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THE GENERAL ASSEMBLY OF PENNSYLVANIA

# HOUSE BILL

# No. 1075 Session of 2013

INTRODUCED BY MOUL, CALTAGIRONE, DAVIS, HENNESSEY, COHEN, KORTZ, D. COSTA, MUNDY, HESS, QUINN, DAVIDSON, FABRIZIO, MURT AND BISHOP, APRIL 2, 2013

AS RE-REPORTED FROM COMMITTEE ON RULES, HOUSE OF REPRESENTATIVES, AS AMENDED, JULY 1, 2013

AN ACT

1 Amending the act of June 13, 1967 (P.L.31, No.21), entitled "An
2 act to consolidate, editorially revise, and codify the public
3 welfare laws of the Commonwealth," ~~changing the name of the~~ <--
4 ~~Department of Public Welfare to the Department of Human~~
5 ~~Services and providing for a transition period; in general~~
6 ~~powers and duties of the Department of Public Welfare,~~
7 ~~further providing for county human services consolidated~~
8 ~~planning and reporting;~~ in public assistance, further
9 providing for medical assistance payments for institutional
10 care and for medical assistance benefit packages, coverage,
11 copayments, premiums and rates; in children and youth,
12 further providing for payments to counties for services to
13 children and providing for provider submissions; in
14 intermediate care facilities assessments, further providing
15 for time periods and making editorial changes; in hospital
16 assessments, further providing for authorization and for time
17 period; in Statewide quality care assessment, reenacting and
18 further defining "net inpatient revenue," providing for
19 implementation, for administration, for limitations and for
20 expiration; in Pennsylvania Trauma Systems Stabilization,
21 further providing for funding; in kinship care, further
22 providing for scope and for definitions; providing for family
23 finding; and, in human services block grant pilot program,
24 further providing for establishment of human services block
25 grant pilot program, for powers and duties of the department,
26 for powers and duties of counties, for allocation and for use
27 of block grant funds.

28 The General Assembly finds and declares as follows:

1 (1) It is the purpose of this act to provide fiscal and
2 administrative support that promotes the health, safety and
3 welfare of the citizens of this Commonwealth.
4 (2) Pennsylvania, through the Department of Public
5 Welfare and the counties, provides a broad array of health
6 care and other human services to low income families,
7 children and youth, those with intellectual and physical
8 disabilities and the elderly.
9 (3) Section 24 of Article III of the Constitution of
10 Pennsylvania requires the General Assembly to adopt all
11 appropriations for the operation of government in this
12 Commonwealth. The Supreme Court has repeatedly affirmed that,
13 "It is fundamental within Pennsylvania's tripartite system
14 that the General Assembly enacts the legislation establishing
15 those programs which the State provides for its citizens and
16 appropriates the funds necessary for their operation."
17 (4) Section 11 of Article III of the Constitution of
18 Pennsylvania requires the adoption of a general appropriation
19 bill that embraces "nothing but appropriations." While actual
20 appropriation can be contained in a general appropriations
21 act, the achievement and implementation of a comprehensive
22 budget involves much more than appropriations. Ultimately,
23 the budget has to be balanced under Section 13 of Article
24 VIII of the Constitution of Pennsylvania. This may
25 necessitate changes to sources of funding and enactment of
26 statutes to achieve full compliance with these constitutional
27 provisions.
28 (5) Therefore, it is the intent of the General Assembly
29 through this act to provide further implementation of the
30 General Appropriation Act of 2013, as it affects the

1 operations and funding for the delivery of health care and
2 human services that protect our most vulnerable and needy
3 citizens.
4 (6) This act shall accomplish all of the following:
5 (i) Provide for the expansion of the Human Services
6 Block Grant Pilot Program.
7 (ii) Extend the authority for State and local
8 assessments that support hospitals and intermediate care
9 facilities for persons with an intellectual disability
10 that serve persons in the medical assistance program.
11 (iii) Provide for separate medical assistance fee-
12 for-service payments for normal newborn care and for
13 mothers' obstetrical delivery.
14 (iv) Reauthorize the nursing facility revenue
15 adjustment neutrality factor to provide continued
16 payments for nursing facilities that serve persons in the
17 medical assistance program.
18 (v) Provide for quarterly medical assistance day one
19 incentive payments to qualified nonpublic nursing
20 facilities.
21 (vi) Provide for publication of a premium schedule
22 for families with children with special needs, who
23 receive benefits under the medical assistance program.
24 (vii) Establish a process to assure that the revenue
25 of the Commonwealth is timely disbursed and expended
26 properly for the delivery of public child welfare
27 services.
28 (viii) Reauthorize the reallocation of excess funds
29 for payment to qualifying hospitals accredited or seeking
30 accreditation as Level III trauma centers.

1 (ix) Change the name of the Department of Public <--
2 Welfare to the Department of Human Services.
3 (x) Provide for the development and implementation
4 of an enhanced medical services delivery system.
5 The General Assembly of the Commonwealth of Pennsylvania
6 hereby enacts as follows:
7 Section 1. Section 102 of the act of June 13, 1967 (P.L.31, <--
8 No.21), known as the Public Welfare Code, is amended to read:
9 Section 102. Definitions. Subject to additional definitions
10 contained in subsequent articles of this act, the following
11 words when used in this act shall have, unless the context
12 clearly indicates otherwise, the meanings given them in this
13 section:
14 "Department" means the Department of [Public Welfare] Human
15 Services of this Commonwealth.
16 "Secretary" means the Secretary of [Public Welfare] Human
17 Services of this Commonwealth.
18 Section 2. The act is amended by adding sections to read:
19 Section 103. Redesignation. (a) The Department of Public
20 Welfare shall be known as the Department of Human Services.
21 (b) A reference to the Department of Public Welfare in a
22 statute or a regulation shall be deemed a reference to the
23 Department of Human Services.
24 (c) In order to provide an efficient and cost-minimizing
25 transition, licenses, contracts, deeds and any other official
26 actions of the Department of Public Welfare shall not be
27 affected by the use of the designation of the department as the
28 Department of Human Services. The department may continue to use
29 the name Department of Public Welfare on badges, licenses,
30 contracts, deeds, stationery and any other official documents

1 ~~until existing supplies are exhausted. The Department of Public~~
2 ~~Welfare may substitute the title "Department of Human Services"~~
3 ~~for "Department of Public Welfare" on its documents and~~
4 ~~materials on such schedule as it deems appropriate.~~
5 ~~(d) The Department of Human Services shall not replace~~
6 ~~existing signage at department locations with the redesignated~~
7 ~~name until the signs are worn and in need of replacement. This~~
8 ~~transition shall be coordinated with changes in administration.~~
9 ~~(e) The department shall continue to use the name Department~~
10 ~~of Public Welfare on its computer systems until the time of~~
11 ~~routine upgrades in each computer system in the department. The~~
12 ~~change in name shall be made at the time of the routine upgrade~~
13 ~~to the department computer systems.~~
14 ~~Section 441.10. Enhanced medical services delivery system.~~
15 ~~(a) Any enhanced medical services delivery system developed~~
16 ~~collaboratively with the United States Department of Health and~~
17 ~~Human Services and approved for this Commonwealth shall consider~~
18 ~~and recognize all of the following design options or reforms:~~
19 ~~(1) Benefit design modifications that make the medical~~
20 ~~assistance program responsive and flexible to changing needs and~~
21 ~~demands, thereby allowing an expansion of coverage to additional~~
22 ~~citizens of this Commonwealth.~~
23 ~~(2) Improved accountability and personal responsibility~~
24 ~~through cost sharing that includes reasonable low cost premiums~~
25 ~~or copay requirements, which encourage proper utilization and~~
26 ~~the delivery of services to those who need them most.~~
27 ~~(3) Plan design features that parallel the services and~~
28 ~~benefits available to citizens of this Commonwealth with~~
29 ~~commercial insurance coverage and meet the requirements of an~~
30 ~~essential health benefit plan as defined under the Patient~~

~~Protection and Affordable Care Act (Public Law 111-148, 1124 Stat. 119), including the delivery of behavioral health services.~~

~~(4) Maximized use of commercial insurance that takes an integrated and market-based approach with new coverage opportunities, market competition and alternatives to the existing medical assistance program when determined to be more fiscally sound and appropriate, including movement to the health care exchange for those in the Medical Assistance for Workers with Disabilities program.~~

~~(5) Implementation of an enhanced medical services delivery system that utilizes existing or supplemental plans for medical assistance programs as contracted by the department, using a risk-based approach for reimbursing Medicaid managed care organizations.~~

~~(6) Continued operation of the Children's Health Insurance Program in a form that does not unnecessarily require a shift to medical assistance or an enhanced medical services delivery system.~~

~~(7) Reasonable employment and job search requirements for those physically or mentally able, as well as appropriate limits on nonessential benefits, such as nonemergency transportation.~~

~~(8) Improved access and continuity of care, with Federal and State support for the use of community-based health centers, medical homes, expanded scope of practice and targeted chronic care, including a managed long-term care pilot program and other long term care measures, that provide coordination and delivery of preventive care and assure the wellness of the served population.~~

~~(9) Use of competitive and value-based purchasing from~~

~~medical providers and medical equipment suppliers that promotes efficiencies and delivers value to taxpayers.~~

~~(10) Continued emphasis on the reduction of waste, fraud and abuse in all facets of the medical services delivery and provider system, with focused attention on credible allegations of fraud by providers and the use of predictive modeling.~~

~~(11) Resolution on existing Federal deferrals and disallowances as they relate to the Pennsylvania Medicaid Program with minimal financial impact to the Commonwealth.~~

~~(12) Maintained allowance of the Commonwealth's current gross receipts tax on Medicaid managed care organizations for the duration of any enhanced medical services delivery system in the Commonwealth.~~

~~(13) Application of the Federal financial participation rate currently provided to the Commonwealth, based on existing Federal calculations, for medical assistance and all other eligible programs and services that receive a Federal match.~~

~~(14) Affirmation that any expanded coverage under the enhanced medical services delivery system does not constitute an entitlement at the Federal or State level.~~

~~(b) The adoption of an agreement to create an enhanced medical services delivery system in this Commonwealth for adults ranging from 19 to 65 years of age necessitates further discussions with the United States Department of Health and Human Services to ensure that it can be accomplished in an integrated, cost-effective and fiscally sustainable manner and that taxpayer dollars derived directly from citizens of this Commonwealth, which are going to the Federal Government under the Patient Protection and Affordable Care Act (Public Law 111-148, 124 Stat. 119), generate services to the citizens of this~~

~~Commonwealth in proportion to that significant investment.~~

~~(c) Recognition and furtherance of the objectives set forth under subsection (a) are essential as the Commonwealth vigorously pursues its discussions with the United States Department of Health and Human Services to develop and implement an agreement with the Secretary of the United States Department of Health and Human Services to expand eligibility to persons described under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII)), no later than July 1, 2014. The department shall submit an application for an enhanced medical services delivery system to the United States Department of Health and Human Services for review no later than October 1, 2013. The department shall submit a revised State plan or waiver if required to implement an expansion of eligibility under this subsection.~~

~~(d) This section and the authority to expand eligibility under an enhanced medical services delivery system shall cease if the Federal medical assistance percentage under section 1905(y) of the Social Security Act (42 U.S.C. § 1396d(y)) is less than the following:~~

~~(1) One hundred percent for calendar quarters in 2014, 2015 and 2016.~~

~~(2) Ninety-five percent for calendar quarters in 2017.~~

~~(3) Ninety-four percent for calendar quarters in 2018.~~

~~(4) Ninety-three percent for calendar quarters in 2019.~~

~~(5) Ninety percent for calendar quarters in 2020 and each year thereafter.~~

~~(e) Commencing in fiscal year 2019-2020, continued participation by recipients in an enhanced medical services delivery system shall be conditioned on the options of increased~~

~~cost sharing or the purchase of coverage with Federal subsidies through the exchange.~~

~~(f) The General Assembly finds and declares as follows:~~

~~(1) The Commonwealth has initiated transformative changes in the medical assistance health care delivery system through the expansive use of managed care; alignment of payment incentives; recognition of the need for rural, underserved and community-based health care access; support of community-based health care centers; multifaceted initiatives to reduce waste, fraud and abuse; targeted resources for the delivery of chronic care; and the establishment of medical homes. The Commonwealth is also known for its nationally recognized programs to promote patient safety and the use of electronic medical records, to reduce health care infections and to advance medical, technological and biological research, which collectively have contributed to advances in the care, treatment and cure of medical disease.~~

~~(2) The Commonwealth established the PACE and PACENET programs to provide affordable pharmaceutical drugs for our seniors, which became model programs for the nation.~~

~~(3) The Commonwealth created the innovative Children's Health Insurance Program, which also became a model for the nation by providing access to comprehensive health care services for children across this Commonwealth and is a vital program that should be preserved.~~

~~(4) In 2001, the Commonwealth established a nonentitlement program known as AdultBasic for the purpose of providing health care insurance coverage to eligible adults not otherwise eligible for medical assistance, initially using funds available through the act of June 26, 2001 (P.L.755, No.77), known as the Tobacco Settlement Act. Any agreement between the Commonwealth~~

1 ~~and the United States Department of Health and Human Services on~~
2 ~~the establishment of an enhanced medical assistance delivery~~
3 ~~system will serve to advance these same interests.~~
4 ~~(5) Commonwealth taxpayers currently provide publicly~~
5 ~~subsidized health care for nearly 2,400,000 thousand citizens of~~
6 ~~this Commonwealth, or almost 19% of the total population of this~~
7 ~~Commonwealth, which includes coverage for a broad array of~~
8 ~~mandatory and optional health care benefits.~~
9 ~~Section 3. Section 443.1 (1.1)(i), (1.4) and (7)(iv) of the~~
10 ~~act, amended or added June 30, 2011 (P.L.89, No.22), are~~
11 ~~amended, paragraph (7) is amended by adding a subparagraph and~~
12 ~~the section is amended by adding a paragraph to read:~~
13 SECTION 1. SECTION 443.1(1.1)(I), (1.4) AND (7)(IV) OF THE **<--**
14 ACT OF JUNE 13, 1967 (P.L.31, NO.21), KNOWN AS THE PUBLIC
15 WELFARE CODE, AMENDED OR ADDED JUNE 30, 2011 (P.L.89, NO.22),
16 ARE AMENDED, PARAGRAPH (7) IS AMENDED BY ADDING A SUBPARAGRAPH
17 AND THE SECTION IS AMENDED BY ADDING A PARAGRAPH TO READ:
18 Section 443.1. Medical Assistance Payments for Institutional
19 Care.--The following medical assistance payments shall be made
20 on behalf of eligible persons whose institutional care is
21 prescribed by physicians:
22 * * *
23 (1.1) Subject to section 813-G, for inpatient acute care
24 hospital services provided during a fiscal year in which an
25 assessment is imposed under Article VIII-G, payments under the
26 medical assistance fee-for-service program shall be determined
27 in accordance with the department's regulations, except as
28 follows:
29 (i) If the Commonwealth's approved Title XIX State Plan for
30 inpatient hospital services in effect for the period of July 1,

1 2010, through June 30, [2013] <u>2016</u>, specifies a methodology for
2 calculating payments that is different from the department's
3 regulations or authorizes additional payments not specified in
4 the department's regulations, such as inpatient disproportionate
5 share payments and direct medical education payments, the
6 department shall follow the methodology or make the additional
7 payments as specified in the approved Title XIX State Plan.
8 * * *
9 (1.4) Subject to section 813-G, for inpatient hospital
10 services provided under the physical health medical assistance
11 managed care program during State fiscal [year] <u>years</u> 2012-2013,
12 <u>2013-2014, 2014-2015 and 2015-2016,</u> the following shall apply:
13 (A) The department may adjust its capitation payments to
14 medical assistance managed care organizations to provide
15 additional funds for inpatient hospital services.
16 (B) For an out-of-network inpatient discharge of a recipient
17 enrolled in a medical assistance managed care organization that
18 occurs in State fiscal year 2012-2013, <u>2013-2014, 2014-2015 or</u>
19 <u>2015-2016,</u> the medical assistance managed care organization
20 shall pay, and the hospital shall accept as payment in full, the
21 amount that the department's fee-for-service program would have
22 paid for the discharge if the recipient [were] <u>was</u> enrolled in
23 the department's fee-for-service program.
24 <u>(C) Nothing in this paragraph shall prohibit an inpatient</u>
25 <u>acute care hospital and a medical assistance managed care</u>
26 <u>organization from executing a new participation agreement or</u>
27 <u>amending an existing participation agreement on or after July 1,</u>
28 <u>2013.</u>
29 * * *
30 <u>(1.6) Notwithstanding any other provision of law or</u>

departmental regulation to the contrary, the department shall make separate fee-for-service APR-DRG payments for medically necessary inpatient acute care general hospital services provided for normal newborn care and for mothers' obstetrical delivery.

* * *

(7) After June 30, 2007, payments to county and nonpublic nursing facilities enrolled in the medical assistance program as providers of nursing facility services shall be determined in accordance with the methodologies for establishing payment rates for county and nonpublic nursing facilities specified in the department's regulations and the Commonwealth's approved Title XIX State Plan for nursing facility services in effect after June 30, 2007. The following shall apply:

* * *

(iv) Subject to Federal approval of such amendments as may be necessary to the Commonwealth's approved Title XIX State Plan, for each fiscal year beginning on or after July 1, 2011, the department shall apply a revenue adjustment neutrality factor to county and nonpublic nursing facility payment rates so that the estimated Statewide day-weighted average payment rate in effect for that fiscal year is limited to the amount permitted by the funds appropriated by the General Appropriation Act for the fiscal year. The revenue adjustment neutrality factor shall remain in effect until the sooner of June 30, [2013] 2016, or the date on which a new rate-setting methodology for medical assistance nursing facility services which replaces the rate-setting methodology codified in 55 Pa. Code Chs. 1187 (relating to nursing facility services) and 1189 (relating to county nursing facility services) takes effect.

1 (v) Subject to Federal approval of such amendments as may be
2 necessary to the Commonwealth's approved Title XIX State Plan,
3 for fiscal year 2013-2014, the department shall make quarterly
4 medical assistance day one incentive payments to qualified
5 nonpublic nursing facilities. The department shall determine the
6 nonpublic nursing facilities that qualify for the quarterly
7 medical assistance day one incentive payments and calculate the
8 payments using the Total Pennsylvania medical assistance (PA MA)
9 days and Total Resident Days as reported by nonpublic nursing
10 facilities under Article VIII-A (relating to nursing facility
11 assessments). The department's determination and calculations
12 under this subparagraph shall be based on the nursing facility
13 assessment quarterly resident day reporting forms available on
14 October 31, January 31, April 30 and July 31. The department
15 shall not retroactively revise a medical assistance day one
16 incentive payment amount based on a nursing facility's late
17 submission or revision of its report after these dates. The
18 department, however, may recoup payments based on an audit of a
19 nursing facility's report. The following shall apply:
20 (A) A nonpublic nursing facility shall meet all of the
21 following criteria to qualify for a medical assistance day one
22 incentive payment:
23 (I) The nursing facility shall have an overall occupancy
24 rate of at least eighty-five percent during the resident day
25 quarter. For purposes of determining a nursing facility's
26 overall occupancy rate, a nursing facility's Total Resident
27 Days, as reported by the facility under Article VIII-A, shall be
28 divided by the product of the facility's licensed bed capacity,
29 at the end of the quarter, multiplied by the number of calendar
30 days in the quarter.

1 (II) The nursing facility shall have a medical assistance
2 occupancy rate of at least sixty-five percent during the
3 resident day quarter. For purposes of determining a nursing
4 facility's medical assistance occupancy rate, the nursing
5 facility's Total PA MA days shall be divided by the nursing
6 facility's Total Resident Days, as reported by the facility
7 under Article VIII-A.
8 (III) The nursing facility shall be a nonpublic nursing
9 facility for a full resident day quarter prior to the applicable
10 quarterly reporting due dates of October 31, January 31, April
11 30 and July 31.
12 (B) The department shall calculate a qualified nonpublic
13 nursing facility's medical assistance day one incentive
14 quarterly payment as follows:
15 (I) The total funds appropriated for payments under this
16 subparagraph shall be divided by four.
17 (II) To establish the quarterly per diem rate, the amount
18 under subclause (I) shall be divided by the Total PA MA days, as
19 reported by all qualifying nonpublic nursing facilities under
20 Article VIII-A.
21 (III) To determine a qualifying nonpublic nursing facility's
22 quarterly medical assistance day one incentive payment, the
23 quarterly per diem rate shall be multiplied by a nonpublic
24 nursing facility's Total PA MA days, as reported by the facility
25 under Article VIII-A.
26 (C) For fiscal year 2013-2014, the State funds available for
27 the nonpublic nursing facility medical assistance day one
28 incentive payments shall equal ~~seven million dollars~~ <--
29 ~~($7,000,000)~~ EIGHT MILLION DOLLARS ($8,000,000). <--
30 * * *

1 Section ~~4~~ 2. Section 454(a) of the act, amended June 30, **<--**
2 2011 (P.L.89, No.22), is amended to read:
3 Section 454. Medical Assistance Benefit Packages; Coverage,
4 Copayments, Premiums and Rates.--(a) Notwithstanding any other
5 provision of law to the contrary, the department shall
6 promulgate regulations as provided in subsection (b) to
7 establish provider payment rates; the benefit packages and any
8 copayments for adults eligible for medical assistance under
9 Title XIX of the Social Security Act (49 Stat 620, 42 U.S.C. §
10 1396 et seq.) and adults eligible for medical assistance in
11 general assistance-related categories; and the premium or
12 copayment requirements for disabled children whose family income
13 is above two hundred percent of the Federal poverty income
14 limit. Subject to such Federal approval as may be necessary, the
15 regulations shall authorize and describe the available benefit
16 packages and any copayments and premiums, except that the
17 department shall set forth the copayment and premium schedule
18 for disabled children whose family income is above two hundred
19 percent of the Federal poverty income limit by publishing a
20 notice in the Pennsylvania Bulletin. The department may adjust
21 such copayments and premiums for disabled children by notice
22 published in the Pennsylvania Bulletin. The regulations shall
23 also specify the effective date for provider payment rates.
24 * * *
25 Section ~~5~~ 3. Section 704.1(g) of the act, added July 9, 1976 **<--**
26 (P.L.846, No.148), is amended and the section is amended by
27 adding subsections to read:
28 Section 704.1. Payments to Counties for Services to
29 Children.--* * *
30 (g) The department shall[, within forty-five days of each

1 calendar quarter, pay fifty percent of the department's share of
2 the county institution district's or its successor's estimated
3 expenditures for that quarter.] process payments to each county
4 pursuant to this article from funds appropriated by the General
5 Assembly for each fiscal year, within 15 days of passage of the
6 general appropriation bill or by a date specified under
7 paragraphs (1), (2), (3), (4) or (5), whichever is later. The
8 department shall process the following applicable payments to
9 the county:
10 (1) By July 15, twenty-five percent of the amount of State
11 funds allocated to the county under section 709.3.
12 (2) By August 31, or upon approval by the department of the
13 county's final cumulative report for its expenditures for the
14 prior fiscal year, whichever is later, twenty-five percent of
15 the amount of State funds allocated to the county under section
16 709.3, reduced by the amount of aggregate unspent State funds
17 provided to the county during the previous fiscal year.
18 (3) By November 30, or upon approval by the department of
19 the county's report for its expenditures for the first quarter
20 of the fiscal year, whichever is later, twenty-five percent of
21 the amount of State funds allocated to the county under section
22 709.3, reduced by the amount of unspent State funds already
23 provided to the county for the first quarter of the fiscal year.
24 (4) By February 28, or upon approval by the department of
25 the county's report for its expenditures for the second quarter
26 of the fiscal year, whichever is later, twelve and five-tenths
27 percent of the amount of State funds allocated to the county
28 under section 709.3, adjusted by the amount of overspending or
29 underspending of State funds in the previous quarters, but not
30 to exceed eighty-seven and five-tenths percent of the county's

approved State allocation.

(5) Upon approval by the department of the county's final cumulative report for its expenditures for the fiscal year, twelve and five-tenths percent of the amount of State funds allocated to the county under section 709.3, adjusted by the amount of overspending or underspending of State funds in the previous quarters.

(g.1) After the final cumulative report for expenditures has been approved, if a county has adjustments to revenues or expenditures for the time period covered by the expenditure report in addition to the payments under subsection (g), the county shall submit to the department a revised expenditure report. After the report is approved, the department may adjust any payment under subsection (g) to account for any revision to a county's expenditure report.

(g.2) Service contracts or agreements shall include a timely payment provision that requires counties to make payment to service providers within thirty days of the county's receipt of an invoice under both of the following conditions:

(1) The invoice satisfies the county's requirements for a complete and accurate invoice.

(2) Funds have been appropriated to the department for payments to counties under subsection (g).

* * *

Section ~~6~~ 4. The act is amended by adding a section to read: **<--**

Section 704.3. Provider submissions.--(a) For fiscal year 2013-2014, a provider shall submit documentation of its costs of providing services and the department shall use such documentation, to the extent necessary, to support the department's claim for Federal funding and for State

reimbursement for allowable direct and indirect costs incurred in the provision of out-of-home placement services.

(b) The department shall convene a task force to include representatives from public and private children and youth social service agencies and other appropriate stakeholders as determined by the secretary or deputy secretary for the Office of Children, Youth and Families.

(c) The task force established under subsection (b) shall develop recommendations for a methodology to determine reimbursement for actual and projected costs, which are reasonable and allowable, for the purchase of services from providers and for other purchased services. The task force shall provide written recommendations for the purchase of services from providers to the General Assembly no later than April 30, 2014. The task force shall provide written recommendations for other purchased services no later than December 31, 2014. The task force shall be convened within sixty days after the effective date of this section.

(d) As used in this section, the term "provider" means an entity licensed or certified to provide twenty-four-hour out-of-home community-based or institutional care and supervision of a child, with the care and supervision being paid for or provided by a county using Federal or State funds disbursed under this article.

Section ~~7~~ 5. The heading of Article VIII-C of the act, added **<--** July 4, 2004 (P.L.528, No.69) is amended to read:

ARTICLE VIII-C

INTERMEDIATE CARE FACILITIES FOR [MENTALLY RETARDED] PERSONS WITH AN INTELLECTUAL DISABILITY

ASSESSMENTS

1 Section ~~8~~ 6. Sections 801-C, 802-C, 803-C, 804-C, 805-C, <--
2 806-C, 807-C, 808-C, 809-C and 810-C of the act, added July 4,
3 2004 (P.L.528, No.69), are amended to read:
4 Section 801-C. Definitions.
5 The following words and phrases when used in this article
6 shall have the meanings given to them in this section unless the
7 context clearly indicates otherwise:
8 "Assessment." The fee implemented pursuant to this article
9 on every intermediate care facility for [mentally retarded]
10 persons with an intellectual disability.
11 "Department." The Department of Public Welfare of the
12 Commonwealth.
13 "Intermediate care facility for [mentally retarded] persons
14 with an intellectual disability" or "[ICF/MR] ICF/ID." A public
15 or private facility defined in section 1905 of the Social
16 Security Act (49 Stat. 620, 42 U.S.C. § 1905).
17 "Medicaid." The program established under Title XIX of the
18 Social Security Act (49 Stat. 620, 42 U.S.C. § 1396 et seq.).
19 "Medical assistance program" or "program." The medical
20 assistance program as administered by the Department of Public
21 Welfare.
22 "Secretary." The Secretary of Public Welfare of the
23 Commonwealth.
24 "Social Security Act." 49 Stat. 620, 42 U.S.C. § 301 et seq.
25 Section 802-C. Authorization.
26 In order to generate additional revenues for medical
27 assistance program recipients to have access to medically
28 necessary [mental retardation] intellectual disability services,
29 the department shall implement a monetary assessment on each
30 [ICF/MR] ICF/ID subject to the conditions and requirements

1 specified in this article.
2 Section 803-C. Implementation.
3 The [ICF/MR] ICF/ID assessments shall be implemented on an
4 annual basis as a health care-related tax as defined in section
5 1903(w)(3)(B) of the Social Security Act, or any amendments
6 thereto, and may be imposed and is required to be paid only to
7 the extent that the revenues generated from the assessment will
8 qualify as the State share of program expenditures eligible for
9 Federal financial participation.
10 Section 804-C. Amount.
11 The assessment rate shall be determined in accordance with
12 this article and implemented on an annual basis by the
13 department, as approved by the Governor, upon notification to
14 and in consultation with the [ICFs/MR] ICFs/ID. In each year in
15 which the assessment is implemented, the assessment rate shall
16 equal the amount established by the department subject to the
17 maximum aggregate amount that may be assessed pursuant to the 6%
18 indirect guarantee threshold set forth in 42 CFR 433.68(f)(3)(i)
19 (relating to permissible health care-related taxes [after the
20 transition period]) or any other maximum aggregate amount
21 established by law.
22 Section 805-C. Administration.
23 (a) Notice of assessment.--The secretary, before
24 implementing an assessment in any fiscal year, shall publish a
25 notice in the Pennsylvania Bulletin that specifies the amount of
26 the assessment being proposed and an explanation of the
27 assessment methodology and amount determination that identifies
28 the aggregate impact on [ICFs/MR] ICFs/ID subject to the
29 assessment. Interested parties shall have 30 days in which to
30 submit comments to the secretary. Upon expiration of the 30-day

1 comment period, the secretary, after consideration of the
2 comments, shall publish a second notice in the Pennsylvania
3 Bulletin announcing the rate of the assessment.
4 (b) Review of assessment.--Except as permitted under section
5 809-C, the secretary's determination of the aggregate amount and
6 the rate of the assessment pursuant to subsection (a) shall not
7 be subject to administrative or judicial review under 2 Pa.C.S.
8 Chs. 5 Subch. A (relating to practice and procedure of
9 Commonwealth agencies) and 7 Subch. A (relating to judicial
10 review of Commonwealth agency action) or any other provision of
11 law. No assessment implemented under this article nor forms or
12 reports required to be completed by [ICFs/MR] ICFs/ID pursuant
13 to this article shall be subject to the act of July 31, 1968
14 (P.L.769, No.240), referred to as the Commonwealth Documents
15 Law, the act of October 15, 1980 (P.L.950, No.164), known as the
16 Commonwealth Attorneys Act, or the act of June 25, 1982
17 (P.L.633, No.181), known as the Regulatory Review Act.
18 Section 806-C. Calculation.
19 Using the assessment rate implemented by the secretary
20 pursuant to section 804-C, each [ICF/MR] ICF/ID shall calculate
21 the assessment amounts it owes for a calendar quarter on a form
22 specified by the department and shall submit the form and the
23 amount owed to the department no later than the last day of that
24 calendar quarter or 30 days from the date of the department's
25 second notice published pursuant to section 805-C(a), whichever
26 is later.
27 Section 807-C. Purposes and uses.
28 No [ICF/MR] ICF/ID shall be directly guaranteed a repayment
29 of its assessment in derogation of 42 CFR 433.68 (relating to
30 permissible health care-related taxes [after the transition

period]), provided, however, in each fiscal year in which an assessment is implemented, the department shall use the State revenue collected from the assessment and any Federal funds received by the Commonwealth as a direct result of the assessment to fund services for persons with [mental retardation] an intellectual disability.

Section 808-C. Records.

Upon request by the department, an [ICF/MR] ICF/ID shall furnish to the department such records as the department may specify in order to determine the assessment rate for a fiscal year or the amount of the assessment due from the [ICF/MR] ICF/ID or to verify that the [ICF/MR] ICF/ID has paid the correct amount due. In the event that the department determines that an [ICF/MR] ICF/ID has failed to pay an assessment or that it has underpaid an assessment, the department shall notify the [ICF/MR] ICF/ID in writing of the amount due, including interest, and the date on which the amount due must be paid, which shall not be less than 30 days from the date of the notice. In the event that the department determines that an [ICF/MR] ICF/ID has overpaid an assessment, the department shall notify the [ICF/MR] ICF/ID in writing of the overpayment and, within 30 days of the date of the notice of the overpayment, shall either authorize a refund of the amount of the overpayment or offset the amount of the overpayment against any amount that may be owed to the department by the [ICF/MR] ICF/ID.

Section 809-C. Appeal rights.

An [ICF/MR] ICF/ID that is aggrieved by a determination of the department as to the amount of the assessment due from the [ICF/MR] ICF/ID or a remedy imposed pursuant to section 810-C may file a request for review of the decision of the department

1 by the Bureau of Hearings and Appeals within the department,
2 which shall have exclusive jurisdiction in such matters. The
3 procedures and requirements of 67 Pa.C.S. Ch. 11 (relating to
4 medical assistance hearings and appeals) shall apply to requests
5 for review filed pursuant to this section except that, in any
6 such request for review, an [ICF/MR] <u>ICF/ID</u> may not challenge
7 the assessment rate determined by the secretary, but only
8 whether the department correctly determined the assessment
9 amount due from the [ICF/MR] <u>ICF/ID</u> using the assessment rate in
10 effect for the fiscal year.
11 Section 810-C. Enforcement.
12 In addition to any other remedy provided by law, the
13 department may enforce this article by imposing one or more of
14 the following remedies:
15 (1) When an [ICF/MR] <u>ICF/ID</u> fails to pay an assessment
16 or penalty in the amount or on the date required by this
17 article, the department may add interest at the rate provided
18 in section 806 of the act of April 9, 1929 (P.L.343, No.176),
19 known as The Fiscal Code, to the unpaid amount of the
20 assessment or penalty from the date prescribed for its
21 payment until the date it is paid.
22 (2) When an [ICF/MR] <u>ICF/ID</u> fails to file a report or to
23 furnish records to the department as required by this
24 article, the department may impose a penalty against the
25 [ICF/MR] <u>ICF/ID</u> in the amount of $1,000 per day for each day
26 the report or required records are not filed or furnished to
27 the department.
28 (3) When an [ICF/MR] <u>ICF/ID</u> fails to pay all or part of
29 an assessment or penalty within 60 days of the date that
30 payment is due, the department may terminate the [ICF/MR]

ICF/ID from participation in the medical assistance program and/or deduct the unpaid assessment or penalty and any interest owed thereon from any payments due to the [ICF/MR] ICF/ID until the full amount is recovered. Any such termination or payment deduction shall be made only after written notice to the [ICF/MR] ICF/ID.

(4) The secretary may waive all or part of the interest or penalties assessed against an [ICF/MR] ICF/ID pursuant to this article for good cause as shown by the [ICF/MR] ICF/ID.

Section ~~9~~ 7. Section 811-C of the act, amended July 4, 2008 (P.L.557, No.44), is amended to read: <--

Section 811-C. Time periods.

(a) Imposition.--The assessment authorized under this article shall not be imposed as follows:

(1) Prior to July 1, 2003, for private [ICFs/MR] ICFs/ID.

(2) Prior to July 1, 2004, for public [ICFs/MR] ICFs/ID.

(3) In the absence of Federal financial participation as described under section 803-C.

(b) Cessation.--The assessment authorized under this article shall cease June 30, [2013] 2016, or earlier, if required by law.

Section ~~10~~ 8. Section 802-E of the act is amended by adding a subsection to read: <--

Section 802-E. Authorization.

* * *

(a.1) Adjustments to assessment percentage.--

(1) For State fiscal years beginning after June 30, 2013, and subject to the advance written approval of the secretary as prescribed by the department, the municipality

may make a uniform adjustment to an assessment percentage established by ordinance under subsection (a).

(2) After receiving written approval under paragraph (1) and before implementing an adjustment, the municipality shall provide advance public notice. The notice shall specify the proposed adjusted assessment percentage and identify the aggregate impact on hospitals located in the municipality subject to an assessment. An interested party shall have 30 days in which to submit comments to the municipality. Upon expiration of the 30-day comment period, the municipality, after consideration of the comments, shall publish a subsequent notice announcing the adjusted assessment percentage.

* * *

Section ~~11~~ 9. Section 808-E of the act, reenacted October 22, 2010 (P.L.829, No.84), is amended to read: **<--**

Section 808-E. Time period.

(a) Cessation.--The assessment authorized under this article shall cease June 30, [2013] 2016.

(b) Assessment.--

(1) A municipality shall have the power to enact the assessment authorized in section 802-E(a)(2) either prior to or during its fiscal year ending June 30, 2010.

(2) A municipality may adjust an assessment percentage as specified under section 802-E(a.1) either prior to or during the fiscal year in which the adjusted assessment percentage takes effect.

Section ~~12~~ 10. The heading of Article VIII-G of the act, added July 9, 2010 (P.L.336, No.49), is reenacted to read: **<--**

ARTICLE VIII-G

STATEWIDE QUALITY CARE ASSESSMENT

Section ~~12.1~~ 11. Section 801-G of the act, added or amended <--
July 9, 2010 (P.L.336, No.49) and June 30, 2011 (P.L.89, No.22), is reenacted and amended to read:

Section 801-G. Definitions.

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

"Assessment." The fee, known as the Quality Care Assessment, authorized to be implemented under this article on every covered hospital.

"Bad debt expense." The cost of care for which a hospital expected payment from the patient or a third-party payer, but which the hospital subsequently determines to be uncollectible, as further described in the Medicare Provider Reimbursement Manual published by the United States Department of Health and Human Services.

"Charity care expense." The cost of care for which a hospital ordinarily charges a fee but which is provided free or at a reduced rate to patients who cannot afford to pay but who are not eligible for public programs, and from whom the hospital did not expect payment in accordance with the hospital's charity care policy, as further described in the Medicare Provider Reimbursement Manual published by the United States Department of Health and Human Services.

"Contractual allowance." The difference between what a hospital charges for services and the amounts that certain payers have agreed to pay for the services as further described in the Medicare Provider Reimbursement Manual published by the United States Department of Health and Human Services.

"Covered hospital." A hospital other than an exempt hospital.

"Critical access hospital." Any hospital that has qualified under section 1861(mm)(1) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1395x(mm)(1)) as a critical access hospital under Medicare.

"Exempt hospital." Any of the following:

(1) A Federal veterans' affairs hospital.

(2) A hospital that provides care, including inpatient hospital services, to all patients free of charge.

(3) A private psychiatric hospital.

(4) A State-owned psychiatric hospital.

(5) A critical access hospital.

(6) A long-term acute care hospital.

"Hospital." A facility licensed as a hospital under 28 Pa.Code Pt. IV Subpt. B (relating to general and special hospitals).

"Long-term acute care hospital." A hospital or unit of a hospital whose patients have a length of stay of greater than 25 days and that provides specialized acute care of medically complex patients who are critically ill.

"Medical assistance managed care organization." A Medicaid managed care organization as defined in section 1903(m)(1)(a) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396b(m)(1)(a)) that is a party to a Medicaid managed care contract with the department. The term shall not include a behavioral health managed care organization that is a party to a Medicaid managed care contract with the department.

"Net inpatient revenue." Gross charges for facilities for inpatient services less any deducted amounts for bad debt

expense, charity care expense and contractual allowances as reported on forms specified by the department and:

(1) as identified in the hospital's records for the State fiscal year commencing July 1, [2007] 2010; or

(2) as identified in the hospital's records for the most recent State fiscal year, or part thereof, if amounts are not available under paragraph (1).

"Program." The Commonwealth's medical assistance program as authorized under Article IV.

Section ~~12.2~~ 12. Section 802-G of the act, added July 9, 2010, (P.L.336, No.49), is reenacted to read: **<--**

Section 802-G. Authorization.

In order to generate additional revenues for the purpose of assuring that medical assistance recipients have access to hospital services, the department shall implement a monetary assessment, known as the Quality Care Assessment, on each covered hospital subject to the conditions and requirements specified in this article, including section 813-G.

Section ~~12.3~~ 12.1. Section 803-G of the act, added or amended July 9, 2010 (P.L.336, No.49) and June 30, 2011 (P.L.89, No.22), is reenacted and amended to read: **<--**

Section 803-G. Implementation.

(a) Health care-related fee.--The assessment authorized under this article, once imposed, shall be implemented as a health care-related fee as defined under section 1903(w)(3)(B) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396b(w)(3)(B)) or any amendments thereto and may be collected only to the extent and for the periods that the secretary determines that revenues generated by the assessment will qualify as the State share of program expenditures eligible for Federal

1 financial participation.
2 (b) Assessment percentage.--Subject to subsection (c), each
3 covered hospital shall be assessed as follows:
4 (1) for fiscal year 2010-2011, each covered hospital
5 shall be assessed an amount equal to 2.69% of the net
6 inpatient revenue of the covered hospital; and
7 (2) for fiscal years 2011-2012 [and] , 2012-2013, 2013-
8 2014, 2014-2015 and 2015-2016, an amount equal to 3.22% of
9 the net inpatient revenue of the covered hospital.
10 (c) Adjustments to assessment percentage.--The secretary may
11 adjust the assessment percentage specified in subsection (b),
12 provided that, before adjusting, the secretary shall publish a
13 notice in the Pennsylvania Bulletin that specifies the proposed
14 assessment percentage and identifies the aggregate impact on
15 covered hospitals subject to the assessment. Interested parties
16 shall have 30 days in which to submit comments to the secretary.
17 Upon expiration of the 30-day comment period, the secretary,
18 after consideration of the comments, shall publish a second
19 notice in the Pennsylvania Bulletin announcing the assessment
20 percentage.
21 (d) Maximum amount.--In each year in which the assessment is
22 implemented, the assessment shall be subject to the maximum
23 aggregate amount that may be assessed under 42 CFR 433.68(f)(3)
24 (i) (relating to permissible health care-related taxes) or any
25 other maximum established under Federal law.
26 (e) Limited review.--Except as permitted under section 810-
27 G, the secretary's determination of the assessment percentage
28 pursuant to subsection (b) shall not be subject to
29 administrative or judicial review under 2 Pa.C.S. Chs. 5 Subch.
30 A (relating to practice and procedure of Commonwealth agencies)

1 and 7 Subch. A (relating to judicial review of Commonwealth
2 agency action) or any other provision of law; nor shall any
3 assessments implemented under this article or forms or reports
4 required to be completed by covered hospitals pursuant to this
5 article be subject to the act of July 31, 1968 (P.L.769,
6 No.240), referred to as the Commonwealth Documents Law, the act
7 of October 15, 1980 (P.L.950, No.164), known as the Commonwealth
8 Attorneys Act, and the act of June 25, 1982 (P.L.633, No.181),
9 known as the Regulatory Review Act.
10 Section ~~12.4~~ 12.2. Section 804-G of the act, amended June <--
11 30, 2011 (P.L.89, No.22), is reenacted and amended to read:
12 Section 804-G. Administration.
13 (a) Calculation and notice of assessment amount.--Using the
14 assessment percentage established under section 803-G and
15 covered hospitals' net inpatient revenue, the department shall
16 calculate and notify each covered hospital of the assessment
17 amount owed for the fiscal year. Notification pursuant to this
18 subsection may be made in writing or electronically at the
19 discretion of the department.
20 (a.1) Calculation of assessment with changes of ownership.--
21 (1) If a single covered hospital changes ownership or
22 control, the department will continue to calculate the
23 assessment amount using the hospital's net inpatient revenue
24 for State fiscal year [2008-2009] 2010-2011 or for the most
25 recent State fiscal year, or part thereof, if the State
26 fiscal year [2008-2009] 2010-2011 amounts are not available.
27 The covered hospital is liable for any outstanding assessment
28 amounts, including outstanding amounts related to periods
29 prior to the change of ownership or control.
30 (2) If two or more hospitals merge or consolidate into a

1 single covered hospital as a result of a change in ownership
2 or control, the department will calculate the covered
3 hospital assessment amount using the combined net inpatient
4 revenue for State fiscal year [2008-2009] <u>2010-2011</u> or for
5 the most recent State fiscal year, or part thereof, if the
6 State fiscal year [2008-2009] <u>2010-2011</u> amounts are not
7 available, of any covered hospitals that were merged or
8 consolidated into the single covered hospital. The single
9 covered hospital is liable for any outstanding assessment
10 amounts, including outstanding amounts related to periods
11 prior to the change of ownership or control, of any covered
12 hospital that was merged or consolidated.
13 (a.2) Calculation of assessment with closures or other
14 changes in operation.--Except as provided in subsection (a.1)
15 (2), a covered hospital that closes or that becomes an exempt
16 hospital during a fiscal year is liable for both:
17 (1) The annual assessment amount for the fiscal year in
18 which the closure or change occurs prorated by the number of
19 days in the fiscal year during which the covered hospital was
20 in operation.
21 (2) Any outstanding assessment amounts related to
22 periods prior to the closure or change in operation.
23 <u>(a.3) Calculation of assessment for new hospitals.--A</u>
24 <u>hospital that begins operation as a covered hospital during a</u>
25 <u>fiscal year in which an assessment is in effect shall be</u>
26 <u>assessed as follows:</u>
27 <u>(1) During the State fiscal year in which a covered</u>
28 <u>hospital begins operation or in which a hospital becomes a</u>
29 <u>covered hospital, the covered hospital is not subject to the</u>
30 <u>assessment.</u>

(2) For the State fiscal year following the State fiscal year under paragraph (1), the department shall calculate the hospital's assessment amount using the net inpatient revenue from the State fiscal year in which the covered hospital began operation or became a covered hospital.

(3) For the State fiscal years following the first full State fiscal year under paragraph (2), the department shall calculate the hospital's assessment amount using the net inpatient revenue from the prior State fiscal year.

(b) Payment.--A covered hospital shall pay the assessment amount due for a fiscal year in four quarterly installments. Payment of a quarterly installment shall be made on or before the first day of the second month of the quarter or 30 days from the date of the notice of the quarterly assessment amount, whichever day is later.

(c) Records.--Upon request by the department, a covered hospital shall furnish to the department such records as the department may specify in order for the department to validate the net inpatient revenue reported by the hospital or to determine the assessment for a fiscal year or the amount of the assessment due from the covered hospital or to verify that the covered hospital has paid the correct amount due.

(d) Underpayments and overpayments.--In the event that the department determines that a covered hospital has failed to pay an assessment or that it has underpaid an assessment, the department shall notify the covered hospital in writing of the amount due, including interest, and the date on which the amount due must be paid, which shall not be less than 30 days from the date of the notice. In the event that the department determines that a covered hospital has overpaid an assessment, the

department shall notify the covered hospital in writing of the overpayment and, within 30 days of the date of the notice of the overpayment, shall either refund the amount of the overpayment or offset the amount of the overpayment against any amount that may be owed to the department from the covered hospital.

Section ~~12.5~~ 12.3. Section 805-G of the act, amended or added July 9, 2010 (P.L.336, No.49) and June 30, 2011 (P.L.89, No.22), is reenacted and amended to read: <--

Section 805-G. Restricted account.

(a) Establishment.--There is established a restricted account, known as the Quality Care Assessment Account, in the General Fund for the receipt and deposit of revenues collected under this article. Funds in the account are appropriated to the department for the following:

(1) Making medical assistance payments to hospitals in accordance with section 443.1(1.1) and as otherwise specified in the Commonwealth's approved Title XIX State Plan.

(2) Making adjusted capitation payments to medical assistance managed care organizations for additional payments for inpatient hospital services in accordance with section 443.1(1.2), (1.3) and (1.4).

(3) Any other purpose approved by the secretary for inpatient hospital, outpatient hospital and hospital-related services.

(b) Limitations.--

(1) For the first year of the assessment, the amount used for the medical assistance payments for hospitals and Medicaid managed care organizations may not exceed the aggregate amount of assessment funds collected for the year less $121,000,000.

(2) For the second year of the assessment, the amount used for the medical assistance payments for hospitals and medical assistance managed care organizations may not exceed the aggregate amount of assessment funds collected for the year less $109,000,000.

(4) For the third year of the assessment, the amount used for the medical assistance payment for hospitals and medical assistance managed care organizations may not exceed the aggregate amount of the assessment funds collected for the year less $109,000,000.

(4.1) For State fiscal years 2013-2014 and 2014-2015, the amount used for the medical assistance payment for hospitals and medical assistance managed care organizations may not exceed the aggregate amount of the assessment funds collected for the year less $150,000,000.

(4.2) For State fiscal year 2015-2016, the amount used for the medical assistance payment for hospitals and medical assistance managed care organizations may not exceed the aggregate amount of the assessment funds collected for the year less $140,000,000.

(5) The amounts retained by the department pursuant to paragraphs (1), (2) [and], (4), (4.1) and (4.2) and any additional amounts remaining in the restricted accounts after the payments described in subsection (a)(1) and (2) are made shall be used for purposes approved by the secretary under subsection (a)(3).

(c) Lapse.--Funds in the Quality Care Assessment Account shall not lapse to the General Fund at the end of a fiscal year. If this article expires, the department shall use any remaining funds for the purposes stated in this section until the funds in

the Quality Care Assessment Account are exhausted.

Section 13. Sections 806-G, 807-G, 808-G, 809-G, 810-G, 811-G and 812-G of the act, added July 9, 2010, (P.L.336, No.49), are reenacted to read:

Section 806-G. No hold harmless.

No covered hospital shall be directly guaranteed a repayment of its assessment in derogation of 42 CFR 433.68(f) (relating to permissible health care-related taxes), except that, in each fiscal year in which an assessment is implemented, the department shall use the funds received under this article for the purposes outlined under section 805-G to the extent permissible under Federal and State law or regulation and without creating an indirect guarantee to hold harmless, as those terms are used under 42 CFR 433.68(f)(i). The secretary shall submit to the United States Department of Health and Human Services any State Medicaid plan amendments that are necessary to make the payments authorized under section 805-G.

Section 807-G. Federal waiver.

To the extent necessary in order to implement this article, the department shall seek a waiver under 42 CFR 433.68(e) (relating to permissible health care-related taxes) from the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services. The department shall not implement the assessment until approval of the waiver is obtained. Upon approval of the waiver, the assessment shall be implemented retroactive to the first day of the fiscal year to which the waiver applies.

Section 808-G. Tax exemption.

(a) General rule.--Notwithstanding any exemptions granted by any other Federal, State or local tax or other law, no covered

1 hospital other than an exempt hospital shall be exempt from the
2 assessment.
3 (b) Interpretation.--The assessment imposed under this
4 article shall be recognized by the Commonwealth as uncompensated
5 goods and services under the act of November 26, 1997 (P.L.508,
6 No.55), known as the Institutions of Purely Public Charity Act,
7 and shall be considered a community benefit for purposes of any
8 required or voluntary community benefit report filed or prepared
9 by a covered hospital.
10 Section 809-G. Remedies.
11 In addition to any other remedy provided by law, the
12 department may enforce this article by imposing one or more of
13 the following remedies:
14 (1) When a covered hospital fails to pay an assessment
15 or penalty in the amount or on the date required by this
16 article, the department shall add interest at the rate
17 provided in section 806 of the act of April 9, 1929 (P.L.343,
18 No.176), known as The Fiscal Code, to the unpaid amount of
19 the assessment or penalty from the date prescribed for its
20 payment until the date it is paid.
21 (2) When a covered hospital fails to file a report or to
22 furnish records to the department as required by this
23 article, the department shall impose a penalty against the
24 covered hospital in the amount of $1,000, plus an additional
25 amount of $200 per day for each additional day that the
26 failure to file the report or furnish the records continues.
27 (3) When a covered hospital that is a medical assistance
28 provider, or that is related through common ownership or
29 control as defined in 42 CFR 413.17(b) (relating to cost to
30 related organizations) to a medical assistance provider,

fails to pay all or part of an assessment or penalty within 60 days of the date that payment is due, the department may deduct the unpaid assessment or penalty and any interest owed thereon from any medical assistance payments due to the covered hospital or to any related medical assistance provider until the full amount is recovered. Any such deduction shall be made only after written notice to the covered hospital and medical assistance provider and may be taken in installments over a period of time, taking into account the financial condition of the medical assistance provider.

(4) Within 60 days after the end of each calendar quarter, the department shall notify the Department of Health of any covered hospital that has assessment, penalty or interest amounts that have remained unpaid for 90 days or more. The Department of Health shall not renew the license of any such covered hospital until the department notifies the Department of Health that the covered hospital has paid the outstanding amount in its entirety or that the department has agreed to permit the covered hospital to repay the outstanding amount in installments and that, to date, the covered hospital has paid the installments in the amount and by the date required by the department.

(5) The secretary may waive all or part of the interest or penalties assessed against a covered hospital pursuant to this article for good cause as shown by the covered hospital.

Section 810-G. Request for review.

A covered hospital that is aggrieved by a determination of the department as to the amount of the assessment due from the covered hospital or a remedy imposed pursuant to section 809-G

1 may file a request for review of the decision of the department
2 by the Bureau of Hearings and Appeals, which shall have
3 exclusive jurisdiction in such matters. The procedures and
4 requirements of 67 Pa.C.S. Ch. 11 (relating to medical
5 assistance hearings and appeals) shall apply to requests for
6 review filed pursuant to this section, except that in any such
7 request for review, a covered hospital may not challenge an
8 assessment percentage determined by the secretary pursuant to
9 section 803-G(b) but only whether the department correctly
10 determined the assessment amount due from the covered hospital
11 using the assessment percentage in effect for the fiscal year. A
12 notice of review filed pursuant to this section shall not
13 operate as a stay of the covered hospital's obligation to pay
14 the assessment amount due for a fiscal year as specified in
15 section 804-G(b).
16 Section 811-G. Liens.
17 Any assessments implemented and interest and penalties
18 assessed against a covered hospital under this article shall be
19 a lien on the real and personal property of the covered hospital
20 in the manner provided by section 1401 of the act of April 9,
21 1929 (P.L.343, No.176), known as The Fiscal Code, may be entered
22 by the department in the manner provided by section 1404 of The
23 Fiscal Code and shall continue and retain priority in the manner
24 provided in section 1404.1 of The Fiscal Code.
25 Section 812-G. Regulations.
26 The department may issue such regulations and orders as may
27 be necessary to implement the Quality Care Assessment program in
28 accordance with the requirements of this article.
29 Section 14. Section 813-G of the act, amended June 30, 2011
30 (P.L.89, No.22), is reenacted to read:

Section 813-G. Conditions for payments.

The department shall not be required to make payments as specified in section 443.1(1.1), (1.2), (1.3) and (1.4) and a covered hospital shall not be required to pay the Quality Care Assessment as specified in section 804-G(b) unless all of the following have occurred:

(1) The department receives Federal approval of a waiver under 42 CFR 433.68(e) (relating to permissible health care-related taxes) authorizing the department to implement the Quality Care Assessment as specified in this article.

(2) The department receives Federal approval of a State plan amendment authorizing the changes to its payment methods and standards specified in § 443.1(1.1)(ii).

(3) The department receives Federal approval of amendments to its medical assistance managed care organization contracts authorizing adjustments to its capitation payments funded in accordance with section 805-G.

Section 15. Section 814-G of the act, added July 9, 2010 (P.L.336, No.49), is reenacted to read:

Section 814-G. Report.

Not later than 180 days prior to the expiration date specified in section 815-G, the department shall prepare and submit a report to the chair and minority chair of the Public Health and Welfare Committee of the Senate, the chair and minority chair of the Appropriations Committee of the Senate, the chair and minority chair of the Health and Human Services Committee of the House of Representatives and the chair and minority chair of the Appropriations Committee of the House of Representatives. The report shall include the following:

(1) The name, address and amount of assessment for each

1 covered hospital subject to the Quality Care Assessment.
2 (2) The total amount of assessment revenue collected for
3 each year.
4 (3) The amount of assessment paid by each covered
5 hospital, including any interest and penalties paid.
6 (4) The name and address of each hospital receiving
7 supplemental payments instituted as a result of the Quality
8 Care Assessment.
9 (5) The payment amount and type of supplemental payment
10 received by each hospital.
11 (6) The total amount of fee-for-service inpatient acute
12 care payment made to each hospital.
13 (7) The number of medical assistance patient days and
14 discharges by hospital.
15 (8) Any proposed changes to the payment methodologies
16 and standards.
17 Section 15.1. Section 815-G of the act, added July 9, 2010
18 (P.L.336, No.49), is reenacted and amended to read:
19 Section 815-G. Expiration.
20 This article shall expire June 30, [2013] <u>2016</u>.
21 Section 16. Section 816-G of the act, added July 9, 2010
22 (P.L.336, No.49), is reenacted to read:
23 Section 816-G. Retroactive applicability.
24 This article shall apply retroactively to July 1, 2010.
25 Section 17. Section 805-H(c) of the act is amended by adding
26 a paragraph to read:
27 Section 805-H. Funding.
28 * * *
29 (c) Payment calculation.--
30 * * *

1 (5) Funds not used to make payments to qualifying
2 hospitals accredited or seeking accreditation as Level III
3 trauma centers shall be used to make payments to qualifying
4 hospitals accredited as Level I and Level II trauma centers.
5 * * *
6 Section 18. The heading of Article XIII of the act, added
7 September 30, 2003 (P.L.169, No.25), is amended to read:
8 ARTICLE XIII
9 FAMILY FINDING AND KINSHIP CARE
10 Section 19. Section 1301 of the act, added September 30,
11 2003 (P.L.169, No.25), is amended to read:
12 Section 1301. [Scope] Legislative intent.
13 [This article relates to the Kinship Care Program.] This
14 article is intended to ensure that family finding occurs on an
15 ongoing basis for all children entering the child welfare
16 system. This article is also intended to promote the use of
17 kinship care when it is necessary to remove a child from the
18 child's home in an effort to:
19 (1) Identify and build positive connections between the
20 child and the child's relatives and kin.
21 (2) Support the engagement of relatives and kin in
22 children and youth social service planning and delivery.
23 (3) Create a network of extended family support to
24 assist in remedying the concerns that led the child to be
25 involved with the county agency.
26 Section 20. Section 1302 of the act is amended by adding
27 definitions to read:
28 Section 1302. Definitions.
29 The following words and phrases when used in this article
30 shall have the meanings given to them in this section unless the

context clearly indicates otherwise:

"Accept for service." Decide on the basis of the needs and problems of an individual to admit or receive the individual as a client of the county agency or as required by a court order entered under 42 Pa.C.S. Ch. 63 (relating to juvenile matters).

* * *

"Family finding." Ongoing diligent efforts between a county agency, or its contracted providers, and relatives and kin to:

(1) Search for and identify adult relatives and kin and engage them in children and youth social service planning and delivery.

(2) Gain commitment from relatives and kin to support a child or parent receiving children and youth social services.

* * *

Section 21. The act is amended by adding sections to read:

Section 1302.1. Family finding required.

Family finding shall be conducted for a child when the child is accepted for services and at least annually thereafter, until the child's involvement with the county agency is terminated or the family finding is discontinued in accordance with section 1302.2.

Section 1302.2. Discontinuance of family finding.

(a) General rule.--A county agency may discontinue family finding for a child under the following circumstances:

(1) The child has been adjudicated dependent pursuant to 42 Pa.C.S. Ch. 63 (relating to juvenile matters) and a court has made a specific determination that continued family finding no longer serves the best interests of the child or is a threat to the child's safety.

(2) The child is not under the jurisdiction of a court

and the county agency has determined that continued family finding is a threat to the child's safety. A determination that continued family finding is a threat to the child's safety must be based on credible information about a specific safety threat, and the county agency shall document the reasons for its determination.

(3) The child is in a preadoptive placement, and court proceedings to adopt the child have been commenced pursuant to 23 Pa.C.S. Part III (relating to adoption).

(b) Resuming family finding.--Notwithstanding the provisions of subsection (a), a county agency shall resume family finding for a child if:

(1) the child is under the jurisdiction of a court, and the court determines that resuming family finding is best suited to the safety, protection and physical, mental and moral welfare of the child and does not pose a threat to the child's safety; or

(2) the child is not under the jurisdiction of a court, and the county agency determines that resuming family finding serves the best interest of the child and does not pose a threat to the child's safety.

Section 22. Sections 1402-B, 1404-B, 1405-B and 1406-B of the act, added June 30, 2012 (P.L.668, No.80), are amended to read:

Section 1402-B. Establishment of Human Services Block Grant Pilot Program.

The following shall apply to the Human Services Block Grant Pilot Program.

(1) The Human Services Block Grant Pilot Program is established for the purpose of allocating block grant funds to

1 county governments to provide locally identified county-based
2 human services that will meet the service needs of county
3 residents. A county's request to participate in the block grant
4 shall be on a form and contain such information as the
5 department may prescribe.

6 (2) The department[, in its discretion,] may approve a
7 county's request based on [criteria determined by the
8 department.] the county's plan to provide human services and
9 integrate its human service programs. A county with a history of
10 participation or application to participate in the block grant
11 shall have priority over a county which has not previously
12 applied for the block grant. The department shall also consider
13 diversity in representation of counties, regarding such factors
14 as:

15 (i) Geographic location.

16 (ii) Total population.

17 (iii) Urban, rural and suburban population.

18 (iv) Proximity to a large urban area.

19 (v) County class.

20 (vi) Form of county government.

21 (vii) Whether the county is part of a local collaborative
22 arrangement.

23 (viii) The county's human services administrative structure.

24 (3) No more than [20] 30 counties may participate in the
25 block grant in any fiscal year. A county's participation in the
26 block grant is voluntary.

27 Section 1404-B. Powers and duties of counties.

28 The local county officials of each county government
29 participating in the block grant shall have the power and duty
30 to:

(1) Administer and disburse block grant funds for the provision of county-based human services in accordance with this article and regulations promulgated under section 1403-B(10) and Federal requirements.

(2) Establish or maintain, in agreement with another county or counties, local collaborative arrangements for the delivery of any county-based human service. Counties may establish new local collaborative arrangements under this paragraph for the provision of a specific county-based human service or county-based human services, subject to approval by the secretary.

(3) Determine and redetermine, when necessary, whether a person is eligible to participate in a county-based human service, subject to appeal under 2 Pa.C.S. Ch. 5 Subch. B (relating to practice and procedures of local agencies).

(4) Submit required reports under section 1403-B(b)(4).

(5) Submit to the department an annual Human Services Block Grant Pilot Plan to include the intended delivery of county-based human services by client population to be served, including a detailed description of how the county intends to serve its residents in the least restrictive setting appropriate to their needs and the distribution and the projected expenditure level of block grant funds by county-based human services allocated under this article in such form and containing such information as the department may require. Prior to submitting the annual Human Services Block Grant Pilot Plan to the department, the county shall hold at least two public hearings on the plan under 65 Pa.C.S. Ch. 7 (relating to open meetings), which shall include an opportunity for individuals and families who

receive services to testify about the plan.

(6) Submit to the department a written notice if a county intends to opt out of the block grant. Such opt out shall take effect at the beginning of the next State fiscal year.

Section 1405-B. Allocation.

(a) Allocation.--The department shall allocate State block grant funds to counties as follows:

(1) The department shall allocate State block grant funds according to each county's proportional share of the aggregate amount of the following State funds allocated for fiscal year 2011-2012:

(i) Funds allocated to counties under the act of October 5, 1994 (P.L.531, No.78), known as the Human Services Development Fund Act.

(ii) Funds allocated to counties for mental health and intellectual disability services under the act of October 20, 1966 (3rd Sp.Sess., P.L.96, No.6), known as the Mental Health and Intellectual Disability Act of 1966.

(iii) Funds allocated to counties for behavioral health services.

(iv) Funds allocated to counties for drug and alcohol services under section 2334 of the act of April 9, 1929 (P.L.177, No.175), known as The Administrative Code of 1929.

(v) Funds allocated to counties for the provision of services to the homeless.

(vi) Funds allocated to county child welfare agencies as certain additional grants under section

704.1(b).

(2) The department shall allocate Federal block grant funds to counties according to each county's fiscal year 2011-2012 proportional share of each Federal appropriation associated with the funds identified in paragraph (1).

(3) Funds identified in paragraphs (1) and (2) that were allocated to county local collaborative arrangements shall be allocated to individual counties based on the individual county population.

(4) The department may revise the allocation of Federal funds identified in paragraph (2) as necessary to comply with applicable Federal requirements.

(a.1) Adjustment of allocation.--The department may adjust grants under this article to a county participating in the block grant based on the county's demonstrated need for funds to meet the specific human services needs of its residents for a fiscal year. Such adjustment shall not be considered in the county's allocation under subsection (a) for any subsequent fiscal year.

(b) Expenditure.--Each county participating in the block grant shall expend its allocated block grant funds as follows:

(1) For State fiscal year 2012-2013, each county shall expend on each of the following county-based human services at least 80% of the amount the county is allocated under the funds identified in subsection (a)(1) for that county-based human service:

(i) Community-based mental health services.

(ii) Intellectual disability services.

(iii) Child welfare services.

(iv) Drug and alcohol treatment and prevention services.

1 (v) Homeless assistance services.
2 (vi) Behavioral health services.
3 (2) For State fiscal year 2013-2014, each county shall
4 expend on each of the following county-based human services
5 at least 75% of the amount the county was allocated under the
6 funds identified in subsection (a)(1) for that county-based
7 human service:
8 (i) Community-based mental health services.
9 (ii) Intellectual disability services.
10 (iii) Child welfare services.
11 (iv) Drug and alcohol treatment and prevention
12 services.
13 (v) Homeless assistance services.
14 (vi) Behavioral health services.
15 (3) For State fiscal year 2014-2015, each county shall
16 expend on each of the following county-based human services
17 at least 50% of the amount the county is allocated under the
18 funds identified in subsection (a)(1) for that county-based
19 human service:
20 (i) Community-based mental health services.
21 (ii) Intellectual disability services.
22 (iii) Child welfare services.
23 (iv) Drug and alcohol treatment and prevention
24 services.
25 (v) Homeless assistance services.
26 (vi) Behavioral health services.
27 (4) For State fiscal year 2015-2016, each county shall
28 expend on each of the following county-based human services
29 at least 25% of the amount the county is allocated under the
30 funds identified in subsection (a)(1), for that county-based

human service:

(i) Community-based mental health services.

(ii) Intellectual disability services.

(iii) Child welfare services.

(iv) Drug and alcohol treatment and prevention services.

(v) Homeless assistance services.

(vi) Behavioral health services.

(5) For State fiscal year 2016-2017 and thereafter, counties may expend block grant funds on county-based human services as determined by local need.

(c) Waiver.--A county may request in writing that the department waive the requirements of subsection (b). [The department may, in its discretion, grant the request upon good cause shown by the county.] <u>The department may grant the request upon a showing by the county that specific circumstances create a local need for funds to provide a human service that cannot be met without a waiver, and that adequate and appropriate access to other human services will remain available in the county. A request for a waiver under this subsection shall specify the amount of funds and the human services on which those funds will be transferred and expended.</u>

(d) Use of remaining funds.--Except as provided in subsection (b), counties may expend the remaining block grant funds on county-based human services needs as determined by county officials.

(e) Contribution to local collaborative arrangement.--Each county that is part of a local collaborative arrangement in accordance with section 1404-B(2) shall contribute at a minimum the percentage of funds specified in subsection (b) to the local

collaborative arrangement for the provision of the county-based human services delivered by the local collaborative arrangement.

Section 1406-B. Use of block grant funds.

(a) General rule.--Block grant funds received by counties under this article shall be used solely for the provision of county-based human services.

(b) Reinvestment.--A county participating in the block grant may submit to the department a written plan to reinvest up to 3% of its block grant allocation for any State fiscal year to be expended on county-based human services in the next State fiscal year. The 3% limitation may be waived by the department upon [good cause shown by the county.] a showing by the county that it has a specific and detailed plan to reinvest the funds to expand access to human services based on local need and that adequate and available human services will remain available in the county. A request for a waiver under this subsection shall include all of the following:

(1) The specific amount of funds the county seeks to reinvest.

(2) An explanation why the funds were not expended for human services during the fiscal year.

(3) An explanation how the reinvestment will support the plan submitted under section 1404-B(5).

(4) The projected time period for expenditure of the funds.

(c) Eligibility.--No county shall be required to expend block grant funds under this article on behalf of an individual until the individual has exhausted eligibility and receipt of benefits under all other existing Federal, State, local or private programs.

(d) Allocation.--For State fiscal year 2012-2013, each county in expending block grant funds shall provide local matching funds for block grant funds allocated to it in the same percentage as that county's aggregate local match percentage for the State funds identified in section 1405-B(a)(1) in State fiscal year 2010-2011. For each State fiscal year thereafter, each county in expending block grant funds shall provide local matching funds for State block grant funds allocated to it in the same percentage as that county's aggregate local match percentage for the State funds identified in section 1405-B(a)(1) in State fiscal year 2011-2012.

(e) County obligation.--Except as provided in subsection (d), counties shall have no financial obligation to provide human services under this article in excess of their allocation of block grant funds for any fiscal year.

Section 23. This act shall take effect as follows:

(1) The amendment or addition of sections 102 and 103 of the act shall take effect December 31, 2013.

(2) The following provisions shall take effect immediately:

(i) ~~The addition of section 441.10 of the act.~~ <--

~~(ii)~~ The amendment of section 443.1(1.1)(i), (1.4) and (7)(iv) and (v) of the act.

~~(iii)~~ (II) The amendment or addition of sections 704.1(g), (g.1) and (g.2) and 704.3 of the act. <--

~~(iv)~~ (III) The amendment of the heading of Article VIII-C and sections 801-C, 802-C, 803-C, 804-C, 805-C, 806-C, 807-C, 808-C, 809-C, 810-C and 811-C of the act. <--

~~(v)~~ (IV) The amendment of sections 802-E and 808-E of the act. <--

1 ~~(vi)~~ (V) The reenactment and amendment of Article **<--**
2 VIII-G of the act.
3 ~~(vii)~~ (VI) The amendment of the heading of Article **<--**
4 XIV-B, and sections 1402-B, 1403-B, 1404-B, 1405-B and
5 1406-B of the act.
6 ~~(viii)~~ (VII) This section. **<--**
7 (3) The remainder of this act shall take effect in 60
8 days.