regulation to the Department. The Department received 16 topically-related comments from 85 commentators. The Department also discussed the Act 22 regulations and responded to questions at the House Health Committee hearing on March 8, 2012.

The Department considered the comments in response to the draft regulation.

Discussion of Comments

The following is a summary of the major comments received within the public comment period and the Department's response to those comments.

Comment: Several commentators stated that the Department did not allow sufficient time for review and comment of the regulations.

Response: The Department engaged in a transparent public process through which the Department solicited and received numerous comments and input from stakeholders and other interested parties.

As previously mentioned, the Department published advance public notice at 42 Pa.B. 1001 announcing its intent to amend the copayment provisions under Chapter 1101. The Department invited interested persons to comment. The Department also posted the draft regulation on the Department's web site on February 24, 2012. The Department again invited interested persons to submit written comments, on or before March 9, 2012, regarding the regulation to the Department. As a final-omitted regulation under Act 22, the Department was not required to have a public comment process. However, to encourage transparency and public input the Department provided an opportunity for comment by publishing the notice and posting the draft regulation on the Department's web site. This public comment process provided sufficient opportunity for interested parties to submit comments, as supported by the number of comments that were submitted.

Comment: Several commentators stated that the Department exceeded its authority under Act 22 by issuing a final-omitted rulemaking that changes copayments in future years. Further, the Department may not give itself the authority to adjust copayments by publishing a notice in the *Pennsylvania Bulletin*. Under State law, the Department may only adjust copayments by adopting regulations through a full rulemaking process.

Response: Act 22 authorizes the Department to promulgate final-omitted regulations that revise payment rates. To ensure that the Department's expenditures for State FY 2011-2012 do not exceed the amount appropriated by the General Assembly, these regulations are exempt from the Regulatory Review Act, section 205 of the CDL and section 204(b) of the Commonwealth Attorneys Act. There is nothing in Act 22 that precludes the promulgation of final-omitted regulations that will have an impact in both State FY 2011-2012 and in future years.

The Department is not required to undertake the full rulemaking process to adjust copayments. Federal law provides for annual increases in the maximum Medicaid nominal sliding copayment amounts each year based upon the annual percentage increase in the medical care component of the CPI-U for the period September to September ending in the preceding calendar year and rounded to the next higher 5 cent increment. See section 1916(a)(3) and (b)(3) of the Social Security Act and 42 CFR 447.54. The Department's regulation simply authorizes this inflation adjustment to be made to the Department's existing copayments if and only to the extent permitted by Federal law. Regulatory authority for routine adjustments to be made by notice in the *Pennsylvania Bulletin* is neither novel nor unusual. For example, see the following: § 501.7 (authorizing the Department to make adjustments to the standard utility allowance amounts, the telephone allowances and the homeless shelter allowances for recipients by publishing a notice in the *Pennsylvania Bulletin*); § 1187.2 (authorizing the Department to define certain types of Durable Medical Equipment by publishing a notice in the *Pennsylvania Bulletin*); § 1151.54(i) (authorizing the Department to publish a notice in *Pennsylvania Bulletin* to list qualifying inpatient psychiatric facilities and their annual disproportionate share payment percentages); § 1150.61 (authorizing the Department to publish a notice when fees are changed and when procedures or items are added to or deleted from the MA Program Fee Schedule); § 1128.52 (for renal dialysis services, authorizing the Department to publish notice for rate increases and decreases and changes in methodology used in establishing maximum fees).

Comment: Several commentators suggested that eliminating the copayment reimbursement provision would impose a severe financial hardship on MA consumers.

Response: The Department acknowledges that the elimination of the copayment reimbursement provision may be viewed by some as a financial burden but is compelled to implement cost saving initiatives. The Department determined that eliminating the copayment reimbursement provision is preferable to other options, such as reducing or eliminating services.

Comment: Several commentators expressed concern that an increase in the sliding scale copayment amount will put added strain on MA consumer's limited income and reduce their ability to become self-sufficient.

Response: As noted in the previous response, the Department is compelled to implement cost savings initiatives. After analyzing the options, the Department concluded that increasing the sliding scale copayment amounts as authorized under the DRA is preferable to other options, such as reducing or eliminating services.

Comment: Several commentators stated that it is unfair for GA recipients to be required to pay double the copayment of MA recipients.

Response: The Department has considered the fiscal impact on GA recipients. However, GA copayments have always been double that of MA recipients. This change is simply in keeping with that standard.

Comment: Several commentators suggested providers should be able to deny services to individuals who cannot or refuse to pay their copayments.

Response: The Department acknowledges concerns that some recipients will be unable to pay the copayments at time of service. Section 1916(e) of the Social Security Act and 42 CFR 447.53(e), which pertain to the Department's nominal MA copayments for Medicaid recipients, prohibit denial of service due to a MA recipient's inability to pay the copayment. The DRA includes state options regarding enforcement of alternative cost-sharing. The Department may consider alternative cost sharing options provided for in the DRA in the future.

Comment: Many commentators, including several county MA transportation providers, objected to the imposition of a $2 per one-way trip copayment for non-emergency medical transportation (NEMT) paratransit services.

Response: The Department included the NEMT paratransit copayment in the public notice description of the intended regulatory change and the draft regulation. After careful consideration of public comments on this subject, the Department is removing the NEMT paratransit copayment from this final-omitted rulemaking.

Comment: Many comments expressed concern over the application of copayments for children with disabilities whose family income exceeds 200% of the Federal Poverty Income Guidelines.

Response: This final-omitted rulemaking does not impose MA copayments for children with disabilities.

Requirements

The final-omitted rulemaking amends § 1101.63(b)(2) as follows:

• Subsection (b)(5)(vi) is amended by updating the sliding scale copayment amounts for MA recipients other than GA recipients to coincide with the current CPI-U medical component adjustment.

• Subsection (b)(5)(vi) is amended by adding clause (E) to state that the Department may update the sliding scale copayment amount on a recurring basis to account for future CPI-U adjustments by publication of a notice in the *Pennsylvania Bulletin*.

• Subsection (b)(6)(iv) is amended by updating the sliding scale copayment amounts for GA recipients to twice the amounts established for MA recipients other than GA recipients.

• Subsection (b)(6)(iv) is amended by adding clause (E) to state that the Department may update the sliding scale copayment amount on a recurring basis to account for future CPI-U adjustments by publication of a notice in the *Pennsylvania Bulletin*.

• Subsection (b)(7) regarding recipient copayment reimbursement is deleted and the remaining paragraphs are renumbered accordingly.

• Subsection (b)(2)(ii) is amended to add language to clarify that the copayment exclusion for services furnished to pregnant women extends throughout the postpartum period.

• Subsection (b)(2)(iii) is amended to add language to clarify that the copayment exclusion for services furnished to institutionalized individuals includes individuals residing in ICF/MRs or ICF/ORCs.

• Subsection (b)(2)(iv) is added to exclude from MA copayment requirements services furnished to individuals residing in PCHs or DCHs.

• Subsection (b)(2)(v) is added to specify that services furnished to women eligible under the BCCPT Program are excluded from MA copayment requirements.

• Subsection (b)(2)(vi) is added to specify that services furnished to individuals for whom assistance is made available under Titles IV-B and IV-E of the Social Security Act, without regard to the individual's ages, are excluded from MA copayment requirements.

• Subsection (b)(2)(xii) is added to specify that services provided to individuals receiving hospice care are excluded from MA copayment requirements.

• Subsection (b)(2)(xxi) is added to specify that tobacco cessation counseling services are excluded from MA copayment requirements.

• Numbering under subsection (b)(2) is changed as a result of these additions.

Affected Individuals and Organizations

MA recipients who are not otherwise excluded from copayment requirements will be affected by the final-omitted rulemaking, which increases the nominal sliding scale MA copayment amounts and eliminates excess copayment reimbursement to recipients.

MA enrolled providers will benefit from the enhanced clarity of the copayment regulation afforded through the technical amendments.

Accomplishments and Benefits

This final-omitted rulemaking imposes limited additional copayment liability on MA and GA MA recipients who are not otherwise excluded from copayment requirements, which will enable the Department to preserve vital benefits to the greatest number of MA recipients while reducing costs in accordance with the goals in section 403.1 of the code. The technical amendments will codify copayment exclusions as well as enhance clarity of the regulation.

Fiscal Impact

The final-omitted rulemaking ensures that the Department's expenditures do not exceed the aggregate amount appropriated by the General Assembly for FY 2011-2012.

Paperwork Requirements

There are no additional reports, paperwork or new forms needed to comply with the final-omitted rulemaking.

Regulatory Review Act

Under section 403.1 of the code, this final-omitted rulemaking is not subject to review under the Regulatory Review Act.

Findings

The Department finds that:

(1) Notice of proposed rulemaking is omitted in accordance with section 204(1)(iv) of the CDL, 1 Pa. Code § 7.4(1)(iv) and section 403.1(d) of the code because the final-omitted rulemaking relates to Commonwealth grants and benefits.

(2) The adoption of this final-omitted rulemaking in the manner provided by this order is necessary and appropriate for the administration and enforcement of the code.

Order

The Department, acting under the code, orders that:

(a) The regulations of the Department, 55 Pa. Code Chapter 1101, are amended by amending § 1101.63 to read as set forth in Annex A.

(b) The Secretary of the Department shall submit this order and Annex A to the Office of General Counsel 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 on May 15, 2012.

GARY D. ALEXANDER,
Secretary

Fiscal Note: 14-529. No fiscal impact; (8) recommends adoption.

Annex A

TITLE 55. PUBLIC WELFARE

PART III. MEDICAL ASSISTANCE MANUAL

CHAPTER 1101. GENERAL PROVISIONS

FEES AND PAYMENTS

§ 1101.63. Payment in full.

(a) *Supplementary payment for a compensable service.* A provider shall accept as payment in full, the amounts paid by the Department plus a copayment required to be paid by a recipient under subsection (b). A provider who seeks or accepts supplementary payment of another kind

from the Department, the recipient or another person for a compensable service or item is required to return the supplementary payment. A provider may bill a MA recipient for a noncompensable service or item if the recipient is told before the service is rendered that the program does not cover it.

(b) *Copayments for MA services.*

(1) Recipients receiving services under the MA Program are responsible to pay the provider the applicable copayment amounts set forth in this subsection.

(2) The following services are excluded from the copayment requirement for all categories of recipients:

(i) Services furnished to individuals under 18 years of age.

(ii) Services and items furnished to pregnant women, which include services during the postpartum period.

(iii) Services furnished to an individual who is a patient in a long term care facility, an intermediate care facility for the mentally retarded or other related conditions, as defined in 42 CFR 435.1009 (relating to definitions relating to institutional status) or other medical institution if the individual is required as a condition of receiving services in the institution, to spend all but a minimal amount of his income for medical care costs.

(iv) Services provided to individuals residing in personal care homes and domiciliary care homes.

(v) Services provided to individuals eligible for benefits under the Breast and Cervical Cancer Prevention and Treatment Program.

(vi) Services provided to individuals eligible for benefits under Title IV-B Foster Care and Title IV-E Foster Care and Adoption Assistance.

(vii) Services provided in an emergency situation as defined in § 1101.21 (relating to definitions).

(viii) Laboratory services.

(ix) The professional component of diagnostic radiology, nuclear medicine, radiation therapy and medical diagnostic services, when the professional component is billed separately from the technical component.

(x) Family planning services and supplies.

(xi) Home health agency services.

(xii) Services provided to individuals receiving hospice care.

(xiii) Psychiatric partial hospitalization program services.

(xiv) Services furnished by a funeral director.

(xv) Renal dialysis services.

(xvi) Blood and blood products.

(xvii) Oxygen.

(xviii) Ostomy supplies.

(xix) Rental of durable medical equipment.

(xx) Targeted case management services.

(xxi) Tobacco cessation counseling services.

(xxii) Outpatient services when the MA fee is under $2.

(xxiii) Medical examinations when requested by the Department.

(xxiv) Screenings provided under the EPSDT Program.

(xxv) More than one of a series of a specific allergy test provided in a 24-hour period.

(3) The following services are excluded from the copayment requirement for categories of recipients except GA recipients age 21 to 65:

(i) Drugs, including immunizations, dispensed by a physician.

(ii) Specific drugs identified by the Department in the following categories:

(A) Antihypertensive agents.

(B) Antidiabetic agents.

(C) Anticonvulsants.

(D) Cardiovascular preparations.

(E) Antipsychotic agents, except those that are also schedule C-IV antianxiety agents.

(F) Antineoplastic agents.

(G) Antiglaucoma drugs.

(H) Antiparkinson drugs.

(I) Drugs whose only approved indication is the treatment of acquired immunodeficiency syndrome (AIDS).

(4) Except for the exclusions specified in paragraphs (2) and (3), each MA service furnished by a provider to an eligible recipient is subject to copayment requirements.

(5) The amount of the copayment, which is to be paid to providers by categories of recipients, except GA recipients, and which is deducted from the Commonwealth's MA fee to providers for each service, is as follows:

(i) For pharmacy services, drugs and over-the-counter medications:

(A) For recipients other than State Blind Pension recipients, $1 per prescription and $1 per refill for generic drugs.

(B) For recipients other than State Blind Pension recipients, $3 per prescription and $3 per refill for brand name drugs.

(C) For State Blind Pension recipients, $1 per prescription and $1 per refill for brand name drugs and generic drugs.

(ii) For inpatient hospital services, provided in a general hospital, rehabilitation hospital or private psychiatric hospital, the copayment is $3 per covered day of inpatient care, to an amount not to exceed $21 per admission.

(iii) For nonemergency services provided in a hospital emergency room, the copayment on the hospital support component is double the amount shown in subparagraph (vi), if an approved waiver exists from the United States Department of Health and Human Services. If an approved waiver does not exist, the copayment will follow the schedule shown in subparagraph (vi).

(iv) When the total component or only the technical component of the following services are billed, the copayment is $1:

(A) Diagnostic radiology.

(B) Nuclear medicine.

(C) Radiation therapy.

(D) Medical diagnostic services.

(v) For outpatient psychotherapy services, the copayment is 50¢ per unit of service.

(vi) For all other services, the amount of the copayment is based on the MA fee for the service, using the following schedule:

(A) If the MA fee is $2 through $10, the copayment is 65¢.

(B) If the MA fee is $10.01 through $25, the copayment is $1.30.

(C) If the MA fee is $25.01 through $50, the copayment is $2.55.

(D) If the MA fee is $50.01 or more, the copayment is $3.80.

(E) The Department may, by publication of a notice in the *Pennsylvania Bulletin*, adjust these copayment amounts based on the percentage increase in the medical care component of the Consumer Price Index for All Urban Consumers for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

(6) The amount of the copayment, which is to be paid to providers by GA recipients age 21 to 65, and which is deducted from the Commonwealth's MA fee to providers for each service, is as follows:

(i) For prescription drugs:

(A) $1 per prescription and $1 per refill for generic drugs.

(B) $3 per prescription and $3 per refill for brand name drugs.

(ii) For inpatient hospital services, provided in a general hospital, rehabilitation hospital or private psychiatric hospital, the copayment is $6 per covered day of inpatient care, not to exceed $42 per admission.

(iii) When the total component or only the technical component of the following services are billed, the copayment is $2:

(A) Diagnostic radiology.

(B) Nuclear medicine.

(C) Radiation therapy.

(D) Medical diagnostic services.

(iv) For all other services, the amount of the copayment is based on the MA fee for the service, using the following schedule:

(A) If the MA fee is $2 through $10, the copayment is $1.30.

(B) If the MA fee is $10.01 through $25, the copayment is $2.60.

(C) If the MA fee is $25.01 through $50, the copayment is $5.10.

(D) If the MA fee is $50.01 or more, the copayment is $7.60.

(E) The Department may, by publication of a notice in the *Pennsylvania Bulletin*, adjust these copayment amounts based on the percentage increase in the medical care component of the Consumer Price Index for All Urban Consumers for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

(7) A provider participating in the program may not deny covered care or services to an eligible MA recipient because of the recipient's inability to pay the copayment amount. This paragraph does not change the fact that the recipient is liable for the copayment, and it does not prevent the provider from attempting to collect the copayment amount. If a recipient believes that a provider has charged the recipient incorrectly, the recipient shall continue to pay copayments charged by that provider until the Department determines whether the copayment charges are correct.

(8) A provider may not waive the copayment requirement or compensate the recipient for the copayment amount.

(9) If a recipient is covered by a third-party resource and the provider is eligible for an additional payment from MA, the copayment required of the recipient may not exceed the amount of the MA payment for the item or service.

(c) *MA deductible.*

(1) A $150 deductible per fiscal year shall be applied to adult GA recipients for the following MA compensable services:

(i) Ambulatory surgical center services.

(ii) Inpatient hospital services.

(iii) Outpatient hospital services.

(2) Laboratory and X-ray services are excluded from the deductible requirement.

[Pa.B. Doc. No. 12-645. Filed for public inspection April 13, 2012, 9:00 a.m.]

DEPARTMENT OF PUBLIC WELFARE

[55 PA. CODE CH. 1121]

Pharmaceutical Services; Amendments to Pharmacy Payment Methodology

The Department of Public Welfare (Department) amends Chapter 1121 (relating to pharmaceutical services) to read as set forth in Annex A under the authority in sections 201(2), 403(b) and 403.1 of the Public Welfare Code (code) (62 P. S. §§ 201(2), 403(b), 403.1), as amended by the act of June 30, 2011 (P. L. 89, No. 22) (Act 22).

Omission of Proposed Rulemaking

On July 1, 2011, the General Assembly enacted Act 22, which amended the code. Act 22 added several new provisions to the code, including section 403.1. Section 403.1(a)(1) and (4) of the code authorizes the Department to promulgate final-omitted regulations under the act of July 31, 1968 (P. L. 769, No. 240) (45 P. S. §§ 1102—1208), known as the Commonwealth Documents Law (CDL) to establish rules, regulations, procedures and standards for the nature and extent of assistance and to revise provider payment rates. Section 204(1)(iv) of the CDL (45 P. S. § 1204(1)(v)) authorizes an agency to omit or modify notice of proposed rulemaking when a regulation relates to Commonwealth grants or benefits. The Medical Assistance (MA) Program is a Commonwealth grant program through which eligible recipients receive coverage of certain health care benefits, including pharmaceuticals. In addition, to ensure that the Department's expenditures for State Fiscal Year (FY) 2011-2012 do not exceed the aggregate amount appropriated by the General Assembly, section 403.1 of the code expressly exempts these regulations from the Regulatory Review Act (71 P. S. §§ 745.1—745.12), section 205 of the CDL (45 P. S. § 1205) and section 204(b) of the Commonwealth Attorneys Act (71 P. S. § 732-204(b)).

The Department is amending Chapter 1121 in accordance with section 403.1(a)(1) and (4) of the code because this final-omitted rulemaking pertains to the MA Program provider payments for compensable services. Further, consistent with section 403.1(c) of the code, this final-omitted rulemaking is necessary to ensure that expenditures for State FY 2011-2012 for assistance programs administered by the Department do not exceed the aggregate amount appropriated for the program by the General Appropriations Act of 2011.

Purpose

The purpose of this final-omitted rulemaking is to amend the current regulations in Chapter 1121 as follows:

• To set the dispensing fee paid to pharmacies at $2 for prescriptions for compensable noncompounded legend and nonlegend drugs and $3 for compensable compounded prescriptions.

• To set the dispensing fee paid to pharmacies for prescriptions for compensable legend and nonlegend drugs and compensable compounded prescriptions for MA recipients with a pharmacy benefit resource, which is a primary third-party payer, to MA at $0.50 to cover the pharmacy's cost to transmit the claim to the MA program for secondary payment.

• To revise the calculation of wholesale acquisition cost (WAC) when establishing the estimated acquisition cost (EAC) as follows:

o For brand name drugs, the WAC calculation is being amended to the lowest WAC listed for the drug in available Nationally recognized pricing services, plus 3.2%.

o For generic drugs, the WAC calculation is being amended to the lowest WAC listed for the drug in available Nationally recognized pricing services.

• To modify the provision relating to the frequency of the update to the EAC for individual drugs from a monthly to an at least monthly basis.

Background

The Department administers the MA Program under Title XIX of the Social Security Act (act) (42 U.S.C.A. §§ 1396—1396w-5) for low-income individuals, pregnant women, infants and children, and individuals who are aged, blind or disabled. In addition, the Department administers an MA program for General Assistance MA recipients, principally single adults, which is funded solely by State funds and is not mandated by the Federal government. Both MA programs provide a wide array of medically necessary healthcare services, supplies and equipment to approximately 2.1 million indigent persons. Pharmaceutical services are among the healthcare services covered by the MA Program.

Since 2005, the Department has implemented a series of initiatives in the MA Program designed to provide cost effective pharmaceutical services while enhancing quality, addressing health and safety concerns, and improving administrative efficiencies. Initiatives included implementation of a payment methodology more consistent with other public and private third-party payers in this Commonwealth; implementation and expansion of a Preferred Drug List; expansion of utilization management programs including quantity limits, clinical prior authorizations, early refill and appropriate age edits; increasing the generic dispensing rate to 76%; maximization of Federal and supplemental rebates; selective contracting with specialty pharmacies for costly specialty drugs; automated prior authorization; and a comprehensive Retrospective Drug Use Review program for provider educational interventions. These sophisticated, industry-standard, pharmacy management tools enabled the Department to realize significant cost savings, minimize the per-member per-month increase in pharmacy expenditures and increase quality of care without compromising access or imposing overly burdensome requirements on providers.

In an effort to ensure that expenditures for assistance programs administered by the Department do not exceed the aggregate amount appropriated for the program by the General Appropriations Act of 2011, the Department has taken steps to implement additional initiatives to further reduce costs while still providing needed care to MA recipients, including limiting pharmacy benefits for recipients 21 years of age and older to six prescriptions per calendar month and limiting certain dental benefits for recipients 21 years of age and older. Despite these and other cost saving efforts, the Department must identify more ways to achieve necessary cost savings. The Department has determined that changing the method of payment for pharmacy services will produce savings, with the least impact on services and care provided to MA recipients.

Changes to Dispensing Fees

Federal law requires that State Medicaid pharmacy payments for drugs[1] include a drug cost based on the EAC,[2] plus a reasonable dispensing fee established by the Department. See 42 CFR 447.512 (relating to drugs: aggregate upper limits of payment). In December 2010, The Lewin Group issued a report titled "Potential Federal and State-by-State Savings if Medicaid Pharmacy Programs were Optimally Managed" (Lewin report) (http://www.lewin.com/publications/publication/436/). Based on its analysis of 2009 Centers for Medicare and Medicaid Services (CMS) Medicaid Fee-for-Service (FFS) data and using what it characterized as typical Medicare Part D dispensing fees estimated at $1.90 for brand drugs and $2.20 for generic drugs, the Lewin report concluded that Federal and State Medicaid pharmacy expenditures could be reduced by, among other things, decreasing dispensing fees.[3]

Currently, the Department pays a $4 dispensing fee for prescriptions for compensable, noncompounded brand name and generic drugs and a $5 dispensing fee for compensable compounded prescriptions in the MA FFS program. In deciding whether these fees could be reduced, the Department reviewed the State Medicaid prescription reimbursement information available on the CMS web site. For the quarter ending September 2011, CMS reported that states are paying a dispensing fee ranging from a low of $1.75 (New Hampshire) to a high of $14.01 (Oregon) for brand name drugs and generic drugs. The wide variance in dispensing fees paid by other state Medicaid programs is attributable, in part, to the different methods that states use to determine EAC. Given these differences and because, as previously mentioned,

[1] Drugs available from multiple manufacturers and distributors are often referred to as generic or multisource drugs. Drugs available from only one manufacturer that holds or held the patent for the drug product are referred to as brand name or single source drugs.

[2] The EAC is defined in 42 CFR 447.502 (relating to definitions) as the state Medicaid "agency's best estimate of the price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer or labeler in the package size of the drug most frequently purchased by providers."

[3] The Lewin report also recommended increasing generic dispensing rates, reducing ingredient costs and implementing more effective drug utilization controls as other means to reduce Federal and State Medicaid pharmacy expenditures. As previously noted, the Department has already implemented multiple initiatives consistent with these recommendations.

the dispensing fees of the Medicaid programs have been criticized as too high, the Department concluded that it was appropriate to consider other factors in determining whether to change the MA FFS dispensing fees.

Rather than focusing on other state Medicaid payments, the Department decided that a comparison of the current MA FFS dispensing fees with the fees paid by other third-party payers in this Commonwealth would provide a more accurate and realistic view of what a reasonable dispensing fee should be. The Department found that, with the exception of the Pharmaceutical Assistance Contract for the Elderly program, which also pays a $4 dispensing fee, the Department's MA FFS dispensing fees are higher than, and in most cases more than double, the dispensing fees paid by all of the Department's contracted HealthChoices managed care organizations (MCO), the Pennsylvania Employees Benefits Trust Fund, private commercial third-party prescription drug programs in this Commonwealth and Medicare Part D plans.

The HealthChoices MCOs, which furnish pharmacy services to 57% of the MA population, pay dispensing fees between $0.96 and $2 for brand name drugs and between $0.97 and $2.29 for generic drugs. Notwithstanding these fees, HealthChoices MA MCO enrollees continue to have access to pharmacy services to the same extent as members of the general public in the HealthChoices geographic areas.

While specific information on dispensing fees paid by private commercial third-party plans is not made public, the Department did consider the information that is generally available for these payers. According to the Lewin report, state Medicaid programs pay pharmacies dispensing fees that are "more than twice the amount paid by private sector health plans." Lewin report at 12. In its 2011 "Prescription Drug Benefit Cost and Plan Design Report," which provides an overview of trends in prescription drug coverage, plan design, utilization and drug costs as reported by United States employers, the Pharmacy Benefit Management Institute noted that the average dispensing fee for both brand and generic drugs is $1.54. Consistent with these reports, several of the Department's HealthChoices MCOs advised the Department that the dispensing fees in their private commercial book of business are under $2. Further, according to Mercer Government Human Services Consultant, the Department's actuary contractor, its commercial clients based in this Commonwealth or who have a significant number of employees located in this Commonwealth pay dispensing fees ranging from $1 to $1.50.

The MA program cannot ignore that the dispensing fees paid to pharmacies in this Commonwealth by the HealthChoices MCOs, Medicare and private commercial third-party plans are significantly lower than those paid by the FFS program. The amendment to § 1121.55 (relating to method of payment) implements a dispensing fee in the MA FFS program that is comparable with the dispensing fees adopted by the HealthChoices MCOs, Medicare Part D plans and private commercial third-party plans.

The Department is also amending § 1121.55(a) with respect to the dispensing fee when the MA recipient has a medical resource that includes coverage of pharmacy services and is a primary third-party payer to MA. In these situations, the pharmacy agreed to accept the third-party resource's dispensing fee to cover the cost of dispensing the drug. Rather than paying a $2 dispensing fee for prescriptions for compensable noncompounded legend and nonlegend drugs and $3 for compensable compounded prescriptions, the Department will pay a $0.50 dispensing fee to account for the pharmacy's cost to transmit the claim to the MA program for secondary payment. This fee is intended to cover any additional transaction costs that the pharmacies incur to transmit the claims for processing. The industry average claim transaction fee ranges from $0.20 to $0.35. The Department's $0.50 dispensing fee accounts for small independent pharmacies with lower claims volume and the potential for higher fees.

Changes to WAC Calculation

The Department is also revising the payment methodology for the drug cost component under § 1121.56 (relating to drug cost determination). In 2005, the Department amended the regulations governing the payment methodology for both brand name and generic drugs making the payment for the drug cost component of reimbursement more consistent with other public and private third-party payers. This amendment added WAC to the "lower of" payment methodology, establishing the EAC for brand name drugs at the lower of the lowest WAC listed for the drug in available Nationally recognized pricing services plus 7% or the lowest average wholesale price (AWP) listed for the drug in available Nationally recognized pricing services minus 14% for brand name drugs. The EAC for generic drugs was established at the lower of the lowest WAC listed for the drug in available Nationally recognized pricing services plus 66%, the lowest AWP listed for the drug in available Nationally recognized pricing services minus 25% or the State Maximum Allowable Cost (MAC) established by the Department. This "lower of" payment methodology assured the Department a payment methodology that is efficient and economic without compromising quality or access.

The Department is amending § 1121.56 to reflect the original intent of the 2005 amendment to the regulation. Because the current metrics to determine the AWP and WAC pricing are not equalized, when determining the EAC for a drug claim, the AWP metric is almost always the "lower of" amount when compared to the current WAC metric and typically is the amount used to determine the drug cost component of the payment to the pharmacy. Current predictions within the pharmacy industry are that eventually AWP will be phased out. In 2011, First Data Bank, one of the three Nationally recognized pricing services, stopped publishing AWP. Although Micromedex and Medi-Span, the other two pricing services, continue to publish AWP, most public and private industry stakeholders are seeking to identify a replacement benchmark metric for standardized drug pricing. If the National pricing services discontinue publishing AWP, the consequence will be that the MA Program will pay for the drug cost component at the higher WAC metric. Therefore, the Department must equalize the AWP and WAC metrics now to avoid unintended increases in payments of drug claims in the future.

The amendment to § 1121.56 equalizes the calculation of AWP and WAC by amending the WAC calculation to equal the result of the AWP calculation. Specifically, for brand name drugs, the WAC calculation is the lowest WAC listed in the available Nationally recognized drug pricing services, plus 3.2%. For generic drugs, it is the lowest WAC listed in the Nationally recognized pricing services. The AWP calculation, however, is not changing. The amendment will have minimal impact on pharmacy providers, as most drug claims are paid using the AWP metric. The amendment will not have an impact on consumers.

Public Process

The Department published advance public notice at 42 Pa.B. 1002 (February 18, 2012) announcing its intent to amend the method of payment for pharmacy services under Chapter 1121. The Department invited interested persons to comment. In addition, the Department discussed these pharmacy amendments with the Medical Assistance Advisory Committee at its meeting on February 23, 2012.

The Department also posted the draft regulation on the Department's web site on February 24, 2012, with a 15-day comment period. The Department again invited interested persons to submit written comments regarding the regulation to the Department. The Department received 32 topically-related comments from 20 commentators. The Department also discussed the Act 22 regulations and responded to questions at the House Health Committee hearing on March 8, 2012.

The Department considered all comments in response to the draft regulation.

Discussion of Comments

The following is a summary of the major comments received within the public comment period and the Department's responses to those comments.

Comment

Some commentators stated the changes may lead to the closing of some community pharmacies and others stated the changes would force pharmacies to discontinue services to MA recipients, both of which would result in limited access to pharmacy services for MA recipients. Some commentators also stated that the changes threaten the viability of long-term care pharmacies. Others also expressed concern about access for residents of rural areas and residents of long-term care facilities.

Response

The amended pharmacy payments are consistent with payments made by other public and private third-party payers and those MA recipients and beneficiaries continue to have access to pharmacy services to the same extent as members of the general public. Therefore, the changes to the pharmacy payments do not adversely affect provider participation and access to service, even in rural areas and long-term care facilities.

- The HealthChoices MCOs furnish pharmacy services to 57% of the MA population. Most of the MCOs pay lower ingredient rates for brand and generic medications and all pay dispensing fees between $0.96 and $2 for brand name drugs and between $0.97 and $2.29 for generic drugs.

- 42% of the MA recipients who qualify for pharmacy services are dual eligible recipients (eligible for both Medicare and Medicaid). Most dual eligible recipients receive their drug coverage under Medicare Part D. (Pharmacy coverage for a dual eligible recipient in the MA program is limited to over-the-counter drugs, benzodiazepines and barbiturates not covered by Part D plans.) Typical Medicare Part D dispensing fees are estimated at $1.90 for brand drugs and $2.20 for generic drugs.

- A published report indicated a National average dispensing fee for both brand and generic drugs of $1.54 in the commercial sector.

Comment

Several commentators recommended increasing use of generic medications, medication therapy management (MTM) programs and requiring mandatory cost sharing for certain recipients as alternative methods to achieve savings.

Response

The MA program already requires generic substitution and generic drug utilization increased from 67.03% in 2008 to 76% in 2011. The MA Program monitors the cost of brand name and generic drugs and the impact of Federal and supplemental rebates on net cost to the Department and maximizes the use of generic drugs when they are cost effective. In some instances, the cost of the brand drug after rebates (Federal and supplemental) is less than the cost of the generic equivalent after the Federal rebate. When the brand drug costs the Department less than the generic equivalent, the Department designates the brand name drug as preferred in the FFS program. This pricing is unique to the FFS delivery system in the Medicaid program.

Although the Department does not have an MTM program for high risk patients, the Department has a disease management program and an intensive care management program in FFS. These programs serve to educate MA recipients, coordinate care and lower the total cost of health care.

The Department may consider cost sharing options provided for in the Deficit Reduction Act of 2005 (Pub. L. No. 109-171) in the future.

Comment

Several commentators disagree with the decrease in dispensing fees stating that the new fees will be "difficult" for the pharmacies, the cost of dispensing medications falls into the range of $5 to $10 and the dispensing of compounded products takes much skill and time to accomplish.

Response

As previously provided, the amendment to § 1121.55 implements a dispensing fee in the MA FFS program that is comparable with the dispensing fees adopted by the HealthChoices MCOs, Medicare Part D plans and private commercial third-party plans. The payments made by these public and private third-party payers are accepted by pharmacies Statewide and have not compromised access to patients. The amended dispensing fees in the FFS program bring the Department in line with current pharmacy industry standards and continue to recognize compounding with a higher $3 dispensing fee.

Comment

Several commentators commented on the changes to the EAC. Two commentators estimated reductions in payment for brand-name medications by $7.57 per prescription and $3.45 per prescription on generic medications. One of the commentators inquired regarding the Department's savings estimates, including the payment for generic medications.

Response

The Department disagrees with these estimated reductions in payment for brand name and generic medications. The Department, however, is unable to respond to the specific numbers because the commentators did not provide an explanation of how they estimated the reductions or provide any data to support the estimated reductions.

The Department's reported savings were estimated based on paid claims history. During calendar year 2011, the FFS program paid 9,091,734 pharmacy claims.

Because of the significant differential among generic prices, a literal crosswalk from AWP and WAC is more difficult than the crosswalk from AWP to WAC for brand name drugs. Information from retail pricing surveys was used to estimate the WAC-5% metric for the equivalency to AWP-25%. The actual impact in terms of payment to pharmacies is minimal based on an analysis of 2011 FFS Pharmacy Claims data. Only 3.64% of generic claims would have been paid using the WAC minus 5% metric. The 3.64% is comprised of claims that were billed at the usual and customary charge or paid at the current WAC plus 66% payment metric. The remaining 96.4% of generic claims were paid using AWP minus 25%, the Federal Upper Limit or at the State MAC and would continue to be paid on that basis.

Despite the minimal impact, the Department recognizes that the cost of generics to pharmacies may vary according to the pharmacy size and volume of business and can range on average anywhere from WAC to WAC-6%. In recognition of these differences and after consideration of the comments received on this provision, the Department changed the regulation to amend the calculation of WAC when establishing the EAC for generic drugs from "the lowest WAC listed for the drug in available Nationally recognized pricing services, minus 5%" to "the lowest WAC listed for the drug in available Nationally recognized pricing services."

Comment

Two commentators inquired whether the Department will update the EAC on a daily or weekly basis. In addition, one commentator questioned what data will be used to determine the WAC metric and whether the data will be available to pharmacies to verify the accuracy.

Response

Currently, in accordance with § 1121.56(b), the EAC is updated monthly. The Department, however, is amending subsection (b) to change "monthly" to "at least monthly" to provide the flexibility for more frequent updates to the ingredient cost component of reimbursement.

The MA program uses three Nationally recognized pricing services, First Data Bank, Micromedex and Medi-Span, when determining the "lower of" payment. Drug pricing information from each of these pricing services is available by subscription.

Comment

Several commentators stated that the Department did not allow sufficient time for review and comment of the regulations.

Response

The Department engaged in a transparent public process through which the Department solicited and received numerous comments and input from stakeholders and other interested parties.

As previously mentioned, the Department published advance public notice at 42 Pa.B. 1002 announcing its intent to amend the method of payment for pharmacy services under Chapter 1121. The Department invited interested persons to comment. The Department also posted the draft regulation on the Department's web site on February 24, 2012. The Department again invited interested persons to submit written comments, on or before March 9, 2012, regarding the regulation to the Department. As a final-omitted regulation under Act 22, the Department was not required to have a public comment process. However, to encourage transparency and public input the Department provided an opportunity for comment by publishing the notice and posting the draft regulation on the Department's web site. This public comment process provided sufficient opportunity for interested parties to submit comments, as supported by the number of comments that were submitted.

Comment

The Department exceeded its authority under Act 22 by issuing final-omitted regulations that change pharmacy reimbursement methods in future years.

Response

Act 22 authorizes the Department to promulgate final-omitted regulations that revise payment rates. To ensure that the Department's expenditures for State FY 2011-2012 do not exceed the amount appropriated by the General Assembly, this final-omitted rulemaking is exempt from the Regulatory Review Act, section 205 of the CDL and section 204(b) of the Commonwealth Attorneys Act. There is nothing in Act 22 that precludes the promulgation of final-omitted regulations that will have an impact in both State FY 2011-2012 and in future years.

Technical Amendments

To promote understanding and application of MA payment for pharmaceutical services, the Department is making several technical corrections to Chapter 1121. These technical corrections do not represent changes to the Department's current MA payment or coverage policies. They reflect and clarify payment for pharmaceutical services that have been in effect under the MA Program, based upon Federal Medicaid requirements and MA payment policies, but have not yet been incorporated into Chapter 1121. These technical corrections are as follows:

• Clarification that in the definition of "usual and customary charge" the phrase "other discounts extended to a particular group of patients" includes generic drug savings and discount programs.

• Deletion of the requirement for the licensed prescriber to write the prior authorization number on the prescription form as that information is now located in PROMISe, the Department's claims processing system.

• Deletion of the reference to the 5-day grace period and the exclusions to the 5-day grace period for prescriptions filled and delivered to a recipient in a skilled nursing facility, an intermediate care facility or an intermediate care facility for the mentally retarded prior to the normal 30-day cycle. Pharmacy claims are now submitted through PROMISe, the Department's online, point-of-sale claims adjudication system. The Department notified prescribing providers and pharmacies of the requirement for prior authorization of an early refill effective August 4, 2008, by way of MA Bulletin Number 02-08-04, et al, "Prior Authorization of Early Refills of Prescriptions," issued July 18, 2008, and issued handbook pages that include the type of information needed to evaluate requests for early refills of prescriptions for medical necessity.

• Deletion of the following from the list of noncompensable services and items:

o Methadone. Methadone meets the conditions for coverage under the Medicaid Program (see section 1927(a)(1) of the act (42 U.S.C.A. § 1396r-8(a)(1))) and consequently it has been included in the Department's list of covered drugs.

o Drugs prescribed for treatment of pulmonary tuberculosis. These drugs meet the conditions for coverage under the Medicaid Program (see section 1927(a)(1) of the act) and have been included on the Department's list of covered drugs.

o Drugs prescribed for cessation of smoking. In 2002, the Department expanded the scope of covered services for eligible MA recipients to include tobacco cessation drug products and tobacco cessation counseling services and notified all providers of this addition by way of MA Bulletin Number 99-02-02, "Coverage of Tobacco Cessation Drug Products and Counseling Services," issued January 16, 2002.

o Single entity and multiple vitamins with exceptions, legend and nonlegend aqueous saline solutions, legend and nonlegend water preparations and impregnated gauze and identical, similar or related products. In accordance with the CMS Medicaid Drug Rebate Program Release No. 155, issued August 11, 2010, substances that do not meet the definition of a covered outpatient drug as defined in section 1927(a)(1) of the act are considered nondrug products and are not subject to the requirements of the Medicaid Drug Rebate program. The MA program covers these products under the medical supplies and equipment category of service.

o Emollients. Emollients are included on the Department's list of covered drugs.

o Legend and nonlegend food supplements and substitutes. The Department expanded the scope of covered services for eligible MA recipients to include enteral nutritional supplements effective January 1, 2002, and notified providers of this addition by way of MA Bulletin Number 99-01-13, "Coverage of Enteral Nutritional Supplements," issued December 28, 2001.

• Addition of the following to the list of noncompensable services and items:

o Erectile dysfunction (ED) drugs. Prescriptions for ED drugs are noncompensable unless used for a Food and Drug Administration-approved indication other than for the treatment of sexual or ED. The Department notified prescribing providers and pharmacies that effective March 1, 2006, coverage of drugs for the treatment of sexual or ED is eliminated in the Medicaid Program in accordance with notice from CMS by way of MA Bulletin Number 02-06-04, et al, "Federal Clarification—Elimination of Medicaid Coverage of Drugs for Treatment of Erectile Dysfunction," issued March 7, 2006.

Therefore, the Department is amending §§ 1121.2, 1121.53 and 1121.54 (relating to definitions; limitations on payment; and noncompensable services and items) to codify and better clarify the scope and applicability of coverage and payment conditions for pharmaceutical services. These technical amendments do not impose new or additional coverage exclusions or payment conditions and reflect the manner in which these services are currently covered under the Commonwealth's MA Program.

Requirements

The following is a summary of the major provisions of this final-omitted rulemaking.

§ 1121.2. Definitions

The Department is amending the definition of "usual and customary charge" to specifically include generic drug savings and discount programs.

§ 1121.53. Limitations on payment

The Department is amending subsection (b)(1)(ii) by deleting the requirement for a licensed prescriber to write the prior authorization number on the prescription form. In addition, subsection (f) is amended to delete the reference to a 5-day grace period to accommodate prescriptions filled and delivered prior to the normal 30-day cycle. Paragraphs (1)—(10), which provided the exemptions to this limitation, are deleted as well.

§ 1121.54. Noncompensable services and items

The Department is making technical corrections that reflect current MA coverage policies. This section is amended to delete the services and items to reflect the current payment policies. The remaining paragraphs were renumbered accordingly.

§ 1121.55. Method of payment

The Department is amending subsection (a)(1) and (2) to change the $4 dispensing fee to a $2 dispensing fee. Subsection (b) is also amended to change the $5 dispensing fee to a $3 dispensing fee. In addition, paragraph (4) is added to provide a $0.50 dispensing fee to cover the cost of the transaction to submit the claim when the MA recipient has a medical resource that includes coverage of pharmacy services and is a primary third-party to MA.

§ 1121.56. Drug cost determination

As stated previously, the Department is amending subsection (a)(1)(i)(A) to change the reference to WAC plus 7% to WAC plus 3.2%. Subsection (a)(1)(ii)(A) is also amended to change the reference to WAC plus 66% to WAC. Subsection (b) is amended to change the frequency of updates to EAC from monthly to at least monthly. Finally, subsection (f) is amended to correct a typographical error and change "CMF" to "CMS," which is the Centers for Medicare and Medicaid Services.

Affected Individuals and Organizations

Pharmacies that are enrolled as MA providers will be affected by the changes. MA recipients, however, will not be affected by these changes.

Accomplishments and Benefits

The final-omitted rulemaking aligns the Department's dispensing fee with those of other public and private third-party payers, enables the MA program to ensure the savings intended when the Department adopted the "lower of" payment methodology and clarifies the method of payment when the MA recipient has a pharmacy third-party benefit resource. In addition, the technical amendments codify the requirements for coverage and payment and enhance the clarity of the regulations.

Fiscal Impact

The final-omitted rulemaking will result in reduced payments to pharmacies enrolled in the MA program. The Commonwealth will realize $1.589 million ($0.714 million in State funds) in savings in FY 2011-2012.

Paperwork Requirements

There are not additional reports, paperwork or new forms needed to comply with the final-omitted rulemaking.

Regulatory Review Act

Under section 403.1 of the code, this final-omitted rulemaking is not subject to review under the Regulatory Review Act.

Findings

The Department finds that:

(1) Notice of proposed rulemaking is omitted in accordance with section 204(1)(iv) of the CDL, 1 Pa. Code § 7.4(1)(iv) and section 403.1 of the code because the final-omitted rulemaking relates to Commonwealth grants and benefits.

(2) That the adoption of this final-omitted rulemaking in the manner provided by this order is necessary and appropriate for the administration and enforcement of the code.

Order

The Department, acting under the code, orders that:

(a) The regulations of the Department, 55 Pa. Code Chapter 1121, are amended by amending §§ 1121.2 and 1121.53—1121.56 to read as set forth in Annex A, with ellipses referring to the existing text of the regulations.

(b) The Secretary of the Department shall submit this order and Annex A to the Office of General Counsel 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 upon publication in the *Pennsylvania Bulletin*.

GARY D. ALEXANDER,
Secretary

Fiscal Note: 14-530. No fiscal impact; (8) recommends adoption.

Annex A

TITLE 55. PUBLIC WELFARE

PART III. MEDICAL ASSISTANCE MANUAL

CHAPTER 1121. PHARMACEUTICAL SERVICES

GENERAL PROVISIONS

§ 1121.2. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

* * * * *

Usual and customary charge—The pharmacy's lowest net charge an MA recipient would pay for a prescription as a non-Medicaid patient at the time of dispensing for the same quantity and strength of a particular drug or product, including applicable discounts, such as special rates to nursing home residents, senior citizens or other discounts extended to a particular group of patients, including generic drug discount and savings programs. This lowest net price does not apply to special in-store rates or discounts extended to charitable organizations, religious groups, store employees and their families, nonprofit organizations, members of the medical profession or other similar non-Medicaid groups.

* * * * *

PAYMENT FOR PHARMACEUTICAL SERVICES

§ 1121.53. Limitations on payment.

(a) The Department will not pay a provider an amount that exceeds the provider's usual and customary charge to the general public.

(b) The Department establishes a State MAC which sets a limit on the drug cost component of the payment formula for selected multisource drugs. The State MAC will include a combination of CMS multisource drugs and the Department's MAC drugs and does not apply if the following exist:

(1) The licensed prescriber certifies that a specific brand is medically necessary by doing all of the following:

(i) Writes on the prescription form "Brand Necessary" or "Brand Medically Necessary" in the prescriber's own handwriting.

(ii) Receives prior authorization from the Department to use the brand name product.

(2) In the case of a telephone prescription, the licensed prescriber sends a properly completed prescription, as described in paragraph (1), to the pharmacist within 15 days of the date of service.

* * * * *

(f) Payment to a pharmacy for prescriptions dispensed to a recipient in either a skilled nursing facility, an intermediate care facility or an intermediate care facility for the mentally retarded shall be limited to one dispensing fee for each drug dispensed within a 30-day period.

§ 1121.54. Noncompensable services and items.

Payment will not be made to a pharmacy for the following services and items:

(1) Drugs and other items prescribed for obesity, appetite control or other similar or related habit altering tendencies. Drugs which have been cleared for use in the treatment of hyperkinesis in children and primary and secondary narcolepsy due to structural damage of the brain are compensable if the physician indicates the diagnosis on the original prescription.

(2) Nonlegend drugs in the form of troches, lozenges, throat tablets, cough drops, chewing gum, mouthwashes and similar items.

(3) Pharmaceutical services provided to a hospitalized person.

(4) Drugs and devices classified as experimental by the FDA or whose use is classified as experimental by the FDA.

(5) Drugs and devices not approved by the FDA or whose use is not approved by the FDA.

(6) Placebos.

(7) Legend and nonlegend soaps, cleansing agents, dentifrices, mouthwashes, douche solutions, diluents, ear wax removal agents, deodorants, liniments, antiseptics, irrigants and other personal care and medicine chest items.

(8) Compounded prescriptions when one of the following applies:

(i) Compensable items are used in less than therapeutic quantities.

(ii) Noncompensable items are compounded.

(9) Nonlegend drugs not listed in § 1121.53(d) (relating to limitations on payment).

(10) Drugs prescribed in conjunction with sex reassignment procedures or other noncompensable procedures.

(11) The following items when prescribed for recipients in a skilled nursing facility, an intermediate care facility or an intermediate care facility for the mentally retarded:

(i) Intravenous solutions.

(ii) Noncompensable drugs and items as specified in this section.

(iii) The following nonlegend drugs:

(A) Analgesics.

(B) Antacids.

(C) Antacids with simethicone.

(D) Cough—cold preparations.

(E) Contraceptives.

(F) Laxative and stool softeners.

(G) Ophthalmic preparations.

(H) Diagnostic agents.

(iv) Legend laxatives.

(12) Items prescribed or ordered by a prescriber who has been barred or suspended from participation in the MA Program. The Department will periodically send pharmacies a list of the names of suspended, terminated or reinstated practitioners and the dates of the various actions. Pharmacies are responsible for checking this list before filling prescriptions.

(13) Prescriptions or orders filled by a pharmacy other than the one to which a recipient has been restricted under § 1101.91 (relating to recipient misutilization and abuse). The Department will issue special medical services eligibility cards to restricted recipients indicating the name of the pharmacy to which the recipient is restricted. Pharmacies are responsible for checking the recipient's medical services eligibility card before filling the prescription.

(14) DESI drugs and identical, similar or related products or combinations of these products.

(15) A pharmaceutical service for which payment is available from another public agency or another insurance or health program except for those drugs prescribed through the county mental health/mental retardation programs as specified in § 1121.51 (relating to general payment policy).

(16) FDA approved pharmaceutical products whose indicated use is not to treat or manage a medical condition, illness or disorder.

(17) Legend and nonlegend pharmaceutical products distributed by a company that has not entered into a National rebate agreement with the Federal government as provided under section 4401 of OBRA '90, except for those specific drug products authorized by the Federal government as essential to the health of an MA recipient. The Department will issue a special list comprised of those companies that signed rebate agreements with the Federal government and those products authorized as essential to the health of an MA recipient. Pharmacies are responsible for checking the list before filling the prescription.

(18) Legend and nonlegend cough and cold preparations, except when prescribed for MA recipients under 21 years of age.

(19) Erectile dysfunction drugs unless used for an FDA approved indication other than for the treatment of sexual or erectile dysfunction.

§ 1121.55. Method of payment.

(a) The Department will pay a pharmacy for a compensable legend and nonlegend drug (after deducting the applicable copayment amount, as described in § 1101.63(b) (relating to payment in full)), the lowest of the following amounts:

(1) The EAC for the drug, multiplied by the number of units dispensed, plus a $2 dispensing fee.

(2) The State MAC for the drug, multiplied by the number of units dispensed, plus a $2 dispensing fee.

(3) The provider's usual and customary charge to the general public.

(4) For MA recipients with a pharmacy benefit resource which is a primary third party payer to MA, the lower of the following amounts:

(i) The EAC for the drug, multiplied by the number of units dispensed, plus a $0.50 dispensing fee.

(ii) The State MAC, multiplied by the number of units dispensed, plus a $0.50 dispensing fee.

(b) The Department will pay a pharmacy for a compensable compounded prescription at the lower of the cost of all ingredients plus a $3 dispensing fee or the provider's usual and customary charge to the general public. For MA recipients with a pharmacy benefit resource which is a primary third party payer to MA, the dispensing fee shall be $0.50.

(c) The provider shall bill the Department at its usual and customary charge to the general public.

§ 1121.56. Drug cost determination.

(a) The Department will base its drug cost for compensable legend and nonlegend drugs on the lower of:

(1) The EAC established by the Department.

(i) For brand name drugs, the EAC is established by the Department as one of the following:

(A) The lowest WAC listed for the drug in available Nationally recognized pricing services, plus 3.2%.

(B) If WAC data are not available from a Nationally recognized pricing service, the lowest AWP listed for the drug in available Nationally recognized pricing services, minus 14%.

(C) If both WAC and AWP cost data are available for the drug from a Nationally recognized pricing service, the lower of the two amounts.

(ii) For generic drugs, the EAC is established by the Department as one of the following:

(A) The lowest WAC listed for the drug in available Nationally recognized pricing services.

(B) If WAC data are not available from a Nationally recognized pricing service, the lowest AWP listed for the drug in available Nationally recognized pricing services, minus 25%.

(C) If both WAC and AWP cost data are available for the drug from a Nationally recognized pricing service, the lower of the two amounts.

(2) The State MAC established by the Department.

(b) The Department will update the EAC for individual drugs at least on a monthly basis as it appears in available Nationally recognized pricing services.

(c) CMS establishes lists that identify and set Federal upper limits for CMS multisource drugs and provides the listing of these drugs and revisions to the list to the Department through Medicaid manual transmittals on a periodic basis.

(d) The Department will determine the State MAC by one of the following methods:

(1) For multisource drugs, the Department will set the State MAC at the lower of the following:

(i) The upper payment limit established by the CMS.

(ii) Provided that the generic product is available at the price established by the Department from at least two wholesalers:

(A) If the generic product is available from more than one manufacturer, the base price of 150% of the lowest acquisition cost for the generic product, unless 150% of the lowest acquisition cost is not at least 120% of the second lowest acquisition cost, in which case the base price will be set at 120% of the second lowest acquisition cost.

(B) If the generic product is available from only one manufacturer, the base price is 120% of the acquisition cost for the generic product.

(2) For disposable insulin syringes, the Department will set the State MAC at the amount listed in the MA Program Fee Schedule.

(e) The Department will update the State MAC:

(1) If the State MAC for a multisource drug is set at the Federal upper payment limit established by CMS, the Department will apply the Federal upper limits for CMS multisource drugs to be effective on the date established by CMS and will describe the update to each pharmacy enrolled in the MA Program when it is available.

(2) The Department will apply the price for all other State MAC multisource drugs every 3 months, and will distribute the update to each pharmacy enrolled in the MA Program.

(f) With the exception of the CMS multisource drugs, the Department will make further additions to the list of State MAC drugs after consultation with the Medical Assistance Advisory Committee as to whether the application of a State MAC is cost effective to the Department for a particular multisource drug. The Department will add the CMS multisource drugs to the State MAC list effective as of the effective date established by CMS.

(g) With the exception of disposable insulin syringes, the State MAC does not apply if the conditions are met as described in § 1121.53(b)(1) and (2) (relating to limitations on payment).

(h) The most common package size for the purposes of determining the product cost is one of the following:

(1) For capsules, tablets and liquids available in breakable package sizes:

(i) The listed package size if only one package size is listed.

(ii) The 100 or pint package size if more than one package size is listed.

(iii) The next smaller package size from the 100 or pint size, excluding a drug company's unit-dose package size, if more than one package size is listed other than the 100 or pint package size.

(iv) The package size closest to the 100 or pint package size, excluding a drug company's unit-dose package size, if the next smaller package is the unit-dose package size.

(2) The listed package size for all dosage forms available for all nonlegend drug products.

(3) The smallest package size for all dosage forms available in nonbreakable packages.

[Pa.B. Doc. No. 12-646. Filed for public inspection April 13, 2012, 9:00 a.m.]

DEPARTMENT OF PUBLIC WELFARE

[55 PA. CODE CH. 1163]

Newborn Payment Policy for Acute Care General Hospitals

The Department of Public Welfare (Department) amends Chapter 1163 (relating to inpatient hospital services) to read as set forth in Annex A under the authority in sections 201(2), 403(b) and 403.1 of the Public Welfare Code (code) (62 P. S. §§ 201(2), 403(b) and 403.1), as amended by the act of June 30, 2011 (P. L. 89, No. 22) (Act 22).

Omission of Proposed Rulemaking

On July 1, 2011, the General Assembly enacted Act 22, which amended the code. Act 22 added several new provisions to the code, including section 403.1. Section 403.1(a)(4), (c) and (d) of the code authorizes the Department to promulgate final-omitted regulations under section 204(1)(iv) of the act of July 31, 1968 (P. L. 769, No. 240) (45 P. S. § 1204(1)(iv)), known as the Commonwealth Documents Law (CDL), to establish or revise provider payment rates or fee schedules, reimbursement models or payment methodologies for particular services. Section 204(1)(iv) of the CDL authorizes an agency to omit or modify notice of proposed rulemaking when a regulation relates to Commonwealth grants or benefits. The Medical Assistance (MA) Program is a Commonwealth grant program through which eligible recipients receive coverage of certain health care benefits, including inpatient hospital services. In addition, to ensure that the Department's expenditures for State Fiscal Year (FY) 2011-2012 do not exceed the aggregate amount appropriated by the General Assembly, section 403.1 of the code expressly exempts these regulations from the Regulatory Review Act (71 P. S. §§ 745.1—745.12), section 205 of the CDL (45 P. S. § 1205) and section 204(b) of the Commonwealth Attorneys Act (71 P. S. § 732-204(b)).

The Department is amending Chapter 1163 in accordance with section 403.1 of the code because this final-omitted rulemaking pertains to the revision of MA provider payment rates and methodologies for inpatient acute general hospital services.

Additionally, section 204(3) of the CDL provides authority for an agency to omit notice of proposed rulemaking when impracticable or unnecessary. Notice of proposed rulemaking is impracticable and unnecessary for the amendments to § 1163.57(a) and (b) (relating to payment policy for readmissions) because Act 22 statutorily amended the readmission time period to 30 days. See section 443.9 of the code (62 P. S. § 443.9). The Department is amending Chapter 1163 to conform the regulations to the Act 22 requirements for inpatient readmissions to acute care general hospitals.

Purpose

The purpose of this final-omitted rulemaking is to amend Chapter 1163, Subchapter A (relating to acute care general hospitals under the prospective payment system) to restructure the inpatient payment for normal newborn care for MA births in inpatient acute care general

hospitals. For normal newborn care, the Department will make one payment for inpatient services related to the mother's obstetrical delivery using the All Patient Refined (APR) Diagnosis Related Group (DRG) payment.

Additionally, the Department is amending regulations regarding its payment policy for readmissions to an inpatient acute care general hospital to increase the readmission time period from 7 to 30 days of the date of previous discharge. See section 443.9 of the code.

Background

The Department administers the MA Program under Title XIX of the Social Security Act (act) (42 U.S.C.A. §§ 1396—1396w-5). The MA Program provides a continuum of physical and behavioral health services, including long-term care, inpatient hospital, pharmacy, outpatient services, such as physician, podiatry, medical and psychiatric clinics, chiropractic and dental service, and medical supplies and durable medical equipment to approximately 2.1 million MA recipients.

In an effort to address the current budget constraints, the Department has taken steps to implement a series of initiatives aimed at reducing costs while still providing needed care to MA recipients, including limiting pharmacy benefits for recipients 21 years of age and older and by limiting certain dental benefits for recipients 21 years of age and older. Despite these and other cost savings efforts, the Department was compelled to identify additional ways to achieve the necessary cost savings. The Department determined that changing the payment method for normal newborn care will produce savings with the least impact on services and care provided to MA recipients.

Public Process

The Department published advance public notice at 42 Pa.B. 1005 (February 18, 2012) announcing its intent to amend the MA payment policy for normal newborn births. The Department invited interested persons to comment. In addition, the Department discussed these payment amendments with the Medical Assistance Advisory Committee at its February 23, 2012, meeting.

The Department also posted the draft regulation on the Department's web site on February 24, 2012, with a 15-day comment period. The Department again invited interested persons to submit written comments regarding the regulation to the Department. The Department received 19 topically-related comments from 27 commentators. The Department also discussed the Act 22 regulations and responded to questions at the House Health Committee hearing on March 8, 2012.

The Department considered the comments received in response to the draft regulation. For the following reasons, the Department decided to maintain the policies as provided in the draft regulation.

Discussion of Comments

Following is a summary of the major comments received within the public comment period and the Department's response to the comments.

Comment

Several commentators stated that the elimination of a normal newborn payment will increase the chance of poor newborn outcomes, such as children who are impaired before or during birth. One commentator noted that eliminating the Fee-for-Service (FFS) payment for normal newborn births undermines the historical mission of the Medicaid program, which is a program for pregnant women and newborns.

Response

The Department disagrees that restructuring the inpatient payment for normal newborns will increase the chance of poor newborn outcomes. Newborn outcomes are generally attributed to the quality of obstetrical and delivery services and the Department is not changing its payment policy for prenatal care or obstetrical deliveries. The Department will continue to pay for inpatient hospitalizations and high cost outliers for neonates that are not normal newborns. The Department will also pay for newborn inpatient hospitalizations when the Department does not make an APR-DRG payment for the mother's obstetrical delivery. The Department will monitor outcomes to ensure that there are not unintended consequences regarding the health of mothers and their newborns.

Comment

Several commentators noted that "normal newborn" is not defined consistent with the APR-DRG classification system.

Response

The Department disagrees. The Department believes that the regulatory definition of "normal newborn" is consistent with and specific to APR-DRG 640 with a severity of illness level 1.

Comment

One commentator noted that the payment change conflicts with the Federal requirement to pay for mandatory Medicaid services. Normal newborns covered by Medicaid are entitled to mandatory services. Inpatient hospital care is a mandatory service.

Response

MA coverage for eligible normal newborns includes inpatient hospital services, which is a mandatory class of service under Federal Medicaid rules. Federal rules allow states to establish limitations on payment under the state Medicaid Plan, subject to Federal approval.

Comment

Some commentators expressed access to care concerns in that the change in the inpatient newborn payment will continue the loss of access to obstetrical and newborn services. Another commentator expressed concern regarding the comparison of the Department's payment to other payers without an access to care analysis. The commentator also inquired whether the Department had historic access data concerning the availability of birthing services and newborn care for Medicaid recipients.

Response

The change in the payment for normal newborns will not create a loss of access to obstetrical and newborn services. Access to obstetrical and newborn inpatient care was maintained through the old DRG payment system, under which hospitals received less payment for both the mother's and newborn's care, than is currently paid under the APR-DRG payment system for the mother's obstetrical delivery. For years, under the ACCESS Plus Program and managed care delivery system, consumer responses to the Department's "Consumer Assessment of Healthcare Providers and Systems" (CAHPS) survey demonstrate sustained satisfaction regarding access to health care, satisfaction with specialist care, getting the appropriate needed care and obtaining care quickly. The Department's CAHPS surveys were completed, in part, by women who had obstetrical deliveries. Through the use of Healthcare Effectiveness Data and Information Set and similar

tools, the Department has monitored obstetrical services for both the FFS ACCESS Plus Program and the HealthChoices Program, the Department's mandatory managed care program. The Department will continue to monitor both outpatient and inpatient obstetrical services, including access.

Even with the change to the normal newborn payment policy, the APR-DRG system provides a significant increase in the total payment for the episode of care as compared to the prior DRG payments for both the mother's delivery and the newborn's hospitalization.

Comment

Several commentators noted that the notice published at 42 Pa.B. 1005 did not include a substantive analysis of the costs of newborn care, which requires specifically trained staff, infant supplies and mandated testing and screening, all of which hospitals shall provide even absent payment.

Response

The current MA payment policy for inpatient services is not cost based and neither is the payment methodology under this final-omitted rulemaking. Based on the Department's findings, hospitals are accepting payments from the MA managed care plans for the mother's delivery and normal newborn care (whether separate or combined) that are lower than the total payments for both the mother's delivery and the normal newborn's care made under the FFS delivery system. The Department determined that even with the change in the normal newborn payment, the APR-DRG system provides a significant increase in the total payment for the episode of care as compared to the previous DRG payments for both the mother's delivery and the newborn's hospitalization.

Comment

Multiple commentators expressed concern regarding the impact of the policy change on the qualification for and payment of Disproportionate Share Hospital (DSH) payments for both the MA and Medicare Programs. Commentators expressed concern that the data associated with inpatient newborn care will not be considered in determining a hospital's DSH qualification or payments, shifting DSH payments to hospitals not providing birthing services. Commentators also noted that MA births represent a large category of MA admissions and the potential impact of the change can be substantial.

Response

The Department acknowledges the concern about DSH qualification and payment calculations regarding the MA Program. The Department does not foresee that this policy change will affect a hospital's DSH qualification or payment or that it will result in a shift of DSH payments to providers who do not provide birthing services. For those DSH payments in which normal newborn data was previously used, the Department will use cost reports and develop other data sources, as necessary, to ensure that normal newborn days and payments are appropriately accounted for in DSH eligibility and payment calculations. In addition, the majority of FY 2011-12 and FY 2012-13 DSH payment programs under MA will not be affected by this change in payment policy since eligibility and payment distribution methodologies rely on historic utilization data.

Comment

Several commentators noted that the current APR-DRG relative payment for obstetrical and newborn care already is lower than payment made under the previously used Centers for Medicare and Medicaid Services (CMS) DRGs and that the Department is actually paying less for the delivery and newborn care inpatient services relative to other inpatient services. Further, the relative value for what has been defined as normal newborn care under the APR-DRG is less than the relative value for this care under the CMS DRG system. Commentators suggest that not paying for the care hospitals provide to newborns removes the actuarial soundness of the entire DRG system by removing payment without adjusting payments or costs made for the mother.

Response

The payment made under the APR-DRG system is not calculated solely using the relative weight of the APR-DRG. Along with the implementation of APR-DRGs, hospitals received an increase in their base payment rates which also affects payment for inpatient services

The change in the payment for newborn inpatient services does not remove the actuarial soundness of the entire APR-DRG system. The Department determined that even with this payment change, the APR-DRG system provides a significant increase in the total payment for the episode of care from payment under the CMS DRG-based system. The Department will monitor the APR-DRG payments and the relative values for unintended consequences.

Comment

Several commentators also expressed concern regarding the relative value calculation for the APR-DRG system. Because births are the most prevalent DRG and the relative value assigned to APR-DRG 640.1 is an integral component of the calibration of APR-DRG relative values, the Department must recalibrate remaining APR-DRGs to account for this change. Otherwise, the Department will realize significant additional savings by underpaying all other cases.

Response

The Department recognizes the concern and will continue to monitor the appropriateness of relative weights moving forward. The assignment of relative weights, however, is distinct from the newborn payment policy.

Comment

Several commentators noted that the APR-DRG system enables the MA Program to group care categories and develop payments based on resource use and patient intensity, as well as to enable the Department to monitor care. The removal of the normal newborn payment inappropriately distorts the classification system that was designed to match resource use with patient needs.

Response

The Department's analysis shows that under the FFS delivery system, the MA Program is paying significantly more for the mother's delivery and normal newborn care than the global or separate payments made for the mother's delivery and normal newborn care under the MA managed care delivery system.

Comment

Several commentators suggested that the Department surveyed a limited number of health plans and states and that a single payment for the care of the mother during delivery and postpartum and the newborn are not common place. Rather, MA managed care organizations (MCO) and commercial health plans use a variety of payment means, including separate payments. When pay-

ments are combined in a singular case rate, there are clear criteria for what costs are incorporated into the single rate and what criteria constitute normal newborn.

Commentators also noted that the Department compares the combined payment for a delivery and normal newborn made under the MA FFS program, with the total payment made by MA MCOs. Commentators state this comparison is faulty because MCO payments were not based on the higher FFS rates or the APR-DRG grouping system. Commentators further added that MCO payments for hospital care would be higher than that of the MA FFS program, in recognition that patients would be managed more effectively.

Response

While the payment change will result in smaller MA FFS payment for the inpatient stay of a mother and her normal newborn, based on the Department's findings, hospitals are accepting payments from the MA MCOs for the mother's delivery and normal newborn care (whether separate or combined) that are lower than the MA FFS payments for mother's delivery alone. Even with the change in the normal newborn payment, the APR-DRG system provides a significant increase in the total payment for the episode of care as compared to the prior DRG payments for both the mother's delivery and the newborn's hospitalization. This new payment policy more closely aligns payment into the range of MA MCOs.

With the change to APR-DRGs, the per-admission average inpatient payment increased 33% under the FFS delivery system. After restructuring the normal newborn payments, the FFS payments will still be, on average, 31% higher on a per admission basis than under the DRG system. Over the same period of time, the MCO per admission payments increased by 0.65%.

Comment

Several commentators noted that the newborn payment policy does not address the interrelationship of the FFS program and the State's mandatory MA MCO program. The MA MCO programs are required to adhere to the FFS program payment policies. Commentators stated that removing the newborn payment will result in a further negative financial impact for hospitals providing care under the MA MCO program.

Response

The MA MCOs are not required to pay in the same manner as the MA Program and there is not a requirement for the MA MCOs to adopt any aspect of this payment change.

Comment

Multiple commentators suggested the payment policy does not clearly reflect the total potential financial impact (including State and Federal funds) on hospitals. Several commentators also noted that it is not clear how the Department arrived at the estimated savings. There is concern that the fiscal impact will be far greater than the Department's estimate of $18 million.

Response

The Department's analysis shows that MA is paying significantly more for the mother's delivery and normal newborn care than other payers. The new payment policy more closely aligns payment into the range of MA MCOs.

The Department calculated the number of newborns who met "normal" definition in recent historical claims data, projected the number of normal newborns for current and next fiscal year and multiplied by the average current normal newborn payment.

Comment

One commentator noted that this policy unfairly impacts safety net hospitals, both in rural and urban areas. Hospitals will need to evaluate their ability to continue providing birthing services.

Response

The Department disagrees that this policy unfairly targets those hospitals in rural Pennsylvania and that there is any disproportionate impact on safety net hospitals. This payment policy applies to all acute care general hospitals. The Department's analysis shows that under the FFS delivery system, the MA Program is paying significantly more for the mother's delivery and normal newborn care than other payers. The new payment policy more closely aligns payment into the range of MA MCOs.

Comment

One commentator noted concern about the Department's authority under Act 22 to continue the proposed change beyond July 1, 2012.

Response

Act 22 authorizes the Department to promulgate final-omitted regulations that revise payment rates. To ensure that the Department's expenditures for State FY 2011-2012 do not exceed the amount appropriated by the General Assembly, these regulations are exempt from the Regulatory Review Act, section 205 of the CDL and section 204(b) of the Commonwealth Attorneys Act. There is nothing in Act 22 that precludes the promulgation of final-omitted regulations that will have an impact in State FY 2011-2012 and in future years.

Comment

Several commentators stated that the Department did not allow sufficient time for review and comment of the regulations.

Response

The Department engaged in a transparent public process through which the Department solicited and received numerous comments and input from stakeholders and other interested parties.

As previously mentioned, the Department published advance public notice at 42 Pa.B. 1005 announcing its intent to amend the MA payment policy for the inpatient care related to the mother's delivery of a normal newborn. The Department invited interested persons to comment. The Department also posted the draft regulation on the Department's web site on February 24, 2012. The Department again invited interested persons to submit written comments, on or before March 9, 2012, regarding the regulations to the Department. To comply with Federal law and to encourage transparency and public input, the Department provided an opportunity for comment by publishing the notice and posting the draft regulation on the Department's web site. This public comment process provided sufficient opportunity for interested parties to submit comments, as supported by the number of comments that were submitted.

Comment

One commentator suggested that the expedited rulemaking violates Federal law. Under section 1902(a)(13)(A) of the Social Security Act (42 U.S.C.A. § 1396a(a)(13)(A)), a state agency may not materially change payment methods for hospital services without first publishing the

change as a proposal and soliciting and considering public comment. Federal law is not satisfied by publishing a "final" rule, subject to after the fact comments, because rulemaking parameters are deemed finalized when they are adopted in final-form and comments on final rules are considered by the courts to be window dressing. Under the Supremacy Clause, State law permitting the Department to forego notice and comment does not eliminate the public process obligations imposed by Federal law.

Response

Contrary to the commentator's contention and as required under Federal law, the Department published notice of its intent to change its payment for inpatient services at 42 Pa.B. 1005. The Department discussed the intended change and provided for a public comment period. The change will not be effective prior to the date on which the Department published its notice of the intended change.

Related Readmission Payment Policy

The Department implemented the 30-day readmission time period effective July 1, 2011, as required under Act 22, and announced the change at 41 Pa.B. 4818 (September 3, 2011).

The Department received written comments from two hospitals and the Urban Health Care Coalition of Pennsylvania regarding the readmission payment policy as published in the *Pennsylvania Bulletin*. The majority of these comments did not relate to the 30-day readmission time period. Instead, the comments related to the Department's operational review procedures for review of readmissions and the inability of hospitals to control patient behavior. Although the Department appreciates the comments received, the Department is codifying the 30-day readmission time period as required under Act 22.

Requirements

The following is a summary of the major provisions of the final-omitted rulemaking.

§ 1163.2. Definitions

The Department is adding a definition for "normal newborn" as "a liveborn neonate whose diagnosis is categorized into severity of illness level 1 of the newborn APR-DRG 640 as of July 1, 2011."

§ 1163.51. General payment policy

This section is amended by adding subsection (v) to provide that the Department will not make a separate APR-DRG payment for an inpatient acute care general hospital stay for a normal newborn.

§ 1163.52. Prospective payment methodology

This section is amended by adding subsection (e) to provide the nonpayment conditions for newborns when the following occur:

• The hospital receives an APR-DRG payment for the mother's obstetrical delivery.

• The newborn meets the definition of a "normal newborn" under § 1163.2 (relating to definitions).

• The normal newborn is discharged from the hospital before or on the same date as the mother.

• The normal newborn is not discharged to another acute care inpatient setting.

Currently, the Department makes two separate MA APR-DRG payments to a hospital for the inpatient acute care general hospital admission related to a mother's obstetrical delivery and the admission related to her newborn's care. For FY 2010-2011, the average MA APR-DRG payment for vaginal and cesarean section deliveries was $5,712 and the average MA APR-DRG payment for normal newborn care was $1,155, for a total average payment of $6,867.

Some commercial insurers, as well as several Medicaid programs in other states, pay hospitals a single payment for both the inpatient stay related to the mother's obstetrical delivery and to the normal newborn nursery care, rather than separate payments for the mother and normal newborn. The Department surveyed three health plans that cover a large percentage of commercial lives throughout this Commonwealth. Two of the three health plans typically pay one DRG for the mother's delivery and the newborn care, but pay separately for medically necessary newborn care in the neonatal intensive care unit (NICU) or when the newborn's stay exceeds 3 days or the DRG trim point for the mother's delivery. The third health plan varies its payments. It makes either a single payment for the mother's and newborn's inpatient stay or separate payments for the mother's delivery and newborn care depending on the particular hospital contracts involved. In addition, the Department's contracted MA managed care plans pay hospitals, on average, either an all-inclusive payment of $3,745 for the delivery and newborn care or separate payments that on average total $4,884 ($3,578 for the delivery and $1,306 for the newborn care), depending on their provider specific contracts. Both these average payment amounts are significantly less than the current average MA APR-DRG payments for the mother's delivery alone.

The Department also surveyed several states concerning their Medicaid payment methodology for these services. Some states pay a global payment for both the mother's delivery and normal newborn care. However, these states make separate payments to the hospital for newborns who are detained in the NICU or newborn nursery after the mother is discharged. Other states make separate payments to the hospital for the mother's delivery and newborn care, similar to the Department's current practice.

In an effort to address the current budgetary constraints, the Department is changing its policy of making a separate APR-DRG payment to the hospital for the normal newborn's care. Instead, the hospital will receive a single APR-DRG payment for the mother's delivery. In the event the newborn stays in the NICU or experiences other complications not associated with normal newborn care, the hospital will receive two APR-DRG payments for the delivery and newborn care.

§ 1163.57. Payment policy for readmissions

This section is amended to conform the regulation to the Act 22 requirements for readmissions. Act 22 amended section 443.9 of the code by increasing the readmission time period from 14 days to 30 days from the date of previous discharge.

The Department also implemented the 30-day readmission time period effective July 1, 2011, as required under Act 22, and announced the change in the *Pennsylvania Bulletin* at 41 Pa.B. 4818.

Affected Individuals and Organizations

The newborn and readmission payment policies affect MA payments to acute care general hospitals. As a result of the change to the Department's methodology for payments related to the delivery of normal newborns, hospitals will not receive a separate APR-DRG payment for the inpatient stay of a normal newborn. The readmission

requirement, however, was implemented through Act 22. Therefore, the amendment to § 1163.57 merely codifies existing law.

Accomplishments and Benefits

This final-omitted rulemaking changes MA Program payment policy for normal newborn admissions. This change will enable the Department to preserve vital benefits to the greatest number of MA recipients while reducing costs in accordance with the goals in section 403.1 of the code. The amendments to § 1163.57 also codifies current payment polices as required under section 443.9 of the code.

Fiscal Impact

The changes are anticipated to result in savings of $1.029 million ($0.463 million in State funds) in the MA Program in FY 2011-2012.

Paperwork Requirements

There are no additional reports, paperwork or new forms needed to comply with the final-omitted rulemaking.

Regulatory Review Act

Under section 403.1 of the code, this final-omitted rulemaking is not subject to review under the Regulatory Review Act.

Findings

The Department finds that:

(1) Notice of proposed rulemaking is omitted in accordance with section 204(1)(iv) and (3) of the CDL, 1 Pa. Code § 7.4(1)(iv) and (3) and section 403.1(a) of the code because this final-omitted rulemaking relates to Commonwealth grants and benefits.

(2) The adoption of this final-omitted rulemaking in the manner provided by this order is necessary and appropriate for the administration and enforcement of the code.

(3) Notice of proposed rulemaking is impracticable and unnecessary for the amendments to § 1163.57(a) and (b) because Act 22 statutorily amended the readmission time periods to 30 days.

Order

The Department, acting under the code, orders that:

(a) The regulations of the Department, 55 Pa. Code Chapter 1163, are amended by amending §§ 1163.2, 1163.51, 1163.52 and 1163.57 to read as set forth in Annex A, with ellipses referring to the existing text of the regulations.

(b) The Secretary of the Department shall submit this order and Annex A to the Office of General Counsel 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 for dates of discharge on and after May 1, 2012, and upon publication in the *Pennsylvania Bulletin* with the exception of § 1163.57. Section 1163.57 is effective July 1, 2011.

GARY D. ALEXANDER,
Secretary

Fiscal Note: 14-528. No fiscal impact; (8) recommends adoption.

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

GENERAL PROVISIONS

§ 1163.2. Definitions.

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:

APR-DRG—All Patient Refined Diagnosis Related Group.

Buildings—The basic structure or shell and additions thereto.

* * * * *

Institutionalized individual—A person who is detained or confined under one of the following:

(i) A civil or criminal statute in a correctional, rehabilitative or mental retardation facility, psychiatric hospital or other facility for the care and treatment of mental illness or mental retardation.

(ii) Voluntary commitment in a psychiatric hospital, mental retardation facility or other facility for the care and treatment of mental illness or mental retardation.

Normal newborn—A liveborn neonate whose diagnosis is categorized into severity level 1 of the newborn APR-DRG 640 as of July 1, 2011.

Outlier—An inpatient hospital case having either an extremely long length of stay or extraordinarily high costs in comparison to most discharges for the same DRG.

* * * * *

PAYMENT FOR HOSPITAL SERVICES

§ 1163.51. General payment policy.

* * * * *

(u) Capital and operating costs related to new or additional beds are nonallowable for purposes of this subchapter unless a Certificate of Need or letter of nonreviewability related to those beds was issued by the Department of Health prior to July 1, 1993.

(v) The Department will not make a separate APR-DRG payment for inpatient acute care general hospital services of a normal newborn.

§ 1163.52. Prospective payment methodology.

(a) The Department will base payment for inpatient hospital services on the classification of inpatient hospital discharges by DRGs used by the Medicare Program.

(b) The Department will assign a DRG to each MA discharge. The assignment of a DRG is based on:

(1) The recipient's diagnoses.

(2) The procedures performed during the recipient's hospital stay.

(3) The recipient's sex.

(4) The recipient's age.

(5) The recipient's discharge status.

(c) For a DRG, the Department will determine a relative value which reflects the cost of hospital resources used to treat cases in that DRG relative to the Statewide average cost of hospital cases. The Department will determine the relative value under § 1163.122 (relating to determination of DRG relative values).

(d) The Department will base payment for compensable inpatient hospital services under the DRG payment system on the hospital's base DRG rate determined under § 1163.126 (relating to computation of hospital specific base payment rates).

(e) The Department will not make a separate APR-DRG payment for a normal newborn when the following occur:

(1) The hospital receives an APR-DRG payment for the mother's obstetrical delivery.

(2) The newborn meets the definition of a "normal newborn" under § 1163.2 (relating to definitions).

(3) The normal newborn is discharged from the hospital before or on the same date as the mother.

(4) The normal newborn is not discharged to another inpatient setting.

§ 1163.57. Payment policy for readmissions.

(a) Except as specified in subsection (c), if a recipient is readmitted to a hospital within 30 days of discharge, the Department makes no payment in addition to the hospital's original DRG payment. If the combined hospital stay qualifies as an outlier, an outlier payment will be made.

(b) If a patient is readmitted within 30 days of discharge for the treatment of conditions that could or should have been treated during the previous admission, the Department makes no payment in addition to the hospital's original DRG payment.

(c) Except as specified in subsection (b), if a patient is readmitted to the hospital due to complications of the original diagnosis and this results in a different DRG with a higher payment rate, the Department pays the higher DRG payment rate rather than the original DRG rate.

(d) Except as specified in subsection (b), if a patient is readmitted to the hospital due to conditions unrelated to the previous admission, the Department considers the readmission a new admission for payment purposes.

[Pa.B. Doc. No. 12-647. Filed for public inspection April 13, 2012, 9:00 a.m.]

DEPARTMENT OF PUBLIC WELFARE

[55 PA. CODE CH. 3041]

Subsidized Child Care Eligibility

The Department of Public Welfare (Department) amends Chapter 3041 and Appendix A (relating to subsidized child care eligibility; and income to be included, deducted and excluded in determining gross monthly income) to read as set forth in Annex A under the authority of sections 201(2), 403(b) and 403.1 of the Public Welfare Code (code) (62 P. S.§§ 201(2), 403(b) and 403.1), as amended by the act of June 30, 2011 (P. L. 89, No. 22) (Act 22).

Omission of Proposed Rulemaking

Act 22 amended the code and added several new provisions. Specifically, Act 22 added section 403.1 of the code. Section 403.1(a)(1) of the code authorizes the Department to promulgate final-omitted regulations to establish standards for determining eligibility and the nature and extent of assistance. The basis for the final-omitted regulation is section 204(1)(iv) of the act of July 31, 1968 (P. L. 769, No. 240) (45 P. S. § 1204(1)(iv)), known as the Commonwealth Documents Law (CDL), which authorizes an agency to omit or modify notice of proposed rulemaking when the regulation relates to Commonwealth grants or benefits. See section 403.1(d) of the code. Child care subsidy is a Commonwealth benefit. In addition, until June 30, 2012, section 403.1 of the code expressly exempts certain regulations under the Regulatory Review Act (71 P. S. §§ 745.1—745.12), section 205 of the CDL (45 P. S. § 1205) and section 204(b) of the Commonwealth Attorneys Act (71 P. S. § 732-204(b)).

The Department is amending Chapter 3041 and Appendix A in accordance with section 403.1 of the code because this final-omitted rulemaking pertains to establishing standards for determining eligibility and the nature and extent of assistance. In addition, this final-omitted rulemaking implements section 403.1(c) of the code. As provided in section 403.1(c) of the code, the Department is permitted to exercise its rulemaking authority granted under section 403.1(a) of the code as may be necessary to ensure that expenditures for State Fiscal Year (FY) 2011-2012 for assistance programs administered by the Department do not exceed the aggregate amount appropriated for the program by the General Appropriations Act of 2011. Specifically, this final-omitted rulemaking will save $641,000 in State FY 2011-2012.

Purpose

The purpose of this final-omitted rulemaking is to amend the definition of "self-employment," rescind subsidized child care special eligibility for children enrolled in a prekindergarten program and amend copayment requirements for school-age child care subsidies. "Prekindergarten" is defined as a program serving children 3 or 4 years of age operated by a school entity or a certified child care center or licensed private academic school under contract with a school entity.

Requirements

§ 3041.3. Definitions

The definition of "self-employment" is being amended to include "profit equal or greater than the hourly Pennsylvania minimum wage."

§ 3041.52

Special eligibility granted to parents or caretakers who have a child enrolled in a prekindergarten program is being rescinded. Under the regulation, parents or caretakers who are eligible for special eligibility under this section are not subject to 6-month redeterminations and are not required to report changes in circumstances regarding work hours and income. In some instances, this results in parents or caretakers who do not meet the work requirements receiving additional hours of child care beyond their work or training schedule and pay co-payments that are not reflective of their changes in family income and size. Families enrolled in Pennsylvania Pre-K Counts, a prekindergarten program administered through the Department of Education and managed locally through school entities, have income at or below 300% of the Federal Poverty Income Guidelines. This income limit is higher than the income limit for other families that receive subsidized child care, making it more likely that a family with a child enrolled in Pennsylvania Pre-K Counts could be over the income

limit for subsidized child care, as compared to other families that receive subsidy. By rescinding this regulation, parents or caretakers who have a child enrolled in a prekindergarten program will be required to report all changes and have a redetermination every 6 months, as required for all other subsidy recipients under §§ 3041.127 and 3041.130 (relating to parent and caretaker report of change; and redetermination of eligibility), with the exception of those families enrolled in a Head Start expansion program. Under the amended regulations, parents or caretakers will be required to meet the work requirement, only be eligible for child care for the hours they are in a work or training activity and pay a co-payment based on their family size and income.

§ 3041.65. Verification of income

This section is amended to specify that the verification of income from self-employment must be documented by Federal Income Tax Returns, including all schedules related to self-employment. A notarized statement of gross earnings, minus allowable cost of doing business, is acceptable verification for a parent or caretaker who has not been self-employed for more than 1 year in the same business. However, the notarized statement is only valid until the Federal Income Tax Return is filed. At the time the Federal Income Tax Return is filed, a redetermination of eligibility shall be completed.

§ 3041.67. Verification of work, education and training

This section adds the requirement for submission of a Federal Income Tax Return as verification of work for a parent or caretaker who is self-employed. The Federal Income Tax Return must show profit from self-employment, that when divided by the Pennsylvania minimum wage, is equal to or greater than the number of hours required under § 3041.43 (relating to work, education and training) and is equal to or greater than the number of hours of care needed.

§ 3041.108. Co-payment for families headed by a parent

The Department is deleting subsection (c) and renumbering the section accordingly. By deleting subsection (c), parents or caretakers shall pay the full co-payment amount, regardless of the child's age or hours of care. Deleting this subsection will provide for equal application for all families that receive subsidy under § 3041.101 (relating to general co-payment requirements) which requires co-payments to be based on family income and size.

Appendix A, Part I. Income inclusions

The following items are being deleted from the list of allowable deductions for the cost of doing business for self-employment income: professional licensing fees and union dues, if necessary to practice a profession or trade; depreciation; and other deductions allowed by the Internal Revenue Service (IRS). The reason for disallowing these IRS deductions is to standardize the calculation of gross annual income for the purposes of determining eligibility and co-payment amount. Currently, these deductions are allowable for self-employed individuals only. For example, parents or caretakers who are not self-employed may not use professional licensing fees or unions dues as allowable deductions when determining their gross annual income.

The changes regarding self-employment income will serve to better align calculation of gross annual income for parents or caretakers receiving subsidized child care and clarify standards for acceptable verification relating to self-employment. Parents or caretakers will need to be able to show a profit equal to or greater than the Pennsylvania hourly minimum wage to be eligible. This change will result in a cost savings to the Commonwealth and meet the Department's goal that only income-eligible families are served.

Affected Individuals and Organizations

Parents or caretakers who have a child enrolled in a prekindergarten program will have to comply with the same reporting requirements as other parents or caretakers who receive child care subsidy, with the exception of those families enrolled in the Head Start expansion program. The new requirements include the need to report a decrease in work or training hours which could result in ineligibility for subsidized child care and redetermination of income eligibility which will result in paying the appropriate co-payments based on their income and family size. Parents or caretakers will be ineligible for additional hours of child care beyond their work or training schedule.

Under the amended regulations, acceptable verification to demonstrate self-employment will be more specific than existing requirements for parents or caretakers who are self-employed. In addition to specifying acceptable documentation to establish self-employment, parents or caretakers shall show a profit equal to or greater than the Pennsylvania minimum wage to be eligible for subsidized child care.

Co-payments will increase for families of school-age children who have only one child receiving part-time subsidized child care. For example, if a parent or caretaker has a child who is in first grade that receives subsidized child care to attend a before and after school program for a total of 3 hours per day, the parent or caretaker will pay the full co-payment amount for the family size and income, the same as other families with one child receiving part-time care.

Each of these amendments will strengthen the eligibility requirements to be certain that those receiving subsidized child care truly are eligible for subsidy. This is imperative as there is currently a waiting list of otherwise eligible parents or caretakers in most counties in this Commonwealth.

Accomplishments and Benefits

This final-omitted rulemaking implements section 403.1 of the code. As provided in Act 22, this final-omitted rulemaking will help the Department's efforts to conserve resources to ensure that the expenditures for State FY 2011-2012 for assistance programs administered by the Department do not exceed the aggregate amount appropriated for assistance programs by the General Appropriations Act of 2011.

Fiscal Impact

The Commonwealth will realize an estimated savings of $641,000 in State FY 2011-2012.

Paperwork Requirements

There are new paperwork requirements under the final-omitted rulemaking. There will be increased reporting requirements for families with a child enrolled in a prekindergarten program. Parents or caretakers will be required to complete a redetermination every 6 months, as well as report changes relating to work hours and income.

Parents or caretakers who are self-employed will be required to submit Federal Income Tax Returns. If the parent or caretaker has been self-employed for less than 1

year in the same business, a notarized statement of gross earnings, minus allowable cost of doing business, shall be submitted as verification until a Federal Income Tax Return is filed.

Public Comment

Although this rulemaking is being adopted without publication as proposed rulemaking, the Department posted a draft regulation on the Department's web site on February 24, 2012, with a 15-day comment period. The Department invited interested persons to submit written comments regarding the final-omitted rulemaking to the Department. The Department received 23 comments. The Department also discussed the Act 22 regulations and responded to questions at the House Health Committee hearing on March 8, 2012.

The Department considered the comments received in response to the draft regulation. For the following reasons, the Department has decided to maintain the policies as provided in the draft regulation.

Discussion of Comments

Following is a summary of the major comments received within the public comment period and the Department's response to the comments.

Comment

Several commentators stated that the Department did not allow sufficient time for review and comment of the regulations. In addition, commentators requested the public comment period be extended an additional 30 days due to the policy changes and the volume of regulations.

Response

The Department engaged in a transparent public process through which the Department solicited and received numerous comments and input from stakeholders and other interested parties. As previously mentioned, the Department posted the draft regulation on the Department's web site on February 24, 2012. The Department invited interested persons to submit written comments, on or before March 9, 2012, regarding the draft regulation to the Department. In addition, the Department's Regulatory Agenda announced the Act 22 regulations at 42 Pa.B. 879, 893 (February 11, 2012).

As a final-omitted regulation under Act 22, the Department was not required to have a public comment process. However, to encourage transparency and public input the Department provided an opportunity for comment by posting the draft regulation on the Department's web site. This public comment process provided sufficient opportunity for interested parties to submit comments, as supported by the number of comments that were submitted. Therefore, the Department is not extending the public comment period.

Comment

Comments were received both in support and opposition to the amendments regarding self-employment.

Response

The Department is maintaining the changes regarding self-employment. These changes standardize the calculation of gross annual income for the purposes of determining eligibility and co-payment amount. Further, the amendments clarify the verification requirements for self-employment.

Comment

Comments were received in opposition to the change to the school-age copayment regulation. Recommendations received included monitoring the drop in the number of school-aged children being served, maintaining eligibility during the school year and creating a summer school-age set aside.

Response

The Department is maintaining the change to delete § 3041.108(c) (relating to co-payment for families headed by a parent). This amendment will require parents and caretakers to pay a full co-payment throughout the year.

Co-payment amounts are based on family size and income under § 3041.108. However, families receiving a subsidy with school-age children only pay the full co-payment amount from mid-June to the end of August. This amendment aligns the co-payment provisions for families receiving a child care subsidy since parents of school-age children will be required to pay the full co-payment amount throughout the year, just as other parents receiving child care subsidy are required to pay.

The Department will monitor the number of school-age children that become ineligible due to the copayment being greater than the cost of part-time care. In addition, the Department will create a summer school-age set aside to provide care for children that are only eligible during summer months when the cost of care is higher due to the need for full-time enrollment.

Comment

Comments were received in opposition concerning the change in regulation allowing special eligibility for children enrolled in prekindergarten programs. Recommendations included developing clear information to families regarding prekindergarten redetermination changes and sufficient time for families to adjust to the changes.

Response

The Department is maintaining the changes to remove the special conditions for subsidy-eligible children enrolled in prekindergarten. This amendment will align the requirements for receipt of subsidized child care. As previously stated, parents and caretakers who have a child enrolled in a prekindergarten program will be required to report all changes and have a redetermination every 6 months, as required for other subsidy recipients under §§ 3041.127 and 3041.130.

Parents or caretakers will receive written notification of the change in regulation as soon as the regulation becomes effective. In the following month, parents and caretakers with children enrolled in prekindergarten who have not received a redetermination in the last 6 months will receive a redetermination packet allowing the parent or caretaker 6 weeks to provide the required information. The Department anticipates that children currently eligible under the current prekindergarten section will be able to finish the 2011-2012 school year.

Regulatory Review Act

Under section 403.1 of the code, this final-omitted rulemaking is not subject to the Regulatory Review Act.

Findings

The Department finds that:

(1) Notice of proposed rulemaking is omitted in accordance with section 204(1)(iv) of the CDL, 1 Pa. Code § 7.4(1)(iv) and section 403.1(d) of the code because the regulations relate to Commonwealth grants and benefits.

(2) Adoption of this final-omitted rulemaking in the manner provided by this order is necessary and appropriate for the administration and enforcement of the code.

Order

The Department, acting under the code, orders that:

(a) The regulation of the Department, 55 Pa. Code Chapter 3041, are amended by deleting § 3041.52 and amending §§ 3041.3, 3041.65, 3041.67 and 3041.108 and Appendix A to read as set forth in Annex A, with ellipses referring to the existing text of the regulations.

(b) The Secretary of the Department shall submit this order and Annex A to the Offices of General Counsel 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 upon publication in the *Pennsylvania Bulletin*.

GARY D. ALEXANDER,
Secretary

Fiscal Note: 14-527. No fiscal impact; (8) recommends adoption.

Annex A

TITLE 55. PUBLIC WELFARE

PART V. CHILDREN, YOUTH AND FAMILIES MANUAL

Subpart B. ELIGIBILITY FOR SERVICES

CHAPTER 3041. SUBSIDIZED CHILD CARE ELIGIBILITY

GENERAL PROVISIONS

§ 3041.3. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

* * * * *

Self-employment—Operating one's own business, trade or profession for profit equal to or greater than the hourly Pennsylvania minimum wage.

* * * * *

SPECIAL ELIGIBILITY PROGRAMS

§ 3041.52. (Reserved).

SELF-CERTIFICATION AND VERIFICATION

§ 3041.65. Verification of income.

(a) Acceptable verification of earned income from employment includes one of the following:

(1) Pay stubs reflecting earnings for 4 weeks in the most recent 6-week period, the Department's Employment Verification form reflecting actual or anticipated earnings, the Internal Revenue Service form used for reporting tips, an employer statement of anticipated earnings and hours or other document that establishes the parent's or caretaker's earnings or anticipated earnings from employment.

(2) A collateral contact, as specified in § 3041.62 (relating to collateral contact).

(3) A written self-declaration by the parent or caretaker as specified in § 3041.64 (relating to self-declaration).

(b) Acceptable verification of income from self-employment includes one of the following:

(1) Tax returns, including schedules related to self-employment, filed for the preceding Federal tax year and which document profit for that year.

(2) A notarized statement of gross earnings, minus allowable cost of doing business which shows hourly profit equal to or more than the Pennsylvania minimum wage, for the preceding Federal tax quarter is acceptable and is valid until the next Federal Income Tax Return is filed. At the time the Federal Income Tax Return is filed, a redetermination of eligibility shall be completed.

(3) An annual Federal Income Tax Return shall be used as income documentation when the parent or caretaker has been self-employed for more than 1 year in the same business and is only valid until the next Federal Income Tax Return is filed.

(c) Acceptable verification of unearned income includes one of the following:

(1) A copy of a current benefit check, an award letter that designates the amount of a grant or benefit, such as a letter from the Social Security Administration stating the amount of the Social Security benefit, a bank statement, a court order, or other document or database report that establishes the amount of unearned income.

(2) A collateral contact, as specified in § 3041.62.

(3) A written self-declaration by the parent or caretaker, as specified in § 3041.64.

(d) If a family receives or pays child support, the eligibility agency shall verify the amount of support received or paid by the family by requesting this information from the Department, whether the information is found in the Pennsylvania Child Support Enforcement System or in another source.

§ 3041.67. Verification of work, education and training.

Acceptable verification of hours of work, education, training or enrollment in education or training includes one of the following:

(1) A document provided by the parent or caretaker as verification of earned or anticipated earned income, provided this verification indicates or can be used to compute the number of hours the parent or caretaker worked, is normally scheduled to work or in cases when hours vary, the average number of hours worked.

(2) A copy of a work schedule signed by the employer.

(3) A copy of the class or training schedule from an education or training representative.

(4) Another document that establishes hours of work or anticipated hours of work, education or training.

(5) A collateral contact, as specified in § 3041.62 (relating to collateral contact).

(6) A written self-declaration by the parent or caretaker that indicates the parent or caretaker works or will work at least 20 hours per week, as specified in § 3041.64 (relating to self-declaration).

(7) A Federal Income Tax Return showing profit from self-employment that when divided by the Pennsylvania minimum wage is equal to or greater than the required number of hours, as specified in § 3041.43 (relating to work, education and training) and is equal to or greater than the number of hours of care needed.

CO-PAYMENT AND PAYMENT BY THE DEPARTMENT

§ 3041.108. Co-payment for families headed by a parent.

(a) For families headed by a parent, the family co-payment shall be determined based on the following:

(1) The family size and family income, as specified in §§ 3041.31—3041.34 (relating to determining family size and income).

(2) The co-payment shall be at least $5, unless waived as specified in §§ 3041.44(a) and 3041.91(c) (relating to prospective work, education and training; and general domestic violence waiver requirements).

(3) The family's annual co-payment may not exceed 11% of the family's annual income.

(4) If the family's annual income is 100% of FPIG or less, the annual co-payment may not exceed 8% of the family's annual income.

(b) The eligibility agency shall determine the co-payment by using the co-payment chart in Appendix B (relating to co-payment chart family co-payment scale based on the 2005 FPIGs). The co-payment is calculated in $5 increments for each $2,000 of annual income.

(c) If the co-payments for 1 month are equal to or exceed the monthly payment for care, the family is not eligible for subsidized child care with that provider.

APPENDIX A

INCOME TO BE INCLUDED, DEDUCTED AND EXCLUDED IN DETERMINING GROSS MONTHLY INCOME

PART I. INCOME INCLUSIONS

Income from the following sources is included when determining total gross monthly income:

* * * * *

T. Profit from self-employment; total gross receipts minus costs of doing business. The costs of doing business shall only include:

(1) Costs of maintaining a place of business such as rent, utilities, insurance on the business and its property and property taxes. Note: If a business is operated in a home, the costs of maintaining a place of business are only those costs identified for the part of the home used exclusively for the business.

(2) Interest on the purchase of income-producing equipment and property.

(3) Employee labor costs, such as wage, salaries, taxes, benefits, Unemployment Compensation or Worker's Compensation.

(4) Cost of goods sold, supplies and materials.

(5) Advertising costs.

(6) Accounting and legal fees.

(7) Transportation costs necessary to produce income.

U. Net income from room rent or room and board: Gross income received minus $10 per month for each room rented. Divide the remainder by 2. That number is the income inclusion.

* * * * *

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