
 THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1677 Session of
2017

INTRODUCED BY ORTITAY, WARD, WATSON, WHEELAND, D. MILLER,
PHILLIPS-HILL AND SAYLOR, JULY 21, 2017

SENATOR BROWNE, APPROPRIATIONS, IN SENATE, RE-REPORTED AS
AMENDED, JUNE 22, 2018

AN ACT

1 ~~Amending the act of June 13, 1967 (P.L.31, No.21), entitled "An~~ <--
 2 ~~act to consolidate, editorially revise, and codify the public~~
 3 ~~welfare laws of the Commonwealth," in public assistance,~~
 4 ~~further providing for meeting special needs and work supports~~
 5 ~~and incentives AND FOR EMPLOYMENT INCENTIVE PAYMENTS; in~~ <--
 6 ~~departmental powers and duties as to supervision, further~~
 7 ~~providing for definitions; and, in departmental powers and~~
 8 ~~duties as to licensing, further providing for definitions.~~
 9 AMENDING THE ACT OF JUNE 13, 1967 (P.L.31, NO.21), ENTITLED "AN <--
 10 ACT TO CONSOLIDATE, EDITORIALY REVISE, AND CODIFY THE PUBLIC
 11 WELFARE LAWS OF THE COMMONWEALTH," IN GENERAL POWERS AND
 12 DUTIES, PROVIDING FOR COORDINATED SERVICE DELIVERY PILOT
 13 PROGRAM; IN PUBLIC ASSISTANCE, FURTHER PROVIDING FOR MEETING
 14 SPECIAL NEEDS, WORK SUPPORTS AND INCENTIVES, FOR MEDICAL
 15 ASSISTANCE PAYMENTS FOR INSTITUTIONAL CARE AND PROVIDING FOR
 16 NONEMERGENCY MEDICAL TRANSPORTATION SERVICES; CREATING
 17 OPPORTUNITIES FOR HOSPITALS AND MANAGED CARE ORGANIZATIONS TO
 18 IMPROVE HEALTH CARE OUTCOMES AND TO FURTHER REDUCE
 19 UNNECESSARY AND INAPPROPRIATE SERVICES IN THE COMMONWEALTH'S
 20 MEDICAL ASSISTANCE PROGRAM; IN THE AGED, ESTABLISHING THE
 21 LIFE PROGRAM; IN CHILDREN AND YOUTH, FURTHER PROVIDING FOR
 22 PROVIDER SUBMISSIONS; IN STATEWIDE QUALITY CARE ASSESSMENT,
 23 FURTHER PROVIDING FOR DEFINITIONS, FOR IMPLEMENTATION, FOR
 24 ADMINISTRATION, FOR THE QUALITY CARE ASSESSMENT ACCOUNT AND
 25 FOR EXPIRATION; IN DEPARTMENTAL POWERS AND DUTIES AS TO
 26 SUPERVISION, FURTHER PROVIDING FOR DEFINITIONS; IN
 27 DEPARTMENTAL POWERS AND DUTIES AS TO LICENSING, FURTHER
 28 PROVIDING FOR DEFINITIONS; AND IMPOSING A DUTY ON THE
 29 DEPARTMENT OF HUMAN SERVICES.

30 The General Assembly of the Commonwealth of Pennsylvania

1 hereby enacts as follows:

2 ~~Section 1. Section 408(b) of the act of June 13, 1967~~ <--
3 ~~(P.L.31, No.21), known as the Human Services Code, is amended to~~
4 ~~read:~~

5 ~~SECTION 1. SECTIONS 408(B) AND 491(C) (2) OF THE ACT OF JUNE~~ <--
6 ~~13, 1967 (P.L.31, NO.21), KNOWN AS THE HUMAN SERVICES CODE, ARE~~
7 ~~AMENDED TO READ:~~

8 ~~Section 408. Meeting Special Needs; Work Supports and~~
9 ~~Incentives. * * *~~

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

23 ~~* * *~~

24 ~~SECTION 491. EMPLOYMENT INCENTIVE PAYMENTS. * * *~~ <--

25 ~~(C) * * *~~

26 ~~(2) IF THE EMPLOYER PROVIDES OR PAYS FOR [DAY] CHILD CARE~~
27 ~~SERVICES FOR THE CHILDREN OF THE EMPLOYEE, THE EMPLOYER SHALL BE~~
28 ~~ELIGIBLE TO RECEIVE AN ADDITIONAL EMPLOYMENT INCENTIVE PAYMENT~~
29 ~~OF SIX HUNDRED DOLLARS (\$600) DURING THE FIRST YEAR OF~~
30 ~~EMPLOYMENT, FIVE HUNDRED DOLLARS (\$500) DURING THE SECOND YEAR~~

1 ~~OF EMPLOYMENT, AND FOUR HUNDRED DOLLARS (\$400) DURING THE THIRD~~
2 ~~YEAR OF EMPLOYMENT.~~

3 * * *

4 ~~Section 2. The definitions of "child day care" and~~
5 ~~"children's institutions" in section 901 of the act, amended or <--~~
6 ~~added December 28, 2015 (P.L.500, No.92), are amended to read:~~

7 ~~Section 901. Definitions. As used in this article~~

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

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

28 * * *

29 ~~Section 3. The definitions of "child day care," "child day~~
30 ~~care center," "facility" and "family child care home" in section~~

1 ~~1001 of the act, amended or added December 28, 2015 (P.L.500,~~
2 ~~No.92), are amended to read:~~

3 ~~Section 1001. Definitions. As used in this article—~~

4 ~~* * *~~

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

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

14 ~~* * *~~

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

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

26 ~~* * *~~

27 ~~Section 4. Within one year of the effective date of this~~
28 ~~section, the Department of Human Services shall amend any~~
29 ~~regulation at 55 Pa. Code Pt. V that uses the term "day care" as~~
30 ~~it relates to children and replace the term with the term "child~~

1 care."

2 ~~Section 5. This act shall take effect in 60 days.~~

3 SECTION 1. THE ACT OF JUNE 13, 1967 (P.L.31, NO.21), KNOWN <--
4 AS THE HUMAN SERVICES CODE, IS AMENDED BY ADDING A SECTION TO
5 READ:

6 SECTION 216. COORDINATED SERVICE DELIVERY PILOT PROGRAM.--

7 (A) TO THE EXTENT PERMITTED BY FEDERAL LAW, THE DEPARTMENT, IN
8 CONSULTATION WITH THE DEPARTMENT OF EDUCATION, SHALL ESTABLISH A
9 PILOT PROGRAM AT A SCHOOL ENTITY OR ENTITIES WITHIN THE CITY OF
10 THE FIRST CLASS TO ASSIST IN THE COORDINATED DELIVERY OF
11 EDUCATION SERVICES AND HUMAN SERVICES TO STUDENTS AND THEIR
12 FAMILIES FOR THE PURPOSES OF PROMOTING AND IMPLEMENTING
13 INNOVATIVE RESEARCH-BASED PRACTICES WITHIN SELECTED SCHOOL
14 ENTITIES. COORDINATION SHALL BE BASED UPON JOINT PLANNING
15 BETWEEN THE DEPARTMENT, THE DEPARTMENT OF EDUCATION AND A SCHOOL
16 ENTITY'S COMPREHENSIVE ASSESSMENTS OF THE NEED TO PROVIDE
17 SERVICES, COORDINATE SERVICE DELIVERY, CLOSE GAPS IN SERVICES,
18 AND COORDINATE TO ADDRESS THE PROVISION OF NEEDED SERVICES. IN
19 ORDER TO ASSIST IN THE COORDINATED DELIVERY OF EDUCATION
20 SERVICES AND HUMAN SERVICES TO STUDENTS AND THEIR FAMILIES, THE
21 PILOT PROGRAM MAY CONSIDER THE FOLLOWING:

22 (1) A SCHOOL ENTITY ASSISTING STUDENTS AND THEIR FAMILIES IN
23 APPLYING FOR AND RECEIVING EDUCATION SERVICES AND HUMAN
24 SERVICES.

25 (2) AN EXPANDED SCHOOL DAY FOR THE PURPOSE OF PROVIDING
26 OPPORTUNITIES FOR INCREASED INSTRUCTIONAL TIME, TUTORING BY
27 STAFF, PUPILS AND VOLUNTEERS, AN ENVIRONMENT CONDUCTIVE TO
28 LEARNING BEFORE AND AFTER THE REGULAR SCHOOL DAY AND
29 PERSONALIZED INSTRUCTION AND MENTORING.

30 (3) OTHER BEST PRACTICES AS DETERMINED BY THE DEPARTMENT AND

1 THE DEPARTMENT OF EDUCATION.

2 (B) A SCHOOL ENTITY PARTICIPATING IN THE PILOT PROGRAM SHALL
3 SUBMIT REPORTS TO THE DEPARTMENT CONTAINING SUCH INFORMATION AND
4 IN THE FORM AND BY THE DEADLINE PRESCRIBED BY THE DEPARTMENT.

5 (C) AS USED IN THIS SECTION, THE TERM "SCHOOL ENTITY" SHALL
6 MEAN ANY PUBLIC SCHOOL, INCLUDING A CHARTER SCHOOL OR CYBER
7 CHARTER SCHOOL OR AREA VOCATIONAL-TECHNICAL SCHOOL OPERATING
8 WITHIN THIS COMMONWEALTH.

9 SECTION 2. SECTIONS 408(B) AND 443.1(7)(VI) OF THE ACT ARE
10 AMENDED TO READ:

11 SECTION 408. MEETING SPECIAL NEEDS; WORK SUPPORTS AND
12 INCENTIVES.--* * *

13 (B) THE DEPARTMENT MAY PROVIDE ASSISTANCE TO RECIPIENTS FOR
14 CHILD [DAY] CARE WHEN THE DEPARTMENT HAS DETERMINED THAT,
15 WITHOUT SUCH SERVICES, THE RECIPIENT WOULD BE EXEMPT FROM
16 COMPLIANCE WITH THE CONDITIONS OF THE AGREEMENT OF MUTUAL
17 RESPONSIBILITY OR WORK REQUIREMENTS OR WHEN A FORMER RECIPIENT
18 WHO IS EMPLOYED HAS CEASED TO RECEIVE CASH ASSISTANCE FOR A
19 REASON OTHER THAN A SANCTION FOR NONCOMPLIANCE WITH AN
20 ELIGIBILITY CONDITION. IN ESTABLISHING THE TIME LIMITS AND
21 LEVELS OF ACCESS TO CHILD [DAY-CARE] CARE FUNDS, THE DEPARTMENT
22 SHALL TAKE INTO ACCOUNT AVAILABILITY, COSTS AND THE NUMBER OF
23 ASSISTANCE GROUPS NEEDING SERVICES WITHIN THE GEOGRAPHIC AREA
24 AND SHALL SEEK TO PROVIDE ESSENTIAL SERVICES TO THE GREATEST
25 NUMBER OF RECIPIENTS.

26 * * *

27 SECTION 443.1. MEDICAL ASSISTANCE PAYMENTS FOR INSTITUTIONAL
28 CARE.--THE FOLLOWING MEDICAL ASSISTANCE PAYMENTS SHALL BE MADE
29 ON BEHALF OF ELIGIBLE PERSONS WHOSE INSTITUTIONAL CARE IS
30 PRESCRIBED BY PHYSICIANS:

1 * * *

2 (7) AFTER JUNE 30, 2007, PAYMENTS TO COUNTY AND NONPUBLIC
3 NURSING FACILITIES ENROLLED IN THE MEDICAL ASSISTANCE PROGRAM AS
4 PROVIDERS OF NURSING FACILITY SERVICES SHALL BE DETERMINED IN
5 ACCORDANCE WITH THE METHODOLOGIES FOR ESTABLISHING PAYMENT RATES
6 FOR COUNTY AND NONPUBLIC NURSING FACILITIES SPECIFIED IN THE
7 DEPARTMENT'S REGULATIONS AND THE COMMONWEALTH'S APPROVED TITLE
8 XIX STATE PLAN FOR NURSING FACILITY SERVICES IN EFFECT AFTER
9 JUNE 30, 2007. THE FOLLOWING SHALL APPLY:

10 * * *

11 (VI) SUBJECT TO FEDERAL APPROVAL OF SUCH AMENDMENTS AS MAY
12 BE NECESSARY TO THE COMMONWEALTH'S APPROVED TITLE XIX STATE
13 PLAN, FOR FISCAL YEARS 2015-2016 [AND], 2016-2017 AND 2018-2019,
14 THE DEPARTMENT SHALL MAKE UP TO FOUR MEDICAL ASSISTANCE DAY-ONE
15 INCENTIVE PAYMENTS TO QUALIFIED NONPUBLIC NURSING FACILITIES.
16 THE DEPARTMENT SHALL DETERMINE THE NONPUBLIC NURSING FACILITIES
17 THAT QUALIFY FOR THE MEDICAL ASSISTANCE DAY-ONE INCENTIVE
18 PAYMENTS AND CALCULATE THE PAYMENTS USING THE TOTAL PENNSYLVANIA
19 MEDICAL ASSISTANCE (PA MA) DAYS AND TOTAL RESIDENT DAYS AS
20 REPORTED BY NONPUBLIC NURSING FACILITIES UNDER ARTICLE VIII-A.
21 THE DEPARTMENT'S DETERMINATION AND CALCULATIONS UNDER THIS
22 SUBPARAGRAPH SHALL BE BASED ON THE NURSING FACILITY ASSESSMENT
23 QUARTERLY RESIDENT DAY REPORTING FORMS, AS DETERMINED BY THE
24 DEPARTMENT. THE DEPARTMENT SHALL NOT RETROACTIVELY REVISE A
25 MEDICAL ASSISTANCE DAY-ONE INCENTIVE PAYMENT AMOUNT BASED ON A
26 NURSING FACILITY'S LATE SUBMISSION OR REVISION OF THE
27 DEPARTMENT'S REPORT AFTER THE DATES DESIGNATED BY THE
28 DEPARTMENT. THE DEPARTMENT, HOWEVER, MAY RECOUP PAYMENTS BASED
29 ON AN AUDIT OF A NURSING FACILITY'S REPORT. THE FOLLOWING SHALL
30 APPLY:

1 (A) A NONPUBLIC NURSING FACILITY SHALL MEET ALL OF THE
2 FOLLOWING CRITERIA TO QUALIFY FOR A MEDICAL ASSISTANCE DAY-ONE
3 INCENTIVE PAYMENT:

4 (I) THE NURSING FACILITY SHALL HAVE AN OVERALL OCCUPANCY
5 RATE OF AT LEAST EIGHTY-FIVE PERCENT DURING THE RESIDENT DAY
6 QUARTER. FOR PURPOSES OF DETERMINING A NURSING FACILITY'S
7 OVERALL OCCUPANCY RATE, A NURSING FACILITY'S TOTAL RESIDENT
8 DAYS, AS REPORTED BY THE FACILITY UNDER ARTICLE VIII-A, SHALL BE
9 DIVIDED BY THE PRODUCT OF THE FACILITY'S LICENSED BED CAPACITY,
10 AT THE END OF THE QUARTER, MULTIPLIED BY THE NUMBER OF CALENDAR
11 DAYS IN THE QUARTER.

12 (II) THE NURSING FACILITY SHALL HAVE A MEDICAL ASSISTANCE
13 OCCUPANCY RATE OF AT LEAST SIXTY-FIVE PERCENT DURING THE
14 RESIDENT DAY QUARTER. FOR PURPOSES OF DETERMINING A NURSING
15 FACILITY'S MEDICAL ASSISTANCE OCCUPANCY RATE, THE NURSING
16 FACILITY'S TOTAL PA MA DAYS SHALL BE DIVIDED BY THE NURSING
17 FACILITY'S TOTAL RESIDENT DAYS, AS REPORTED BY THE FACILITY
18 UNDER ARTICLE VIII-A.

19 (III) THE NURSING FACILITY SHALL BE A NONPUBLIC NURSING
20 FACILITY FOR A FULL RESIDENT DAY QUARTER PRIOR TO THE APPLICABLE
21 QUARTERLY REPORTING DUE DATES, AS DETERMINED BY THE DEPARTMENT.

22 (B) THE DEPARTMENT SHALL CALCULATE A QUALIFIED NONPUBLIC
23 NURSING FACILITY'S MEDICAL ASSISTANCE DAY-ONE INCENTIVE PAYMENT
24 AS FOLLOWS:

25 (I) THE TOTAL FUNDS APPROPRIATED FOR PAYMENTS UNDER THIS
26 SUBPARAGRAPH SHALL BE DIVIDED BY THE NUMBER OF PAYMENTS, AS
27 DETERMINED BY THE DEPARTMENT.

28 (II) TO ESTABLISH THE PER DIEM RATE FOR A PAYMENT, THE
29 AMOUNT UNDER SUBCLAUSE (I) SHALL BE DIVIDED BY THE TOTAL PA MA
30 DAYS, AS REPORTED BY ALL QUALIFYING NONPUBLIC NURSING FACILITIES

1 UNDER ARTICLE VIII-A FOR THAT PAYMENT.

2 (III) TO DETERMINE A QUALIFYING NONPUBLIC NURSING FACILITY'S
3 MEDICAL ASSISTANCE DAY-ONE INCENTIVE PAYMENT, THE PER DIEM RATE
4 CALCULATED FOR THE PAYMENT SHALL BE MULTIPLIED BY A NONPUBLIC
5 NURSING FACILITY'S TOTAL PA MA DAYS, AS REPORTED BY THE FACILITY
6 UNDER ARTICLE VIII-A FOR THE PAYMENT.

7 (C) FOR FISCAL YEARS 2015-2016 [AND], 2016-2017 AND 2018-
8 2019, THE STATE FUNDS AVAILABLE FOR THE NONPUBLIC NURSING
9 FACILITY MEDICAL ASSISTANCE DAY-ONE INCENTIVE PAYMENTS SHALL
10 EQUAL EIGHT MILLION DOLLARS (\$8,000,000).

11 * * *

12 SECTION 3. THE ACT IS AMENDED BY ADDING A SECTION TO READ:

13 SECTION 443.12. NONEMERGENCY MEDICAL TRANSPORTATION
14 SERVICES.--(A) THE DEPARTMENT SHALL AMEND THE COMMONWEALTH'S
15 STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT (49 STAT.
16 620, 42 U.S.C. § 1396 ET SEQ.) TO PROVIDE NONEMERGENCY MEDICAL
17 TRANSPORTATION SERVICES TO ELIGIBLE AND ENROLLED MEDICAL
18 ASSISTANCE RECIPIENTS UTILIZING A STATEWIDE OR REGIONAL FULL-
19 RISK BROKERAGE MODEL.

20 (B) SUBJECT TO FEDERAL APPROVAL OF THE AMENDMENTS TO THE
21 COMMONWEALTH'S APPROVED TITLE XIX STATE PLAN, THE DEPARTMENT
22 SHALL DEVELOP A PROPOSAL AND SOLICIT A BROKER TO ADMINISTER THE
23 PROGRAM. A BROKER DETERMINED ELIGIBLE BY THE DEPARTMENT MAY
24 SUBMIT A PROPOSAL. THE DEPARTMENT SHALL ENTER INTO A CONTRACT
25 WITH EACH BROKER WHOSE PROPOSAL HAS BEEN SELECTED TO ADMINISTER
26 THE PROGRAM.

27 (C) THE DEPARTMENT SHALL ISSUE THE SOLICITATION FOR A
28 STATEWIDE OR REGIONAL FULL-RISK BROKERAGE MODEL WITHIN ONE
29 HUNDRED EIGHTY DAYS AFTER THE EFFECTIVE DATE OF THIS SUBSECTION.

30 SECTION 3.1. THE ACT IS AMENDED BY ADDING AN ARTICLE TO

1 READ:

2 ARTICLE V-A

3 HEALTH CARE OUTCOMES

4 SUBARTICLE A

5 PRELIMINARY PROVISIONS

6 SECTION 501-A. DEFINITIONS.

7 THE FOLLOWING WORDS AND PHRASES WHEN USED IN THIS ARTICLE
8 SHALL HAVE THE MEANINGS GIVEN TO THEM IN THIS SECTION UNLESS THE
9 CONTEXT CLEARLY INDICATES OTHERWISE:

10 "ALL PATIENT REFINED DIAGNOSIS RELATED GROUPS." A VERSION OF
11 DIAGNOSIS RELATED GROUPS THAT FURTHER SUBDIVIDE THE DIAGNOSIS
12 RELATED GROUPS INTO FOUR SEVERITY-OF-ILLNESS AND FOUR RISK-OF-
13 MORTALITY SUBCLASSES WITHIN EACH DIAGNOSIS RELATED GROUPS.

14 "DIAGNOSIS RELATED GROUPS." A CLASSIFICATION SYSTEM THAT
15 USES PATIENT DISCHARGE INFORMATION TO CLASSIFY PATIENTS INTO
16 CLINICALLY MEANINGFUL GROUPS.

17 "HOSPITAL." A PUBLIC OR PRIVATE INSTITUTION LICENSED AS A
18 HOSPITAL UNDER THE LAWS OF THIS COMMONWEALTH THAT PARTICIPATES
19 IN THE MEDICAID PROGRAM.

20 "MANAGED CARE ORGANIZATION." A LICENSED MANAGED CARE
21 ORGANIZATION WITH WHOM THE DEPARTMENT HAS CONTRACTED TO PROVIDE
22 OR ARRANGE FOR SERVICES TO A MEDICAID RECIPIENT.

23 "MEDICAID PROGRAM." THE COMMONWEALTH'S MEDICAL ASSISTANCE
24 PROGRAM AUTHORIZED UNDER ARTICLE IV.

25 "POTENTIALLY AVOIDABLE ADMISSION." AN ADMISSION OF AN
26 INDIVIDUAL TO A HOSPITAL OR LONG-TERM CARE FACILITY THAT MAY
27 HAVE REASONABLY BEEN PREVENTED WITH ADEQUATE ACCESS TO
28 AMBULATORY CARE OR HEALTH CARE COORDINATION.

29 "POTENTIALLY AVOIDABLE COMPLICATION." A HARMFUL EVENT OR
30 NEGATIVE OUTCOME WITH RESPECT TO AN INDIVIDUAL, INCLUDING AN

1 INFECTION OR SURGICAL COMPLICATION, THAT:

2 (1) OCCURS AFTER THE PERSON'S ADMISSION TO A HOSPITAL OR
3 LONG-TERM CARE FACILITY; AND

4 (2) MAY HAVE RESULTED FROM THE CARE, LACK OF CARE OR
5 TREATMENT PROVIDED DURING THE HOSPITAL OR LONG-TERM CARE
6 FACILITY STAY RATHER THAN FROM A NATURAL PROGRESSION OF AN
7 UNDERLYING DISEASE.

8 "POTENTIALLY AVOIDABLE EMERGENCY VISIT." TREATMENT OF AN
9 INDIVIDUAL IN A HOSPITAL EMERGENCY ROOM OR FREESTANDING
10 EMERGENCY MEDICAL CARE FACILITY FOR A CONDITION THAT MAY NOT
11 REQUIRE EMERGENCY MEDICAL ATTENTION BECAUSE THE CONDITION COULD
12 BE OR COULD HAVE BEEN TREATED OR PREVENTED BY A PHYSICIAN OR
13 OTHER HEALTH CARE PROVIDER IN A NONEMERGENCY SETTING.

14 "POTENTIALLY AVOIDABLE EVENT." ANY OF THE FOLLOWING:

15 (1) A POTENTIALLY AVOIDABLE ADMISSION.

16 (2) A POTENTIALLY AVOIDABLE COMPLICATION.

17 (3) A POTENTIALLY AVOIDABLE EMERGENCY VISIT.

18 (4) A POTENTIALLY AVOIDABLE READMISSION.

19 (5) A COMBINATION OF THE EVENTS LISTED UNDER THIS
20 DEFINITION.

21 "POTENTIALLY AVOIDABLE READMISSION." A RETURN
22 HOSPITALIZATION OF AN INDIVIDUAL WITHIN A PERIOD SPECIFIED BY
23 THE DEPARTMENT THAT MAY HAVE RESULTED FROM A DEFICIENCY IN THE
24 CARE OR TREATMENT PROVIDED TO THE INDIVIDUAL DURING A PREVIOUS
25 HOSPITAL STAY OR FROM A DEFICIENCY IN POST-HOSPITAL DISCHARGE
26 FOLLOW-UP. THE TERM DOES NOT INCLUDE A HOSPITAL READMISSION
27 NECESSITATED BY THE OCCURRENCE OF UNRELATED EVENTS AFTER THE
28 DISCHARGE. THE TERM INCLUDES THE READMISSION OF AN INDIVIDUAL TO
29 A HOSPITAL FOR:

30 (1) THE SAME CONDITION OR PROCEDURE FOR WHICH THE

1 INDIVIDUAL WAS PREVIOUSLY ADMITTED.

2 (2) AN INFECTION OR OTHER COMPLICATION RESULTING FROM
3 CARE PREVIOUSLY PROVIDED.

4 (3) A CONDITION OR PROCEDURE THAT INDICATES THAT A
5 SURGICAL INTERVENTION PERFORMED DURING A PREVIOUS ADMISSION
6 WAS UNSUCCESSFUL IN ACHIEVING THE ANTICIPATED OUTCOME.

7 SECTION 502-A. APPLICABILITY.

8 THIS ARTICLE SHALL APPLY TO THE EXTENT PERMITTED BY FEDERAL
9 LAW.

10 SUBARTICLE B

11 MEDICAID OUTCOMES-BASED PROGRAMS

12 SECTION 511-A. ESTABLISHMENT.

13 THE DEPARTMENT SHALL ESTABLISH THE FOLLOWING LINKED MEDICAID
14 OUTCOMES-BASED PROGRAMS:

15 (1) A HOSPITAL OUTCOMES PROGRAM DESIGNED TO PROVIDE A
16 HOSPITAL WITH INFORMATION TO REDUCE POTENTIALLY AVOIDABLE
17 EVENTS AND FURTHER INCREASE EFFICIENCY IN MEDICAID HOSPITAL
18 SERVICES.

19 (2) A MANAGED CARE ORGANIZATION OUTCOMES PROGRAM
20 DESIGNED TO PROVIDE A MEDICAID MANAGED CARE ORGANIZATION WITH
21 INFORMATION TO REDUCE POTENTIALLY AVOIDABLE EVENTS AND
22 FURTHER INCREASE EFFICIENCY IN MEDICAID MANAGED CARE
23 PROGRAMS.

24 SECTION 512-A. SELECTION OF POTENTIALLY AVOIDABLE EVENT
25 METHODOLOGY.

26 THE DEPARTMENT SHALL SELECT A METHODOLOGY FOR IDENTIFYING
27 POTENTIALLY AVOIDABLE EVENTS AND THE COSTS ASSOCIATED WITH THE
28 EVENTS AND FOR MEASURING HOSPITAL AND MANAGED CARE ORGANIZATION
29 PERFORMANCE WITH RESPECT TO THE EVENTS. THE FOLLOWING SHALL
30 APPLY:

1 (1) THE DEPARTMENT SHALL DEVELOP PARAMETERS FOR EACH OF
2 THE POTENTIALLY AVOIDABLE EVENTS IN ACCORDANCE WITH THE
3 SELECTED METHODOLOGY.

4 (2) TO THE EXTENT POSSIBLE, THE METHODOLOGY SHALL BE ONE
5 THAT HAS BEEN USED BY A STATE PROGRAM UNDER TITLE XIX OF THE
6 SOCIAL SECURITY ACT (49 STAT. 620, 42 U.S.C. § 301 ET SEQ.)
7 OR BY A COMMERCIAL PAYER IN HEALTH CARE OUTCOMES PERFORMANCE
8 MEASUREMENT AND IN OUTCOME-BASED PROGRAMS.

9 (3) THE METHODOLOGY SHALL UTILIZE A CLINICAL CATEGORICAL
10 MODEL, ENABLE THE PROVISION OF PERFORMANCE INFORMATION ON
11 BOTH THE AGGREGATE AND CASE LEVEL AND RISK ADJUST SCORING TO
12 ACCOUNT FOR PATIENT SEVERITY OF ILLNESS AND POPULATION
13 CHRONIC ILLNESS BURDEN.

14 SECTION 513-A. STATEWIDE ANALYSIS OF MEDICAID SYSTEM.

15 THE DEPARTMENT SHALL CONDUCT A COMPREHENSIVE ANALYSIS OF
16 EXISTING RELEVANT STATE DATABASES TO INCREASE EFFICIENCY IN THE
17 MEDICAID SYSTEM. THE FOLLOWING SHALL APPLY:

18 (1) THE ANALYSIS SHALL IDENTIFY INSTANCES OF POTENTIALLY
19 AVOIDABLE EVENTS IN THE MEDICAID SYSTEM AND THE COSTS
20 ASSOCIATED WITH THESE CASES.

21 (2) THE OVERALL ESTIMATE OF COST SHALL BE BROKEN DOWN
22 INTO ACTIONABLE CATEGORIES, INCLUDING, BUT NOT LIMITED TO,
23 REGIONS, HOSPITALS, MANAGED CARE ORGANIZATIONS, PHYSICIANS,
24 SERVICE LINES, DIAGNOSIS RELATED GROUPS, MEDICAL CONDITIONS
25 AND PROCEDURES, PATIENT CHARACTERISTICS, PROVIDER
26 CHARACTERISTICS AND MEDICAID PROGRAM TYPE.

27 (3) INFORMATION COLLECTED FROM THE POTENTIALLY AVOIDABLE
28 EVENT STUDY SHALL BE UTILIZED IN THE HOSPITAL OUTCOMES
29 PROGRAM AND MANAGED CARE ORGANIZATION OUTCOMES PROGRAM.

30 SECTION 514-A. REPORT ON STATEWIDE ANALYSIS OF MEDICAID SYSTEM.

1 (A) REPORT.--THE DEPARTMENT SHALL PROVIDE A REPORT ON THE
2 COMPREHENSIVE ANALYSIS CONDUCTED UNDER SECTION 513-A TO THE
3 GENERAL ASSEMBLY NO LATER THAN DECEMBER 31, 2019.

4 (B) RECOMMENDATIONS.--THE REPORT SHALL INCLUDE
5 RECOMMENDATIONS ON HOW HOSPITALS AND MANAGED CARE ORGANIZATIONS
6 CAN IMPROVE EFFICIENCY AND OUTCOMES BY REDUCING UNNECESSARY
7 SERVICES. THE DEPARTMENT SHALL ALIGN THE RECOMMENDATIONS WITH
8 THE DEPARTMENT'S OBJECTIVES TO ADVANCE HIGH-VALUE CARE, IMPROVE
9 POPULATION HEALTH, ENGAGE AND SUPPORT PROVIDERS AND ESTABLISH A
10 SUSTAINABLE MEDICAID PROGRAM WITH PREDICTABLE COSTS.

11 SUBARTICLE C

12 HOSPITAL OUTCOMES PROGRAM

13 SECTION 521-A. PROCEDURE.

14 THE HOSPITAL OUTCOMES PROGRAM SHALL:

15 (1) TARGET REDUCTION OF POTENTIALLY AVOIDABLE
16 READMISSIONS AND COMPLICATIONS.

17 (2) APPLY TO EACH STATE ACUTE CARE HOSPITAL
18 PARTICIPATING IN THE MEDICAID PROGRAM, EXCEPT THAT PROGRAM
19 ADJUSTMENTS MAY BE MADE FOR CERTAIN TYPES OF HOSPITALS.

20 (3) ESTABLISH A PERFORMANCE REPORTING SYSTEM FOR
21 POTENTIALLY AVOIDABLE READMISSIONS AND COMPLICATIONS FOR
22 HOSPITALS PARTICIPATING IN MEDICAID.

23 SECTION 522-A. HOSPITAL PERFORMANCE REPORTING.

24 THE DEPARTMENT SHALL DEVELOP AND MAINTAIN A REPORTING SYSTEM
25 TO PROVIDE EACH HOSPITAL WITH REGULAR CONFIDENTIAL REPORTS
26 REGARDING THE HOSPITAL'S PERFORMANCE WITH RESPECT TO POTENTIALLY
27 AVOIDABLE READMISSIONS AND POTENTIALLY AVOIDABLE COMPLICATIONS.

28 THE DEPARTMENT SHALL:

29 (1) CONDUCT ONGOING ANALYSES OF EXISTING AND RELEVANT
30 STATE CLAIMS DATABASES TO IDENTIFY INSTANCES OF POTENTIALLY

1 AVOIDABLE COMPLICATIONS AND READMISSIONS AND THE EXPENDITURES
2 ASSOCIATED WITH THE CASES.

3 (2) CREATE OR LOCATE STATEWIDE COMPLICATIONS AND
4 READMISSIONS NORMS.

5 (3) MEASURE ACTUAL-TO-EXPECTED HOSPITAL PERFORMANCE
6 COMPARED TO STATEWIDE NORMS.

7 (4) COMPARE HOSPITALS WITH THE HOSPITALS' PEERS USING
8 RISK ADJUSTMENT PROCEDURES THAT ACCOUNT FOR THE SEVERITY OF
9 ILLNESS OF EACH HOSPITAL'S PATIENTS.

10 (5) DISTRIBUTE REPORTS TO HOSPITALS TO PROVIDE THEM WITH
11 ACTIONABLE INFORMATION TO CREATE POLICIES, CONTRACTS AND
12 PROGRAMS DESIGNED TO IMPROVE TARGET OUTCOMES.

13 (6) FOSTER COLLABORATION AMONG HOSPITALS IN SHARING BEST
14 PRACTICES.

15 SECTION 523-A. HOSPITAL OUTCOMES INFORMATION SHARING.

16 A HOSPITAL MAY SHARE THE INFORMATION CONTAINED IN THE OUTCOME
17 PERFORMANCE REPORTS WITH PHYSICIANS AND OTHER HEALTH CARE
18 PROVIDERS PROVIDING SERVICES AT THE HOSPITAL TO FOSTER
19 COORDINATION AND COOPERATION IN THE HOSPITAL'S OUTCOME
20 IMPROVEMENT AND EFFICIENCY INITIATIVES.

21 SECTION 524-A. VALUE-BASED MODELS.

22 AFTER THE IMPLEMENTATION OF THE REPORTING SYSTEM UNDER
23 SECTION 522-A, THE DEPARTMENT SHALL EVALUATE VALUE-BASED MODELS
24 THAT WILL SUPPORT HOSPITALS IN REDUCING RATES OF POTENTIALLY
25 AVOIDABLE COMPLICATIONS AND READMISSIONS.

26 SECTION 525-A. MEDICAID ENROLLED HOSPITAL CONTRACT.

27 THE DEPARTMENT SHALL AMEND CONTRACTS ENTERED INTO OR RENEWED
28 ON OR AFTER THE EFFECTIVE DATE OF THIS SECTION WITH THE
29 DEPARTMENT'S MEDICAID ENROLLED HOSPITALS AS NECESSARY TO
30 INCORPORATE THE HOSPITAL OUTCOMES PROGRAM.

1 SECTION 526-A. PROGRESS REPORT ON HOSPITAL OUTCOMES PROGRAM.
2 BY MARCH 1, 2020, AND EACH MARCH 1 THEREAFTER, THE DEPARTMENT
3 SHALL PROVIDE A REPORT ON THE PROGRESS OF THE HOSPITAL OUTCOMES
4 PROGRAM TO THE GENERAL ASSEMBLY. THE REPORT SHALL CHART THE
5 REDUCTIONS IN THE RATES OF POTENTIALLY AVOIDABLE COMPLICATIONS
6 AND READMISSIONS AND THE IMPACT OF SUCH REDUCTIONS ON MEDICAID
7 COSTS.

8 SUBARTICLE D

9 MANAGED CARE ORGANIZATION OUTCOMES PROGRAM

10 SECTION 531-A. PROCEDURE.

11 THE MANAGED CARE ORGANIZATION OUTCOMES PROGRAM SHALL:

12 (1) TARGET REDUCTION OF AVOIDABLE ADMISSIONS,
13 READMISSIONS AND EMERGENCY VISITS.

14 (2) APPLY TO EACH MANAGED CARE ORGANIZATION
15 PARTICIPATING IN THE MEDICAID PROGRAM.

16 (3) ESTABLISH A PERFORMANCE REPORTING SYSTEM FOR
17 POTENTIALLY AVOIDABLE ADMISSIONS, READMISSIONS AND EMERGENCY
18 VISITS FOR MANAGED CARE ORGANIZATIONS PARTICIPATING IN
19 MEDICAID MANAGED CARE.

20 (4) ACCOUNT FOR THE DIVERSE MEDICALLY COMPLEX
21 POPULATIONS.

22 SECTION 532-A. MANAGED CARE ORGANIZATION PERFORMANCE REPORTING.

23 THE DEPARTMENT SHALL DEVELOP AND MAINTAIN A REPORTING SYSTEM
24 TO PROVIDE EACH MANAGED CARE ORGANIZATION WITH REGULAR
25 CONFIDENTIAL REPORTS REGARDING THE MANAGED CARE ORGANIZATION'S
26 PERFORMANCE WITH RESPECT TO POTENTIALLY AVOIDABLE ADMISSIONS,
27 READMISSIONS AND EMERGENCY VISITS. THE DEPARTMENT SHALL:

28 (1) CONDUCT ONGOING ANALYSES OF EXISTING AND RELEVANT
29 STATE CLAIMS DATABASES TO IDENTIFY INSTANCES OF POTENTIALLY
30 AVOIDABLE ADMISSIONS, READMISSIONS AND EMERGENCY VISITS WITH

1 POTENTIAL EXCESS EXPENDITURES ASSOCIATED WITH THE CASES.

2 (2) CREATE OR LOCATE STATEWIDE NORMS FOR ADMISSIONS,
3 READMISSIONS AND EMERGENCY VISITS.

4 (3) MEASURE ACTUAL-TO-EXPECTED MANAGED CARE ORGANIZATION
5 PERFORMANCE COMPARED TO STATEWIDE NORMS.

6 (4) COMPARE MANAGED CARE ORGANIZATIONS WITH THE MANAGED
7 CARE ORGANIZATIONS' PEERS USING RISK ADJUSTMENT PROCEDURES
8 THAT ACCOUNT FOR THE CHRONIC ILLNESS BURDEN OF EACH PLAN'S
9 ENROLLEES.

10 (5) DISTRIBUTE REPORTS TO MANAGED CARE ORGANIZATIONS TO
11 PROVIDE THE MANAGED CARE ORGANIZATIONS WITH ACTIONABLE
12 INFORMATION TO CREATE POLICIES, CONTRACTS AND PROGRAMS
13 DESIGNED TO IMPROVE TARGET OUTCOMES.

14 SECTION 533-A. MANAGED CARE ORGANIZATION OUTCOMES INFORMATION
15 SHARING.

16 A MANAGED CARE ORGANIZATION MAY SHARE THE INFORMATION
17 CONTAINED IN THE OUTCOME PERFORMANCE REPORTS WITH THE MANAGED
18 CARE ORGANIZATION'S PARTICIPATING PROVIDERS TO FOSTER
19 COORDINATION AND COOPERATION IN THE MANAGED CARE ORGANIZATION'S
20 OUTCOME IMPROVEMENT AND EFFICIENCY INITIATIVES.

21 SECTION 534-A. VALUE-BASED MODELS.

22 AFTER THE IMPLEMENTATION OF THE REPORTING SYSTEM UNDER
23 SECTION 532-A, THE DEPARTMENT SHALL EVALUATE VALUE-BASED MODELS
24 THAT WILL SUPPORT MANAGED CARE ORGANIZATIONS IN REDUCING RATES
25 OF POTENTIALLY AVOIDABLE ADMISSIONS, READMISSIONS AND EMERGENCY
26 VISITS.

27 SECTION 535-A. MANAGED CARE ORGANIZATION MEDICAID CONTRACTS.

28 THE DEPARTMENT SHALL AMEND CONTRACTS ENTERED INTO OR RENEWED
29 ON OR AFTER THE EFFECTIVE DATE OF THIS SECTION WITH THE
30 DEPARTMENT'S PARTICIPATING MANAGED CARE ORGANIZATIONS AS

1 NECESSARY TO INCORPORATE THE MANAGED CARE ORGANIZATION OUTCOMES
2 PROGRAM.

3 SECTION 536-A. PROGRESS REPORT ON MANAGED CARE ORGANIZATION
4 OUTCOMES PROGRAM.

5 BY MARCH 1, 2020, AND EACH MARCH 1 THEREAFTER, THE DEPARTMENT
6 SHALL PROVIDE A REPORT ON THE PROGRESS OF THE MANAGED CARE
7 ORGANIZATION OUTCOMES PROGRAM TO THE GENERAL ASSEMBLY. THE
8 REPORT SHALL CHART THE REDUCTIONS IN THE RATES OF POTENTIALLY
9 AVOIDABLE COMPLICATIONS, READMISSIONS AND EMERGENCY ROOM VISITS
10 AND THE IMPACT OF SUCH REDUCTIONS ON MEDICAID COSTS.

11 SECTION 3.2. THE ACT IS AMENDED BY ADDING A SECTION TO READ:

12 SECTION 602. LIFE PROGRAM.--(A) INFORMATIONAL MATERIALS AND
13 DEPARTMENT CORRESPONDENCE USED BY THE DEPARTMENT TO EDUCATE OR
14 NOTIFY AN ELIGIBLE INDIVIDUAL ABOUT LONG-TERM CARE SERVICES AND
15 SUPPORTS, INCLUDING AN INDIVIDUAL'S RIGHTS, RESPONSIBILITIES AND
16 CHOICE OF MANAGED CARE ORGANIZATION TO COVER LONG-TERM CARE
17 SERVICES AND SUPPORTS, SHALL INCLUDE THE FOLLOWING:

18 (1) A DESCRIPTION OF THE LIFE PROGRAM.

19 (2) A STATEMENT THAT AN ELIGIBLE INDIVIDUAL HAS THE OPTION
20 TO ENROLL IN THE LIFE PROGRAM OR A MANAGED CARE ORGANIZATION
21 UNDER THE COMMUNITY HEALTH CHOICES PROGRAM.

22 (3) CONTACT INFORMATION FOR LIFE PROVIDERS.

23 (B) THE DEPARTMENT SHALL CONTINUE TO PROVIDE TRAINING TO THE
24 INDEPENDENT ENROLLMENT BROKER ON THE LIFE PROGRAM THROUGH THE
25 INDEPENDENT ENROLLMENT BROKER LIFE MODULE TO BETTER EDUCATE THE
26 INDEPENDENT ENROLLMENT BROKER.

27 (C) AT THE END OF EACH QUARTER, THE DEPARTMENT SHALL ISSUE A
28 REPORT THAT TRACKS BY COUNTY THE ENROLLMENT OF ELIGIBLE
29 INDIVIDUALS IN LONG-TERM CARE SERVICE PROGRAMS, INCLUDING
30 MANAGED CARE ORGANIZATIONS AND LIFE PROGRAMS.

1 (D) AS USED IN THIS SECTION, THE FOLLOWING WORDS AND PHRASES
2 SHALL HAVE THE MEANINGS GIVEN TO THEM IN THIS SUBSECTION UNLESS
3 THE CONTEXT CLEARLY INDICATES OTHERWISE:

4 "ELIGIBLE INDIVIDUAL." AN INDIVIDUAL, AGE 55 OR OLDER, WHO
5 IS A RESIDENT OF THIS COMMONWEALTH AND WHO REQUIRES LONG-TERM
6 SERVICES OR SUPPORTS IN ORDER TO REMAIN LIVING IN THE COMMUNITY
7 AND NOT IN A NURSING FACILITY.

8 "INDEPENDENT ENROLLMENT BROKER." A CONTRACTED STATEWIDE
9 ENTITY THAT FACILITATES THE ELIGIBILITY AND ENROLLMENT PROCESS
10 FOR INDIVIDUALS SEEKING HOME AND COMMUNITY-BASED SERVICES AND
11 WORKS WITH SERVICE COORDINATION PROVIDERS TO RESPOND TO
12 PARTICIPANTS' NEEDS.

13 "LIFE PROGRAM." A PROGRAM WHICH IS A MANAGED CARE PROGRAM
14 THAT PROVIDES ALL-INCLUSIVE CARE FOR ELDERLY INDIVIDUALS IN THIS
15 COMMONWEALTH AS ESTABLISHED IN ACCORDANCE WITH 42 CFR PT. 460
16 (RELATING TO PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY
17 (PACE)).

18 SECTION 4. SECTION 704.3(A) OF THE ACT IS AMENDED TO READ:

19 SECTION 704.3. PROVIDER SUBMISSIONS.--(A) [FOR FISCAL YEARS
20 2013-2014, 2014-2015, 2015-2016 AND 2016-2017, A] A PROVIDER
21 SHALL SUBMIT DOCUMENTATION OF ITS COSTS OF PROVIDING SERVICES;
22 AND THE DEPARTMENT SHALL USE SUCH DOCUMENTATION, TO THE EXTENT
23 NECESSARY, TO SUPPORT THE DEPARTMENT'S CLAIM FOR FEDERAL FUNDING
24 AND FOR STATE REIMBURSEMENT FOR ALLOWABLE DIRECT AND INDIRECT
25 COSTS INCURRED IN THE PROVISION OF OUT-OF-HOME PLACEMENT
26 SERVICES. THE DEPARTMENT MAY INCLUDE COMPONENTS OF THE
27 RECOMMENDATIONS OF THE RATE METHODOLOGY TASK FORCE ESTABLISHED
28 UNDER THIS SECTION AS PART OF THE PROVIDER DOCUMENTATION TO
29 ENSURE FEDERAL REIMBURSEMENT.

30 * * *

1 SECTION 5. THE DEFINITION OF "NET INPATIENT REVENUE" IN
2 SECTION 801-G OF THE ACT IS AMENDED AND THE SECTION IS AMENDED
3 BY ADDING A DEFINITION TO READ:

4 SECTION 801-G. DEFINITIONS.

5 THE FOLLOWING WORDS AND PHRASES WHEN USED IN THIS ARTICLE
6 SHALL HAVE THE MEANINGS GIVEN TO THEM IN THIS SECTION UNLESS THE
7 CONTEXT CLEARLY INDICATES OTHERWISE:

8 * * *

9 "NET INPATIENT REVENUE." GROSS CHARGES FOR FACILITIES FOR
10 INPATIENT SERVICES LESS ANY DEDUCTED AMOUNTS FOR BAD DEBT
11 EXPENSE, CHARITY CARE EXPENSE AND CONTRACTUAL ALLOWANCES AS
12 REPORTED ON FORMS SPECIFIED BY THE DEPARTMENT AND:

13 (1) AS IDENTIFIED IN THE HOSPITAL'S RECORDS FOR THE
14 STATE FISCAL YEAR COMMENCING JULY 1, [2010] 2014, OR SUCH
15 LATER STATE FISCAL YEAR, AS MAY BE SPECIFIED BY THE
16 DEPARTMENT FOR USE IN DETERMINING AN ANNUAL ASSESSMENT AMOUNT
17 OWED ON OR AFTER JULY 1, [2016] 2018; OR

18 (2) AS IDENTIFIED IN THE HOSPITAL'S RECORDS FOR THE MOST
19 RECENT STATE FISCAL YEAR, OR PART THEREOF, IF AMOUNTS ARE NOT
20 AVAILABLE UNDER PARAGRAPH (1).

21 "NET OUTPATIENT REVENUE." GROSS CHARGES FOR FACILITIES FOR
22 OUTPATIENT SERVICES LESS ANY DEDUCTED AMOUNTS FOR BAD DEBT
23 EXPENSE, CHARITY CARE EXPENSE AND CONTRACTUAL ALLOWANCES AS
24 REPORTED ON FORMS SPECIFIED BY THE DEPARTMENT AND:

25 (1) AS IDENTIFIED IN THE HOSPITAL'S RECORDS FOR THE
26 STATE FISCAL YEAR COMMENCING JULY 1, 2014, OR A LATER STATE
27 FISCAL YEAR, AS MAY BE SPECIFIED BY THE DEPARTMENT FOR USE IN
28 DETERMINING AN ANNUAL ASSESSMENT AMOUNT OWED ON OR AFTER JULY
29 1, 2018; OR

30 (2) AS IDENTIFIED IN THE HOSPITAL'S RECORDS FOR THE MOST

1 RECENT STATE FISCAL YEAR, OR PART THEREOF, IF AMOUNTS ARE NOT
2 AVAILABLE UNDER PARAGRAPH (1).

3 * * *

4 SECTION 6. SECTION 803-G(B), (C) AND (C.1) OF THE ACT ARE
5 AMENDED AND THE SECTION IS AMENDED BY ADDING A SUBSECTION TO
6 READ:

7 SECTION 803-G. IMPLEMENTATION.

8 * * *

9 (B) ASSESSMENT PERCENTAGE.--SUBJECT TO SUBSECTION (C), EACH
10 COVERED HOSPITAL SHALL BE ASSESSED AS FOLLOWS:

11 (1) FOR FISCAL YEAR 2010-2011, EACH COVERED HOSPITAL
12 SHALL BE ASSESSED AN AMOUNT EQUAL TO 2.69% OF THE NET
13 INPATIENT REVENUE OF THE COVERED HOSPITAL;

14 (2) FOR FISCAL YEARS 2011-2012, 2012-2013, 2013-2014 AND
15 2014-2015, AN AMOUNT EQUAL TO 3.22% OF THE NET INPATIENT
16 REVENUE OF THE COVERED HOSPITAL; [AND]

17 (3) FOR FISCAL YEARS 2015-2016, 2016-2017 AND 2017-2018,
18 AN AMOUNT EQUAL TO 3.71% OF THE NET INPATIENT REVENUE OF THE
19 COVERED HOSPITAL[.];

20 (4) FOR FISCAL YEAR 2018-2019, AN AMOUNT EQUAL TO 2.98%
21 OF THE NET INPATIENT REVENUE OF THE COVERED HOSPITAL AND
22 1.55% OF THE NET OUTPATIENT REVENUE OF THE COVERED HOSPITAL;
23 AND

24 (5) FOR FISCAL YEARS 2019-2020, 2020-2021, 2021-2022 AND
25 2022-2023, AN AMOUNT EQUAL TO 3.32% OF THE NET INPATIENT
26 REVENUE OF THE COVERED HOSPITAL AND 1.73% OF THE NET
27 OUTPATIENT REVENUE OF THE COVERED HOSPITAL.

28 (C) ADJUSTMENTS TO ASSESSMENT PERCENTAGE.--THE SECRETARY MAY
29 ADJUST THE ASSESSMENT PERCENTAGE SPECIFIED IN SUBSECTION (B) FOR
30 ALL OR PART OF THE FISCAL YEAR FOR INPATIENT SERVICES,

1 OUTPATIENT SERVICES OR BOTH, PROVIDED THAT, BEFORE IMPLEMENTING
2 AN ADJUSTMENT, THE SECRETARY SHALL PUBLISH A NOTICE IN THE
3 PENNSYLVANIA BULLETIN THAT SPECIFIES THE PROPOSED ASSESSMENT
4 PERCENTAGE AND IDENTIFIES THE AGGREGATE IMPACT ON COVERED
5 HOSPITALS SUBJECT TO THE ASSESSMENT. INTERESTED PARTIES SHALL
6 HAVE 30 DAYS IN WHICH TO SUBMIT COMMENTS TO THE SECRETARY. UPON
7 EXPIRATION OF THE 30-DAY COMMENT PERIOD, THE SECRETARY, AFTER
8 CONSIDERATION OF THE COMMENTS, SHALL PUBLISH A SECOND NOTICE IN
9 THE PENNSYLVANIA BULLETIN ANNOUNCING THE ASSESSMENT PERCENTAGE.

10 (C.1) REBASING NET INPATIENT REVENUE AMOUNTS.--FOR PURPOSES
11 OF CALCULATING THE ANNUAL ASSESSMENT AMOUNT OWED [ON OR AFTER
12 JULY 1, 2016] FOR FISCAL YEARS 2016-2017 AND 2017-2018, THE
13 SECRETARY MAY REQUIRE THE USE OF NET INPATIENT REVENUE AMOUNTS
14 AS IDENTIFIED IN THE RECORDS OF COVERED HOSPITALS FOR A STATE
15 FISCAL YEAR COMMENCING ON OR AFTER JULY 1, 2011. IF THE
16 SECRETARY DECIDES THAT THE NET INPATIENT REVENUE AMOUNTS SHOULD
17 BE REBASED, THE SECRETARY SHALL PUBLISH A NOTICE IN THE
18 PENNSYLVANIA BULLETIN SPECIFYING THE STATE FISCAL YEAR FOR WHICH
19 THE NET INPATIENT REVENUE AMOUNTS WILL BE USED AT LEAST 30 DAYS
20 PRIOR TO THE DATE ON WHICH AN ASSESSMENT AMOUNT CALCULATED WITH
21 THOSE REBASED AMOUNTS IS DUE TO BE PAID TO THE DEPARTMENT.

22 (C.2) REBASING NET INPATIENT AND NET OUTPATIENT REVENUE
23 AMOUNTS.--FOR PURPOSES OF CALCULATING THE ANNUAL ASSESSMENT
24 AMOUNT OWED ON OR AFTER JULY 1, 2018, THE SECRETARY MAY REQUIRE
25 THE USE OF NET INPATIENT REVENUE AND NET OUTPATIENT REVENUE
26 AMOUNTS AS IDENTIFIED IN THE RECORDS OF COVERED HOSPITALS FOR A
27 STATE FISCAL YEAR COMMENCING ON OR AFTER JULY 1, 2015. IF THE
28 SECRETARY DECIDES THAT THE NET INPATIENT AND NET OUTPATIENT
29 REVENUE AMOUNTS SHOULD BE BASED ON A STATE FISCAL YEAR
30 COMMENCING ON OR AFTER JULY 1, 2015, THE SECRETARY SHALL

1 TRANSMIT A NOTICE TO THE LEGISLATIVE REFERENCE BUREAU FOR
2 PUBLICATION IN THE PENNSYLVANIA BULLETIN SPECIFYING THE STATE
3 FISCAL YEAR FOR WHICH THE NET INPATIENT AND NET OUTPATIENT
4 REVENUE AMOUNTS WILL BE USED AT LEAST 30 DAYS PRIOR TO THE DATE
5 ON WHICH AN ASSESSMENT AMOUNT CALCULATED WITH THE REBASED
6 AMOUNTS IS DUE TO BE PAID TO THE DEPARTMENT.

7 * * *

8 SECTION 7. SECTIONS 804-G(A), (A.1), (A.3), (C) AND (D),
9 805-G(B) AND 815-G OF THE ACT ARE AMENDED TO READ:

10 SECTION 804-G. ADMINISTRATION.

11 (A) CALCULATION AND NOTICE OF ASSESSMENT AMOUNT.--USING THE
12 ASSESSMENT PERCENTAGE ESTABLISHED UNDER SECTION 803-G AND
13 COVERED HOSPITALS' NET INPATIENT REVENUE FOR FISCAL YEARS
14 COMMENCING PRIOR TO JULY 1, 2018, OR COVERED HOSPITALS' NET
15 INPATIENT REVENUE AND NET OUTPATIENT REVENUE FOR FISCAL YEARS
16 COMMENCING ON OR AFTER JULY 1, 2018, THE DEPARTMENT SHALL
17 CALCULATE AND NOTIFY EACH COVERED HOSPITAL OF THE ASSESSMENT
18 AMOUNT OWED FOR THE FISCAL YEAR. NOTIFICATION PURSUANT TO THIS
19 SUBSECTION MAY BE MADE IN WRITING OR ELECTRONICALLY AT THE
20 DISCRETION OF THE DEPARTMENT.

21 (A.1) CALCULATION OF ASSESSMENT WITH CHANGES OF OWNERSHIP.--

22 (1) IF A SINGLE COVERED HOSPITAL CHANGES OWNERSHIP OR
23 CONTROL, THE DEPARTMENT WILL CONTINUE TO CALCULATE THE
24 ASSESSMENT AMOUNT USING [THE HOSPITAL'S NET INPATIENT REVENUE
25 FOR]:

26 (I) THE HOSPITAL'S NET INPATIENT REVENUE FOR STATE
27 FISCAL YEAR 2010-2011 IF THE CHANGE OF OWNERSHIP OCCURS
28 BEFORE JULY 1, 2018;

29 (II) [FOR A CHANGE ON OR AFTER JULY 1, 2016, THE
30 LATER STATE FISCAL YEAR, IF ANY,] THE HOSPITAL'S NET

1 INPATIENT REVENUE AND NET OUTPATIENT REVENUE AMOUNTS FOR
2 STATE FISCAL YEAR 2014-2015, OR A LATER FISCAL YEAR THAT
3 HAS BEEN SPECIFIED BY THE SECRETARY FOR USE IN
4 DETERMINING THE ASSESSMENT AMOUNTS DUE FOR THE FISCAL
5 YEAR IN WHICH THE CHANGE OCCURS, IF THE CHANGE OF
6 OWNERSHIP OCCURS ON OR AFTER JULY 1, 2018; OR

7 (III) THE HOSPITAL'S NET INPATIENT REVENUE AND NET
8 OUTPATIENT REVENUE AMOUNTS FOR THE MOST RECENT STATE
9 FISCAL YEAR, OR PART THEREOF, IF THE NET INPATIENT
10 REVENUE AND NET OUTPATIENT REVENUE AMOUNTS SPECIFIED IN
11 [SUBPARAGRAPHS (I) AND (II) ARE] SUBPARAGRAPH (II) IS NOT
12 AVAILABLE. THE COVERED HOSPITAL IS LIABLE FOR ANY
13 OUTSTANDING ASSESSMENT AMOUNTS, INCLUDING OUTSTANDING
14 AMOUNTS RELATED TO PERIODS PRIOR TO THE CHANGE OF
15 OWNERSHIP OR CONTROL.

16 (2) IF TWO OR MORE HOSPITALS MERGE OR CONSOLIDATE INTO A
17 SINGLE COVERED HOSPITAL AS A RESULT OF A CHANGE IN OWNERSHIP
18 OR CONTROL, THE DEPARTMENT WILL CALCULATE THE ASSESSMENT
19 AMOUNT OWED BY THE SINGLE COVERED HOSPITAL RESULTING FROM THE
20 MERGER OR CONSOLIDATION USING [THE MERGED OR CONSOLIDATED
21 HOSPITALS' COMBINED NET INPATIENT REVENUE FOR]:

22 (I) THE MERGED OR CONSOLIDATED HOSPITALS' COMBINED
23 NET INPATIENT REVENUE FOR STATE FISCAL YEAR 2010-2011 IF
24 THE MERGER OR CONSOLIDATION OCCURS BEFORE JULY 1, 2018;

25 (II) [FOR A MERGER OR CONSOLIDATION ON OR AFTER JULY
26 1, 2016, THE LATER STATE FISCAL YEAR, IF ANY,] THE MERGED
27 OR CONSOLIDATED HOSPITALS' COMBINED NET INPATIENT REVENUE
28 AND NET OUTPATIENT REVENUE AMOUNTS FOR STATE FISCAL YEAR
29 2014-2015 OR A LATER FISCAL YEAR THAT HAS BEEN SPECIFIED
30 BY THE SECRETARY FOR USE IN DETERMINING THE ASSESSMENT

1 AMOUNTS DUE FOR THE FISCAL YEAR IN WHICH THE MERGER OR
2 CONSOLIDATION OCCURS, IF THE MERGER OR CONSOLIDATION
3 OCCURS ON OR AFTER JULY 1, 2018; OR

4 (III) THE HOSPITAL'S NET INPATIENT REVENUE AND NET
5 OUTPATIENT REVENUE AMOUNTS FOR THE MOST RECENT STATE
6 FISCAL YEAR, OR PART THEREOF, IF THE NET INPATIENT
7 REVENUE AND NET OUTPATIENT REVENUE AMOUNTS SPECIFIED IN
8 [SUBPARAGRAPHS (I) AND (II) ARE] SUBPARAGRAPH (II) IS NOT
9 AVAILABLE, [OF] FOR ANY COVERED HOSPITALS THAT WERE
10 MERGED OR CONSOLIDATED INTO THE SINGLE COVERED HOSPITAL.
11 THE SINGLE COVERED HOSPITAL IS LIABLE FOR ANY OUTSTANDING
12 ASSESSMENT AMOUNTS, INCLUDING OUTSTANDING AMOUNTS RELATED
13 TO PERIODS PRIOR TO THE CHANGE OF OWNERSHIP OR CONTROL,
14 OF ANY COVERED HOSPITAL THAT WAS MERGED OR CONSOLIDATED.

15 * * *

16 (A.3) CALCULATION OF ASSESSMENT FOR NEW HOSPITALS.--A
17 HOSPITAL THAT BEGINS OPERATION AS A COVERED HOSPITAL DURING A
18 FISCAL YEAR IN WHICH AN ASSESSMENT IS IN EFFECT SHALL BE
19 ASSESSED AS FOLLOWS:

20 (1) DURING THE STATE FISCAL YEAR IN WHICH A COVERED
21 HOSPITAL BEGINS OPERATION OR IN WHICH A HOSPITAL BECOMES A
22 COVERED HOSPITAL, THE COVERED HOSPITAL IS NOT SUBJECT TO THE
23 ASSESSMENT.

24 (2) FOR THE STATE FISCAL YEAR FOLLOWING THE STATE FISCAL
25 YEAR UNDER PARAGRAPH (1), THE DEPARTMENT SHALL CALCULATE THE
26 HOSPITAL'S ASSESSMENT AMOUNT USING:

27 (I) THE NET INPATIENT REVENUE FROM THE STATE FISCAL
28 YEAR IN WHICH THE COVERED HOSPITAL BEGAN OPERATION OR
29 BECAME A COVERED HOSPITAL[.] IF THE COVERED HOSPITAL
30 BEGAN OPERATION OR BECAME A COVERED HOSPITAL PRIOR TO

1 JULY 1, 2018; OR

2 (II) USING THE NET INPATIENT REVENUE AND NET
3 OUTPATIENT REVENUE FROM THE STATE FISCAL YEAR IN WHICH
4 THE COVERED HOSPITAL BEGAN OPERATION OR BECAME A COVERED
5 HOSPITAL IF THE COVERED HOSPITAL BEGAN OPERATION OR
6 BECAME A COVERED HOSPITAL ON OR AFTER JULY 1, 2018.

7 (3) FOR THE STATE FISCAL YEARS FOLLOWING THE FIRST FULL
8 STATE FISCAL YEAR UNDER PARAGRAPH (2) BUT ENDING PRIOR TO
9 JULY 1, 2018, THE DEPARTMENT SHALL CALCULATE THE HOSPITAL'S
10 ASSESSMENT AMOUNT USING THE NET INPATIENT REVENUE FROM THE
11 PRIOR STATE FISCAL YEAR. FOR THE STATE FISCAL YEARS FOLLOWING
12 THE FIRST FULL STATE FISCAL YEAR UNDER PARAGRAPH (2)
13 COMMENCING ON OR AFTER JULY 1, 2018, THE DEPARTMENT SHALL
14 CALCULATE THE HOSPITAL'S ASSESSMENT AMOUNT USING THE NET
15 INPATIENT AND NET OUTPATIENT REVENUE FROM THE PRIOR STATE
16 FISCAL YEAR.

17 * * *

18 (C) RECORDS.--UPON REQUEST BY THE DEPARTMENT, A COVERED
19 HOSPITAL SHALL FURNISH TO THE DEPARTMENT SUCH RECORDS AS THE
20 DEPARTMENT MAY SPECIFY IN ORDER FOR THE DEPARTMENT TO VALIDATE
21 THE NET INPATIENT [REVENUE] AND NET OUTPATIENT REVENUES REPORTED
22 BY THE HOSPITAL OR TO DETERMINE THE ASSESSMENT FOR A FISCAL YEAR
23 OR THE AMOUNT OF THE ASSESSMENT DUE FROM THE COVERED HOSPITAL OR
24 TO VERIFY THAT THE COVERED HOSPITAL HAS PAID THE CORRECT AMOUNT
25 DUE.

26 (D) UNDERPAYMENTS AND OVERPAYMENTS.--IN THE EVENT THAT THE
27 DEPARTMENT DETERMINES THAT A COVERED HOSPITAL HAS FAILED TO PAY
28 AN ASSESSMENT OR THAT IT HAS UNDERPAID AN ASSESSMENT, THE
29 DEPARTMENT SHALL NOTIFY THE COVERED HOSPITAL IN WRITING OF THE
30 AMOUNT DUE, INCLUDING INTEREST, AND THE DATE ON WHICH THE AMOUNT

1 DUE MUST BE PAID, WHICH SHALL NOT BE LESS THAN 30 DAYS FROM THE
2 DATE OF THE NOTICE. IN THE EVENT THAT THE DEPARTMENT DETERMINES
3 THAT A COVERED HOSPITAL HAS OVERPAID AN ASSESSMENT, THE
4 DEPARTMENT SHALL NOTIFY THE COVERED HOSPITAL IN WRITING OF THE
5 OVERPAYMENT AND, WITHIN 30 DAYS OF THE DATE OF THE NOTICE OF THE
6 OVERPAYMENT, SHALL [EITHER REFUND THE AMOUNT OF THE OVERPAYMENT
7 OR] OFFSET THE AMOUNT OF THE OVERPAYMENT AGAINST ANY AMOUNT THAT
8 MAY BE OWED TO THE DEPARTMENT FROM THE COVERED HOSPITAL.

9 SECTION 805-G. RESTRICTED ACCOUNT.

10 * * *

11 (B) LIMITATIONS.--

12 (1) FOR THE FIRST YEAR OF THE ASSESSMENT, THE AMOUNT
13 USED FOR THE MEDICAL ASSISTANCE PAYMENTS FOR HOSPITALS AND
14 MEDICAID MANAGED CARE ORGANIZATIONS MAY NOT EXCEED THE
15 AGGREGATE AMOUNT OF ASSESSMENT FUNDS COLLECTED FOR THE YEAR
16 LESS \$121,000,000.

17 (2) FOR THE SECOND YEAR OF THE ASSESSMENT, THE AMOUNT
18 USED FOR THE MEDICAL ASSISTANCE PAYMENTS FOR HOSPITALS AND
19 MEDICAL ASSISTANCE MANAGED CARE ORGANIZATIONS MAY NOT EXCEED
20 THE AGGREGATE AMOUNT OF ASSESSMENT FUNDS COLLECTED FOR THE
21 YEAR LESS \$109,000,000.

22 (4) FOR THE THIRD YEAR OF THE ASSESSMENT, THE AMOUNT
23 USED FOR THE MEDICAL ASSISTANCE PAYMENT FOR HOSPITALS AND
24 MEDICAL ASSISTANCE MANAGED CARE ORGANIZATIONS MAY NOT EXCEED
25 THE AGGREGATE AMOUNT OF THE ASSESSMENT FUNDS COLLECTED FOR
26 THE YEAR LESS \$109,000,000.

27 (4.1) FOR STATE FISCAL YEARS 2013-2014 AND 2014-2015,
28 THE AMOUNT USED FOR THE MEDICAL ASSISTANCE PAYMENT FOR
29 HOSPITALS AND MEDICAL ASSISTANCE MANAGED CARE ORGANIZATIONS
30 MAY NOT EXCEED THE AGGREGATE AMOUNT OF THE ASSESSMENT FUNDS

1 COLLECTED FOR THE YEAR LESS \$150,000,000.

2 (4.2) FOR STATE FISCAL YEARS 2015-2016, 2016-2017 AND
3 2017-2018, THE AMOUNT USED FOR THE MEDICAL ASSISTANCE PAYMENT
4 FOR HOSPITALS AND MEDICAL ASSISTANCE MANAGED CARE
5 ORGANIZATIONS MAY NOT EXCEED THE AGGREGATE AMOUNT OF THE
6 ASSESSMENT FUNDS COLLECTED FOR THE YEAR LESS \$220,000,000.

7 (4.3) FOR STATE FISCAL YEARS 2018-2019, 2019-2020 AND
8 2020-2021, THE AMOUNT USED FOR THE MEDICAL ASSISTANCE PAYMENT
9 FOR HOSPITALS AND MEDICAL ASSISTANCE MANAGED CARE
10 ORGANIZATIONS MAY NOT EXCEED THE AGGREGATE AMOUNT OF THE
11 ASSESSMENT FUNDS COLLECTED FOR THE YEAR LESS \$295,000,000.

12 (4.4) FOR STATE FISCAL YEARS 2021-2022 AND 2022-2023,
13 THE AMOUNT USED FOR THE MEDICAL ASSISTANCE PAYMENT FOR
14 HOSPITALS AND MEDICAL ASSISTANCE MANAGED CARE ORGANIZATIONS
15 MAY NOT EXCEED THE AGGREGATE AMOUNT OF THE ASSESSMENT FUNDS
16 COLLECTED FOR THE YEAR LESS \$300,000,000.

17 (5) THE AMOUNTS RETAINED BY THE DEPARTMENT PURSUANT TO
18 PARAGRAPHS (1), (2), (4), (4.1) [AND (4.2)], (4.2), (4.3) AND
19 (4.4) AND ANY ADDITIONAL AMOUNTS REMAINING IN THE RESTRICTED
20 ACCOUNTS AFTER THE PAYMENTS DESCRIBED IN SUBSECTION (A) (1)
21 AND (2) ARE MADE SHALL BE USED FOR PURPOSES APPROVED BY THE
22 SECRETARY UNDER SUBSECTION (A) (3), SUBJECT TO PARAGRAPH (7).

23 (6) NOT LATER THAN 180 DAYS FOLLOWING THE END OF THE
24 STATE FISCAL YEAR, THE DEPARTMENT SHALL PREPARE A REVENUE
25 RECONCILIATION SCHEDULE FOR THE PRIOR STATE FISCAL YEAR THAT
26 INCLUDES INFORMATION SUPPORTING THE AMOUNTS RECEIVED OR
27 DEPOSITED INTO AND PAID OUT OF THE RESTRICTED ACCOUNT TO
28 SUPPORT ACTUAL PAYMENTS TO HOSPITALS AND MANAGED CARE
29 ORGANIZATIONS PURSUANT TO SUBSECTION (A) (1) AND (2).

30 (7) ANY POSITIVE BALANCE REMAINING IN THE RESTRICTED

1 ACCOUNT IN EXCESS OF \$10,000,000 ANNUALLY, WHICH IS NOT USED
2 BY THE COMMONWEALTH TO OBTAIN FEDERAL MATCHING FUNDS AND PAID
3 OUT FOR HOSPITAL PAYMENTS, SHALL BE FACTORED INTO THE
4 CALCULATION OF A NEW ASSESSMENT RATE BY REDUCING THE AMOUNT
5 OF HOSPITAL ASSESSMENT FUNDS THAT MUST BE GENERATED DURING
6 THE NEXT FISCAL YEAR IN WHICH THE DEPARTMENT IS ABLE TO
7 CALCULATE A NEW RATE. IF A NEW ASSESSMENT RATE IS NOT
8 CALCULATED, THE FUNDS REMAINING IN THE RESTRICTED ACCOUNT
9 SHALL BE REFUNDED TO THE COVERED HOSPITAL THAT PAID THE
10 ASSESSMENT IN PROPORTION TO THE COVERED HOSPITAL'S ASSESSMENT
11 AMOUNT PAID IN THE FISCAL YEAR.

12 * * *

13 SECTION 815-G. EXPIRATION.

14 THE ASSESSMENT UNDER THIS ARTICLE SHALL EXPIRE JUNE 30,
15 [2018] 2023.

16 SECTION 8. THE DEFINITIONS OF "CHILD DAY CARE" AND
17 "CHILDREN'S INSTITUTIONS" IN SECTION 901 OF THE ACT ARE AMENDED
18 TO READ:

19 SECTION 901. DEFINITIONS.--AS USED IN THIS ARTICLE--

20 "CHILD [DAY] CARE" MEANS CARE IN LIEU OF PARENTAL CARE GIVEN
21 FOR PART OF THE TWENTY-FOUR HOUR DAY TO A CHILD UNDER SIXTEEN
22 YEARS OF AGE, AWAY FROM THE CHILD'S HOME BUT DOES NOT INCLUDE
23 CHILD [DAY] CARE FURNISHED IN A PLACE OF WORSHIP DURING
24 RELIGIOUS SERVICES.

25 "CHILDREN'S INSTITUTIONS" MEANS ANY INCORPORATED OR
26 UNINCORPORATED ORGANIZATION, SOCIETY, CORPORATION OR AGENCY,
27 PUBLIC OR PRIVATE, WHICH MAY RECEIVE OR CARE FOR CHILDREN, OR
28 PLACE THEM IN FOSTER FAMILY HOMES, EITHER AT BOARD, WAGES OR
29 FREE; OR ANY INDIVIDUAL WHO, FOR HIRE, GAIN OR REWARD, RECEIVES
30 FOR CARE A CHILD, UNLESS HE IS RELATED TO SUCH CHILD BY BLOOD OR

1 MARRIAGE WITHIN THE SECOND DEGREE; OR ANY INDIVIDUAL, NOT IN THE
2 REGULAR EMPLOY OF THE COURT OR OF AN ORGANIZATION, SOCIETY,
3 ASSOCIATION OR AGENCY, DULY CERTIFIED BY THE DEPARTMENT, WHO IN
4 ANY MANNER BECOMES A PARTY TO THE PLACING OF CHILDREN IN FOSTER
5 HOMES, UNLESS HE IS RELATED TO SUCH CHILDREN BY BLOOD OR
6 MARRIAGE WITHIN THE SECOND DEGREE, OR IS THE DULY APPOINTED
7 GUARDIAN THEREOF. THE TERM SHALL NOT INCLUDE A FAMILY CHILD CARE
8 HOME OR CHILD [DAY] CARE CENTER OPERATED FOR PROFIT AND SUBJECT
9 TO THE PROVISIONS OF ARTICLE X.

10 * * *

11 SECTION 9. THE DEFINITIONS OF "CHILD DAY CARE," "CHILD DAY
12 CARE CENTER," "FACILITY" AND "FAMILY CHILD CARE HOME" IN SECTION
13 1001 OF THE ACT ARE AMENDED TO READ:

14 SECTION 1001. DEFINITIONS.--AS USED IN THIS ARTICLE--

15 * * *

16 "CHILD [DAY] CARE" MEANS CARE IN LIEU OF PARENTAL CARE GIVEN
17 FOR PART OF THE TWENTY-FOUR HOUR DAY TO CHILDREN UNDER SIXTEEN
18 YEARS OF AGE, AWAY FROM THEIR OWN HOMES, BUT DOES NOT INCLUDE
19 CHILD [DAY] CARE FURNISHED IN PLACES OF WORSHIP DURING RELIGIOUS
20 SERVICES.

21 "CHILD [DAY] CARE CENTER" MEANS ANY PREMISES OPERATED FOR
22 PROFIT IN WHICH CHILD [DAY] CARE IS PROVIDED SIMULTANEOUSLY FOR
23 SEVEN OR MORE CHILDREN WHO ARE NOT RELATIVES OF THE OPERATOR,
24 EXCEPT SUCH CENTERS OPERATED UNDER SOCIAL SERVICE AUSPICES.

25 * * *

26 "FACILITY" MEANS AN ADULT DAY CARE CENTER, CHILD [DAY] CARE
27 CENTER, FAMILY CHILD CARE HOME, BOARDING HOME FOR CHILDREN,
28 MENTAL HEALTH ESTABLISHMENT, PERSONAL CARE HOME, ASSISTED LIVING
29 RESIDENCE, NURSING HOME, HOSPITAL OR MATERNITY HOME, AS DEFINED
30 HEREIN, EXCEPT TO THE EXTENT THAT SUCH A FACILITY IS OPERATED BY

1 THE STATE OR FEDERAL GOVERNMENTS OR THOSE SUPERVISED BY THE
2 DEPARTMENT OR LICENSED PURSUANT TO THE ACT OF JULY 19, 1979
3 (P.L.130, NO.48), KNOWN AS THE "HEALTH CARE FACILITIES ACT."

4 "FAMILY CHILD CARE HOME" MEANS A HOME WHERE CHILD [DAY] CARE
5 IS PROVIDED AT ANY TIME TO NO LESS THAN FOUR CHILDREN AND NO
6 MORE THAN SIX CHILDREN WHO ARE NOT RELATIVES OF THE CAREGIVER.

7 * * *

8 SECTION 10. WITHIN ONE YEAR OF THE EFFECTIVE DATE OF THIS
9 SECTION, THE DEPARTMENT OF HUMAN SERVICES SHALL AMEND ANY
10 REGULATION AT 55 PA. CODE PT. V THAT USES THE TERM "DAY CARE" AS
11 IT RELATES TO CHILDREN AND REPLACE THE TERM WITH THE TERM "CHILD
12 CARE."

13 SECTION 11. THIS ACT SHALL TAKE EFFECT AS FOLLOWS:

14 (1) THE ADDITION OF ARTICLE V-A OF THE ACT SHALL TAKE
15 EFFECT MARCH 31, 2019.

16 (2) THIS SECTION SHALL TAKE EFFECT JULY 1, 2018, OR
17 IMMEDIATELY, WHICHEVER IS LATER.

18 (3) THE REMAINDER OF THIS ACT SHALL TAKE EFFECT JULY 1,
19 2018, OR IMMEDIATELY, WHICHEVER IS LATER.