

AMENDMENTS TO HOUSE BILL NO. 1677

Sponsor: SENATOR BROWNE

Printer's No. 3675

1 Amend Bill, page 1, lines 1 through 8, by striking out all of
2 said lines and inserting

3 Amending the act of June 13, 1967 (P.L.31, No.21), entitled "An
4 act to consolidate, editorially revise, and codify the public
5 welfare laws of the Commonwealth," in general powers and
6 duties, providing for coordinated service delivery pilot
7 program; in public assistance, further providing for meeting
8 special needs, work supports and incentives, for medical
9 assistance payments for institutional care and providing for
10 nonemergency medical transportation services; creating
11 opportunities for hospitals and managed care organizations to
12 improve health care outcomes and to further reduce
13 unnecessary and inappropriate services in the Commonwealth's
14 medical assistance program; in the aged, establishing the
15 LIFE Program; in children and youth, further providing for
16 provider submissions; in Statewide quality care assessment,
17 further providing for definitions, for implementation, for
18 administration, for the Quality Care Assessment Account and
19 for expiration; in departmental powers and duties as to
20 supervision, further providing for definitions; in
21 departmental powers and duties as to licensing, further
22 providing for definitions; and imposing a duty on the
23 Department of Human Services.

24 Amend Bill, page 1, lines 14 through 20; pages 2 and 3, lines
25 1 through 30; page 4, lines 1 through 21; by striking out all of
26 said lines on said pages and inserting

27 Section 1. The act of June 13, 1967 (P.L.31, No.21), known
28 as the Human Services Code, is amended by adding a section to
29 read:

30 Section 216. Coordinated Service Delivery Pilot Program.--
31 (a) To the extent permitted by Federal law, the department, in
32 consultation with the Department of Education, shall establish a
33 pilot program at a school entity or entities within the city of
34 the first class to assist in the coordinated delivery of
35 education services and human services to students and their

1 families for the purposes of promoting and implementing
2 innovative research-based practices within selected school
3 entities. Coordination shall be based upon joint planning
4 between the department, the Department of Education and a school
5 entity's comprehensive assessments of the need to provide
6 services, coordinate service delivery, close gaps in services,
7 and coordinate to address the provision of needed services. In
8 order to assist in the coordinated delivery of education
9 services and human services to students and their families, the
10 pilot program may consider the following:

11 (1) A school entity assisting students and their families in
12 applying for and receiving education services and human
13 services.

14 (2) An expanded school day for the purpose of providing
15 opportunities for increased instructional time, tutoring by
16 staff, pupils and volunteers, an environment conducive to
17 learning before and after the regular school day and
18 personalized instruction and mentoring.

19 (3) Other best practices as determined by the department and
20 the Department of Education.

21 (b) A school entity participating in the pilot program shall
22 submit reports to the department containing such information and
23 in the form and by the deadline prescribed by the department.

24 (c) As used in this section, the term "school entity" shall
25 mean any public school, including a charter school or cyber
26 charter school or area vocational-technical school operating
27 within this Commonwealth.

28 Section 2. Sections 408(b) and 443.1(7)(vi) of the act are
29 amended to read:

30 Section 408. Meeting Special Needs; Work Supports and
31 Incentives.--* * *

32 (b) The department may provide assistance to recipients for
33 child [day] care when the department has determined that,
34 without such services, the recipient would be exempt from
35 compliance with the conditions of the agreement of mutual
36 responsibility or work requirements or when a former recipient
37 who is employed has ceased to receive cash assistance for a
38 reason other than a sanction for noncompliance with an
39 eligibility condition. In establishing the time limits and
40 levels of access to child [day-care] care funds, the department
41 shall take into account availability, costs and the number of
42 assistance groups needing services within the geographic area
43 and shall seek to provide essential services to the greatest
44 number of recipients.

45 * * *

46 Section 443.1. Medical Assistance Payments for Institutional
47 Care.--The following medical assistance payments shall be made
48 on behalf of eligible persons whose institutional care is
49 prescribed by physicians:

50 * * *

51 (7) After June 30, 2007, payments to county and nonpublic

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

8 * * *

9 (vi) Subject to Federal approval of such amendments as may
10 be necessary to the Commonwealth's approved Title XIX State
11 Plan, for fiscal years 2015-2016 [and], 2016-2017 and 2018-2019,
12 the department shall make up to four medical assistance day-one
13 incentive payments to qualified nonpublic nursing facilities.
14 The department shall determine the nonpublic nursing facilities
15 that qualify for the medical assistance day-one incentive
16 payments and calculate the payments using the total Pennsylvania
17 medical assistance (PA MA) days and total resident days as
18 reported by nonpublic nursing facilities under Article VIII-A.
19 The department's determination and calculations under this
20 subparagraph shall be based on the nursing facility assessment
21 quarterly resident day reporting forms, as determined by the
22 department. The department shall not retroactively revise a
23 medical assistance day-one incentive payment amount based on a
24 nursing facility's late submission or revision of the
25 department's report after the dates designated by the
26 department. The department, however, may recoup payments based
27 on an audit of a nursing facility's report. The following shall
28 apply:

29 (A) A nonpublic nursing facility shall meet all of the
30 following criteria to qualify for a medical assistance day-one
31 incentive payment:

32 (I) The nursing facility shall have an overall occupancy
33 rate of at least eighty-five percent during the resident day
34 quarter. For purposes of determining a nursing facility's
35 overall occupancy rate, a nursing facility's total resident
36 days, as reported by the facility under Article VIII-A, shall be
37 divided by the product of the facility's licensed bed capacity,
38 at the end of the quarter, multiplied by the number of calendar
39 days in the quarter.

40 (II) The nursing facility shall have a medical assistance
41 occupancy rate of at least sixty-five percent during the
42 resident day quarter. For purposes of determining a nursing
43 facility's medical assistance occupancy rate, the nursing
44 facility's total PA MA days shall be divided by the nursing
45 facility's total resident days, as reported by the facility
46 under Article VIII-A.

47 (III) The nursing facility shall be a nonpublic nursing
48 facility for a full resident day quarter prior to the applicable
49 quarterly reporting due dates, as determined by the department.

50 (B) The department shall calculate a qualified nonpublic
51 nursing facility's medical assistance day-one incentive payment

1 as follows:

2 (I) The total funds appropriated for payments under this
3 subparagraph shall be divided by the number of payments, as
4 determined by the department.

5 (II) To establish the per diem rate for a payment, the
6 amount under subclause (I) shall be divided by the total PA MA
7 days, as reported by all qualifying nonpublic nursing facilities
8 under Article VIII-A for that payment.

9 (III) To determine a qualifying nonpublic nursing facility's
10 medical assistance day-one incentive payment, the per diem rate
11 calculated for the payment shall be multiplied by a nonpublic
12 nursing facility's total PA MA days, as reported by the facility
13 under Article VIII-A for the payment.

14 (C) For fiscal years 2015-2016 [and], 2016-2017 and 2018-
15 2019, the State funds available for the nonpublic nursing
16 facility medical assistance day-one incentive payments shall
17 equal eight million dollars (\$8,000,000).

18 * * *

19 Section 3. The act is amended by adding a section to read:

20 Section 443.12. Nonemergency Medical Transportation
21 Services.--(a) The department shall amend the Commonwealth's
22 State Plan under Title XIX of the Social Security Act (49 Stat.
23 620, 42 U.S.C. § 1396 et seq.) to provide nonemergency medical
24 transportation services to eligible and enrolled medical
25 assistance recipients utilizing a Statewide or regional full-
26 risk brokerage model.

27 (b) Subject to Federal approval of the amendments to the
28 Commonwealth's approved Title XIX State Plan, the department
29 shall develop a proposal and solicit a broker to administer the
30 program. A broker determined eligible by the department may
31 submit a proposal. The department shall enter into a contract
32 with each broker whose proposal has been selected to administer
33 the program.

34 (c) The department shall issue the solicitation for a
35 Statewide or regional full-risk brokerage model within one
36 hundred eighty days after the effective date of this subsection.

37 Section 3.1. The act is amended by adding an article to
38 read:

39 ARTICLE V-A

40 HEALTH CARE OUTCOMES

41 SUBARTICLE A

42 PRELIMINARY PROVISIONS

43 Section 501-A. Definitions.

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

47 "All Patient Refined Diagnosis Related Groups." A version of
48 Diagnosis Related Groups that further subdivide the Diagnosis
49 Related Groups into four severity-of-illness and four risk-of-
50 mortality subclasses within each Diagnosis Related Groups.

51 "Diagnosis Related Groups." A classification system that

1 uses patient discharge information to classify patients into
2 clinically meaningful groups.

3 "Hospital." A public or private institution licensed as a
4 hospital under the laws of this Commonwealth that participates
5 in the Medicaid program.

6 "Managed care organization." A licensed managed care
7 organization with whom the department has contracted to provide
8 or arrange for services to a Medicaid recipient.

9 "Medicaid program." The Commonwealth's medical assistance
10 program authorized under Article IV.

11 "Potentially avoidable admission." An admission of an
12 individual to a hospital or long-term care facility that may
13 have reasonably been prevented with adequate access to
14 ambulatory care or health care coordination.

15 "Potentially avoidable complication." A harmful event or
16 negative outcome with respect to an individual, including an
17 infection or surgical complication, that:

18 (1) occurs after the person's admission to a hospital or
19 long-term care facility; and

20 (2) may have resulted from the care, lack of care or
21 treatment provided during the hospital or long-term care
22 facility stay rather than from a natural progression of an
23 underlying disease.

24 "Potentially avoidable emergency visit." Treatment of an
25 individual in a hospital emergency room or freestanding
26 emergency medical care facility for a condition that may not
27 require emergency medical attention because the condition could
28 be or could have been treated or prevented by a physician or
29 other health care provider in a nonemergency setting.

30 "Potentially avoidable event." Any of the following:

31 (1) A potentially avoidable admission.

32 (2) A potentially avoidable complication.

33 (3) A potentially avoidable emergency visit.

34 (4) A potentially avoidable readmission.

35 (5) A combination of the events listed under this
36 definition.

37 "Potentially avoidable readmission." A return
38 hospitalization of an individual within a period specified by
39 the department that may have resulted from a deficiency in the
40 care or treatment provided to the individual during a previous
41 hospital stay or from a deficiency in post-hospital discharge
42 follow-up. The term does not include a hospital readmission
43 necessitated by the occurrence of unrelated events after the
44 discharge. The term includes the readmission of an individual to
45 a hospital for:

46 (1) The same condition or procedure for which the
47 individual was previously admitted.

48 (2) An infection or other complication resulting from
49 care previously provided.

50 (3) A condition or procedure that indicates that a
51 surgical intervention performed during a previous admission

1 was unsuccessful in achieving the anticipated outcome.

2 Section 502-A. Applicability.

3 This article shall apply to the extent permitted by Federal
4 law.

5 SUBARTICLE B

6 MEDICAID OUTCOMES-BASED PROGRAMS

7 Section 511-A. Establishment.

8 The department shall establish the following linked Medicaid
9 outcomes-based programs:

10 (1) A Hospital Outcomes Program designed to provide a
11 hospital with information to reduce potentially avoidable
12 events and further increase efficiency in Medicaid hospital
13 services.

14 (2) A Managed Care Organization Outcomes Program
15 designed to provide a Medicaid managed care organization with
16 information to reduce potentially avoidable events and
17 further increase efficiency in Medicaid managed care
18 programs.

19 Section 512-A. Selection of potentially avoidable event
20 methodology.

21 The department shall select a methodology for identifying
22 potentially avoidable events and the costs associated with the
23 events and for measuring hospital and managed care organization
24 performance with respect to the events. The following shall
25 apply:

26 (1) The department shall develop parameters for each of
27 the potentially avoidable events in accordance with the
28 selected methodology.

29 (2) To the extent possible, the methodology shall be one
30 that has been used by a State program under Title XIX of the
31 Social Security Act (49 Stat. 620, 42 U.S.C. § 301 et seq.)
32 or by a commercial payer in health care outcomes performance
33 measurement and in outcome-based programs.

34 (3) The methodology shall utilize a clinical categorical
35 model, enable the provision of performance information on
36 both the aggregate and case level and risk adjust scoring to
37 account for patient severity of illness and population
38 chronic illness burden.

39 Section 513-A. Statewide analysis of Medicaid system.

40 The department shall conduct a comprehensive analysis of
41 existing relevant State databases to increase efficiency in the
42 Medicaid system. The following shall apply:

43 (1) The analysis shall identify instances of potentially
44 avoidable events in the Medicaid system and the costs
45 associated with these cases.

46 (2) The overall estimate of cost shall be broken down
47 into actionable categories, including, but not limited to,
48 regions, hospitals, managed care organizations, physicians,
49 service lines, Diagnosis Related Groups, medical conditions
50 and procedures, patient characteristics, provider
51 characteristics and Medicaid program type.

1 (3) Information collected from the potentially avoidable
2 event study shall be utilized in the Hospital Outcomes
3 Program and Managed Care Organization Outcomes Program.

4 Section 514-A. Report on Statewide analysis of Medicaid system.

5 (a) Report.--The department shall provide a report on the
6 comprehensive analysis conducted under section 513-A to the
7 General Assembly no later than December 31, 2019.

8 (b) Recommendations.--The report shall include
9 recommendations on how hospitals and managed care organizations
10 can improve efficiency and outcomes by reducing unnecessary
11 services. The department shall align the recommendations with
12 the department's objectives to advance high-value care, improve
13 population health, engage and support providers and establish a
14 sustainable Medicaid program with predictable costs.

15 SUBARTICLE C

16 HOSPITAL OUTCOMES PROGRAM

17 Section 521-A. Procedure.

18 The Hospital Outcomes Program shall:

19 (1) Target reduction of potentially avoidable
20 readmissions and complications.

21 (2) Apply to each State acute care hospital
22 participating in the Medicaid program, except that program
23 adjustments may be made for certain types of hospitals.

24 (3) Establish a performance reporting system for
25 potentially avoidable readmissions and complications for
26 hospitals participating in Medicaid.

27 Section 522-A. Hospital performance reporting.

28 The department shall develop and maintain a reporting system
29 to provide each hospital with regular confidential reports
30 regarding the hospital's performance with respect to potentially
31 avoidable readmissions and potentially avoidable complications.

32 The department shall:

33 (1) Conduct ongoing analyses of existing and relevant
34 State claims databases to identify instances of potentially
35 avoidable complications and readmissions and the expenditures
36 associated with the cases.

37 (2) Create or locate Statewide complications and
38 readmissions norms.

39 (3) Measure actual-to-expected hospital performance
40 compared to Statewide norms.

41 (4) Compare hospitals with the hospitals' peers using
42 risk adjustment procedures that account for the severity of
43 illness of each hospital's patients.

44 (5) Distribute reports to hospitals to provide them with
45 actionable information to create policies, contracts and
46 programs designed to improve target outcomes.

47 (6) Foster collaboration among hospitals in sharing best
48 practices.

49 Section 523-A. Hospital outcomes information sharing.

50 A hospital may share the information contained in the outcome
51 performance reports with physicians and other health care

1 providers providing services at the hospital to foster
2 coordination and cooperation in the hospital's outcome
3 improvement and efficiency initiatives.

4 Section 524-A. Value-based models.

5 After the implementation of the reporting system under
6 section 522-A, the department shall evaluate value-based models
7 that will support hospitals in reducing rates of potentially
8 avoidable complications and readmissions.

9 Section 525-A. Medicaid enrolled hospital contract.

10 The department shall amend contracts entered into or renewed
11 on or after the effective date of this section with the
12 department's Medicaid enrolled hospitals as necessary to
13 incorporate the Hospital Outcomes Program.

14 Section 526-A. Progress report on Hospital Outcomes Program.

15 By March 1, 2020, and each March 1 thereafter, the department
16 shall provide a report on the progress of the Hospital Outcomes
17 Program to the General Assembly. The report shall chart the
18 reductions in the rates of potentially avoidable complications
19 and readmissions and the impact of such reductions on Medicaid
20 costs.

21 SUBARTICLE D

22 MANAGED CARE ORGANIZATION OUTCOMES PROGRAM

23 Section 531-A. Procedure.

24 The Managed Care Organization Outcomes Program shall:

25 (1) Target reduction of avoidable admissions,
26 readmissions and emergency visits.

27 (2) Apply to each managed care organization
28 participating in the Medicaid program.

29 (3) Establish a performance reporting system for
30 potentially avoidable admissions, readmissions and emergency
31 visits for managed care organizations participating in
32 Medicaid managed care.

33 (4) Account for the diverse medically complex
34 populations.

35 Section 532-A. Managed care organization performance reporting.

36 The department shall develop and maintain a reporting system
37 to provide each managed care organization with regular
38 confidential reports regarding the managed care organization's
39 performance with respect to potentially avoidable admissions,
40 readmissions and emergency visits. The department shall:

41 (1) Conduct ongoing analyses of existing and relevant
42 State claims databases to identify instances of potentially
43 avoidable admissions, readmissions and emergency visits with
44 potential excess expenditures associated with the cases.

45 (2) Create or locate Statewide norms for admissions,
46 readmissions and emergency visits.

47 (3) Measure actual-to-expected managed care organization
48 performance compared to Statewide norms.

49 (4) Compare managed care organizations with the managed
50 care organizations' peers using risk adjustment procedures
51 that account for the chronic illness burden of each plan's

1 enrollees.

2 (5) Distribute reports to managed care organizations to
3 provide the managed care organizations with actionable
4 information to create policies, contracts and programs
5 designed to improve target outcomes.

6 Section 533-A. Managed care organization outcomes information
7 sharing.

8 A managed care organization may share the information
9 contained in the outcome performance reports with the managed
10 care organization's participating providers to foster
11 coordination and cooperation in the managed care organization's
12 outcome improvement and efficiency initiatives.

13 Section 534-A. Value-based models.

14 After the implementation of the reporting system under
15 section 532-A, the department shall evaluate value-based models
16 that will support managed care organizations in reducing rates
17 of potentially avoidable admissions, readmissions and emergency
18 visits.

19 Section 535-A. Managed care organization Medicaid contracts.

20 The department shall amend contracts entered into or renewed
21 on or after the effective date of this section with the
22 department's participating managed care organizations as
23 necessary to incorporate the Managed Care Organization Outcomes
24 Program.

25 Section 536-A. Progress report on Managed Care Organization
26 Outcomes Program.

27 By March 1, 2020, and each March 1 thereafter, the department
28 shall provide a report on the progress of the Managed Care
29 Organization Outcomes Program to the General Assembly. The
30 report shall chart the reductions in the rates of potentially
31 avoidable complications, readmissions and emergency room visits
32 and the impact of such reductions on Medicaid costs.

33 Section 3.2. The act is amended by adding a section to read:

34 Section 602. LIFE Program.--(a) Informational materials and
35 department correspondence used by the department to educate or
36 notify an eligible individual about long-term care services and
37 supports, including an individual's rights, responsibilities and
38 choice of managed care organization to cover long-term care
39 services and supports, shall include the following:

40 (1) A description of the LIFE program.

41 (2) A statement that an eligible individual has the option
42 to enroll in the LIFE program or a managed care organization
43 under the Community Health Choices Program.

44 (3) Contact information for LIFE providers.

45 (b) The department shall continue to provide training to the
46 Independent Enrollment Broker on the LIFE program through the
47 Independent Enrollment Broker LIFE module to better educate the
48 Independent Enrollment Broker.

49 (c) At the end of each quarter, the department shall issue a
50 report that tracks by county the enrollment of eligible
51 individuals in long-term care service programs, including

1 managed care organizations and LIFE programs.

2 (d) As used in this section, the following words and phrases
3 shall have the meanings given to them in this subsection unless
4 the context clearly indicates otherwise:

5 "Eligible individual." An individual, age 55 or older, who
6 is a resident of this Commonwealth and who requires long-term
7 services or supports in order to remain living in the community
8 and not in a nursing facility.

9 "Independent Enrollment Broker." A contracted Statewide
10 entity that facilitates the eligibility and enrollment process
11 for individuals seeking home and community-based services and
12 works with service coordination providers to respond to
13 participants' needs.

14 "LIFE program." A program which is a managed care program
15 that provides all-inclusive care for elderly individuals in this
16 Commonwealth as established in accordance with 42 CFR Pt. 460
17 (relating to programs of all-inclusive care for the elderly
18 (PACE)).

19 Section 4. Section 704.3(a) of the act is amended to read:

20 Section 704.3. Provider Submissions.--(a) [For fiscal years
21 2013-2014, 2014-2015, 2015-2016 and 2016-2017, a] A provider
22 shall submit documentation of its costs of providing services;
23 and the department shall use such documentation, to the extent
24 necessary, to support the department's claim for Federal funding
25 and for State reimbursement for allowable direct and indirect
26 costs incurred in the provision of out-of-home placement
27 services. The department may include components of the
28 recommendations of the rate methodology task force established
29 under this section as part of the provider documentation to
30 ensure Federal reimbursement.

31 * * *

32 Section 5. The definition of "net inpatient revenue" in
33 section 801-G of the act is amended and the section is amended
34 by adding a definition to read:

35 Section 801-G. Definitions.

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

39 * * *

40 "Net inpatient revenue." Gross charges for facilities for
41 inpatient services less any deducted amounts for bad debt
42 expense, charity care expense and contractual allowances as
43 reported on forms specified by the department and:

44 (1) as identified in the hospital's records for the
45 State fiscal year commencing July 1, [2010] 2014, or such
46 later State fiscal year, as may be specified by the
47 department for use in determining an annual assessment amount
48 owed on or after July 1, [2016] 2018; or

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

1 "Net outpatient revenue." Gross charges for facilities for
2 outpatient services less any deducted amounts for bad debt
3 expense, charity care expense and contractual allowances as
4 reported on forms specified by the department and:

5 (1) as identified in the hospital's records for the
6 State fiscal year commencing July 1, 2014, or a later State
7 fiscal year, as may be specified by the department for use in
8 determining an annual assessment amount owed on or after July
9 1, 2018; or

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

13 * * *

14 Section 6. Section 803-G(b), (c) and (c.1) of the act are
15 amended and the section is amended by adding a subsection to
16 read:

17 Section 803-G. Implementation.

18 * * *

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

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

24 (2) for fiscal years 2011-2012, 2012-2013, 2013-2014 and
25 2014-2015, an amount equal to 3.22% of the net inpatient
26 revenue of the covered hospital; [and]

27 (3) for fiscal years 2015-2016, 2016-2017 and 2017-2018,
28 an amount equal to 3.71% of the net inpatient revenue of the
29 covered hospital[.];

30 (4) for fiscal year 2018-2019, an amount equal to 2.98%
31 of the net inpatient revenue of the covered hospital and
32 1.55% of the net outpatient revenue of the covered hospital;
33 and

34 (5) for fiscal years 2019-2020, 2020-2021, 2021-2022 and
35 2022-2023, an amount equal to 3.32% of the net inpatient
36 revenue of the covered hospital and 1.73% of the net
37 outpatient revenue of the covered hospital.

38 (c) Adjustments to assessment percentage.--The secretary may
39 adjust the assessment percentage specified in subsection (b) for
40 all or part of the fiscal year for inpatient services,
41 outpatient services or both, provided that, before implementing
42 an adjustment, the secretary shall publish a notice in the
43 Pennsylvania Bulletin that specifies the proposed assessment
44 percentage and identifies the aggregate impact on covered
45 hospitals subject to the assessment. Interested parties shall
46 have 30 days in which to submit comments to the secretary. Upon
47 expiration of the 30-day comment period, the secretary, after
48 consideration of the comments, shall publish a second notice in
49 the Pennsylvania Bulletin announcing the assessment percentage.

50 (c.1) Rebasing net inpatient revenue amounts.--For purposes
51 of calculating the annual assessment amount owed [on or after

1 July 1, 2016] for fiscal years 2016-2017 and 2017-2018, the
2 secretary may require the use of net inpatient revenue amounts
3 as identified in the records of covered hospitals for a State
4 fiscal year commencing on or after July 1, 2011. If the
5 secretary decides that the net inpatient revenue amounts should
6 be rebased, the secretary shall publish a notice in the
7 Pennsylvania Bulletin specifying the State fiscal year for which
8 the net inpatient revenue amounts will be used at least 30 days
9 prior to the date on which an assessment amount calculated with
10 those rebased amounts is due to be paid to the department.

11 (c.2) Rebasing net inpatient and net outpatient revenue
12 amounts.--For purposes of calculating the annual assessment
13 amount owed on or after July 1, 2018, the secretary may require
14 the use of net inpatient revenue and net outpatient revenue
15 amounts as identified in the records of covered hospitals for a
16 State fiscal year commencing on or after July 1, 2015. If the
17 secretary decides that the net inpatient and net outpatient
18 revenue amounts should be based on a State fiscal year
19 commencing on or after July 1, 2015, the secretary shall
20 transmit a notice to the Legislative Reference Bureau for
21 publication in the Pennsylvania Bulletin specifying the State
22 fiscal year for which the net inpatient and net outpatient
23 revenue amounts will be used at least 30 days prior to the date
24 on which an assessment amount calculated with the rebased
25 amounts is due to be paid to the department.

26 * * *

27 Section 7. Sections 804-G(a), (a.1), (a.3), (c) and (d),
28 805-G(b) and 815-G of the act are amended to read:
29 Section 804-G. Administration.

30 (a) Calculation and notice of assessment amount.--Using the
31 assessment percentage established under section 803-G and
32 covered hospitals' net inpatient revenue for fiscal years
33 commencing prior to July 1, 2018, or covered hospitals' net
34 inpatient revenue and net outpatient revenue for fiscal years
35 commencing on or after July 1, 2018, the department shall
36 calculate and notify each covered hospital of the assessment
37 amount owed for the fiscal year. Notification pursuant to this
38 subsection may be made in writing or electronically at the
39 discretion of the department.

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

41 (1) If a single covered hospital changes ownership or
42 control, the department will continue to calculate the
43 assessment amount using [the hospital's net inpatient revenue
44 for]:

45 (i) the hospital's net inpatient revenue for State
46 fiscal year 2010-2011 if the change of ownership occurs
47 before July 1, 2018;

48 (ii) [for a change on or after July 1, 2016, the
49 later State fiscal year, if any,] the hospital's net
50 inpatient revenue and net outpatient revenue amounts for
51 State fiscal year 2014-2015, or a later fiscal year that

1 has been specified by the secretary for use in
2 determining the assessment amounts due for the fiscal
3 year in which the change occurs, if the change of
4 ownership occurs on or after July 1, 2018; or

5 (iii) the hospital's net inpatient revenue and net
6 outpatient revenue amounts for the most recent State
7 fiscal year, or part thereof, if the net inpatient
8 revenue and net outpatient revenue amounts specified in
9 [subparagraphs (i) and (ii) are] subparagraph (ii) is not
10 available. The covered hospital is liable for any
11 outstanding assessment amounts, including outstanding
12 amounts related to periods prior to the change of
13 ownership or control.

14 (2) If two or more hospitals merge or consolidate into a
15 single covered hospital as a result of a change in ownership
16 or control, the department will calculate the assessment
17 amount owed by the single covered hospital resulting from the
18 merger or consolidation using [the merged or consolidated
19 hospitals' combined net inpatient revenue for]:

20 (i) the merged or consolidated hospitals' combined
21 net inpatient revenue for State fiscal year 2010-2011 if
22 the merger or consolidation occurs before July 1, 2018;

23 (ii) [for a merger or consolidation on or after July
24 1, 2016, the later State fiscal year, if any,] the merged
25 or consolidated hospitals' combined net inpatient revenue
26 and net outpatient revenue amounts for State fiscal year
27 2014-2015 or a later fiscal year that has been specified
28 by the secretary for use in determining the assessment
29 amounts due for the fiscal year in which the merger or
30 consolidation occurs, if the merger or consolidation
31 occurs on or after July 1, 2018; or

32 (iii) the hospital's net inpatient revenue and net
33 outpatient revenue amounts for the most recent State
34 fiscal year, or part thereof, if the net inpatient
35 revenue and net outpatient revenue amounts specified in
36 [subparagraphs (i) and (ii) are] subparagraph (ii) is not
37 available, [of] for any covered hospitals that were
38 merged or consolidated into the single covered hospital.
39 The single covered hospital is liable for any outstanding
40 assessment amounts, including outstanding amounts related
41 to periods prior to the change of ownership or control,
42 of any covered hospital that was merged or consolidated.

43 * * *

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

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

1 (2) For the State fiscal year following the State fiscal
2 year under paragraph (1), the department shall calculate the
3 hospital's assessment amount using:

4 (i) the net inpatient revenue from the State fiscal
5 year in which the covered hospital began operation or
6 became a covered hospital[.] if the covered hospital
7 began operation or became a covered hospital prior to
8 July 1, 2018; or

9 (ii) using the net inpatient revenue and net
10 outpatient revenue from the State fiscal year in which
11 the covered hospital began operation or became a covered
12 hospital if the covered hospital began operation or
13 became a covered hospital on or after July 1, 2018.

14 (3) For the State fiscal years following the first full
15 State fiscal year under paragraph (2) but ending prior to
16 July 1, 2018, the department shall calculate the hospital's
17 assessment amount using the net inpatient revenue from the
18 prior State fiscal year. For the State fiscal years following
19 the first full State fiscal year under paragraph (2)
20 commencing on or after July 1, 2018, the department shall
21 calculate the hospital's assessment amount using the net
22 inpatient and net outpatient revenue from the prior State
23 fiscal year.

24 * * *

25 (c) Records.--Upon request by the department, a covered
26 hospital shall furnish to the department such records as the
27 department may specify in order for the department to validate
28 the net inpatient [revenue] and net outpatient revenues reported
29 by the hospital or to determine the assessment for a fiscal year
30 or the amount of the assessment due from the covered hospital or
31 to verify that the covered hospital has paid the correct amount
32 due.

33 (d) Underpayments and overpayments.--In the event that the
34 department determines that a covered hospital has failed to pay
35 an assessment or that it has underpaid an assessment, the
36 department shall notify the covered hospital in writing of the
37 amount due, including interest, and the date on which the amount
38 due must be paid, which shall not be less than 30 days from the
39 date of the notice. In the event that the department determines
40 that a covered hospital has overpaid an assessment, the
41 department shall notify the covered hospital in writing of the
42 overpayment and, within 30 days of the date of the notice of the
43 overpayment, shall [either refund the amount of the overpayment
44 or] offset the amount of the overpayment against any amount that
45 may be owed to the department from the covered hospital.

46 Section 805-G. Restricted account.

47 * * *

48 (b) Limitations.--

49 (1) For the first year of the assessment, the amount
50 used for the medical assistance payments for hospitals and
51 Medicaid managed care organizations may not exceed the

1 aggregate amount of assessment funds collected for the year
2 less \$121,000,000.

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

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

13 (4.1) For State fiscal years 2013-2014 and 2014-2015,
14 the amount used for the medical assistance payment for
15 hospitals and medical assistance managed care organizations
16 may not exceed the aggregate amount of the assessment funds
17 collected for the year less \$150,000,000.

18 (4.2) For State fiscal years 2015-2016, 2016-2017 and
19 2017-2018, the amount used for the medical assistance payment
20 for hospitals and medical assistance managed care
21 organizations may not exceed the aggregate amount of the
22 assessment funds collected for the year less \$220,000,000.

23 (4.3) For State fiscal years 2018-2019, 2019-2020 and
24 2020-2021, the amount used for the medical assistance payment
25 for hospitals and medical assistance managed care
26 organizations may not exceed the aggregate amount of the
27 assessment funds collected for the year less \$295,000,000.

28 (4.4) For State fiscal years 2021-2022 and 2022-2023,
29 the amount used for the medical assistance payment for
30 hospitals and medical assistance managed care organizations
31 may not exceed the aggregate amount of the assessment funds
32 collected for the year less \$300,000,000.

33 (5) The amounts retained by the department pursuant to
34 paragraphs (1), (2), (4), (4.1) [and (4.2)], (4.2), (4.3) and
35 (4.4) and any additional amounts remaining in the restricted
36 accounts after the payments described in subsection (a) (1)
37 and (2) are made shall be used for purposes approved by the
38 secretary under subsection (a) (3), subject to paragraph (7).

39 (6) Not later than 180 days following the end of the
40 State fiscal year, the department shall prepare a revenue
41 reconciliation schedule for the prior State fiscal year that
42 includes information supporting the amounts received or
43 deposited into and paid out of the restricted account to
44 support actual payments to hospitals and managed care
45 organizations pursuant to subsection (a) (1) and (2).

46 (7) Any positive balance remaining in the restricted
47 account in excess of \$10,000,000 annually, which is not used
48 by the Commonwealth to obtain Federal matching funds and paid
49 out for hospital payments, shall be factored into the
50 calculation of a new assessment rate by reducing the amount
51 of hospital assessment funds that must be generated during

1 the next fiscal year in which the department is able to
2 calculate a new rate. If a new assessment rate is not
3 calculated, the funds remaining in the restricted account
4 shall be refunded to the covered hospital that paid the
5 assessment in proportion to the covered hospital's assessment
6 amount paid in the fiscal year.

7 * * *

8 Section 815-G. Expiration.

9 The assessment under this article shall expire June 30,
10 [2018] 2023.

11 Section 8. The definitions of "child day care" and
12 "children's institutions" in section 901 of the act are amended
13 to read:

14 Section 901. Definitions.--As used in this article--

15 "Child [day] care" means care in lieu of parental care given
16 for part of the twenty-four hour day to a child under sixteen
17 years of age, away from the child's home but does not include
18 child [day] care furnished in a place of worship during
19 religious services.

20 "Children's institutions" means any incorporated or
21 unincorporated organization, society, corporation or agency,
22 public or private, which may receive or care for children, or
23 place them in foster family homes, either at board, wages or
24 free; or any individual who, for hire, gain or reward, receives
25 for care a child, unless he is related to such child by blood or
26 marriage within the second degree; or any individual, not in the
27 regular employ of the court or of an organization, society,
28 association or agency, duly certified by the department, who in
29 any manner becomes a party to the placing of children in foster
30 homes, unless he is related to such children by blood or
31 marriage within the second degree, or is the duly appointed
32 guardian thereof. The term shall not include a family child care
33 home or child [day] care center operated for profit and subject
34 to the provisions of Article X.

35 * * *

36 Section 9. The definitions of "child day care," "child day
37 care center," "facility" and "family child care home" in section
38 1001 of the act are amended to read:

39 Section 1001. Definitions.--As used in this article--

40 * * *

41 "Child [day] care" means care in lieu of parental care given
42 for part of the twenty-four hour day to children under sixteen
43 years of age, away from their own homes, but does not include
44 child [day] care furnished in places of worship during religious
45 services.

46 "Child [day] care center" means any premises operated for
47 profit in which child [day] care is provided simultaneously for
48 seven or more children who are not relatives of the operator,
49 except such centers operated under social service auspices.

50 * * *

51 "Facility" means an adult day care center, child [day] care

1 center, family child care home, boarding home for children,
2 mental health establishment, personal care home, assisted living
3 residence, nursing home, hospital or maternity home, as defined
4 herein, except to the extent that such a facility is operated by
5 the State or Federal governments or those supervised by the
6 department or licensed pursuant to the act of July 19, 1979
7 (P.L.130, No.48), known as the "Health Care Facilities Act."

8 "Family child care home" means a home where child [day] care
9 is provided at any time to no less than four children and no
10 more than six children who are not relatives of the caregiver.

11 * * *

12 Section 10. Within one year of the effective date of this
13 section, the Department of Human Services shall amend any
14 regulation at 55 Pa. Code Pt. V that uses the term "day care" as
15 it relates to children and replace the term with the term "child
16 care."

17 Section 11. This act shall take effect as follows:

18 (1) The addition of Article V-A of the act shall take
19 effect March 31, 2019.

20 (2) This section shall take effect July 1, 2018, or
21 immediately, whichever is later.

22 (3) The remainder of this act shall take effect July 1,
23 2018, or immediately, whichever is later.