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 salary, medical and hospital expenses for employees of the Department of Human Services and survivors' benefits and for evaluation of software programs' efficiency; in public assistance, providing for total population coordinated care management, further providing for persons eligible for medical assistance, providing for medical assistance waiver for treatment at institutions for mental disease related to substance use disorder, for additional funding requests for medical assistance appropriations in fiscal year 2017-2018 and, for supporting self-sufficiency for medical assistance recipients, further providing for medical assistance benefit packages, coverage, copayments, premiums and rates and providing for electronic asset verification for medical assistance eligibility based on age, blindness or disability; in children and youth, further providing for provider submissions and for adoption opportunity payments and reimbursement; in nursing facility assessments, further relating to calculation; providing for ambulatory surgical center data collection; and making a related repeal.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. The act of June 13, 1967 (P.L.31, No.21), known as the Human Services Code, is amended by adding sections to...
Section 216. Salary, Medical and Hospital Expenses for Employes of the Department.--(a) An employe of a State mental hospital or youth development center under the department, who is injured during the course of employment by a person confined in such institution or by a person who has been committed to such institution by a court of this Commonwealth or by any provision of the act of July 9, 1976 (P.L.817, No.143), known as the "Mental Health Procedures Act," and an employe of the department who has been assigned to or who has volunteered to join the firefighting force of an institution of the department injured while carrying out firefighting duties, shall be paid by the Commonwealth the employe's full salary at a salary equal to that earned at the time of injury for no more than three years from the date of injury, or until the disability arising from the injury no longer prevents the employe's return as an employe of the department, whichever is sooner.

(b) All medical and hospital expenses incurred in connection with an injury described in subsection (a) shall be paid by the Commonwealth for no more than three years from the date of injury, or until the disability arising from the injury no longer prevents the employe's return as an employe of the department at a salary equal to that earned at the time of injury, whichever is sooner.

(c) During the time salary for an injury described in subsection (a) shall be paid by the Commonwealth, any workers' compensation received or collected for that period shall be turned over to the Commonwealth and paid into the General Fund. If payment is not made, the amount due the Commonwealth shall be deducted from any salary then or thereafter becoming due and
Owing to the employe.

(d) Payment to the surviving spouse and minor dependents of an employe who dies within one year from the date of the injury as a result of injuries described in subsection (a) shall be:

(1) Equal to fifty percent of the full salary of the deceased employe.

(2) Divided equally between the surviving spouse and the minor dependents if the minor dependents are not in the custody of the surviving spouse. In every case, the amount payable to minor dependents shall be divided equally among them.

(3) Terminated, in the case of a surviving spouse or a surviving spouse with minor dependents in the custody of the surviving spouse, when the surviving spouse remarries.

(4) Terminated, in the case of minor dependents who are not in the custody of a remarried surviving spouse, when all of the minor dependents become eighteen years of age.

(5) Denied if the surviving spouse or minor dependents are receiving benefits under the Social Security Act (49 Stat. 620, 42 U.S.C. § 301 et seq.).

(6) Reduced by the amount of any workers' compensation benefits received or collected by the surviving spouse or minor dependents because of the same injury.

(7) Made to the person having legal custody of the minor dependents.

(e) No absence from duty of a Commonwealth employe to whom this section applies by reason of an injury described in subsection (a) shall in any manner be deducted from any period of leave allowed the employe.

(f) Nothing in this section shall be construed to limit the eligibility of the employe to receive workers' compensation.
benefits after the termination of any compensation received under subsection (a) or (b).

Section 217. Evaluation of Software Programs' Efficiency.-- The department shall evaluate the efficacy of software programs designed to identify and prevent fraudulent, incorrect and duplicative payments and transactions within the medical assistance, Temporary Assistance for Needy Families and Supplemental Nutrition Assistance Program. The following apply:

(1) No later than September 30, 2017, the department shall publish a request for information for prospective participants in the efficiency evaluation. The request for information shall be an informal document and may not be construed to be a request for proposal or an invitation to bid.

(2) No later than December 31, 2017, the department shall select no less than three prospective participants that have responded to the request for information under clause (1) to participate in the efficiency evaluation. The department shall provide participants selected under this clause with a test dataset of transactions and other information relating to medical assistance, Temporary Assistance for Needy Families and the Supplemental Nutrition Assistance Program. The department may require the participant to agree to any relevant confidentiality requirements or redact or otherwise anonymize the information as necessary to comply with law.

(3) No later than February 15, 2018, the participants selected under clause (2) shall provide to the department a report identifying potentially fraudulent, incorrect and duplicative payments and transactions within the dataset. A participant may make a recommendation to the department on ways that the department could have avoided making the payment or
transaction and any methods available for recovering money
relating to the payment or transaction.

(4) No later than March 15, 2018, the department shall issue
a report with respect to the information obtained from the
participants' performance in the efficiency evaluation and any
related recommendations. The report may include a comparison of
the performance of the department's programs to identify and
prevent fraudulent, incorrect and duplicative payments and
transactions on the same dataset. The report shall not include
transaction level data and may not include any identifying
information relating to the payments and transactions. The
report shall be issued to the chairperson and the minority
chairperson of the Appropriations Committee of the Senate, the
chairperson and minority chairperson of the Health and Human
Services Committee of the Senate, the chairperson and minority
chairperson of the Appropriations Committee of the House of
Representatives, and the chairperson and minority chairperson of
the Health Committee of the House of Representatives.

(A) THE DEPARTMENT SHALL EVALUATE THE EFFICACY AND COST EFFECTIVENESS OF
SOFTWARE PROGRAMS DESIGNED TO IDENTIFY AND PREVENT FRAUDULENT,
INCORRECT AND DUPLICATIVE PAYMENTS WITHIN MEDICAL ASSISTANCE,
TEMPORARY ASSISTANCE TO NEEDY FAMILIES AND THE SUPPLEMENTAL
NUTRITION ASSISTANCE PROGRAM. THE FOLLOWING APPLY:

(1) NO LATER THAN SEPTEMBER 30, 2017, THE DEPARTMENT SHALL
PUBLISH A REQUEST FOR INFORMATION REGARDING THE USE OF SOFTWARE
PROGRAMS UNDER THIS SUBSECTION AND REQUESTING PROSPECTIVE
PARTICIPANTS IN AN EFFICIENCY EVALUATION. THE REQUEST FOR
INFORMATION SHALL INCLUDE THE REQUIREMENT THAT THE SAVINGS TO
THE COMMONWEALTH FROM THE USE OF THE SOFTWARE PROGRAM EXCEED THE
COST OF IMPLEMENTING AND MAINTAINING THE SOFTWARE PROGRAM. THE
REQUEST FOR INFORMATION SHALL BE AN INFORMAL DOCUMENT AND MAY
NOT BE CONSTRUED TO BE A REQUEST FOR PROPOSAL OR AN INVITATION
TO BID.

(2) (I) SUBJECT TO SUBCLAUSE (II), NO LATER THAN DECEMBER
31, 2017, THE DEPARTMENT SHALL SELECT NO FEWER THAN THREE
PROSPECTIVE PARTICIPANTS THAT HAVE RESPONDED TO THE REQUEST FOR
INFORMATION UNDER CLAUSE (1) TO PARTICIPATE VOLUNTARILY IN AN
EFFICIENCY EVALUATION. THE DEPARTMENT SHALL PROVIDE PARTICIPANTS
SELECTED UNDER THIS SUBCLAUSE WITH A TEST DATA SET OF CLAIM,
PAYMENT AND OTHER INFORMATION RELATING TO MEDICAL ASSISTANCE,
TEMPORARY ASSISTANCE TO NEEDY FAMILIES AND THE SUPPLEMENTAL
NUTRITION ASSISTANCE PROGRAM. THE DEPARTMENT MAY REQUIRE THE
PARTICIPANT TO AGREE TO ANY RELEVANT CONFIDENTIALITY
REQUIREMENTS OR REDACT OR OTHERWISE ANONYMIZE THE INFORMATION AS
NECESSARY TO COMPLY WITH LAW.

(II) THE DEPARTMENT MAY NOT BE REQUIRED TO CONDUCT THE
EFFICIENCY EVALUATION IF THE RESPONSES TO THE REQUEST FOR
INFORMATION UNDER CLAUSE (1) DO NOT DEMONSTRATE THAT THE SAVINGS
TO THE COMMONWEALTH FROM THE USE OF THE SOFTWARE PROGRAM EXCEED
THE COST OF IMPLEMENTING AND MAINTAINING THE SOFTWARE PROGRAM.

(3) NO LATER THAN FEBRUARY 15, 2018, THE PARTICIPANTS
SELECTED UNDER CLAUSE (2)(I) SHALL PROVIDE TO THE DEPARTMENT A
REPORT IDENTIFYING POTENTIALLY FRAUDULENT, INCORRECT AND
DUPLICATIVE PAYMENTS WITHIN THE DATA SET. A PARTICIPANT MAY MAKE
A RECOMMENDATION TO THE DEPARTMENT ON WAYS THAT THE DEPARTMENT
COULD HAVE AVOIDED MAKING THE PAYMENT AND ANY METHODS AVAILABLE
FOR RECOVERING MONEY RELATING TO THE PAYMENT.

(B) NO LATER THAN MARCH 15, 2018, THE DEPARTMENT SHALL ISSUE
A REPORT WITH RESPECT TO THE INFORMATION OBTAINED FROM THE
PARTICIPANTS' PERFORMANCE IN THE EFFICIENCY EVALUATION AND ANY
RELATED RECOMMENDATIONS. THE REPORT MAY INCLUDE A COMPARISON OF
THE PERFORMANCE OF THE DEPARTMENT'S PROGRAMS TO IDENTIFY AND
PREVENT FRAUDULENT, INCORRECT AND DUPLICATIVE PAYMENTS ON THE
SAME DATA SET. THE REPORT SHALL NOT INCLUDE TRANSACTION-LEVEL
DATA AND MAY NOT INCLUDE ANY IDENTIFYING INFORMATION RELATING TO
THE PAYMENTS. THE REPORT SHALL BE ISSUED TO THE CHAIRPERSON AND
THE MINORITY CHAIRPERSON OF THE APPROPRIATIONS COMMITTEE OF THE
SENATE, THE CHAIRPERSON AND MINORITY CHAIRPERSON OF THE HEALTH
AND HUMAN SERVICES COMMITTEE OF THE SENATE, THE CHAIRPERSON AND
MINORITY CHAIRPERSON OF THE APPROPRIATIONS COMMITTEE OF THE
HOUSE OF REPRESENTATIVES AND THE CHAIRPERSON AND MINORITY
CHAIRPERSON OF THE HEALTH COMMITTEE OF THE HOUSE OF
REPRESENTATIVES.

Section 411.1. Total Population Coordinated Care

Management.--(a) The department shall issue a request for
proposals for a total population coordinated care management
pilot program in one Medicaid managed care region of this
Commonwealth that incorporates evidence-based medicine into each
physical and behavioral health decision concerning a medical
assistance recipient. The purpose of the health initiative is to
increase the use of appropriate primary and preventive care by
medical assistance recipients while decreasing the unnecessary
use of specialty care and hospital emergency department
services. The following apply:

(1) All medical assistance recipients in the selected
Medicaid managed care region will have access to the health
initiative.

(2) The department shall define the coordinated care
services to be provided by the health initiative. The health
initiative shall, at a minimum:
(i) Provide all medical assistance recipients in the Medicaid managed care region with access to resources and services to enhance medical assistance recipient participation and promote continuous engagement, including access provided through a single telephone access point and a private portal specific to each medical assistance recipient.

(ii) Offer services where applicable in a manner that avoids duplication of services.

(iii) Support existing State resources available to medical assistance recipients in the selected Medicaid managed care region by providing health management services and data analytics, as needed.

(iv) Coordinate efforts with existing and future providers, contractors, services and agencies.

(v) Utilize technology to provide an advanced information and evidence-based medical system to guide and support medical assistance recipients and physicians in the selected Medicaid managed care region to improve health care outcomes.

(vi) Report analytic, utilization and cost savings information to the department annually or at more frequent, predetermined intervals.

(3) The department shall enter into a contract with one offeror and require that the annual savings to the Commonwealth resulting from the use of the health initiative exceed the cost of the pilot program. The secretary shall forward notice to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin of the date the contract is awarded to the offeror. No administrative or service fee may be paid to the offeror during the initial pilot program contract period. The department may pay a contingency fee to the offeror based on cost savings.
realized by the participating regional Medicaid managed care
organization as evidenced by a reduction in the capitation rate.

(b) The department shall issue a report to the chairperson
and minority chairperson of the Health and Human Services
Committee of the Senate and the chairperson and minority
chairperson of the Health Committee of the House of
Representatives. The report shall detail outcomes of the pilot
program, including:

(1) Analytic and utilization information.

(2) Cost savings realized by the Commonwealth or the
selected regional Medicaid managed care organization as compared
to other Medicaid managed care organizations in the same region.

(3) Recommendations by the department regarding expansion of
the pilot program.

(c) The pilot program established under this section shall
expire one year from the date the contract is awarded to the
offoror.

(d) As used in this section, the term "health initiative"
means the total population coordinated care management pilot
program.

Section 2. Section 441.1 of the act is amended by adding a
subsection to read:

Section 441.1. Persons Eligible for Medical Assistance.* *

(e) The department shall establish an enrollment process for
individuals eligible for medical assistance under this section
to enroll in an individual plan approved by the department and
offered as part of the State's approved Title XIX plan as
follows:

(1) The enrollment process shall include information for the
individual that, except as otherwise provided for in clause (4), the individual shall remain enrolled with the same plan for one year.

(2) After an individual eligible for medical assistance under this section enrolls in a plan approved by the department under the State's approved Title XIX plan, the individual shall remain enrolled in the individual plan until the individual's redetermination period, but for at least 12 months unless the individual qualifies for an exemption under clause (4), or until such time as the individual is no longer eligible for medical assistance.

(3) The department shall notify the individual eligible for medical assistance under this section about the ability at the time of redetermination to change the plan in which the individual is enrolled for services offered under the State's approved Title XIX plan.

(4) The department may grant an exemption to the limitation on changing plans under this section only if the exemption matches standard practices for health insurance plans approved by the Insurance Department under the insurance laws of this Commonwealth, including, but not limited to:

(i) a qualifying life event;

(ii) a relocation of the individual to a region which is not served by the selected Medicaid managed care organization; or

(iii) a verified health condition which requires treatment by a provider not currently participating in the Medicaid managed care organization.

(5) The department shall approve the exemption for an individual based on applicable Federal regulations regarding enrollment or on the approved State plan.
Nothing in this section shall be construed to remove an individual's eligibility for medical assistance for missing the enrollment period provided in this subsection.

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

Section 441.10. Medical Assistance Waiver for Treatment at Institutions for Mental Disease Related to Substance Use Disorder.--(a) Subject to subsection (c), the department shall request a waiver under section 1115 of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1315) from the requirements under section 1905 of the Social Security Act (42 U.S.C. § 1396d) regarding medical assistance for individuals receiving treatment for substance use disorder at institutions for mental disease.

(b) The waiver shall be written to request Federal financial participation for services to individuals receiving treatment for a substance use disorder in an institution for mental disease.

(c) If the prohibition against using medical assistance for services to individuals receiving treatment for substance use disorder in an institution for mental disease in section 1905 of the Social Security Act (42 U.S.C. § 1396d) is repealed or revised or a Federal agency issues guidance allowing for Federal financial participation for services for individuals receiving treatment for substance use disorder in an institution for mental diseases without a waiver, the department shall either not request a waiver or withdraw a submitted waiver. The department shall notify the chair and minority chair of the Health and Human Services Committee of the Senate, the chair and minority chair of the Health Committee of the House of Representatives and the chair and minority chair of the Human Services Committee of the House of Representatives of its action.
under this subsection.

(d) As used in this section, "substance use disorder" shall be as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, or its successor.

Section 441.11. Additional Funding Requests for Medical Assistance Appropriations in Fiscal Year 2017-2018.--Before submitting to the General Assembly a supplemental appropriation request for the capitation and fee for service General Fund appropriations, the department shall request a waiver from the appropriate Federal agency for approval that is designed to reduce the Commonwealth's financial burden for these programs.

(A) BEFORE SUBMITTING TO THE GENERAL ASSEMBLY A SUPPLEMENTAL APPROPRIATION REQUEST FOR THE MEDICAL ASSISTANCE CAPITATION AND FEE-FOR-SERVICE GENERAL FUND APPROPRIATIONS FOR FISCAL YEAR 2017-2018, THE DEPARTMENT SHALL EITHER REQUEST A WAIVER OR SUBMIT A STATE PLAN AMENDMENT FROM THE APPROPRIATE FEDERAL AGENCY FOR APPROVAL. THE WAIVER REQUEST OR THE STATE PLAN AMENDMENT SHALL REQUEST ADDITIONAL FEDERAL FINANCIAL PARTICIPATION, REDUCE EXPENDITURES FOR THE MEDICAL ASSISTANCE PROGRAM OR PROVIDE PROGRAM EFFICIENCIES.

(B) IF THE DEPARTMENT SUBMITS A WAIVER REQUEST OR STATE PLAN AMENDMENT MEETING THE REQUIREMENTS OF SUBSECTION (A) AFTER THE EFFECTIVE DATE OF THIS SECTION, THE DEPARTMENT IS NOT REQUIRED TO SUBMIT AN ADDITIONAL WAIVER REQUEST OR A STATE PLAN AMENDMENT PRIOR TO SUBMITTING A SUPPLEMENTAL APPROPRIATION REQUEST.

(C) THE DEPARTMENT IS NOT REQUIRED TO SUBMIT A WAIVER REQUEST OR A STATE PLAN AMENDMENT UNDER THIS SECTION IF THERE IS A REDUCTION IN FEDERAL FUNDING DURING THE STATE FISCAL YEAR 2017-2018.

Section 441.12. Supporting Self-Sufficiency for Medical Assistance
The department shall request a waiver from the Centers for Medicare and Medicaid Services for approval of design options or reforms that require reasonable employment and OR job search requirements for those physically or mentally able NONDISABLED, NONPREGNANT, NONELDERLY MEDICAID ELIGIBLE ADULTS, as well as appropriate limits on nonessential benefits, such as nonemergency transportation.

Section 4.  Section 454 of the act is amended by adding a subsection to read:

Section 454.  Medical Assistance Benefit Packages; Coverage, Copayments, Premiums and Rates.* * *

(a.1)  The department shall request a waiver from the appropriate Federal agency for the approval of a premium requirement for medical assistance provided to disabled children whose family income is above one thousand percent of the Federal poverty income limit. The premium payment shall be assessed to the family on a sliding scale basis in accordance with the premiums assessed for individuals who receive health insurance through the children's health insurance program under Article XXIII-A of the act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921."

* * *

Section 5.  The act is amended by adding a section to read:

Section 490.  Electronic Asset Verification for Medical Assistance Eligibility Based on Age, Blindness or Disability.--

(a)  The department shall establish an electronic asset verification program that complies with the requirements of section 1940 of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396w) by agreements with financial institutions as provided
by this section.

(b) The department or its designees shall enter into agreements with financial institutions to request and receive from any financial institution doing business in this Commonwealth the financial information of an applicant for or recipient of medical assistance whose eligibility for medical assistance is based upon the applicant's or recipient's age, blindness or disability and of any other person whose assets are required by law to be disclosed in order to determine the eligibility of the applicant or recipient for medical assistance. The agreements shall:

(1) Determine when and the extent to which financial information is necessary to determine and redetermine eligibility.

(2) Request financial information from financial institutions other than those identified by the applicant or recipient based on additional factors such as geographic proximity to the applicant's or recipient's home address.

(c) (1) A financial institution doing business in this Commonwealth may enter into an agreement with the department under this section to provide, when requested by the department under subsection (b) and subject to the cost reimbursement provisions provided in section 1115(a) of the Right to Financial Privacy Act of 1978 (Public Law 95-630, 12 U.S.C. § 3415), up to five years of financial information, including information on previously held assets.

(2) The financial institution shall provide the requested financial information to the department without cost to the individual who is the subject of the request.

(3) A financial institution that complies with this section
shall not be subject to section 487(a) with respect to financial
information regarding applicants or recipients of medical
assistance subject to this section.

(4) The department, in consultation with representatives of
financial institutions, including the Pennsylvania Bankers
Association, the Pennsylvania Association of Community Bankers,
the Pennsylvania Credit Union Association and other similar
organizations, shall develop a model agreement for this section.

(d) No financial institution shall be required to notify an
individual that the individual's financial information was
requested under this section.

(e) Financial information collected under this section and
in the possession of the department or its designees shall be
confidential and used by the department and its designees only
for purposes of determining eligibility for medical assistance.

(f) A financial institution that discloses financial
information under subsection (b) shall not be subject to civil
or criminal liability for actions taken:

(1) by the financial institution in good faith to comply
with this section; or

(2) by the department or its designees.

(g) As used in this section, the following words and phrases
shall have the following meanings:

"Designee" includes, but is not limited to, contractors and
representatives of the department.

"Financial information" means financial records and
information held by a financial institution with respect to the
applicant, recipient, spouse or such other person, as
applicable, that the department finds necessary in connection
with a determination or redetermination of medical assistance.
eligibility.


(1) Any office of a bank, savings bank, card issuer as defined in section 103(o) of the Truth in Lending Act (Public Law 90-321, 15 U.S.C. § 1602(o)), industrial loan company, trust company, savings association, building and loan association, or homestead association, including a cooperative bank, credit union or consumer finance institution.

(2) Any other person defined as a "financial institution" by 31 U.S.C. § 5312(a)(2) (relating to definitions and application), other than a governmental organization.

Section 6. Section 704.3(a) of the act, amended July 8, 2016 (P.L.480, No.76), is amended to read:

Section 704.3. Provider Submissions.--(a) For fiscal years 2013-2014, 2014-2015, 2015-2016 [and], 2016-2017, 2017-2018, 2018-2019 and 2019-2020, 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.

* * *

Section 7. Section 774 of the act is amended by adding a subsection to read:

Section 774. Adoption Opportunity Payments and Reimbursement.--* * * (d) The amount of the adoption subsidy provided by the local authority may be appealed to the department by the child.
applying for or receiving adoption assistance or a person acting on behalf of the child. The appeal shall be conducted in accordance with sections 403 and 423.

Section 8. Section 805-A of the act is amended by adding subsections to read:

Section 805-A. Administration.

(c) The assessment implemented under this article shall be remitted electronically in periodic submissions as specified by the department not to exceed five times per year.

(d) A nursing facility shall report the total assessment amount owed on forms and in accordance with instructions prescribed by the department. The nursing facility shall remit the total assessment amount owed by the due date specified by the department, which shall not be prior to thirty (30) days from the date of the second notice published pursuant to subsection (a).

Section 9. Section 807-A of the act is repealed:

[Section 807-A. Calculation.—Using the assessment rates implemented by the secretary pursuant to section 805-A(a), each nursing facility shall calculate the assessment amount it owes for a calendar quarter on a form specified by the department and shall submit the form and the amount owed to the department no later than the last day of that calendar quarter or thirty (30) days from the date of the second notice published pursuant to section 805-A(a), whichever is later. A nursing facility's calculation of the assessment amount owed in any quarter is subject to verification by the department pursuant to section 808-A.]

Section 10. The act is amended by adding an article to read:

20170HB0059PN2255
ARTICLE VIII-J

AMBULATORY SURGICAL CENTER DATA COLLECTION

Section 801-J. 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:

"Ambulatory surgical center." An ambulatory surgical facility which is a Medicare certified ambulatory surgical center as defined in 42 CFR 416.2 (relating to definitions).


Section 802-J. Submission of annual financial data reports.

An ambulatory surgical center that is in operation or begins operation, or an ambulatory surgical facility that becomes an ambulatory surgical center, on or after July 1, 2017, shall submit annual financial data reports to the Health Care Cost Containment Council as specified by the council.

Section ¶ 5. Repeals are as follows:

(1) The General Assembly declares that the repeal under paragraph (2) is necessary to effectuate the addition of section 216 of the act.

(2) The act of December 8, 1959 (P.L.1718, No.632) is repealed.

Section ¶ 6. The addition of section 216 of the act is a continuation of the act of December 8, 1959 (P.L.1718, No.632).
The following apply:

(1) Except as otherwise provided in this section, all activities initiated under the act of December 8, 1959 (P.L.1718, No.632) shall continue and remain in full force and effect and may be completed under section 216 of the act. Orders, regulations, rules and decisions which were made under the act of December 8, 1959 (P.L.1718, No.632) and which are in effect on the effective date of this section shall remain in full force and effect until revoked, vacated or modified under section 216 of the act. Contracts and obligations entered into under the act of December 8, 1959 (P.L.1718, No.632) are not affected nor impaired by the repeal of the act of December 8, 1959 (P.L.1718, No.632).

(2) Except as set forth in paragraph (3), any difference in language between section 216 of the act and the act of December 8, 1959 (P.L.1718, No.632) is not intended to change nor affect the legislative intent, judicial construction or administration and implementation of the act of December 8, 1959 (P.L.1718, No.632).

(3) Paragraph (2) does not apply to the following provisions:

(i) The deletion of the term "widow" and addition of the term "surviving spouse."

(ii) The limitation on the receipt of benefits in section 216(a) of the act.

Section 137. This act shall take effect as follows:

(1) The addition of section 490 of the act shall take effect December 31, 2017.

(2) The addition of section 774(d) of the act shall take effect in 60 days.
(3) The remainder of this act shall take effect immediately.