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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 254 Session of 2009

INTRODUCED BY FAIRCHILD, ADOLPH, BAKER, BARRAR, BEAR, BEYER, BOYD, BRENNAN, CIVERA, CLYMER, COHEN, CONKLIN, DENLINGER, EACHUS, EVERETT, FLECK, FRANKEL, GEIST, GEORGE, GINGRICH, GOODMAN, GRELL, GROVE, GRUCELA, HARKINS, HARRIS, HELM, HESS, KIRKLAND, KORTZ, McGEEHAN, McILVAINE SMITH, MICCARELLI, MILLER, MOUL, O'NEILL, PAYNE, PHILLIPS, PICKETT, RAPP, REICHLEY, SAYLOR, SCAVELLO, SIPTROTH, K. SMITH, SOLOBAY, STERN, VULAKOVICH, WANSACZ, YUDICHAK, ROCK, CAUSER, MICOZZIE, MURT AND BOBACK, FEBRUARY 4, 2009

SENATOR VANCE, PUBLIC HEALTH AND WELFARE, IN SENATE, RE-REPORTED AS AMENDED, JULY 1, 2010

AN ACT

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 of the Department of Public Welfare, FURTHER providing for DETERMINING WHETHER APPLICANTS ARE veterans; in public assistance, further providing for ~~establishment of county boards and expenses and for lifetime limit; and, in hospital assessment, further providing for definitions, for authorization, for administration, for no hold harmless, for tax exemption and for cessation~~ MEDICAL ASSISTANCE PAYMENTS FOR INSTITUTIONAL CARE; AND PROVIDING FOR STATEWIDE QUALITY CARE ASSESSMENT.

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 Public Welfare Code, is amended by adding a section to read:~~

~~Section 215. Veterans. (a) The department shall make a~~

good faith effort to determine whether an applicant for cash, medical or energy assistance is a veteran. While in the process of making its determination, the department shall dispense benefits to the applicant, if otherwise eligible.

(b) As a condition of eligibility to receive cash, medical or energy assistance, unless there is good cause not to do so, an applicant who is a veteran shall be required to contact a veteran service officer accredited and recognized by the United States Department of Veterans Affairs, the Department of Military and Veterans Affairs or the county director of veterans affairs in which the applicant resides in order to determine the applicant's eligibility for veteran's benefits or to file a veteran claims packet. The department shall develop a standard form to be used by a veteran service officer to verify the applicant's eligibility for veteran benefits.

(c) An applicant who is a veteran shall provide proof of compliance with this section and the department shall, to the greatest extent possible, require the applicant to provide information on the final determination of eligibility for veteran benefits and the type of benefits the veteran is entitled to receive.

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

"Assistance" means money, services and payment for medical coverage or energy assistance for needy persons who are residents of this Commonwealth, are in need of assistance and meet all conditions of eligibility.

"Veteran claims packet" means an application requesting a determination or entitlement or evidencing a belief in entitlement to a benefit as provided for in 38 CFR (relating to

pensions, bonuses, and veterans' relief) or 51 Pa.C.S. (relating to military affairs).

Section 2. Section 415 of the act is amended to read:

Section 415. Establishment of County Boards; Expenses.--For each county of the Commonwealth, there is hereby established a county board of assistance, to be known as the County Board of Assistance and referred to in this Article IV as the "county board," which shall be composed of men and women, to be appointed by the Governor [with the advice and consent of two-thirds of all members of the Senate]. Each appointment by the Governor shall bear the endorsement of the senator of the district in which the nominee resides. In the case of a vacancy in that senatorial district, the nominee shall be endorsed by the senator of an adjacent district. The county boards shall be composed as far as possible of persons engaged or interested in business, social welfare, labor, industry, education or public administration. The members of the county boards shall serve without compensation, but shall be reimbursed for necessary expenses. No member of a county board shall hold office in any political party. Not all of the members of a county board shall belong to the same political party.

Section 3. Section 441.4 of the act, added July 7, 2005 (P.L.177, No.42), is amended to read:

Section 441.4. [Lifetime Limit] Reasonable Limits on Allowable Income Deductions for Medical Expenses When Determining Payment Toward the Cost of Long Term Care Services.--(a) [Necessary medical or remedial care expenses recognized under Federal or State law but not paid for by the medical assistance program are allowable income deductions when determining a recipient's payment toward the cost of long term

~~care services. An allowable income deduction for unpaid medical expenses incurred prior to the authorization of medical assistance eligibility and those medical expenses incurred for long-term care services after medical assistance is authorized shall be subject to a lifetime maximum of ten thousand dollars ($10,000) unless application of the limit would result in undue hardship.]~~ When determining a recipient's payment toward the cost of long-term care services, long-term care medical expenses incurred six months or more prior to application for medical assistance shall be disallowed as a deduction, and medical and remedial expenses that were incurred as a result of a transfer of assets penalty shall be limited to zero unless application of these limits would result in undue hardship.

~~(b) As used in this section, the term "undue hardship" shall mean that either:~~

~~(1) denial of medical assistance would deprive the individual of medical care and endanger the individual's health or life; or~~

~~(2) the individual or a financially dependent family member would be deprived of food, shelter or the necessities of life.~~

~~Section 4. The definitions of "exempt hospital" and "general acute care hospital" in section 801-E of the act, added July 4, 2008 (P.L.557, No.44), are amended and the section is amended by adding a definition to read:~~

~~Section 801-E. 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:~~

~~* * *~~

~~["Exempt hospital." A hospital that the Secretary of Public~~

~~Welfare has determined meets one of the following:~~

~~(1) Is excluded under 42 CFR 412.23(a), (b), (d) and (f) (relating to excluded hospitals: classifications) as of March 20, 2008, from reimbursement of certain Federal funds under the prospective payment system described by 42 CFR Pt. 412 (relating to prospective payment systems for inpatient hospital services).~~

~~(2) Is a Federal veterans' affairs hospital.~~

~~(3) Is part of an institution with State-related status as that term is defined in 22 Pa. Code § 31.2 (relating to definitions) and provides over 100,000 days of care to medical assistance patients annually.~~

~~(4) Provides care, including inpatient hospital services, to all patients free of charge.]~~

~~"General acute care hospital." A hospital other than [an exempt hospital.]~~ a hospital that the Secretary of Public Welfare has determined meets one of the following:

~~(1) Is excluded under 42 CFR 412.23(a), (b), (d), (e) and (f) (relating to excluded hospitals: Classifications) as of March 20, 2008, from reimbursement of certain Federal funds under the prospective payment system described by 42 CFR 412 (relating to prospective payment systems for inpatient hospital services).~~

~~(2) Is a Federal veterans' affairs hospital.~~

~~(3) Is a high volume Medicaid hospital.~~

~~(4) Provides care, including inpatient hospital services, to all patients free of charge.~~

~~"High volume Medicaid hospital." A hospital that the Secretary of Public Welfare has determined meets all of the following:~~

~~(1) Is a nonprofit hospital subsidiary of a State-related~~

institution as that term is defined in 62 Pa.C.S. § 103 (relating to definitions); and

(2) Provides more than 90,000 days of care to medical assistance patients annually.

* * *

Section 5. Sections 802-E, 804-E, 805-E, 807-E and 808-E of the act, added July 4, 2008 (P.L.557, No.44), are amended to read:

Section 802-E. Authorization.

(a) General rule.--In order to generate additional revenues for the purpose of assuring that medical assistance recipients have access to hospital services and that all citizens have access to emergency department services, and subject to the conditions and requirements specified under this article, a municipality may, by ordinance, [impose] do the following:

(1) Impose a monetary assessment on the net operating revenue reduced by all revenues received from Medicare of each general acute care hospital located in the municipality [subject to the conditions and requirements specified under this article].

(2) Beginning on or after July 1, 2009, and subject to the advance written approval by the secretary, impose a monetary assessment on the net operating revenues reduced by all revenues received from Medicare of each high volume Medicaid hospital located in the municipality.

(b) Administrative provisions.--The [ordinance] ordinances adopted pursuant to subsection (a) may include appropriate administrative provisions including, without limitation, provisions for the collection of interest and penalties.

(c) Maximum assessment.--In each year in which the

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

~~Section 804-E. Administration.~~

~~(a) Remittance.--Upon collection of the funds generated by the assessment authorized under this article, the municipality shall remit a portion of the funds to the Commonwealth for the purposes set forth under section 802-E, except that the municipality may retain funds in an amount necessary to reimburse it for its reasonable costs in the administration and collection of the assessment~~ and to fund a portion of its costs of operating public health clinics ~~as set forth in an agreement to be entered into between the municipality and the Commonwealth acting through the secretary.~~

~~(b) Establishment.--There is established a restricted account in the General Fund for the receipt and deposit of funds under subsection (a). Funds in the account are hereby appropriated to the department for purposes of making supplemental or increased medical assistance payments for emergency department services to general acute care hospitals within the municipality and to maintain or increase other medical assistance payments to hospitals within the municipality, as specified in the Commonwealth's approved Title XIX State Plan.~~

~~Section 805-E. No hold harmless.~~

~~No general acute care hospital~~ or high volume Medicaid hospital ~~shall be directly guaranteed a repayment of its assessment in derogation of 42 CFR 433.68(f) (relating to permissible health care-related taxes), except that, in each~~

~~fiscal year in which an assessment is implemented, the department shall use a portion of the funds received under section 804-E(a) for the purposes outlined under section 804-E(b) to the extent permissible under Federal and State law or regulation and without creating an indirect guarantee to hold harmless, as those terms are used under 42 CFR 433.68(f)(i). The secretary shall submit any State Medicaid plan amendments to the United States Department of Health and Human Services that are necessary to make the payments authorized under section 804-E(b).~~

~~Section 807-E. Tax exemption.~~

~~Notwithstanding any exemptions granted by any other Federal, State or local tax or other law, including section 204(a)(3) of the act of May 22, 1933 (P.L.853, No.155), known as The General County Assessment Law, no general acute care hospital~~ or high-volume Medicaid hospital ~~in the municipality shall be exempt from the assessment.~~

~~Section 808-E. [Cessation]~~ Time period.

~~(a) Cessation.--The assessment authorized under this article shall cease June 30, 2013.~~

~~(b) Assessment.--A municipality shall have the power to enact the assessment authorized in section 802-E(a)(2) either prior to or during its fiscal year ending June 30, 2010.~~

~~Section 6. This act shall take effect immediately.~~

SECTION 1. SECTION 215 OF THE ACT OF JUNE 13, 1967 (P.L.31, NO.21), KNOWN AS THE PUBLIC WELFARE CODE, ADDED DECEMBER 17, 2009 (P.L.598, NO.54), IS AMENDED TO READ:

SECTION 215. DETERMINING WHETHER APPLICANTS ARE VETERANS.--(A) THE DEPARTMENT SHALL MAKE A GOOD FAITH EFFORT TO DETERMINE WHETHER AN APPLICANT FOR CASH, MEDICAL OR ENERGY ASSISTANCE IS A

VETERAN. WHILE IN THE PROCESS OF MAKING ITS DETERMINATION, THE DEPARTMENT SHALL DISPENSE BENEFITS TO THE APPLICANT, IF OTHERWISE ELIGIBLE.

(B) AS A CONDITION OF ELIGIBILITY TO RECEIVE CASH, MEDICAL OR ENERGY ASSISTANCE, UNLESS THERE IS GOOD CAUSE NOT TO DO SO, AN APPLICANT WHO IS A VETERAN SHALL BE REQUIRED TO CONTACT A VETERAN SERVICE OFFICER ACCREDITED AND RECOGNIZED BY THE UNITED STATES DEPARTMENT OF VETERANS AFFAIRS, THE DEPARTMENT OF MILITARY AND VETERANS AFFAIRS OR THE COUNTY DIRECTOR OF VETERANS AFFAIRS IN WHICH THE APPLICANT RESIDES IN ORDER TO DETERMINE THE APPLICANT'S ELIGIBILITY FOR VETERAN'S BENEFITS OR TO FILE A VETERAN CLAIMS PACKET. THE DEPARTMENT SHALL DEVELOP A STANDARD FORM TO BE USED BY A VETERAN SERVICE OFFICER TO VERIFY THE APPLICANT'S ELIGIBILITY FOR VETERAN'S BENEFITS <u>AND MAKE THIS FORM AVAILABLE ON ITS OFFICIAL WEBSITE</u>.

(C) AN APPLICANT WHO IS A VETERAN SHALL PROVIDE PROOF OF COMPLIANCE WITH THIS SECTION AND THE DEPARTMENT SHALL, TO THE GREATEST EXTENT POSSIBLE, REQUIRE THE APPLICANT TO PROVIDE INFORMATION ON THE FINAL DETERMINATION OF ELIGIBILITY FOR VETERAN'S BENEFITS AND THE TYPE OF BENEFITS THE VETERAN IS ENTITLED TO RECEIVE.

(D) AS USED IN THIS SECTION, THE FOLLOWING WORDS AND PHRASES SHALL HAVE THE FOLLOWING MEANINGS:

"ASSISTANCE" MEANS MONEY, SERVICES AND PAYMENT FOR MEDICAL COVERAGE OR ENERGY ASSISTANCE FOR NEEDY PERSONS WHO ARE RESIDENTS OF THIS COMMONWEALTH, ARE IN NEED OF ASSISTANCE AND MEET ALL CONDITIONS OF ELIGIBILITY.

"VETERAN CLAIMS PACKET" MEANS AN APPLICATION REQUESTING A DETERMINATION OR ENTITLEMENT OR EVIDENCING A BELIEF IN ENTITLEMENT TO A BENEFIT AS PROVIDED FOR IN 38 CFR (RELATING TO

PENSIONS, BONUSES, AND VETERANS' RELIEF) OR 51 PA.C.S. (RELATING TO MILITARY AFFAIRS).

SECTION 2. SECTION 443.1 INTRODUCTORY PARAGRAPH AND (1) OF THE ACT, AMENDED JUNE 30, 2007 (P.L.49, NO.16), ARE AMENDED AND THE SECTION IS AMENDED BY ADDING PARAGRAPHS TO READ:

SECTION 443.1. MEDICAL ASSISTANCE PAYMENTS FOR INSTITUTIONAL CARE.--THE FOLLOWING MEDICAL ASSISTANCE PAYMENTS SHALL BE MADE [IN] ON BEHALF OF ELIGIBLE PERSONS WHOSE INSTITUTIONAL CARE IS PRESCRIBED BY PHYSICIANS:

(1) PAYMENTS AS DETERMINED BY THE DEPARTMENT FOR INPATIENT HOSPITAL CARE CONSISTENT WITH TITLE XIX OF THE SOCIAL SECURITY ACT (49 STAT. 620, 42 U.S.C. § 1396 ET SEQ.). TO BE ELIGIBLE FOR SUCH PAYMENTS, A HOSPITAL MUST BE QUALIFIED TO PARTICIPATE UNDER TITLE XIX OF THE SOCIAL SECURITY ACT AND HAVE ENTERED INTO A WRITTEN AGREEMENT WITH THE DEPARTMENT REGARDING MATTERS DESIGNATED BY THE SECRETARY AS NECESSARY TO EFFICIENT ADMINISTRATION, SUCH AS HOSPITAL UTILIZATION, MAINTENANCE OF PROPER COST ACCOUNTING RECORDS AND ACCESS TO PATIENTS' RECORDS. SUCH EFFICIENT ADMINISTRATION SHALL REQUIRE THE DEPARTMENT TO PERMIT PARTICIPATING HOSPITALS TO UTILIZE THE SAME FISCAL INTERMEDIARY FOR THIS TITLE XIX PROGRAM AS SUCH HOSPITALS USE FOR THE TITLE XVIII PROGRAM[;].

(1.1) SUBJECT TO SECTION 813-G, FOR INPATIENT ACUTE CARE HOSPITAL SERVICES PROVIDED DURING A FISCAL YEAR IN WHICH AN ASSESSMENT IS IMPOSED UNDER ARTICLE VIII-G, PAYMENTS UNDER THE MEDICAL ASSISTANCE FEE-FOR-SERVICE PROGRAM SHALL BE DETERMINED IN ACCORDANCE WITH THE DEPARTMENT'S REGULATIONS, EXCEPT AS FOLLOWS:

(I) IF THE COMMONWEALTH'S APPROVED TITLE XIX STATE PLAN FOR INPATIENT HOSPITAL SERVICES IN EFFECT FOR THE PERIOD OF JULY 1,

2010, THROUGH JUNE 30, 2013, SPECIFIES A METHODOLOGY FOR CALCULATING PAYMENTS THAT IS DIFFERENT FROM THE DEPARTMENT'S REGULATIONS OR AUTHORIZES ADDITIONAL PAYMENTS NOT SPECIFIED IN THE DEPARTMENT'S REGULATIONS, SUCH AS INPATIENT DISPROPORTIONATE SHARE PAYMENTS AND DIRECT MEDICAL EDUCATION PAYMENTS, THE DEPARTMENT SHALL FOLLOW THE METHODOLOGY OR MAKE THE ADDITIONAL PAYMENTS AS SPECIFIED IN THE APPROVED TITLE XIX STATE PLAN.

(II) SUBJECT TO FEDERAL APPROVAL OF AN AMENDMENT TO THE COMMONWEALTH'S APPROVED TITLE XIX STATE PLAN, IN MAKING MEDICAL ASSISTANCE FEE-FOR-SERVICE PAYMENTS TO ACUTE CARE HOSPITALS FOR INPATIENT SERVICES PROVIDED ON OR AFTER JULY 1, 2010, THE DEPARTMENT SHALL USE PAYMENT METHODS AND STANDARDS THAT PROVIDE FOR ALL OF THE FOLLOWING:

(A) USE OF THE ALL PATIENT REFINED-DIAGNOSIS RELATED GROUP (APR/DRG) SYSTEM FOR THE CLASSIFICATION OF INPATIENT STAYS INTO DRGS.

(B) CALCULATION OF BASE DRG RATES BASED UPON A STATEWIDE AVERAGE COST WHICH ARE ADJUSTED TO ACCOUNT FOR A HOSPITAL'S REGIONAL LABOR COSTS, TEACHING STATUS, CAPITAL AND MEDICAL ASSISTANCE PATIENT LEVELS AND SUCH OTHER FACTORS AS THE DEPARTMENT DETERMINES MAY SIGNIFICANTLY IMPACT THE COSTS THAT A HOSPITAL INCURS IN DELIVERING INPATIENT SERVICES AND WHICH MAY BE ADJUSTED BASED ON THE ASSESSMENT REVENUE COLLECTED UNDER ARTICLE VIII-G.

(C) ADJUSTMENTS TO PAYMENTS FOR OUTLIER CASES WHERE THE COSTS OF THE INPATIENT STAYS EXCEED COST THRESHOLDS ESTABLISHED BY THE DEPARTMENT.

(III) NOTWITHSTANDING SUBPARAGRAPH (I), THE DEPARTMENT MAY MAKE ADDITIONAL CHANGES TO ITS PAYMENT METHODS AND STANDARDS FOR INPATIENT HOSPITAL SERVICES CONSISTENT WITH TITLE XIX OF THE

SOCIAL SECURITY ACT, INCLUDING CHANGES TO SUPPLEMENTAL PAYMENTS CURRENTLY AUTHORIZED IN THE STATE PLAN BASED ON THE AVAILABILITY OF FEDERAL AND STATE FUNDS.

(1.2) SUBJECT TO SECTION 813-G, FOR INPATIENT ACUTE CARE HOSPITAL SERVICES PROVIDED UNDER THE PHYSICAL HEALTH MEDICAL ASSISTANCE MANAGED CARE PROGRAM DURING A FISCAL YEAR IN WHICH AN ASSESSMENT IS IMPOSED UNDER ARTICLE XIII-G, THE FOLLOWING SHALL APPLY:

(I) FOR INPATIENT HOSPITAL SERVICES PROVIDED UNDER A PARTICIPATION AGREEMENT BETWEEN AN INPATIENT ACUTE CARE HOSPITAL AND A MEDICAL ASSISTANCE MANAGED CARE ORGANIZATION IN EFFECT AS OF JUNE 30, 2010, THE MEDICAL ASSISTANCE MANAGED CARE ORGANIZATION SHALL PAY, AND THE HOSPITAL SHALL ACCEPT AS PAYMENT IN FULL, AMOUNTS DETERMINED IN ACCORDANCE WITH THE PAYMENT TERMS AND RATE METHODOLOGY SPECIFIED IN THE AGREEMENT AND IN EFFECT AS OF JUNE 30, 2010, DURING THE TERM OF THAT PARTICIPATION AGREEMENT. IF A PARTICIPATION AGREEMENT IN EFFECT AS OF JUNE 30, 2010, USES THE DEPARTMENT FEE FOR SERVICE DRG RATE METHODOLOGY IN DETERMINING PAYMENT AMOUNTS, THE MEDICAL ASSISTANCE MANAGED CARE ORGANIZATION SHALL PAY, AND THE HOSPITAL SHALL ACCEPT AS PAYMENT IN FULL, AMOUNTS DETERMINED IN ACCORDANCE WITH THE FEE FOR SERVICE PAYMENT METHODOLOGY IN EFFECT AS OF JUNE 30, 2010, INCLUDING, WITHOUT LIMITATION, CONTINUATION OF THE SAME GROUPER, OUTLIER METHODOLOGY, BASE RATES AND RELATIVE WEIGHTS, DURING THE TERM OF THAT PARTICIPATION AGREEMENT.

(II) NOTHING IN SUBPARAGRAPH (I) SHALL PROHIBIT PAYMENT RATES FOR INPATIENT ACUTE CARE HOSPITAL SERVICES PROVIDED UNDER A PARTICIPATION AGREEMENT TO CHANGE FROM THE RATES IN EFFECT AS OF JUNE 30, 2010, IF THE CHANGE IN PAYMENT RATES IS AUTHORIZED BY THE TERMS OF THE PARTICIPATION AGREEMENT BETWEEN THE

INPATIENT ACUTE CARE HOSPITAL AND THE MEDICAL ASSISTANCE MANAGED CARE ORGANIZATION. FOR PURPOSES OF THIS ACT, ANY CONTRACT PROVISION THAT PROVIDES THAT PAYMENT RATES AND CHANGES TO PAYMENT RATES SHALL BE CALCULATED BASED UPON THE DEPARTMENT'S FEE FOR SERVICE DRG PAYMENT METHODOLOGY SHALL BE INTERPRETED TO MEAN THE DEPARTMENT'S FEE FOR SERVICE MEDICAL ASSISTANCE DRG METHODOLOGY IN PLACE ON JUNE 30, 2010.

(III) IF A PARTICIPATION AGREEMENT BETWEEN A HOSPITAL AND A MEDICAL ASSISTANCE MANAGED CARE ORGANIZATION TERMINATES DURING A FISCAL YEAR IN WHICH AN ASSESSMENT IS IMPOSED UNDER ARTICLE VIII-G PRIOR TO THE EXPIRATION OF THE TERM OF THE PARTICIPATION AGREEMENT, PAYMENT FOR SERVICES, OTHER THAN EMERGENCY SERVICES, COVERED BY THE MEDICAL ASSISTANCE MANAGED CARE ORGANIZATION AND RENDERED BY THE HOSPITAL SHALL BE MADE AT THE RATE IN EFFECT AS OF THE TERMINATION DATE, AS ADJUSTED IN ACCORDANCE WITH SUBPARAGRAPHS (I) AND (II), DURING THE PERIOD IN WHICH THE PARTICIPATION AGREEMENT WOULD HAVE BEEN IN EFFECT HAD THE AGREEMENT NOT TERMINATED. THE HOSPITAL SHALL RECEIVE THE SUPPLEMENTAL PAYMENT IN ACCORDANCE WITH SUBPARAGRAPH (V).

(IV) IF A HOSPITAL AND A MEDICAL ASSISTANCE MANAGED CARE ORGANIZATION DO NOT HAVE A PARTICIPATION AGREEMENT IN EFFECT AS JUNE 30, 2010, THE MEDICAL ASSISTANCE MANAGED CARE ORGANIZATION SHALL PAY, AND THE HOSPITAL SHALL ACCEPT AS PAYMENT IN FULL FOR SERVICES, OTHER THAN EMERGENCY SERVICES, COVERED BY THE MEDICAL ASSISTANCE MANAGED CARE ORGANIZATION AND RENDERED DURING A FISCAL YEAR IN WHICH AN ASSESSMENT IS IMPOSED UNDER ARTICLE XIII-G AN AMOUNT EQUAL TO THE RATES PAYABLE FOR THE SERVICES BY THE MEDICAL ASSISTANCE FEE FOR SERVICE PROGRAM AS OF JUNE 30, 2010. THE HOSPITAL SHALL RECEIVE THE SUPPLEMENTAL PAYMENT IN ACCORDANCE WITH SUBPARAGRAPH (V).

(V) THE DEPARTMENT SHALL MAKE ENHANCED CAPITATION PAYMENTS TO MEDICAL ASSISTANCE MANAGED CARE ORGANIZATIONS EXCLUSIVELY FOR THE PURPOSE OF MAKING SUPPLEMENTAL PAYMENTS TO HOSPITALS IN ORDER TO PROMOTE CONTINUED ACCESS TO QUALITY CARE FOR MEDICAL ASSISTANCE RECIPIENTS. MEDICAL ASSISTANCE MANAGED CARE ORGANIZATIONS SHALL USE THE ENHANCED CAPITATION PAYMENTS RECEIVED PURSUANT TO THIS SECTION SOLELY FOR THE PURPOSE OF MAKING SUPPLEMENTAL PAYMENTS TO HOSPITALS AND SHALL PROVIDE DOCUMENTATION TO THE DEPARTMENT CERTIFYING THAT ALL FUNDS RECEIVED IN THIS MANNER ARE USED IN ACCORDANCE WITH THIS SECTION. THE SUPPLEMENTAL PAYMENTS TO HOSPITALS MADE PURSUANT TO THIS SUBSECTION ARE IN LIEU OF INCREASED OR ADDITIONAL PAYMENTS FOR INPATIENT ACUTE CARE SERVICES FROM MEDICAL ASSISTANCE MANAGED CARE ORGANIZATIONS RESULTING FROM THE DEPARTMENT'S IMPLEMENTATION OF PAYMENTS UNDER PARAGRAPH (1.1)(II). MEDICAL ASSISTANCE MANAGED CARE ORGANIZATIONS SHALL IN NO EVENT BE OBLIGATED UNDER THIS SECTION TO MAKE SUPPLEMENTAL OR OTHER ADDITIONAL PAYMENTS TO HOSPITALS THAT EXCEED THE ENHANCED CAPITATION PAYMENTS MADE TO THE MEDICAL ASSISTANCE MANAGED CARE ORGANIZATION UNDER THIS SECTION. MEDICAL ASSISTANCE MANAGED CARE ORGANIZATIONS SHALL NOT BE REQUIRED TO ADVANCE THE SUPPLEMENTAL PAYMENTS TO HOSPITALS AUTHORIZED BY THIS SUBSECTION AND SHALL ONLY MAKE THE SUPPLEMENTAL PAYMENTS TO HOSPITALS ONCE MEDICAL ASSISTANCE MANAGED CARE ORGANIZATIONS HAVE RECEIVED THE ENHANCED CAPITATION PAYMENTS FROM THE DEPARTMENT.

(VI) NOTHING IN THIS SUBSECTION SHALL PROHIBIT AN INPATIENT ACUTE CARE HOSPITAL AND A MEDICAL ASSISTANCE MANAGED CARE ORGANIZATION FROM EXECUTING A NEW PARTICIPATION AGREEMENT OR AMENDING AN EXISTING PARTICIPATION AGREEMENT ON OR AFTER JULY 1, 2010, IN WHICH THEY AGREE TO PAYMENT TERMS THAT WOULD RESULT IN

PAYMENTS THAT ARE DIFFERENT THAN THE PAYMENTS DETERMINED IN ACCORDANCE WITH SUBPARAGRAPHS (I), (II), (III) AND (IV).

(VII) AS USED IN THIS PARAGRAPH, THE TERM "MEDICAL ASSISTANCE MANAGED CARE ORGANIZATION" MEANS A MEDICAID MANAGED CARE ORGANIZATION AS DEFINED IN SECTION 1903(M)(1)(A) OF THE SOCIAL SECURITY ACT (49 STAT. 620, 42 U.S.C. § 1396B(M)(1)(A)) THAT IS A PARTY TO A MEDICAID MANAGED CARE CONTRACT WITH THE DEPARTMENT, OTHER THAN A BEHAVIORAL HEALTH MANAGED CARE ORGANIZATION THAT IS A PARTY TO A MEDICAL ASSISTANCE MANAGED CARE CONTRACT WITH THE DEPARTMENT.

* * *

SECTION 3. THE ACT IS AMENDED BY ADDING AN ARTICLE TO READ:

ARTICLE VIII-G

STATEWIDE QUALITY CARE ASSESSMENT

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:

"ASSESSMENT." THE FEE, KNOWN AS THE QUALITY CARE ASSESSMENT, AUTHORIZED TO BE IMPLEMENTED UNDER THIS ARTICLE ON EVERY COVERED HOSPITAL.

"BAD DEBT EXPENSE." THE COST OF CARE FOR WHICH A HOSPITAL EXPECTED PAYMENT FROM THE PATIENT OR A THIRD-PARTY PAYER, BUT WHICH THE HOSPITAL SUBSEQUENTLY DETERMINES TO BE UNCOLLECTIBLE, AS FURTHER DESCRIBED IN THE MEDICARE PROVIDER REIMBURSEMENT MANUAL PUBLISHED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

"CHARITY CARE EXPENSE." THE COST OF CARE FOR WHICH A HOSPITAL ORDINARILY CHARGES A FEE BUT WHICH IS PROVIDED FREE OR AT A REDUCED RATE TO PATIENTS WHO CANNOT AFFORD TO PAY BUT WHO

ARE NOT ELIGIBLE FOR PUBLIC PROGRAMS, AND FROM WHOM THE HOSPITAL DID NOT EXPECT PAYMENT IN ACCORDANCE WITH THE HOSPITAL'S CHARITY CARE POLICY, AS FURTHER DESCRIBED IN THE MEDICARE PROVIDER REIMBURSEMENT MANUAL PUBLISHED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

"CONTRACTUAL ALLOWANCE." THE DIFFERENCE BETWEEN WHAT A HOSPITAL CHARGES FOR SERVICES AND THE AMOUNTS THAT CERTAIN PAYERS HAVE AGREED TO PAY FOR THE SERVICES AS FURTHER DESCRIBED IN THE MEDICARE PROVIDER REIMBURSEMENT MANUAL PUBLISHED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

"COVERED HOSPITAL." A HOSPITAL OTHER THAN AN EXEMPT HOSPITAL.

"CRITICAL ACCESS HOSPITAL." ANY HOSPITAL THAT HAS QUALIFIED UNDER SECTION 1861(MM)(1) OF THE SOCIAL SECURITY ACT (49 STAT. 620, 42 U.S.C. § 1395X(MM)(1)) AS A CRITICAL ACCESS HOSPITAL UNDER MEDICARE.

"EXEMPT HOSPITAL." ANY OF THE FOLLOWING:

(1) A FEDERAL VETERANS' AFFAIRS HOSPITAL.

(2) A HOSPITAL THAT PROVIDES CARE, INCLUDING INPATIENT HOSPITAL SERVICES, TO ALL PATIENTS FREE OF CHARGE.

(3) A PRIVATE PSYCHIATRIC HOSPITAL.

(4) A STATE-OWNED PSYCHIATRIC HOSPITAL.

(5) A CRITICAL ACCESS HOSPITAL.

(6) A LONG-TERM ACUTE CARE HOSPITAL.

"HOSPITAL." A FACILITY LICENSED AS A HOSPITAL UNDER 28 PA.CODE PT. IV SUBPT. B (RELATING TO GENERAL AND SPECIAL HOSPITALS).

"LONG-TERM ACUTE CARE HOSPITAL." A HOSPITAL OR UNIT OF A HOSPITAL WHOSE PATIENTS HAVE A LENGTH OF STAY OF GREATER THAN 25 DAYS, AND THAT PROVIDE SPECIALIZED ACUTE CARE OF MEDICALLY COMPLEX PATIENTS WHO ARE CRITICALLY ILL.

"MEDICAL ASSISTANCE MANAGED CARE ORGANIZATION." A MEDICAID MANAGED CARE ORGANIZATION AS DEFINED IN SECTION 1903(M)(1)(A) OF THE SOCIAL SECURITY ACT (49 STAT. 620, 42 U.S.C. § 1396B(M)(1)(A)) THAT IS A PARTY TO A MEDICAID MANAGED CARE CONTRACT WITH THE DEPARTMENT. THE TERM SHALL NOT INCLUDE A BEHAVIORAL HEALTH MANAGED CARE ORGANIZATION THAT IS A PARTY TO A MEDICAID MANAGED CARE CONTRACT WITH THE DEPARTMENT.

"NET INPATIENT REVENUE." GROSS CHARGES FOR FACILITIES FOR INPATIENT SERVICES LESS ANY DEDUCTED AMOUNTS FOR BAD DEBT EXPENSE, CHARITY CARE EXPENSE AND CONTRACTUAL ALLOWANCES AS REPORTED ON THE MEDICARE COST REPORT FOR FEDERAL FISCAL YEAR 2008 OR TO THE PENNSYLVANIA HEALTH CARE COST CONTAINMENT COUNCIL FOR FEDERAL FISCAL YEAR 2008, IF THE MEDICARE COST REPORT IS NOT AVAILABLE, AND VALIDATED BY THE DEPARTMENT.

"PROGRAM." THE COMMONWEALTH'S MEDICAL ASSISTANCE PROGRAM AS AUTHORIZED UNDER ARTICLE IV.

SECTION 802-G. AUTHORIZATION.

IN ORDER TO GENERATE ADDITIONAL REVENUES FOR THE PURPOSE OF ASSURING THAT MEDICAL ASSISTANCE RECIPIENTS HAVE ACCESS TO HOSPITAL SERVICES, THE DEPARTMENT SHALL IMPLEMENT A MONETARY ASSESSMENT, KNOWN AS THE QUALITY CARE ASSESSMENT, ON EACH COVERED HOSPITAL SUBJECT TO THE CONDITIONS AND REQUIREMENTS SPECIFIED IN THIS ARTICLE, INCLUDING SECTION 813-G.

SECTION 803-G. IMPLEMENTATION.

(A) HEALTH CARE-RELATED FEE.--THE ASSESSMENT AUTHORIZED UNDER THIS ARTICLE, ONCE IMPOSED, SHALL BE IMPLEMENTED AS A HEALTH CARE-RELATED FEE AS DEFINED UNDER SECTION 1903(W)(3)(B) OF THE SOCIAL SECURITY ACT (49 STAT. 620, 42 U.S.C. § 1396B(W)(3)(B)) OR ANY AMENDMENTS THERETO AND MAY BE COLLECTED ONLY TO THE EXTENT AND FOR THE PERIODS THAT THE SECRETARY DETERMINES

THAT REVENUES GENERATED BY THE ASSESSMENT WILL QUALIFY AS THE STATE SHARE OF PROGRAM EXPENDITURES ELIGIBLE FOR FEDERAL FINANCIAL PARTICIPATION.

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

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

(2) FOR FISCAL YEARS 2011-2012 AND 2012-2013, AN AMOUNT EQUAL TO 2.84% OF THE NET INPATIENT REVENUE OF THE COVERED HOSPITAL.

(C) ADJUSTMENTS TO ASSESSMENT PERCENTAGE.--THE SECRETARY MAY ADJUST THE ASSESSMENT PERCENTAGE SPECIFIED IN SUBSECTION (B)(2), SUBJECT TO THE FOLLOWING:

(1) BEFORE ADJUSTING, THE SECRETARY SHALL PUBLISH A NOTICE IN THE PENNSYLVANIA BULLETIN THAT SPECIFIES THE PROPOSED ASSESSMENT PERCENTAGE AND IDENTIFIES THE AGGREGATE IMPACT ON COVERED HOSPITALS SUBJECT TO THE ASSESSMENT. INTERESTED PARTIES SHALL HAVE 30 DAYS IN WHICH TO SUBMIT COMMENTS TO THE SECRETARY. UPON EXPIRATION OF THE 30-DAY COMMENT PERIOD, THE SECRETARY, AFTER CONSIDERATION OF THE COMMENTS, SHALL PUBLISH A SECOND NOTICE IN THE PENNSYLVANIA BULLETIN ANNOUNCING THE ASSESSMENT PERCENTAGE.

(2) THE SECRETARY MAY NOT ADJUST THE ASSESSMENT PERCENTAGES TO EXCEED 2.95% OF THE NET INPATIENT REVENUE OF COVERED HOSPITALS.

(3) AN ADJUSTMENT IN THE ASSESSMENT PERCENTAGE SHALL BE APPROVED BY THE GOVERNOR.

(D) MAXIMUM AMOUNT.--IN EACH YEAR IN WHICH THE ASSESSMENT IS IMPLEMENTED, THE ASSESSMENT SHALL BE SUBJECT TO THE MAXIMUM

AGGREGATE AMOUNT THAT MAY BE ASSESSED UNDER 42 CFR 433.68(F)(3)(I) (RELATING TO PERMISSIBLE HEALTH CARE-RELATED TAXES) OR ANY OTHER MAXIMUM ESTABLISHED UNDER FEDERAL LAW.

(E) LIMITED REVIEW.--EXCEPT AS PERMITTED UNDER SECTION 810-G, THE SECRETARY'S DETERMINATION OF THE ASSESSMENT PERCENTAGE PURSUANT TO SUBSECTION (B) SHALL NOT BE SUBJECT TO ADMINISTRATIVE OR JUDICIAL REVIEW UNDER 2 PA.C.S. CHS. 5 SUBCH. A (RELATING TO PRACTICE AND PROCEDURE OF COMMONWEALTH AGENCIES) AND 7 SUBCH. A (RELATING TO JUDICIAL REVIEW OF COMMONWEALTH AGENCY ACTION), OR ANY OTHER PROVISION OF LAW; NOR SHALL ANY ASSESSMENTS IMPLEMENTED UNDER THIS ARTICLE OR FORMS OR REPORTS REQUIRED TO BE COMPLETED BY COVERED HOSPITALS PURSUANT TO THIS ARTICLE BE SUBJECT TO THE ACT OF JULY 31, 1968 (P.L.769, NO.240), REFERRED TO AS THE COMMONWEALTH DOCUMENTS LAW; THE ACT OF OCTOBER 15, 1980 (P.L.950, NO.164), KNOWN AS THE COMMONWEALTH ATTORNEYS ACT; AND THE ACT OF JUNE 25, 1982 (P.L.633, NO.181), KNOWN AS THE REGULATORY REVIEW ACT.

SECTION 804-G. ADMINISTRATION.

(A) CALCULATION AND NOTICE OF ASSESSMENT AMOUNT.--USING THE ASSESSMENT PERCENTAGE ESTABLISHED UNDER SECTION 803-G(B) AND COVERED HOSPITALS' NET INPATIENT REVENUE, THE DEPARTMENT SHALL CALCULATE AND NOTIFY EACH COVERED HOSPITAL OF THE ASSESSMENT AMOUNT OWED FOR THE FISCAL YEAR. NOTIFICATION PURSUANT TO THIS SUBSECTION MAY BE MADE IN WRITING OR ELECTRONICALLY AT THE DISCRETION OF THE DEPARTMENT.

(B) PAYMENT.--A COVERED HOSPITAL SHALL PAY THE ASSESSMENT AMOUNT DUE FOR A FISCAL YEAR IN FOUR QUARTERLY INSTALLMENTS. PAYMENT OF A QUARTERLY INSTALLMENT SHALL BE MADE ON OR BEFORE THE FIRST DAY OF THE SECOND MONTH OF THE QUARTER OR 30 DAYS FROM THE DATE OF THE NOTICE OF THE QUARTERLY ASSESSMENT AMOUNT,

WHICHEVER DAY IS LATER.

(C) RECORDS.--UPON REQUEST BY THE DEPARTMENT, A COVERED HOSPITAL SHALL FURNISH TO THE DEPARTMENT SUCH RECORDS AS THE DEPARTMENT MAY SPECIFY IN ORDER 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.

(A) ESTABLISHMENT.--THERE IS ESTABLISHED A RESTRICTED ACCOUNT, KNOWN AS THE QUALITY CARE ASSESSMENT ACCOUNT, IN THE GENERAL FUND FOR THE RECEIPT AND DEPOSIT OF REVENUES COLLECTED UNDER THIS ARTICLE. FUNDS IN THE ACCOUNT ARE APPROPRIATED TO THE DEPARTMENT FOR THE FOLLOWING:

(1) MAKING MEDICAL ASSISTANCE PAYMENTS TO HOSPITALS IN ACCORDANCE WITH SECTION 443.1(1.1) AND AS OTHERWISE SPECIFIED IN THE COMMONWEALTH'S APPROVED TITLE XIX STATE PLAN.

(2) MAKING ENHANCED CAPITATION PAYMENTS TO MEDICAL

ASSISTANCE MANAGED CARE ORGANIZATIONS FOR SUPPLEMENTAL PAYMENTS FOR INPATIENT HOSPITAL SERVICES IN ACCORDANCE WITH SECTION 443.1(1.2).

(3) ANY OTHER PURPOSE APPROVED BY THE SECRETARY.

(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 $59,000,000.

(3) FOR THE FIRST TWO YEARS OF THE ASSESSMENTS, THE AGGREGATE 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 TWO YEARS LESS $180,000,000.

(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 $51,500,000.

(5) THE AMOUNTS RETAINED BY THE DEPARTMENT SHALL BE USED FOR PURPOSES APPROVED BY THE SECRETARY UNDER SUBSECTION (A)(3).

(C) LAPSE.--FUNDS IN THE QUALITY CARE ASSESSMENT ACCOUNT SHALL NOT LAPSE TO THE GENERAL FUND AT THE END OF A FISCAL YEAR.

IF THIS ARTICLE EXPIRES, THE DEPARTMENT SHALL USE ANY REMAINING FUNDS FOR THE PURPOSES STATED IN THIS SECTION UNTIL THE FUNDS IN THE QUALITY CARE ASSESSMENT ACCOUNT ARE EXHAUSTED.

SECTION 806-G. NO HOLD HARMLESS.

NO COVERED HOSPITAL SHALL BE DIRECTLY GUARANTEED A REPAYMENT OF ITS ASSESSMENT IN DEROGATION OF 42 CFR 433.68(F) (RELATING TO PERMISSIBLE HEALTH CARE-RELATED TAXES), EXCEPT THAT, IN EACH FISCAL YEAR IN WHICH AN ASSESSMENT IS IMPLEMENTED, THE DEPARTMENT SHALL USE THE FUNDS RECEIVED UNDER THIS ARTICLE FOR THE PURPOSES OUTLINED UNDER SECTION 805-G TO THE EXTENT PERMISSIBLE UNDER FEDERAL AND STATE LAW OR REGULATION AND WITHOUT CREATING AN INDIRECT GUARANTEE TO HOLD HARMLESS, AS THOSE TERMS ARE USED UNDER 42 CFR 433.68(F)(I). THE SECRETARY SHALL SUBMIT TO THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES ANY STATE MEDICAID PLAN AMENDMENTS THAT ARE NECESSARY TO MAKE THE PAYMENTS AUTHORIZED UNDER SECTION 805-G.

SECTION 807-G. FEDERAL WAIVER.

TO THE EXTENT NECESSARY IN ORDER TO IMPLEMENT THIS ARTICLE, THE DEPARTMENT SHALL SEEK A WAIVER UNDER 42 CFR 433.68(E) (RELATING TO PERMISSIBLE HEALTH CARE-RELATED TAXES) FROM THE CENTERS FOR MEDICARE AND MEDICAID SERVICES OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES. THE DEPARTMENT SHALL NOT IMPLEMENT THE ASSESSMENT UNTIL APPROVAL OF THE WAIVER IS OBTAINED. UPON APPROVAL OF THE WAIVER, THE ASSESSMENT SHALL BE IMPLEMENTED RETROACTIVE TO THE FIRST DAY OF THE FISCAL YEAR TO WHICH THE WAIVER APPLIES.

SECTION 808-G. TAX EXEMPTION.

(A) GENERAL RULE.--NOTWITHSTANDING ANY EXEMPTIONS GRANTED BY ANY OTHER FEDERAL, STATE OR LOCAL TAX OR OTHER LAW, NO COVERED HOSPITAL OTHER THAN AN EXEMPT HOSPITAL SHALL BE EXEMPT FROM THE

ASSESSMENT.

(B) INTERPRETATION.--THE ASSESSMENT IMPOSED UNDER THIS ARTICLE SHALL BE RECOGNIZED BY THE COMMONWEALTH AS UNCOMPENSATED GOODS AND SERVICES UNDER THE ACT OF NOVEMBER 26, 1997 (P.L.508, NO.55), KNOWN AS THE INSTITUTIONS OF PURELY PUBLIC CHARITY ACT, AND SHALL BE CONSIDERED A COMMUNITY BENEFIT FOR PURPOSES OF ANY REQUIRED OR VOLUNTARY COMMUNITY BENEFIT REPORT FILED OR PREPARED BY A COVERED HOSPITAL.

SECTION 809-G. REMEDIES.

IN ADDITION TO ANY OTHER REMEDY PROVIDED BY LAW, THE DEPARTMENT MAY ENFORCE THIS ARTICLE BY IMPOSING ONE OR MORE OF THE FOLLOWING REMEDIES:

(1) WHEN A COVERED HOSPITAL FAILS TO PAY AN ASSESSMENT OR PENALTY IN THE AMOUNT OR ON THE DATE REQUIRED BY THIS ARTICLE, THE DEPARTMENT SHALL ADD INTEREST AT THE RATE PROVIDED IN SECTION 806 OF THE ACT OF APRIL 9, 1929 (P.L.343, NO.176), KNOWN AS THE FISCAL CODE, TO THE UNPAID AMOUNT OF THE ASSESSMENT OR PENALTY FROM THE DATE PRESCRIBED FOR ITS PAYMENT UNTIL THE DATE IT IS PAID.

(2) WHEN A COVERED HOSPITAL FAILS TO FILE A REPORT OR TO FURNISH RECORDS TO THE DEPARTMENT AS REQUIRED BY THIS ARTICLE, THE DEPARTMENT SHALL IMPOSE A PENALTY AGAINST THE COVERED HOSPITAL IN THE AMOUNT OF $1,000, PLUS AN ADDITIONAL AMOUNT OF $200 PER DAY FOR EACH ADDITIONAL DAY THAT THE FAILURE TO FILE THE REPORT OR FURNISH THE RECORDS CONTINUES.

(3) WHEN A COVERED HOSPITAL THAT IS A MEDICAL ASSISTANCE PROVIDER, OR THAT IS RELATED THROUGH COMMON OWNERSHIP OR CONTROL AS DEFINED IN 42 CFR 413.17(B) (RELATING TO COST TO RELATED ORGANIZATIONS) TO A MEDICAL ASSISTANCE PROVIDER, FAILS TO PAY ALL OR PART OF AN ASSESSMENT OR PENALTY WITHIN

60 DAYS OF THE DATE THAT PAYMENT IS DUE, THE DEPARTMENT MAY DEDUCT THE UNPAID ASSESSMENT OR PENALTY AND ANY INTEREST OWED THEREON FROM ANY MEDICAL ASSISTANCE PAYMENTS DUE TO THE COVERED HOSPITAL OR TO ANY RELATED MEDICAL ASSISTANCE PROVIDER UNTIL THE FULL AMOUNT IS RECOVERED. ANY SUCH DEDUCTION SHALL BE MADE ONLY AFTER WRITTEN NOTICE TO THE COVERED HOSPITAL AND MEDICAL ASSISTANCE PROVIDER AND MAY BE TAKEN IN INSTALLMENTS OVER A PERIOD OF TIME, TAKING INTO ACCOUNT THE FINANCIAL CONDITION OF THE MEDICAL ASSISTANCE PROVIDER.

(4) WITHIN 60 DAYS AFTER THE END OF EACH CALENDAR QUARTER, THE DEPARTMENT SHALL NOTIFY THE DEPARTMENT OF HEALTH OF ANY COVERED HOSPITAL THAT HAS ASSESSMENT, PENALTY OR INTEREST AMOUNTS THAT HAVE REMAINED UNPAID FOR 90 DAYS OR MORE. THE DEPARTMENT OF HEALTH SHALL NOT RENEW THE LICENSE OF ANY SUCH COVERED HOSPITAL UNTIL THE DEPARTMENT NOTIFIES THE DEPARTMENT OF HEALTH THAT THE COVERED HOSPITAL HAS PAID THE OUTSTANDING AMOUNT IN ITS ENTIRETY OR THAT THE DEPARTMENT HAS AGREED TO PERMIT THE COVERED HOSPITAL TO REPAY THE OUTSTANDING AMOUNT IN INSTALLMENTS AND THAT, TO DATE, THE COVERED HOSPITAL HAS PAID THE INSTALLMENTS IN THE AMOUNT AND BY THE DATE REQUIRED BY THE DEPARTMENT.

(5) THE SECRETARY MAY WAIVE ALL OR PART OF THE INTEREST OR PENALTIES ASSESSED AGAINST A COVERED HOSPITAL PURSUANT TO THIS ARTICLE FOR GOOD CAUSE AS SHOWN BY THE COVERED HOSPITAL.

SECTION 810-G. REQUEST FOR REVIEW.

A COVERED HOSPITAL THAT IS AGGRIEVED BY A DETERMINATION OF THE DEPARTMENT AS TO THE AMOUNT OF THE ASSESSMENT DUE FROM THE COVERED HOSPITAL OR A REMEDY IMPOSED PURSUANT TO SECTION 809-G MAY FILE A REQUEST FOR REVIEW OF THE DECISION OF THE DEPARTMENT

BY THE BUREAU OF HEARINGS AND APPEALS, WHICH SHALL HAVE EXCLUSIVE JURISDICTION IN SUCH MATTERS. THE PROCEDURES AND REQUIREMENTS OF 67 PA.C.S. CH. 11 (RELATING TO MEDICAL ASSISTANCE HEARINGS AND APPEALS) SHALL APPLY TO REQUESTS FOR REVIEW FILED PURSUANT TO THIS SECTION, EXCEPT THAT IN ANY SUCH REQUEST FOR REVIEW, A COVERED HOSPITAL MAY NOT CHALLENGE AN ASSESSMENT PERCENTAGE DETERMINED BY THE SECRETARY PURSUANT TO SECTION 803-G(B) BUT ONLY WHETHER THE DEPARTMENT CORRECTLY DETERMINED THE ASSESSMENT AMOUNT DUE FROM THE COVERED HOSPITAL USING THE ASSESSMENT PERCENTAGE IN EFFECT FOR THE FISCAL YEAR. A NOTICE OF REVIEW FILED PURSUANT TO THIS SECTION SHALL NOT OPERATE AS A STAY OF THE COVERED HOSPITAL'S OBLIGATION TO PAY THE ASSESSMENT AMOUNT DUE FOR A FISCAL YEAR AS SPECIFIED IN SECTION 804-G(B).

SECTION 811-G. LIENS.

ANY ASSESSMENTS IMPLEMENTED AND INTEREST AND PENALTIES ASSESSED AGAINST A COVERED HOSPITAL UNDER THIS ARTICLE SHALL BE A LIEN ON THE REAL AND PERSONAL PROPERTY OF THE COVERED HOSPITAL IN THE MANNER PROVIDED BY SECTION 1401 OF THE ACT OF APRIL 9, 1929 (P.L.343, NO.176), KNOWN AS THE FISCAL CODE, MAY BE ENTERED BY THE DEPARTMENT IN THE MANNER PROVIDED BY SECTION 1404 OF THE FISCAL CODE AND SHALL CONTINUE AND RETAIN PRIORITY IN THE MANNER PROVIDED IN SECTION 1404.1 OF THE FISCAL CODE.

SECTION 812-G. REGULATIONS.

THE DEPARTMENT MAY ISSUE SUCH REGULATIONS AND ORDERS AS MAY BE NECESSARY TO IMPLEMENT THE QUALITY CARE ASSESSMENT PROGRAM IN ACCORDANCE WITH THE REQUIREMENTS OF THIS ARTICLE.

SECTION 813-G. CONDITIONS FOR PAYMENTS.

THE DEPARTMENT AND THE MEDICAL ASSISTANCE MANAGED CARE ORGANIZATIONS SHALL NOT BE REQUIRED TO MAKE PAYMENTS AS

SPECIFIED IN SECTION 443.1(1.1) AND (1.2) AND A COVERED HOSPITAL SHALL NOT BE REQUIRED TO PAY THE QUALITY CARE ASSESSMENT AS SPECIFIED IN SECTION 804-G(B) UNLESS ALL OF THE FOLLOWING HAVE OCCURRED:

(1) THE DEPARTMENT RECEIVES FEDERAL APPROVAL OF A WAIVER UNDER 42 CFR 433.68(E) (RELATING TO PERMISSIBLE HEALTH CARE-RELATED TAXES), AUTHORIZING THE DEPARTMENT TO IMPLEMENT THE QUALITY CARE ASSESSMENT AS SPECIFIED IN THIS ARTICLE.

(2) THE DEPARTMENT RECEIVES FEDERAL APPROVAL OF A STATE PLAN AMENDMENT AUTHORIZING THE CHANGES TO ITS PAYMENT METHODS AND STANDARDS SPECIFIED IN § 443.1(1.1)(II).

(3) THE DEPARTMENT RECEIVES FEDERAL APPROVAL OF A WAIVER UNDER SECTION 1915(B) OF THE SOCIAL SECURITY ACT (49 STAT. 620, 42 U.S.C. § 1396N(B)) FOR THE HEALTHCHOICES PROGRAM AND AMENDMENTS TO ITS MEDICAL ASSISTANCE MANAGED CARE ORGANIZATION CONTRACTS AUTHORIZING SUPPLEMENTAL PAYMENTS FOR INPATIENT HOSPITAL SERVICES FUNDED IN ACCORDANCE WITH SECTION 805-G.

SECTION 814-G. REPORT.

NOT LATER THAN 180 DAYS PRIOR TO THE EXPIRATION DATE SPECIFIED IN SECTION 815-G, THE DEPARTMENT SHALL PREPARE AND SUBMIT A REPORT TO THE CHAIR AND MINORITY CHAIR OF THE PUBLIC HEALTH AND WELFARE COMMITTEE OF THE SENATE, THE CHAIR AND MINORITY CHAIR OF THE APPROPRIATIONS COMMITTEE OF THE SENATE, THE CHAIR AND MINORITY CHAIR OF THE HEALTH AND HUMAN SERVICES COMMITTEE OF THE HOUSE OF REPRESENTATIVES AND THE CHAIR AND MINORITY CHAIR OF THE APPROPRIATIONS COMMITTEE OF THE HOUSE OF REPRESENTATIVES. THE REPORT SHALL INCLUDE THE FOLLOWING:

(1) THE NAME, ADDRESS AND AMOUNT OF ASSESSMENT FOR EACH COVERED HOSPITAL SUBJECT TO THE QUALITY CARE ASSESSMENT.

(2) THE TOTAL AMOUNT OF ASSESSMENT REVENUE COLLECTED FOR EACH YEAR.

(3) THE AMOUNT OF ASSESSMENT PAID BY EACH COVERED HOSPITAL, INCLUDING ANY INTEREST AND PENALTIES PAID.

(4) THE NAME AND ADDRESS OF EACH HOSPITAL RECEIVING SUPPLEMENTAL PAYMENTS INSTITUTED AS A RESULT OF THE QUALITY CARE ASSESSMENT.

(5) THE PAYMENT AMOUNT AND TYPE OF SUPPLEMENTAL PAYMENT RECEIVED BY EACH HOSPITAL.

(6) THE TOTAL AMOUNT OF FEE-FOR-SERVICE INPATIENT ACUTE CARE PAYMENT MADE TO EACH HOSPITAL.

(7) THE NUMBER OF MEDICAL ASSISTANCE PATIENT DAYS AND DISCHARGES BY HOSPITAL.

(8) ANY PROPOSED CHANGES TO THE PAYMENT METHODOLOGIES AND STANDARDS.

SECTION 815-G. EXPIRATION.

THIS ARTICLE SHALL EXPIRE JUNE 30, 2013.

SECTION 816-G. RETROACTIVE APPLICABILITY.

THIS ARTICLE SHALL APPLY RETROACTIVELY TO JULY 1, 2010.

SECTION 4. THIS ACT SHALL TAKE EFFECT IMMEDIATELY.