AMENDMENTS TO HOUSE BILL NO. 1677

Sponsor: SENATOR BROWNE

Printer's No. 3675

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

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

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

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

Section 216. Coordinated Service Delivery Pilot Program.--

(a) To the extent permitted by Federal law, the department, in consultation with the Department of Education, shall establish a pilot program at a school entity or entities within the city of the first class to assist in the coordinated delivery of education services and human services to students and their

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

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

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

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

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

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

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

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

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

* * *

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

* * *

(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:

* * *

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

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

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

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

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

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

as follows:

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

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

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

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

* * *

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

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

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

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

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

ARTICLE V-A

HEALTH CARE OUTCOMES

SUBARTICLE A

PRELIMINARY PROVISIONS

Section 501-A. 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:

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

"Diagnosis Related Groups." A classification system that

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

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

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

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

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

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

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

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

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

"Potentially avoidable event." Any of the following:

(1) A potentially avoidable admission.

(2) A potentially avoidable complication.

(3) A potentially avoidable emergency visit.

(4) A potentially avoidable readmission.

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

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

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

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

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

was unsuccessful in achieving the anticipated outcome.

Section 502-A. Applicability.

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

SUBARTICLE B

MEDICAID OUTCOMES-BASED PROGRAMS

Section 511-A. Establishment.

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

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

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

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

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

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

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

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

Section 513-A. Statewide analysis of Medicaid system.

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

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

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

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

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

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

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

SUBARTICLE C

HOSPITAL OUTCOMES PROGRAM

Section 521-A. Procedure.

The Hospital Outcomes Program shall:

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

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

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

Section 522-A. Hospital performance reporting.

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

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

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

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

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

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

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

Section 523-A. Hospital outcomes information sharing.

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

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

Section 524-A. Value-based models.

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

Section 525-A. Medicaid enrolled hospital contract.

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

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

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

SUBARTICLE D

MANAGED CARE ORGANIZATION OUTCOMES PROGRAM

Section 531-A. Procedure.

The Managed Care Organization Outcomes Program shall:

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

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

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

(4) Account for the diverse medically complex populations.

Section 532-A. Managed care organization performance reporting.

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

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

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

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

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

enrollees.

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

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

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

Section 534-A. Value-based models.

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

Section 535-A. Managed care organization Medicaid contracts.

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

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

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

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

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

(1) A description of the LIFE program.

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

(3) Contact information for LIFE providers.

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

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

managed care organizations and LIFE programs.

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

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

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

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

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

Section 704.3. Provider Submissions.--(a) [For fiscal years 2013-2014, 2014-2015, 2015-2016 and 2016-2017, a] 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. The department may include components of the recommendations of the rate methodology task force established under this section as part of the provider documentation to ensure Federal reimbursement.

* * *

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

* * *

"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, [2010] 2014, or such later State fiscal year, as may be specified by the department for use in determining an annual assessment amount owed on or after July 1, [2016] 2018; 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).

"Net outpatient revenue." Gross charges for facilities for outpatient 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, 2014, or a later State fiscal year, as may be specified by the department for use in determining an annual assessment amount owed on or after July 1, 2018; 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).

* * *

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

Section 803-G. Implementation.

* * *

(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;

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

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

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

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

(c) Adjustments to assessment percentage.--The secretary may adjust the assessment percentage specified in subsection (b) for all or part of the fiscal year for inpatient services, outpatient services or both, provided that, before implementing an adjustment, 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.

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

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

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

* * *

Section 7. Sections 804-G(a), (a.1), (a.3), (c) and (d), 805-G(b) and 815-G of the act are 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 for fiscal years commencing prior to July 1, 2018, or covered hospitals' net inpatient revenue and net outpatient revenue for fiscal years commencing on or after July 1, 2018, 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]:

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

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

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

(iii) the hospital's net inpatient revenue and net outpatient revenue amounts for the most recent State fiscal year, or part thereof, if the net inpatient revenue and net outpatient revenue amounts specified in [subparagraphs (i) and (ii) are] subparagraph (ii) is 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 assessment amount owed by the single covered hospital resulting from the merger or consolidation using [the merged or consolidated hospitals' combined net inpatient revenue for]:

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

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

(iii) the hospital's net inpatient revenue and net outpatient revenue amounts for the most recent State fiscal year, or part thereof, if the net inpatient revenue and net outpatient revenue amounts specified in [subparagraphs (i) and (ii) are] subparagraph (ii) is not available, [of] for 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.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:

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

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

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

* * *

(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] and net outpatient revenues 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 805-G. Restricted account.

* * *

(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 years 2015-2016, 2016-2017 and 2017-2018, 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 $220,000,000.

(4.3) For State fiscal years 2018-2019, 2019-2020 and 2020-2021, 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 $295,000,000.

(4.4) For State fiscal years 2021-2022 and 2022-2023, 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 $300,000,000.

(5) The amounts retained by the department pursuant to paragraphs (1), (2), (4), (4.1) [and (4.2)], (4.2), (4.3) and (4.4) 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), subject to paragraph (7).

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

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

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

* * *

Section 815-G. Expiration.

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

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

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

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

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

* * *

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

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

* * *

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

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

* * *

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

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

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

* * *

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

Section 11. This act shall take effect as follows:

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

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

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