AMENDMENTS TO HOUSE BILL NO. 1075

Sponsor: SENATOR VANCE

Printer's No. 2189

1 Amend Bill, page 1, line 17, by inserting after "ASSESSMENT,"
2 reenacting and
3 Amend Bill, page 25, lines 25 through 30; pages 26 through
4 28, lines 1 through 30; page 29, lines 1 through 18, by striking
5 out all of said lines on said pages and inserting
6 Section 12. The heading of Article VIII-G of the act, added
7 July 9, 2010 (P.L.336, No.49), is reenacted to read:
8 ARTICLE VIII-G
9 STATEWIDE QUALITY CARE ASSESSMENT
10 Section 12.1. Section 801-G of the act, added or amended
11 July 9, 2010 (P.L.336, No.49) and June 30, 2011 (P.L.89, No.22),
12 is reenacted and amended to read:
13 Section 801-G. Definitions.
14 The following words and phrases when used in this article
15 shall have the meanings given to them in this section unless the
16 context clearly indicates otherwise:
17 "Assessment." The fee, known as the Quality Care Assessment,
18 authorized to be implemented under this article on every covered
19 hospital.
20 "Bad debt expense." The cost of care for which a hospital
21 expected payment from the patient or a third-party payer, but
22 which the hospital subsequently determines to be uncollectible,
23 as further described in the Medicare Provider Reimbursement
24 Manual published by the United States Department of Health and
25 Human Services.
26 "Charity care expense." The cost of care for which a
27 hospital ordinarily charges a fee but which is provided free or
28 at a reduced rate to patients who cannot afford to pay but who
29 are not eligible for public programs, and from whom the hospital
30 did not expect payment in accordance with the hospital's charity
31 care policy, as further described in the Medicare Provider
32 Reimbursement Manual published by the United States Department
33 of Health and Human Services.
34 "Contractual allowance." The difference between what a
35 hospital charges for services and the amounts that certain
36 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. 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. 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 financial participation.

(b) Assessment percentage.--Subject to subsection (c), each covered hospital shall be assessed as follows:

(1) for fiscal year 2010-2011, each covered hospital shall be assessed an amount equal to 2.69% of the net inpatient revenue of the covered hospital; and

(2) for fiscal years 2011-2012 [and] , 2012-2013, 2013-2014, 2014-2015 and 2015-2016, an amount equal to 3.22% of the net inpatient revenue of the covered hospital.

(c) Adjustments to assessment percentage.--The secretary may adjust the assessment percentage specified in subsection (b), provided that, before adjusting, the secretary shall publish a notice in the Pennsylvania Bulletin that specifies the proposed assessment percentage and identifies the aggregate impact on covered hospitals subject to the assessment. Interested parties shall have 30 days in which to submit comments to the secretary. Upon expiration of the 30-day comment period, the secretary, after consideration of the comments, shall publish a second notice in the Pennsylvania Bulletin announcing the assessment percentage.

(d) Maximum amount.--In each year in which the assessment is implemented, the assessment shall be subject to the maximum aggregate amount that may be assessed under 42 CFR 433.68(f)(3)(i) (relating to permissible health care-related taxes) or any other maximum established under Federal law.

(e) Limited review.--Except as permitted under section 810-G, the secretary's determination of the assessment percentage pursuant to subsection (b) shall not be subject to administrative or judicial review under 2 Pa.C.S. Chs. 5 Subch. A (relating to practice and procedure of Commonwealth agencies) and 7 Subch. A (relating to judicial review of Commonwealth agency action) or any other provision of law; nor shall any assessments implemented under this article or forms or reports required to be completed by covered hospitals pursuant to this article be subject to the act of July 31, 1968 (P.L.769, No.240), referred to as the Commonwealth Documents Law, the act of October 15, 1980 (P.L.950, No.164), known as the Commonwealth Attorneys Act, and the act of June 25, 1982 (P.L.633, No.181), known as the Regulatory Review Act.

Section 12.4. Section 804-G of the act, amended June 30,

2011 (P.L.89, No.22), is reenacted and amended to read:

Section 804-G. Administration.

(a) Calculation and notice of assessment amount.--Using the assessment percentage established under section 803-G and covered hospitals' net inpatient revenue, the department shall calculate and notify each covered hospital of the assessment amount owed for the fiscal year. Notification pursuant to this subsection may be made in writing or electronically at the discretion of the department.

(a.1) Calculation of assessment with changes of ownership.--

(1) If a single covered hospital changes ownership or control, the department will continue to calculate the assessment amount using the hospital's net inpatient revenue for State fiscal year [2008-2009] 2010-2011 or for the most recent State fiscal year, or part thereof, if the State fiscal year [2008-2009] 2010-2011 amounts are not available. The covered hospital is liable for any outstanding assessment amounts, including outstanding amounts related to periods prior to the change of ownership or control.

(2) If two or more hospitals merge or consolidate into a single covered hospital as a result of a change in ownership or control, the department will calculate the covered hospital assessment amount using the combined net inpatient revenue for State fiscal year [2008-2009] 2010-2011 or for the most recent State fiscal year, or part thereof, if the State fiscal year [2008-2009] 2010-2011 amounts are not available, of any covered hospitals that were merged or consolidated into the single covered hospital. The single covered hospital is liable for any outstanding assessment amounts, including outstanding amounts related to periods prior to the change of ownership or control, of any covered hospital that was merged or consolidated.

(a.2) Calculation of assessment with closures or other changes in operation.--Except as provided in subsection (a.1)(2), a covered hospital that closes or that becomes an exempt hospital during a fiscal year is liable for both:

(1) The annual assessment amount for the fiscal year in which the closure or change occurs prorated by the number of days in the fiscal year during which the covered hospital was in operation.

(2) Any outstanding assessment amounts related to periods prior to the closure or change in operation.

(a.3) Calculation of assessment for new hospitals.--A hospital that begins operation as a covered hospital during a fiscal year in which an assessment is in effect shall be assessed as follows:

(1) During the State fiscal year in which a covered hospital begins operation or in which a hospital becomes a covered hospital, the covered hospital is not subject to the assessment.

(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. 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

1 those terms are used under 42 CFR 433.68(f)(i). The secretary
2 shall submit to the United States Department of Health and Human
3 Services any State Medicaid plan amendments that are necessary
4 to make the payments authorized under section 805-G.
5 Section 807-G. Federal waiver.
6 To the extent necessary in order to implement this article,
7 the department shall seek a waiver under 42 CFR 433.68(e)
8 (relating to permissible health care-related taxes) from the
9 Centers for Medicare and Medicaid Services of the United States
10 Department of Health and Human Services. The department shall
11 not implement the assessment until approval of the waiver is
12 obtained. Upon approval of the waiver, the assessment shall be
13 implemented retroactive to the first day of the fiscal year to
14 which the waiver applies.
15 Section 808-G. Tax exemption.
16 (a) General rule.--Notwithstanding any exemptions granted by
17 any other Federal, State or local tax or other law, no covered
18 hospital other than an exempt hospital shall be exempt from the
19 assessment.
20 (b) Interpretation.--The assessment imposed under this
21 article shall be recognized by the Commonwealth as uncompensated
22 goods and services under the act of November 26, 1997 (P.L.508,
23 No.55), known as the Institutions of Purely Public Charity Act,
24 and shall be considered a community benefit for purposes of any
25 required or voluntary community benefit report filed or prepared
26 by a covered hospital.
27 Section 809-G. Remedies.
28 In addition to any other remedy provided by law, the
29 department may enforce this article by imposing one or more of
30 the following remedies:
31 (1) When a covered hospital fails to pay an assessment
32 or penalty in the amount or on the date required by this
33 article, the department shall add interest at the rate
34 provided in section 806 of the act of April 9, 1929 (P.L.343,
35 No.176), known as The Fiscal Code, to the unpaid amount of
36 the assessment or penalty from the date prescribed for its
37 payment until the date it is paid.
38 (2) When a covered hospital fails to file a report or to
39 furnish records to the department as required by this
40 article, the department shall impose a penalty against the
41 covered hospital in the amount of $1,000, plus an additional
42 amount of $200 per day for each additional day that the
43 failure to file the report or furnish the records continues.
44 (3) When a covered hospital that is a medical assistance
45 provider, or that is related through common ownership or
46 control as defined in 42 CFR 413.17(b) (relating to cost to
47 related organizations) to a medical assistance provider,
48 fails to pay all or part of an assessment or penalty within
49 60 days of the date that payment is due, the department may
50 deduct the unpaid assessment or penalty and any interest owed
51 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 may file a request for review of the decision of the department by the Bureau of Hearings and Appeals, which shall have exclusive jurisdiction in such matters. The procedures and requirements of 67 Pa.C.S. Ch. 11 (relating to medical assistance hearings and appeals) shall apply to requests for review filed pursuant to this section, except that in any such request for review, a covered hospital may not challenge an assessment percentage determined by the secretary pursuant to section 803-G(b) but only whether the department correctly determined the assessment amount due from the covered hospital using the assessment percentage in effect for the fiscal year. A notice of review filed pursuant to this section shall not operate as a stay of the covered hospital's obligation to pay the assessment amount due for a fiscal year as specified in section 804-G(b).

Section 811-G. Liens.

Any assessments implemented and interest and penalties assessed against a covered hospital under this article shall be a lien on the real and personal property of the covered hospital in the manner provided by section 1401 of the act of April 9, 1929 (P.L.343, No.176), known as The Fiscal Code, may be entered by the department in the manner provided by section 1404 of The Fiscal Code and shall continue and retain priority in the manner provided in section 1404.1 of The Fiscal Code.

Section 812-G. Regulations.

The department may issue such regulations and orders as may be necessary to implement the Quality Care Assessment program in accordance with the requirements of this article.

Section 14. Section 813-G of the act, amended June 30, 2011 (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 covered hospital subject to the Quality Care Assessment.

(2) The total amount of assessment revenue collected for each year.

(3) The amount of assessment paid by each covered hospital, including any interest and penalties paid.

(4) The name and address of each hospital receiving supplemental payments instituted as a result of the Quality Care Assessment.

(5) The payment amount and type of supplemental payment received by each hospital.

(6) The total amount of fee-for-service inpatient acute care payment made to each hospital.

(7) The number of medical assistance patient days and discharges by hospital.

(8) Any proposed changes to the payment methodologies and standards.

1 Section 15.1. Section 815-G of the act, added July 9, 2010
2 (P.L.336, No.49), is reenacted and amended to read:
3 Section 815-G. Expiration.
4 This article shall expire June 30, [2013] 2016.
5 Section 16. Section 814-G of the act, added July 9, 2010
6 (P.L.336, No.49), is reenacted to read:
7 Section 816-G. Retroactive applicability.
8 This article shall apply retroactively to July 1, 2010.

9 Amend Bill, page 40, line 30; page 41, lines 1 through 3, by

10 striking out all of said lines on said pages and inserting

11 (vi) The reenactment and amendment of Article VIII-G
12 of the act.