

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1322 Session of
2015

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BLOOM, ENGLISH, MILLARD, KAUFFMAN, TOOHL, DIAMOND, TOEPEL,
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DeLUCA, BURNS, DUSH, ROAE AND MICCARELLI, JUNE 10, 2015

AMENDMENTS TO SENATE AMENDMENTS, HOUSE OF REPRESENTATIVES,
DECEMBER 14, 2015

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," as follows:

In public assistance:

establishing the Keystone Education Yields Success
Program; and

further providing for copayments for subsidized child
care, for identification and proof of residence, for
medical assistance payments for institutional care, for
other medical assistance payments, for mileage
reimbursement and paratransit services for individuals
receiving methadone treatment.

In children and youth:

further providing for payments to counties for
services to children, for provider submission and for
limits on reimbursement to counties.

Repealing provisions relating to Medicaid managed care
organization assessments.

In Statewide quality care assessment:

further providing for definitions, for
implementation, for administration, for restricted
account and for expiration.

Providing for managed care organization assessments.

In departmental powers and duties as to supervision:

1 further providing for definitions.

2 In departmental powers and duties as to licensing:
3 further providing for definitions, for fees, for
4 provisional license and for violation and penalty; and
5 repealing provisions relating to registration.

6 In family finding and kinship care:

7 further providing for definitions, for the Kinship
8 Care Program and for permanent legal custodianship
9 subsidy and reimbursement.

10 Making a related repeal.

11 Providing for the licensing of family child-care homes.

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

14 ~~Section 1. Section 101 of the act of June 13, 1967 (P.L.31, <--~~
15 ~~No.21), known as the Public Welfare Code, is amended to read:~~

16 ~~Section 101. Short Title. This act shall be known and may~~
17 ~~be cited as the ["Public Welfare Code."] "Human Services Code."~~

18 ~~Section 2. The act is amended by adding a section to read:~~

19 SECTION 1. THE ACT OF JUNE 30, 1967 (P.L.31, NO.21), KNOWN <--
20 AS THE PUBLIC WELFARE CODE, IS AMENDED BY ADDING A SECTION TO
21 READ:

22 Section 405.1B. Establishment of Keystone Education Yields
23 Success.--(a) There is established in the department a program
24 which shall be known as Keystone Education Yields Success
25 (KEYS). The KEYS program shall be designed to enable and to
26 assist eligible individuals receiving TANF or SNAP benefits to
27 enroll in and pursue a certificate or degree program within one
28 of the Commonwealth's community colleges, a career or technical
29 school registered with the Department of Education or university
30 within the Pennsylvania State System of Higher Education.

31 (b) A KEYS recipient shall be permitted to count vocational
32 education, including class time, clinicals, labs and study time
33 as set by the community college, university or school, toward
34 the recipient's core TANF work requirement for twenty-four

1 months.

2 (c) In accordance with KEYS and notwithstanding section
3 405.1, the following requirements shall apply:

4 (1) A recipient shall be enrolled in an approved degree or
5 certificate program that will assist the recipient in securing a
6 job that pays a family-sustaining wage.

7 (2) A KEYS recipient may be granted extensions for six-month
8 periods to complete the certificate or degree program, if:

9 (i) the recipient is enrolled in a program that will lead to
10 a high-priority occupation, as defined in section 1301 of the
11 act of December 18, 2001 (P.L.949, No.114), known as the
12 Workforce Development Act, or a program the community college
13 has certified meets the same criteria as a high-priority
14 occupation;

15 (ii) the recipient has maintained a 2.0 grade point average;
16 and

17 (iii) the recipient has made satisfactory progress toward
18 completing the program, including, but not limited to,
19 completing all required developmental course work and
20 successfully completing an average of eight credits per
21 semester.

22 (d) A person who, without good cause, fails or refuses to
23 comply with the terms and conditions of the KEYS program shall
24 be terminated from the program.

25 (e) The department is authorized to promulgate regulations
26 to implement this section.

27 (f) The department shall implement this section in
28 conformity with Federal law.

29 (g) Nothing in this section shall create or provide an
30 individual with an entitlement to services or benefits. Services

1 under this section shall only be available to individuals
2 enrolled in the KEYS program to the extent that funds are
3 available.

4 SECTION 2. (RESERVED).

<--

5 Section 3. Section 408.3 of the act, added June 30, 2011
6 (P.L.89, No.22), is amended to read:

7 Section 408.3. Copayments for Subsidized Child Care.--(a)
8 Notwithstanding any other provision of law or departmental
9 regulation, the parent or caretaker of a child enrolled in
10 subsidized child care shall pay a copayment for the subsidized
11 child care based on a percentage of the family's annual income
12 as specified in a copayment schedule established by the
13 department pursuant to this section.

14 (b) The department shall publish a notice setting forth the
15 copayment schedule in the Pennsylvania Bulletin.

16 (c) In establishing the copayment amounts pursuant to this
17 section, all of the following shall apply:

18 (1) Copayments shall be [based upon] on a sliding [income]
19 scale based on a percentage of the family's annual income taking
20 into account Federal poverty income guidelines. Copayments shall
21 be updated annually.

22 (2) At the department's discretion, copayments may be
23 imposed:

24 (i) for each child enrolled in subsidized child care;
25 (ii) based upon family size; or
26 (iii) in accordance with both subparagraphs (i) and (ii).

27 (3) Copayment amounts shall be a minimum of five dollars
28 (\$5) per week and [may] shall increase in incremental amounts,
29 based on a percentage of the family's annual income, as
30 determined by the department [taking into account annual family

1 income].

2 (3.1) At initial application, the family's annual income may
3 not exceed two hundred percent of the Federal poverty income
4 guidelines.

5 (3.2) After an initial determination or redetermination of
6 eligibility, a child shall continue to be enrolled in subsidized
7 child care for twelve months regardless of either of the
8 following:

9 (i) A temporary change in the parent or caretaker's status
10 as working or attending a job training or educational program.

11 (ii) An increase in the family's annual income, if the
12 income does not exceed eighty-five percent of the State median
13 income for a family of the same size.

14 (4) [A] Subject to subsection (e), a family's annual
15 copayment under either paragraph (1) or (2) shall not exceed:

16 (i) eight percent of the family's annual income if the
17 family's annual income is one hundred percent of the Federal
18 poverty income guideline or less; [or]

19 (ii) eleven percent of the family's annual income if the
20 family's annual income exceeds one hundred percent of the
21 Federal poverty income guideline[.], but is not more than two
22 hundred fifty percent of the Federal poverty income guideline;

23 (iii) thirteen percent of the family's annual income if the
24 family's annual income exceeds two hundred fifty percent of the
25 Federal poverty income guideline, but is not more than two
26 hundred seventy-five percent of the Federal poverty income
27 guideline; or

28 (iv) beginning after July 1, 2017, fifteen percent of the
29 family's annual income if the family's annual income exceeds two
30 hundred seventy-five percent of the Federal poverty income

guideline, but is not more than three hundred percent of the
Federal poverty income guideline or eighty-five percent of the
State median income, whichever is lower.

(5) Notwithstanding this subsection, beginning with State
fiscal year 2012-2013, the department may adjust the annual
copayment percentages specified in this subsection by
promulgation of final-omitted regulations under section 204 of
the act of July 31, 1968 (P.L.769, No.240), referred to as the
"Commonwealth Documents Law."

(6) Subject to subsection (e), at a redetermination, after
June 30, 2017, a family that exceeds the minimum work
requirements as a result of each parent or caretaker or, in the
case of a single parent household, as a result of the sole
parent or caretaker, by working additional wage-earning hours
shall have a reduced copayment, not to be less than that which
is set forth under paragraph (3). This paragraph shall apply
only to a family that, after mutually qualifying for and
receiving subsidized child care and being current on the
required copayments as set forth in this subsection, increases
its average work week after the effective date of this paragraph
and has increased the family's annual income as a result of
working additional wage-earning hours. The copayment deduction
shall be applied as follows:

(i) For an average work week of at least twenty-five wage-
earning hours per parent or caretaker, a three-quarters of one
percent deduction from the amount set under this subsection.

(ii) For an average work week of at least thirty wage-
earning hours per parent or caretaker, a one and one-half
percent deduction from the amount set under this subsection.

(iii) For an average work week of at least thirty-five wage-

earning hours per parent or caretaker, a two and one-quarter percent deduction from the amount set under this subsection.

(iv) For an average work week of at least forty wage-earning hours per parent or caretaker, a three percent deduction from the amount set under this subsection.

(7) At its redetermination of eligibility, a parent or caretaker shall provide documentation of its average work week hours to receive the child care copayment deduction. The department shall apply the copayment deduction after receiving the required documentation.

(8) A family that has previously qualified for a deduction in the child care copayment shall continue to remain eligible for the copayment deduction if:

(i) the family's annual income does not exceed three hundred percent of the Federal poverty income guideline or eighty-five percent of the State median income, whichever is lower;

(ii) the parent or caretaker has been in compliance with paragraph (7);

(iii) the parent or caretaker continues to exceed the minimum work requirements by working additional wage-earning hours;

(iv) the family's annual income has increased as a result of working additional wage-earning hours; and

(v) the parent or caretaker is current and remains current with making its copayment to the child care provider.

(9) The average work week of a family shall be calculated by reviewing the family's income statements and taking the number of hours worked per parent over a twelve-month period and dividing by fifty-two.

(d) Notwithstanding subsection (a) or (c), a parent or

1 caretaker copayment may be [waived] adjusted in accordance with
2 department regulations.

3 (e) To the extent that money is appropriated for the
4 purpose, the department shall increase eligibility under
5 subsection (c)(4) for subsidized child care from two hundred
6 thirty-five percent of the Federal poverty income guideline up
7 to three hundred percent of the Federal poverty income guideline
8 and shall apply a copayment deduction under subsection (c)(6).
9 The department shall not be required to maintain eligibility
10 above two hundred thirty-five percent of the Federal poverty
11 income guideline or apply a copayment deduction unless funding
12 is appropriated by the General Assembly.

13 (f) As used in this section, "wage-earning hours" means
14 hours for which an individual is financially compensated by an
15 employer. The term does not include hours spent volunteering, in
16 education or in job training, unless those hours are compensated
17 as a condition of employment.

18 Section 4. Section 432.4 of the act, amended June 16, 1994
19 (P.L.319, No.49) and May 16, 1996 (P.L.175, No.35), is amended
20 to read:

21 Section 432.4. Identification and Proof of Residence.--(a)
22 All persons applying for assistance shall provide acceptable
23 identification and proof of residence[; the department shall by
24 regulations specify what constitutes acceptable identification
25 and proof of residence]. A person shall be deemed to be a
26 resident when he or she documents his or her residency and that
27 residency is verified by the department. Verification may
28 include, but is not limited to the production of rent receipts,
29 mortgage payment receipts, utility receipts, bank accounts or
30 enrollment of children in local schools. [General assistance] <--

1 ASSISTANCE applicants must establish that they have been
2 residents of the Commonwealth for at least twelve months
3 immediately preceding their application[.] and they are not
4 receiving assistance from any other state. ~~General assistance~~ <--
5 ASSISTANCE applicants shall disclose, in their application, all <--
6 states in which they have resided and in which they have
7 collected a form of public assistance in the last five years.
8 The provisions of this subsection shall not apply to [General <--
9 Assistance] ASSISTANCE applicants who can establish that they <--
10 moved to this Commonwealth to escape an abusive living
11 situation. The department shall adopt rules governing the proof
12 required to establish that the applicant has moved to this
13 Commonwealth to escape an abusive living situation.
14 (a.1) When a ~~general~~ AN assistance applicant provides <--
15 information that the applicant is receiving a form of public
16 assistance in another state, the department may not authorize
17 ~~general~~ assistance until it receives verification that the <--
18 public assistance is scheduled to close in the other state.
19 (b) For the purpose of determining eligibility for
20 assistance, the continued absence of a recipient from the
21 Commonwealth for a period of thirty days or longer shall be
22 prima facie evidence of the intent of the recipient to have
23 changed his residence to a place outside the Commonwealth.
24 (c) If a recipient is prevented by illness or other good
25 cause from returning to the Commonwealth at the end of thirty
26 days, and has not acted to establish residence elsewhere, he
27 shall not be deemed to have lost his residence in the
28 Commonwealth.
29 (d) When a recipient of aid to families with dependent
30 children or [general] assistance is absent from the United <--

1 States for a period in excess of thirty days, his aid shall
2 thereafter be suspended whenever need cannot be determined for
3 the ensuing period of his absence.

4 (e) Beginning no later than September 1, 1994, the
5 department shall collect information on all [general] assistance <--
6 applicants to determine how long they have been residents of
7 this Commonwealth. The department shall report its findings to
8 the Governor and the General Assembly no later than December 31,
9 1995. Based on its findings, the department may make
10 recommendations to the Governor and the General Assembly on
11 changes to the residency requirement for [general] assistance <--
12 recipients.

13 Section 5. Section 443.1(1.1) introductory paragraph and
14 (i), (1.4) and (6) of the act, amended June 30, 2007 (P.L.49,
15 No.16) and July 9, 2013 (P.L.369, No.55), are amended and
16 paragraph (7) is amended by adding a subparagraph to read:

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

21 * * *

22 (1.1) Subject to section 813-G, for inpatient [acute care]
23 hospital services provided during a fiscal year in which an
24 assessment is imposed under Article VIII-G, payments under the
25 medical assistance fee-for-service program shall be determined
26 in accordance with the department's regulations, except as
27 follows:

28 (i) If the Commonwealth's approved Title XIX State Plan for
29 inpatient hospital services in effect for the period of July 1,
30 2010, through June 30, [2016] 2018, specifies a methodology for

1 calculating payments that is different from the department's
2 regulations or authorizes additional payments not specified in
3 the department's regulations, such as inpatient disproportionate
4 share payments and direct medical education payments, the
5 department shall follow the methodology or make the additional
6 payments as specified in the approved Title XIX State Plan.

7 * * *

8 (1.4) Subject to section 813-G, for inpatient hospital
9 services provided under the physical health medical assistance
10 managed care program during State fiscal years 2012-2013, 2013-
11 2014, 2014-2015 [and], 2015-2016, 2016-2017 and 2017-2018, the
12 following shall apply:

13 (A) The department may adjust its capitation payments to
14 medical assistance managed care organizations to provide
15 additional funds for inpatient and outpatient hospital services.

16 (B) For an out-of-network inpatient discharge of a recipient
17 enrolled in a medical assistance managed care organization that
18 occurs in State fiscal year 2012-2013, 2013-2014, 2014-2015
19 [or], 2015-2016, 2016-2017 and 2017-2018, the medical assistance
20 managed care organization shall pay, and the hospital shall
21 accept as payment in full, the amount that the department's fee-
22 for-service program would have paid for the discharge if the
23 recipient was enrolled in the department's fee-for-service
24 program.

25 (C) Nothing in this paragraph shall prohibit an inpatient
26 acute care hospital and a medical assistance managed care
27 organization from executing a new participation agreement or
28 amending an existing participation agreement on or after July 1,
29 2013.

30 * * *

1 (6) For public nursing home care provided on or after July
2 1, 2005, the department [shall] may recognize the costs incurred
3 by county nursing facilities to provide services to eligible
4 persons as medical assistance program expenditures to the extent
5 the costs qualify for Federal matching funds and so long as the
6 costs are allowable as determined by the department and reported
7 and certified by the county nursing facilities in a form and
8 manner specified by the department. Expenditures reported and
9 certified by county nursing facilities shall be subject to
10 periodic review and verification by the department or the
11 Auditor General. Notwithstanding this paragraph, county nursing
12 facilities shall be paid based upon rates determined in
13 accordance with paragraphs (5) and (7).

14 (7) After June 30, 2007, payments to county and nonpublic
15 nursing facilities enrolled in the medical assistance program as
16 providers of nursing facility services shall be determined in
17 accordance with the methodologies for establishing payment rates
18 for county and nonpublic nursing facilities specified in the
19 department's regulations and the Commonwealth's approved Title
20 XIX State Plan for nursing facility services in effect after
21 June 30, 2007. The following shall apply:

22 * * *

23 (vi) Subject to Federal approval of such amendments as may
24 be necessary to the Commonwealth's approved Title XIX State
25 Plan, for fiscal year 2015-2016, the department shall make up to
26 four medical assistance day-one incentive payments to qualified
27 nonpublic nursing facilities. The department shall determine the
28 nonpublic nursing facilities that qualify for the medical
29 assistance day-one incentive payments and calculate the payments
30 using the total Pennsylvania medical assistance (PA MA) days and

total resident days as reported by nonpublic nursing facilities
under Article VIII-A. The department's determination and
calculations under this subparagraph shall be based on the
nursing facility assessment quarterly resident day reporting
forms, as determined by the department. The department shall not
retroactively revise a medical assistance day-one incentive
payment amount based on a nursing facility's late submission or
revision of the department's report after the dates designated
by the department. The department, however, may recoup payments
based on an audit of a nursing facility's report. The following
shall apply:

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

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

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

(III) The nursing facility shall be a nonpublic nursing

facility for a full resident day quarter prior to the applicable
quarterly reporting due dates, as determined by the department.

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

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

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

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

(C) For fiscal year 2015-2016, the State funds available for
the nonpublic nursing facility medical assistance day-one
incentive payments shall equal eight million dollars
(\$8,000,000).

Section 6. Section 443.3(a) of the act is amended by a
paragraph to read:

Section 443.3. Other Medical Assistance Payments.--(a)
Payments on behalf of eligible persons shall be made for other
services, as follows:

* * *

(1.1) Rates established by the department for observation
services provided by or furnished under the direction of a
physician and furnished by a hospital. Payment for observation

services shall be made in an amount specified by the department
by notice in the Pennsylvania Bulletin and shall be effective
for dates of service on or after July 1, 2016. Payment for
observation services shall be subject to conditions specified in
the department's regulations, including regulations adopted by
the department to implement this paragraph. Pending adoption of
regulations implementing this paragraph, the conditions for
payment of observation services shall be specified in a medical
assistance bulletin.

* * *

Section 7. Section 443.11(d) of the act, added December 22,
2011 (P.L.561, No.121), is amended to read:

Section 443.11. Mileage Reimbursement and Paratransit
Services for Individuals Receiving Methadone Treatment.--* * *

[(d) The department shall issue biennial reports to the
General Assembly and the Governor detailing costs and cost
savings related to implementing the provisions of this section.
The first biennial report shall be issued not later than one
year from the effective date of this section.]

Section 8. Section 472 of the act, amended July 7, 2005
(P.L.177, No.42), is amended to read:

Section 472. Other Computations Affecting Counties.--To
compute for each month the amount expended as medical assistance
for public nursing home care on behalf of persons at each public
medical institution operated by a county, county institution
district or municipality and the amount expended in each county
for aid to families with dependent children on behalf of
children in foster family homes or child-caring institutions,
plus the cost of administering such assistance. From such total
amount the department shall deduct the amount of Federal funds

1 properly received or to be received by the department on account
2 of such expenditures, and shall certify the remainder increased
3 or decreased, as the case may be, by any amount by which the sum
4 certified for any previous month differed from the amount which
5 should have been certified for such previous month, and by the
6 proportionate share of any refunds of such assistance, to each
7 appropriate county, county institution district or municipality.
8 The amounts so certified shall become obligations of such
9 counties, county institution districts or municipalities to be
10 paid to the department for assistance: Provided, however, That
11 for fiscal year 1979-80 and thereafter, the obligations of the
12 counties shall be the amounts so certified representing aid to
13 dependent children foster care as computed above plus one-tenth
14 of the amount so certified above for public nursing home care:
15 And provided further, That as to public nursing home care, for
16 fiscal year 2005-2006 and thereafter, the obligations of the
17 counties shall be the amount so certified above, less nine-
18 tenths of the non-Federal share of payments made by the
19 department during the fiscal year to county homes for public
20 nursing care at rates established in accordance with section
21 443.1(5) and (7).

22 Section 9. Sections 704.1(g) and (g.2) and 704.3(a) of the
23 act, amended or added July 9, 2013 (P.L.369, No.55), are amended
24 to read:

25 Section 704.1. Payments to Counties for Services to
26 Children.--* * *

27 (g) [The] Except as provided by an executive approval or
28 appropriation under the act of April 9, 1929 (P.L.343, No.176),
29 known as The Fiscal Code, as amended, the department shall
30 process payments to each county pursuant to this article from

funds appropriated by the General Assembly [for each fiscal year], within fifteen days of passage of the general appropriation bill or by a date specified under paragraph (1), (2), (3), (4) or (5), whichever is later. The department shall process the following applicable payments to the county:

(1) By July 15, twenty-five percent of the amount of State funds allocated to the county under section 709.3.

(2) By August 31, or upon approval by the department of the county's final cumulative report for its expenditures for the prior fiscal year, whichever is later, twenty-five percent of the amount of State funds allocated to the county under section 709.3, reduced by the amount of aggregate unspent State funds provided to the county during the previous fiscal year.

(3) By November 30, or upon approval by the department of the county's report for its expenditures for the first quarter of the fiscal year, whichever is later, twenty-five percent of the amount of State funds allocated to the county under section 709.3, reduced by the amount of unspent State funds already provided to the county for the first quarter of the fiscal year.

(4) By February 28, or upon approval by the department of the county's report for its expenditures for the second quarter of the fiscal year, whichever is later, twelve and one-half percent of the amount of State funds allocated to the county under section 709.3, adjusted by the amount of overspending or underspending of State funds in the previous quarters, but not to exceed eighty-seven and one-half percent of the county's approved State allocation.

(5) Upon approval by the department of the county's final cumulative report for its expenditures for the fiscal year, twelve and one-half percent of the amount of State funds

1 allocated to the county under section 709.3, adjusted by the
2 amount of overspending or underspending of State funds in the
3 previous quarters.

4 * * *

5 (g.2) Service contracts or agreements shall include a timely
6 payment provision that requires counties to make payment to
7 service providers within thirty days of the county's receipt of
8 an invoice under both of the following conditions:

9 (1) The invoice satisfies the county's requirements for a
10 complete and accurate invoice.

11 (2) Funds have been appropriated to the department or
12 approved by the Governor for payments to counties under
13 subsection (g).

14 * * *

15 Section 704.3. Provider Submissions.--(a) For fiscal [year]
16 years 2013-2014, 2014-2015 and 2015-2016, a provider shall
17 submit documentation of its costs of providing services; and the
18 department shall use such documentation, to the extent
19 necessary, to support the department's claim for Federal funding
20 and for State reimbursement for allowable direct and indirect
21 costs incurred in the provision of out-of-home placement
22 services.

23 * * *

24 Section 10. Section 709.3 of the act, added August 5, 1991
25 (P.L.315, No.30), is amended to read:

26 Section 709.3. Limits on Reimbursements to Counties.--(a)
27 Reimbursement for child welfare services [made] by the
28 department to counties during a fiscal year pursuant to section
29 704.1 shall not exceed the funds appropriated [each fiscal
30 year].

1 (a.1) Reimbursement for child welfare services provided in a
2 fiscal year shall be appropriated over two fiscal years.

3 (b) The allocation for each county pursuant to section
4 704.1(a) shall be calculated by multiplying the sum of the
5 Social Security Act (Public Law 74-271, 42 U.S.C. § 301 et seq.)
6 Title IV-B funds and State funds appropriated to reimburse
7 counties pursuant to section 704.1(a) by a fraction, the
8 numerator of which is the amount determined for that county's
9 child welfare needs-based budget and the denominator is the
10 aggregate child welfare needs-based budget.

11 (c) If the sum of the amounts appropriated for reimbursement
12 under [section 704.1(a)] subsection (a) during the fiscal year
13 is not at least equivalent to the aggregate child welfare needs-
14 based budget for that fiscal year:

15 (1) Each county shall be provided a proportionate share
16 allocation of that appropriation calculated by multiplying the
17 sum of the amounts appropriated for reimbursement under [section
18 704.1(a)] subsection (a) by a fraction, the numerator of which
19 is the amount determined for that county's child welfare needs-
20 based budget and the denominator is the aggregate child welfare
21 needs-based budget.

22 (2) Notwithstanding subsection (a), a county shall be
23 allowed reimbursement beyond its proportionate share allocation
24 for that fiscal year for expenditures made in accordance with an
25 approved plan and needs-based budget, but not above that amount
26 determined to be its needs-based budget.

27 (c.1) The department shall reimburse counties with funds
28 appropriated in the fiscal year in which the department is to
29 make the reimbursement payment for child welfare services on the
30 earliest date under section 704.1. The aggregate reimbursement

for child welfare services provided during a fiscal year shall
not exceed the amount specified as the aggregate child welfare
needs-based budget allocation by the General Assembly as
necessary to fund child welfare services in the General
Appropriation Act for that fiscal year.

(d) For the purpose of this section, an appropriation shall be considered equivalent to the aggregate child welfare needs if it is equivalent to the result obtained by calculating the aggregate child welfare needs minus the county share of Youth Development Center costs and minus the Social Security Act Title IV-B funding, provided, however, an appropriation shall be deemed equivalent if it is equal to eighty-two percent of the result in 1991-1992, ninety percent of the result in 1992-1993 and ninety-five percent of the result in 1993-1994.

(e) The department shall, by regulation, define allowable costs for authorized child welfare services, provided that no regulation relating to allowable costs shall be adopted as an emergency regulation pursuant to section 6(b) of the act of June 25, 1982 (P.L.633, No.181), known as the "Regulatory Review Act."

Section 11. Article VII-F of the act is repealed:

[ARTICLE VIII-F

MEDICAID MANAGED CARE ORGANIZATION ASSESSMENTS

Section 801-F. 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 percentage." The rate assessed pursuant to this article on every Medicaid managed care organization.

"Assessment period." The time period identified in the

1 contract.

2 "Assessment proceeds." The State revenue collected from the
3 assessment provided for in this article, any Federal funds
4 received by the Commonwealth as a direct result of the
5 assessment and any penalties and interest received under section
6 810-F.

7 "Contract." The agreement between a Medicaid managed care
8 organization and the Department of Public Welfare.

9 "County Medicaid managed care organization." A county, or an
10 entity organized and controlled directly or indirectly by a
11 county or a city of the first class, that is a party to a
12 Medicaid managed care contract with the Department of Public
13 Welfare.

14 "Department." The Department of Public Welfare of the
15 Commonwealth.

16 "Medicaid." The program established under Title XIX of the
17 Social Security Act (49 Stat. 620, 42 U.S.C. § 1396 et seq.).

18 "Medicaid managed care organization." A Medicaid managed
19 care organization as defined in section 1903(m)(1)(A) of the
20 Social Security Act (49 Stat. 620, 42 U.S.C. § 1396b(m)(1)(A))
21 that is a party to a Medicaid managed care contract with the
22 Department of Public Welfare. The term shall include a county
23 Medicaid managed care organization and a permitted assignee of a
24 Medicaid managed care contract but shall not include an assignor
25 of a Medicaid managed care contract.

26 "Secretary." The Secretary of Public Welfare of the
27 Commonwealth.

28 "Social Security Act." 49 Stat. 620, 42 U.S.C. § 301 et seq.
29 Section 802-F. Authorization.

30 The department shall implement an assessment on each Medicaid

managed care organization, subject to the conditions and requirements specified in this article.

Section 803-F. Implementation.

The assessment shall be implemented on an annual basis, through periodic submissions not to exceed five times per year by Medicaid managed care organizations, as a health care-related fee as defined in section 1903(w) (3) (B) of the Social Security Act, or any amendments thereto, and may be imposed and is required to be paid only to the extent that the revenues generated from the assessment qualify as the State share of program expenditures eligible for Federal financial participation.

Section 804-F. Assessment percentage.

(a) Amount.--The assessment percentage shall be uniform for all Medicaid managed care organizations, determined in accordance with this section and implemented by the department as approved by the Governor after notification to and in consultation with the Medicaid managed care organizations. The assessment percentage shall be subject to the maximum aggregate amount that may be assessed pursuant to 42 CFR 433.68(f) (3) (i) (relating to permissible health care-related taxes) or any subsequent maximum established by Federal law.

(b) Notice.--Subject to the provisions of subsection (c), the department shall notify each Medicaid managed care organization of a proposed assessment percentage. Medicaid managed care organizations shall have 30 days from the date of the proposed assessment percentage notice to provide written comments to the department regarding the proposed assessment. Upon expiration of the 30-day comment period, the department, after consideration of the comments, shall provide each Medicaid

1 managed care organization with a second notice announcing the
2 assessment percentage. Once effective, an assessment percentage
3 will remain in effect until the department notifies each
4 Medicaid managed care organization of a new assessment
5 percentage in accordance with the notice provisions contained in
6 this section.

7 (c) Initial assessment.--The initial assessment percentage
8 may be imposed retroactively to the beginning of an assessment
9 period beginning on or after July 1, 2004. Once effective, the
10 initial assessment percentage will remain in effect until the
11 department notifies each Medicaid managed care organization of a
12 new assessment percentage in accordance with the notice
13 provisions contained in this section.

14 Section 805-F. Calculation and payment.

15 Using the assessment percentage established under section
16 804-F, each Medicaid managed care organization shall calculate
17 the assessment amount for each assessment period on a report
18 form specified by the contract and shall submit the completed
19 report form and total amount owed to the department on a due
20 date specified by the contract. The Medicaid managed care
21 organization shall report net operating revenue for purposes of
22 the assessment calculation as specified in the contract.

23 Section 806-F. Use of assessment proceeds.

24 No Medicaid managed care organization shall be guaranteed a
25 repayment of its assessment in derogation of 42 CFR 433.68(f)
26 (relating to permissible health care-related taxes), provided,
27 however, in each fiscal year in which an assessment is
28 implemented, the department shall use the assessment proceeds to
29 maintain actuarially sound rates as defined in the contract for
30 the Medicaid managed care organizations to the extent

1 permissible under Federal and State law or regulation and
2 without creating a guarantee to hold harmless, as those terms
3 are used in 42 CFR 433.68(f).

4 Section 807-F. Records.

5 Upon written request by the department, a Medicaid managed
6 care organization shall furnish to the department such records
7 as the department may specify in order to determine the amount
8 of assessment due from the Medicaid managed care organization or
9 to verify that the Medicaid managed care organization has
10 calculated and paid the correct amount due. The requested
11 records shall be provided to the department within 30 days from
12 the date of the Medicaid managed care organization's receipt of
13 the written request unless required at an earlier date for
14 purposes of the department's compliance with a request from a
15 Federal or another State agency.

16 Section 808-F. Payment of assessment.

17 In the event that the department determines that a Medicaid
18 managed care organization has failed to pay an assessment or
19 that it has underpaid an assessment, the department shall
20 provide written notification to the Medicaid managed care
21 organization within 180 days of the original due date of the
22 amount due, including interest, and the date on which the amount
23 due must be paid, which shall not be less than 30 days from the
24 date of the notice. In the event that the department determines
25 that a Medicaid managed care organization has overpaid an
26 assessment, the department shall notify the Medicaid managed
27 care organization in writing of the overpayment, and, within 30
28 days of the date of the notice of the overpayment, the Medicaid
29 managed care organization shall advise the department to either
30 authorize a refund of the amount of the overpayment or offset

1 the amount of the overpayment against any amount that may be
2 owed to the department by the Medicaid managed care
3 organization.

4 Section 809-F. Appeal rights.

5 A Medicaid managed care organization that is aggrieved by a
6 determination of the department relating to the assessment may
7 file a request for review of the decision of the department by
8 the Bureau of Hearings and Appeals within the department, which
9 shall have exclusive primary jurisdiction in such matters. The
10 procedures and requirements of 67 Pa.C.S. Ch. 11 (relating to
11 medical assistance hearings and appeals) shall apply to requests
12 for review filed pursuant to this section except that, in any
13 such request for review, a Medicaid managed care organization
14 may not challenge the assessment percentage determined by the
15 department pursuant to section 804-F.

16 Section 810-F. Enforcement.

17 In addition to any other remedy provided by law, the
18 department may enforce this article by imposing one or more of
19 the following remedies:

20 (1) When a Medicaid managed care organization fails to
21 pay an assessment or penalty in the amount or on the date
22 required by this article, the department may add interest at
23 the rate provided in section 806 of the act of April 9, 1929
24 (P.L.343, No.176), known as The Fiscal Code, to the unpaid
25 amount of the assessment or penalty from the date prescribed
26 for its payment until the date it is paid.

27 (2) When a Medicaid managed care organization fails to
28 submit a report form concerning the calculation of the
29 assessment or to furnish records to the department as
30 required by this article, the department may impose a penalty

1 against the Medicaid managed care organization in the amount
2 of \$1,000 per day for each day the report form or required
3 records are not submitted or furnished to the department. If
4 the \$1,000 per day penalty is imposed, it shall commence on
5 the first day after the date for which a report form or
6 records are due.

7 (3) When a Medicaid managed care organization fails to
8 pay all or part of an assessment or penalty within 30 days of
9 the date that payment is due, the department may deduct the
10 unpaid assessment or penalty and any interest owed from any
11 capitation payments due to the Medicaid managed care
12 organization until the full amount is recovered. Any
13 deduction shall be made only after written notice to the
14 Medicaid managed care organization.

15 (4) Upon written request by a Medicaid managed care
16 organization to the secretary, the secretary may waive all or
17 part of the interest or penalties assessed against a Medicaid
18 managed care organization pursuant to this article for good
19 cause as shown by the Medicaid managed care organization.

20 Section 811-F. Time periods.

21 The assessment authorized in this article shall not be
22 imposed or paid prior to July 1, 2004, or in the absence of
23 Federal financial participation as described in section 803-F.
24 The assessment shall cease on June 30, 2013, or earlier if
25 required by law.]

26 Section 12. The definitions of "exempt hospital" and "net
27 inpatient revenue" in section 801-G of the act, reenacted and
28 amended July 9, 2013 (P.L.369, No.55), are amended to read:

29 Section 801-G. Definitions.

30 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." 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.

(7) A free-standing acute care hospital organized primarily for the treatment of and research on cancer in which at least 30% of the inpatient admissions had cancer as the principal diagnosis based on Pennsylvania Health Care Cost Containment Council CY 2014 inpatient discharge data. For the purposes of meeting this definition, only discharges with ICD-9-CM principal diagnoses codes of 140 through 239, V58.0, V58.1, V66.1, V66.2 or 990 are considered.

* * *

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

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

(2) as identified in the hospital's records for the most

recent State fiscal year, or part thereof, if amounts are not available under paragraph (1).

* * *

Section 13. Sections 803-G(b) and (c) and 804-G(a.1) and (b) of the act, reenacted and amended July 9, 2013 (P.L.369, No.55), are amended to read:

Section 803-G. Implementation.

* * *

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

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

(2) for fiscal years 2011-2012, 2012-2013, 2013-2014[,], and 2014-2015 [and 2015-2016], an amount equal to 3.22% of the net inpatient revenue of the covered hospital[.]; and

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

(c) Adjustments to assessment percentage.--The secretary may adjust the assessment percentage specified in subsection (b), provided that, before [adjusting] implementing an adjustment, the secretary shall publish a notice in the Pennsylvania Bulletin that specifies the proposed assessment percentage and identifies the aggregate impact on covered hospitals subject to the assessment. Interested parties shall have 30 days in which to submit comments to the secretary. Upon expiration of the 30-day comment period, the secretary, after consideration of the comments, shall publish a second notice in the Pennsylvania Bulletin announcing the assessment percentage.

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

13 * * *

14 Section 804-G. Administration.

15 * * *

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

17 (1) If a single covered hospital changes ownership or
18 control, the department will continue to calculate the
19 assessment amount using the hospital's net inpatient revenue
20 for:

21 (i) State fiscal year 2010-2011 [or for]; or

22 (ii) for a change on or after July 1, 2016, the
23 later State fiscal year, if any, that has been specified
24 by the secretary for use in determining the assessment
25 amounts due for the fiscal year in which the change
26 occurs; or

27 (iii) the most recent State fiscal year, or part
28 thereof, if the [State fiscal year 2010-2011] net
29 inpatient revenue amounts specified in subparagraphs (i)
30 and (ii) are not available. The covered hospital is

1 liable for any outstanding assessment amounts, including
2 outstanding amounts related to periods prior to the
3 change of ownership or control.

4 (2) If two or more hospitals merge or consolidate into a
5 single covered hospital as a result of a change in ownership
6 or control, the department will calculate the [covered
7 hospital] assessment amount owed by the single covered
8 hospital resulting from the merger or consolidation using the
9 merged or consolidated hospitals' combined net inpatient
10 revenue for:

11 (i) State fiscal year 2010-2011 [or for]; or

12 (ii) for a merger or consolidation on or after July
13 1, 2016, the later State fiscal year, if any, that has
14 been specified by the secretary for use in determining
15 the assessment amounts due for the fiscal year in which
16 the merger or consolidation occurs; or

17 (iii) the most recent State fiscal year, or part
18 thereof, if the [State fiscal year 2010-2011] net
19 inpatient revenue amounts specified in subparagraphs (i)
20 and (ii) are not available, of any covered hospitals that
21 were merged or consolidated into the single covered
22 hospital. The single covered hospital is liable for any
23 outstanding assessment amounts, including outstanding
24 amounts related to periods prior to the change of
25 ownership or control, of any covered hospital that was
26 merged or consolidated.

27 * * *

28 (b) Payment.--A covered hospital shall pay the assessment
29 amount due for a fiscal year in four quarterly installments.
30 Payment of a quarterly installment shall be made electronically

1 on or before the first day of the second month of the quarter or
2 30 days from the date of the notice of the quarterly assessment
3 amount, whichever day is later.

4 * * *

5 Section 14. Sections 805-G and 815-G of the act, reenacted
6 and amended July 9, 2013 (P.L.369, No.55), are amended to read:
7 Section 805-G. Restricted account.

8 (a) Establishment.--There is established a restricted
9 account, known as the Quality Care Assessment Account, in the
10 General Fund for the receipt and deposit of revenues collected
11 under this article. Funds in the account are appropriated to the
12 department for the following:

13 (1) Making medical assistance payments to hospitals for
14 inpatient services in accordance with section 443.1(1.1), and
15 outpatient services, including for observation services in
16 accordance with section 443.3(a)(1.1), and as otherwise
17 specified in the Commonwealth's approved Title XIX State
18 Plan.

19 (2) Making adjusted capitation payments to medical
20 assistance managed care organizations for additional payments
21 for inpatient hospital services in accordance with section
22 443.1(1.2), (1.3) and (1.4) and outpatient services.

23 (3) Any other purpose approved by the secretary for
24 inpatient hospital, outpatient hospital and hospital-related
25 services.

26 (b) Limitations.--

27 (1) For the first year of the assessment, the amount
28 used for the medical assistance payments for hospitals and
29 Medicaid managed care organizations may not exceed the
30 aggregate amount of assessment funds collected for the year

1 less \$121,000,000.

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

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

12 (4.1) For State fiscal years 2013-2014 and 2014-2015,
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 \$150,000,000.

17 (4.2) For State fiscal [year] years 2015-2016, 2016-2017
18 and 2017-2018, the amount used for the medical assistance
19 payment for hospitals and medical assistance managed care
20 organizations may not exceed the aggregate amount of the
21 assessment funds collected for the year less [\$140,000,000]
22 \$220,000,000.

23 (5) The amounts retained by the department pursuant to
24 paragraphs (1), (2), (4), (4.1) and (4.2) and any additional
25 amounts remaining in the restricted accounts after the
26 payments described in subsection (a)(1) and (2) are made
27 shall be used for purposes approved by the secretary under
28 subsection (a)(3).

29 (c) Lapse.--Funds in the Quality Care Assessment Account
30 shall not lapse to the General Fund at the end of a fiscal year.

1 If this article expires, the department shall use any remaining
2 funds for the purposes stated in this section until the funds in
3 the Quality Care Assessment Account are exhausted.

4 Section 815-G. Expiration.

5 [This] The assessment under this article shall expire June
6 30, [2016] 2018.

7 Section 15. The act is amended by adding an article to read:

8 ARTICLE VIII-I

9 MANAGED CARE ORGANIZATION ASSESSMENTS

10 Section 801-I. Definitions.

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

14 "Assessment proceeds." The State revenue collected from the
15 assessment provided for under this article, any Federal funds
16 received by the Commonwealth as a direct result of the
17 assessment and any penalties and interest received.

18 "Children's Health Insurance Program" or "CHIP." The
19 children's health care program under Article XXIII of the act of
20 May 17, 1921 (P.L.682, No.284), known as The Insurance Company
21 Law of 1921.

22 "Contract." The agreement between a Medicaid managed care
23 organization and the department.

24 "County Medicaid managed care organization." A county, or an
25 entity organized and controlled directly or indirectly by a
26 county or a city of the first class, that is a party to a
27 Medicaid managed care contract with the department.

28 "Department." The Department of Human Services of the
29 Commonwealth.

30 "Fixed fee." The assessment amount imposed on a per member

1 per month basis as specified under section 803-I(b).

2 "Insurance Department." The Insurance Department of the
3 Commonwealth.

4 "Managed care organization." A Medicaid managed care
5 organization or a managed care service entity.

6 "Managed care service entity." An entity, other than a
7 Medicaid managed care organization, that:

8 (1) is a managed care plan as defined in the act of June
9 17, 1998 (P.L.464, No.68).

10 (2) (i) provides managed health care coverage through a
11 State program for persons of low income or through CHIP; and

12 (ii) is obligated to comply with the requirements of
13 the act of June 17, 1998 (P.L.464, No.68).

14 "Medicaid." The program established under Title XIX of the
15 Social Security Act (49 Stat. 620, 42 U.S.C. § 1396 et seq.).

16 "Medicaid managed care organization." A Medicaid managed
17 care organization as defined in section 1903(m) (1) (A) of the
18 Social Security Act (49 Stat. 620, 42 U.S.C. § 1396b(m) (1) (A))
19 that is a party to a contract with the department. The term
20 includes a county Medicaid managed care organization and a
21 permitted assignee of a contract. The term does not include an
22 assignor of a contract.

23 "Member." A policyholder, subscriber, covered person or
24 other individual who is enrolled to receive health care services
25 through a contract or from a managed care services entity. The
26 term shall not include individuals who receive health care
27 services under any of the following:

28 (1) A Medicare Advantage plan.

29 (2) A TRICARE or other health care plan provided through
30 the Civilian Health and Medical Program of the Uniformed

1 Services (CHAMPUS) as defined under 10 U.S.C. § 1072.

2 (3) A health care plan provided through the Federal
3 Employees Health Benefits Program established under the
4 Federal Employees Health Benefit Act (5 U.S.C. Ch. 89
5 (relating to health insurance)).

6 "Program." The Commonwealth's medical assistance program as
7 authorized under Article IV.

8 "Social Security Act." The Social Security Act (49 Stat.
9 620, 42 U.S.C. § 301 et seq.).

10 Section 802-I. Authorization.

11 The department shall implement an assessment on each managed
12 care organization operating in this Commonwealth, subject to the
13 following conditions and requirements:

14 (1) The assessment shall be implemented as a health
15 care-related fee as defined in section 1903(w)(3)(B) of the
16 Social Security Act (42 U.S.C. § 1396b(w)(3)(B)), or any
17 amendments thereto, and may be imposed and is required to be
18 paid only to the extent that the revenues generated from the
19 assessment qualify as the State share of program expenditures
20 eligible for Federal financial participation.

21 (2) A managed care organization shall report the total
22 assessment amount owed on forms and in accordance with
23 instructions prescribed by the department.

24 (3) A managed care organization shall remit the total
25 assessment amount due by the due date specified by the
26 department.

27 (4) In the event that the department determines that a
28 managed care organization has failed to pay an assessment or
29 that it has underpaid an assessment, the department shall
30 notify the managed care organization in writing of the amount

1 due, including interest, and the date on which the amount due
2 must be paid. The date the amount is due shall not be less
3 than 30 days from the date of the notice.

4 (5) In the event that the department determines that a
5 managed care organization has overpaid an assessment, the
6 department shall notify the managed care organization in
7 writing of the overpayment, and within 30 days of the date of
8 the notice of the overpayment, the managed care organization
9 shall advise the department to either authorize a refund of
10 the amount of the overpayment or offset the amount of the
11 overpayment against any amount that may be owed to the
12 department by the managed care organization.

13 (6) An assessment implemented under this article, and
14 any instructions, forms or reports issued by the department
15 and required to be completed by a managed care organization
16 under this article shall not be subject to the act of July
17 31, 1968 (P.L.769, No.240), referred to as the Commonwealth
18 Documents Law, the act of October 15, 1980 (P.L.950, No.164),
19 known as the Commonwealth Attorneys Act, and the act of June
20 25, 1982 (P.L.633, No.181), known as the Regulatory Review
21 Act.

22 Section 803-I. Assessment amount.

23 (a) Assessment.--The assessment implemented under this
24 article shall be imposed as a fixed fee in accordance with
25 subsection (b). The assessment shall be remitted electronically
26 in periodic submissions as specified by the department not to
27 exceed five times per year.

28 (b) Fixed fee.--Beginning July 1, 2016, and ending June 30,
29 2020, the managed care organization shall be assessed a fixed
30 fee of \$13.48 for each unduplicated member for each month the

1 member is enrolled for any period of time with the managed care
2 organization.

3 (c) Adjustments.--The secretary may make further adjustments
4 to the fixed fee specified under subsection (b) for all or part
5 of the fiscal year so long as the assessment does not exceed the
6 maximum limit specified under subsection (d). Before adjusting
7 the fixed fee, the secretary shall publish a notice in the
8 Pennsylvania Bulletin that specifies the proposed adjusted fixed
9 fee and identifies the estimated aggregate impact on managed
10 care organizations. Interested parties shall have 30 days in
11 which to submit comments to the secretary. Upon expiration of
12 the 30-day comment period, the secretary, after consideration of
13 the comments, shall publish a second notice in the Pennsylvania
14 Bulletin announcing the adjusted fixed fee.

15 (d) Maximum amount.--In each year in which the assessment is
16 implemented, the assessment shall not exceed the maximum
17 aggregate amount that may be assessed under 42 CFR 433.68(f)(3)
18 (i) (relating to permissible health care-related taxes) or any
19 other maximum established under Federal law.

20 (e) Limited review.--

21 (1) Except as permitted under section 809-I, the
22 secretary's determination of the assessment amounts under
23 subsections (b) and (c) shall not be subject to
24 administrative or judicial review under 2 Pa.C.S. Chs. 5
25 Subch. A (relating to practice and procedure of Commonwealth
26 agencies) and 7 Subch. A (relating to judicial review of
27 Commonwealth agency action) or any other provision of law.

28 (2) Any assessments implemented under this article or
29 forms or reports required to be completed by managed care
30 organizations under this article shall not be subject to the

1 act of July 31, 1968 (P.L.769, No.240), referred to as the
2 Commonwealth Documents Law, the act of October 15, 1980
3 (P.L.950, No.164), known as the Commonwealth Attorneys Act,
4 and the act of June 25, 1982 (P.L.633, No.181), known as the
5 Regulatory Review Act.

6 Section 804-I. No hold harmless.

7 No managed care organization shall be guaranteed a repayment
8 of its assessment in derogation of 42 CFR 433.68(f) (relating to
9 permissible health care-related taxes), except that, in each
10 fiscal year in which an assessment is implemented, the
11 department shall use the assessment proceeds for the purposes
12 specified in section 805-I to the extent permissible under
13 Federal and State law or regulation and without creating an
14 indirect guarantee to hold harmless, as those terms are used
15 under 42 CFR 433.68(f).

16 Section 805-I. Restricted account.

17 There is established a restricted account in the General Fund
18 for the receipt and deposit of assessment proceeds. Funds in the
19 account are appropriated to the department and shall be used to
20 maintain actuarially sound rates for the Medicaid managed care
21 organizations and to fund other medical assistance expenditures.
22 Funds in the account may be used to fund expenditures for
23 managed care health coverage provided through State administered
24 programs for persons of low income or CHIP, to the extent
25 permissible under Federal and State law or regulation and
26 without creating a guarantee to hold harmless, as those terms
27 are used in 42 CFR 433.68(f) (relating to permissible health-
28 care related taxes).

29 Section 806-I. Access to information and records.

30 (a) Reports and access.--A managed care organization shall

1 report such information and shall provide access to and shall
2 furnish such records to the department, without charge, as the
3 department may specify in order for the department to:

4 (1) determine the amount of assessment due from the
5 managed care organization;

6 (2) verify that the managed care organization has
7 calculated and paid the correct amount due; or

8 (3) determine that the assessment, as a percentage of
9 managed care revenue, does not exceed the maximum limit
10 specified in section 803-I(d).

11 (b) Use.--Information and records submitted to the
12 department under this section shall be used only for the
13 purposes specified in this section.

14 Section 807-I. Remedies.

15 In addition to any other remedy provided by law, the
16 department may enforce this article by imposing one or more of
17 the following remedies:

18 (1) If a managed care organization fails to pay an
19 assessment or penalty in the amount or on the date required
20 by this article, the department shall add interest at the
21 rate provided in section 806 of the act of April 9, 1929
22 (P.L.343, No.176), known as The Fiscal Code, to the unpaid
23 amount of the assessment or penalty from the date prescribed
24 for its payment until the date it is paid.

25 (2) If a managed care organization fails to file a
26 report or to furnish records to the department as required by
27 this article, the department shall impose a penalty against
28 the managed care organization in the amount of \$1,000 per day
29 for each day the report or required records are not submitted
30 or furnished to the department. If the penalty under this

1 paragraph is imposed, it shall commence on the first day
2 after the date for which a report form or records are due.

3 (3) If a Medicaid managed care organization, or a
4 managed care organization that is related through common
5 ownership or control as defined in 42 CFR 413.17(b) (relating
6 to cost to related organizations) to a medical assistance
7 provider or to a managed care services entity providing
8 managed health care coverage through a State program for
9 persons of low income or CHIP, fails to pay all or part of an
10 assessment or penalty within 60 days of the date that payment
11 is due, at the direction of the department, the amount of the
12 unpaid assessment or penalty and any interest owed by the
13 managed care organization, may be deducted from any medical
14 assistance payments due to the Medicaid managed care
15 organization or to any related medical assistance provider or
16 from any other State payments due to a related managed care
17 service entity until the full amount is recovered. Any such
18 deduction shall be made only after written notice to the
19 Medicaid managed care organization and the related medical
20 assistance provider or managed care service entity and may be
21 taken in installments over a period of time, taking into
22 account the financial condition of the medical assistance
23 provider or managed care service entity.

24 (4) The secretary may waive all or part of the interest
25 or penalties assessed against a managed care organization
26 under this article for good cause shown by the managed care
27 organization.

28 Section 808-I. Liens.

29 Any assessments implemented and interest and penalties
30 assessed against a managed care organization under this article

1 shall be a lien on the real and personal property of the managed
2 care organization in the manner provided by section 1401 of the
3 act of April 9, 1929 (P.L.343, No.176), known as The Fiscal
4 Code, may be entered by the department in the manner provided by
5 section 1404 of The Fiscal Code and shall continue and retain
6 priority in the manner provided in section 1404.1 of The Fiscal
7 Code.

8 Section 809-I. Appeal rights.

9 (a) Request for review.--A managed care organization that is
10 aggrieved by a determination of the department as to the amount
11 of the assessment due from the managed care organization or a
12 remedy imposed under section 807-I may file a request for review
13 of the decision of the department by the Bureau of Hearings and
14 Appeals, which shall have exclusive jurisdiction in such
15 matters.

16 (b) Procedures.--The procedures and requirements of 67
17 Pa.C.S. Ch. 11 (relating to medical assistance hearings and
18 appeals) shall apply to requests for review filed under this
19 section, except that in any such request for review, a managed
20 care organization may not challenge the fixed fee under section
21 803-I, but only whether the department correctly determined the
22 assessment amount due from the managed care organization using
23 the applicable fixed fee in effect for the fiscal year.

24 (c) Assessment obligation.--A notice of review filed under
25 this section shall not operate as a stay of the managed care
26 organization's obligation to pay the assessment amount due for a
27 fiscal year.

28 Section 810-I. Tax exemption provisions superseded.

29 The provisions of the following acts shall not apply to the
30 assessment imposed by this article:

1 (1) Section 2462 of the act of May 17, 1921 (P.L.682,
2 No.284), known as The Insurance Company Law of 1921.

3 (2) Section 13 of the act of December 29, 1972
4 (P.L.1701, No. 364), known as the Health Maintenance
5 Organization Act.

6 (3) The provisions of 40 Pa.C.S. § 6103(b) (relating to
7 exemption applicable to certified hospital plan
8 corporations).

9 (4) The provisions of 40 Pa.C.S. § 6307(b) (relating to
10 exemptions applicable to certificated professional health
11 service corporations).

12 Section 811-I. Expiration.

13 The assessment authorized under this article shall expire
14 June 30, 2020.

15 Section 812-I. Coordination with other agencies.

16 Consistent with its authority as the only Commonwealth agency
17 responsible for the Medical Assistance Program, the department
18 may delegate responsibility to perform functions and activities
19 required to implement the assessment authorized under this
20 article to other Commonwealth departments and agencies under
21 sections 501 and 502 of the act of April 9, 1929 (P.L.177,
22 No.175), known as The Administrative Code of 1929.

23 Section 15.1. The definition of "children's institutions" in
24 section 901 of the act, amended December 5, 1980 (P.L.1112,
25 No.193), is amended and the section is amended by adding a
26 definition to read:

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

28 "Child day care" means care in lieu of parental care given
29 for part of the twenty-four hour day to a child under sixteen
30 years of age, away from the child's home, but does not include

1 child day care furnished in a place of worship during religious
2 services.

3 "Children's institutions" means any incorporated or
4 unincorporated organization, society, corporation or agency,
5 public or private, which may receive or care for children, or
6 place them in foster family homes, either at board, wages or
7 free; or any individual who, for hire, gain or reward, receives
8 for care a child, unless he is related to such child by blood or
9 marriage within the second degree; or any individual, not in the
10 regular employ of the court or of an organization, society,
11 association or agency, duly certified by the department, who in
12 any manner becomes a party to the placing of children in foster
13 homes, unless he is related to such children by blood or
14 marriage within the second degree, or is the duly appointed
15 guardian thereof. The term shall not include a family [day]
16 child care home [in which care is provided in lieu of parental
17 care to six or less children for part of a twenty-four hour day]
18 or child day care center operated for profit and subject to the
19 provisions of Article X.

20 * * *

21 Section 15.2. The definition of "facility" in section 1001
22 of the act, amended July 25, 2007 (P.L.402, No.56), is amended
23 and the section is amended by adding a definition to read:

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

25 * * *

26 "Facility" means an adult day care center, child day care
27 center, family [day] child care home, boarding home for
28 children, mental health establishment, personal care home,
29 assisted living residence, nursing home, hospital or maternity
30 home, as defined herein, except to the extent that such a

1 facility is operated by the State or Federal governments or
2 those supervised by the department, or licensed pursuant to the
3 act of July 19, 1979 (P.L.130, No.48), known as the "Health Care
4 Facilities Act."

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

8 * * *

9 Section 15.3. Section 1006 of the act, amended December 21,
10 1988 (P.L.1883, No.185), is amended to read:

11 Section 1006. Fees.--Annual licenses shall be issued when
12 the proper fee, if required, is received by the department and
13 all the other conditions prescribed in this act are met. For
14 personal care homes, the fee shall be an application fee. The
15 fees shall be:

16 Facility	Annual Fee
17 Adult day care center	\$ 15
18 Mental health establishment	50
19 Personal care home-- 0 - 20 beds	15
20 -- 21 - 50 beds	20
21 -- 51 - 100 beds	30
22 --101 beds and above	50

23 No fee shall be required for the annual license in the case
24 of day care centers, family [day] child care homes, boarding
25 homes for children or for public or nonprofit mental
26 institutions.

27 Section 15.4. Section 1008 of the act is amended to read:

28 Section 1008. Provisional License.--(a) When there has been
29 substantial but not complete compliance with all the applicable
30 statutes, ordinances and regulations and when the applicant has

1 taken appropriate steps to correct deficiencies, the department
2 shall issue a provisional license [for a specified period of not
3 more than six months which may be renewed three times. Upon full
4 compliance, a regular license shall be issued immediately].

5 (b) The department may issue a provisional license under
6 this section when it is unable to assess compliance with all
7 statutes, ordinances and regulations because the facility has
8 not yet begun to operate.

9 (c) A provisional license shall be for a specified period of
10 not more than six months which may be renewed no more than three
11 times.

12 (d) Upon full compliance by the facility, the department
13 shall issue a regular license immediately.

14 Section 15.5. Section 1031 of the act is amended to read:

15 Section 1031. Violation; Penalty.--(a) Any person operating
16 a facility within this Commonwealth without a license required
17 by this act, shall upon conviction [thereof in a summary
18 proceeding be sentenced to pay a fine of not less than twenty-
19 five dollars (\$25) nor more than three hundred dollars (\$300),
20 and costs of prosecution, and in default of the payment thereof
21 to undergo imprisonment for not less than ten days nor more than
22 thirty days. Each day of operating a facility without a license
23 required by this act shall constitute a separate offense.] be
24 sentenced as follows:

25 (1) For a first offense, the person commits a summary
26 offense and shall, upon conviction, be sentenced to pay a fine
27 not less than twenty-five dollars (\$25) nor more than three
28 hundred dollars (\$300), costs of prosecution, and if in default
29 of payment thereof, to imprisonment for not less than ten days
30 nor more than thirty days.

1 (2) For a second offense, the person commits a misdemeanor
2 of the third degree and shall, upon conviction, be sentenced to
3 pay a fine not less than five hundred dollars (\$500) nor more
4 than two thousand dollars (\$2,000), costs of prosecution, and if
5 in default of payment thereof, to imprisonment for not less than
6 thirty days nor more than one year.

7 (3) For a third offense or if the operation of the
8 unlicensed facility resulted in a bodily injury as defined in 18
9 Pa.C.S. § 2301 (relating to definitions), the person commits a
10 misdemeanor of the second degree and shall, upon conviction, be
11 sentenced to pay a fine of not less than two thousand five
12 hundred dollars (\$2,500) nor more than five thousand dollars
13 (\$5,000), costs of prosecution, and if in default in payment
14 thereof, to imprisonment for not less than one year nor more
15 than two years.

16 (4) For a fourth or subsequent offense, or if the operation
17 of the unlicensed facility resulted in a serious bodily injury,
18 as defined in 18 Pa.C.S. § 2301, or death, the person commits a
19 felony of the third degree and shall, upon conviction, be
20 sentenced to pay a fine of not less than ten thousand dollars
21 (\$10,000), costs of prosecution, and if in default in payment
22 thereof, to imprisonment for not less than five years nor more
23 than seven years.

24 (b) (1) If, after fourteen days, a provider cited for
25 operating without a license fails to file an application for a
26 license, the department shall assess an additional twenty
27 dollars (\$20) for each resident for each day in which the
28 facility fails to make an application. Each day of operating a
29 facility without a license required by this act shall constitute
30 a separate offense.

1 (2) When a non-residential facility is found to be operating
2 on multiple days, there shall be a rebuttable presumption that
3 the facility was operating each business day between the days it
4 was found to be in operation. When a residential facility is
5 found to be operating on multiple days, there shall be a
6 rebuttable presumption that a facility was operating each
7 calendar day between the days it was found to be in operation.

8 (3) Any provider charged with violation of this subsection
9 shall have thirty days to pay the assessed penalty in full, or,
10 if the provider wishes to contest either the amount of the
11 penalty or the fact of the violation, the party shall forward
12 the assessed penalty to the Secretary of Human Services for
13 placement in an escrow account with the State Treasurer. If,
14 through administrative hearing or judicial review of the
15 proposed penalty, it is determined that no violation occurred or
16 that the amount of the penalty shall be reduced, the secretary
17 shall within thirty days remit the appropriate amount to the
18 provider with any interest accumulated by the escrow deposit.
19 Failure to forward the payment to the secretary within thirty
20 days shall result in a waiver of rights to contest the fact of
21 the violation or the amount of the penalty. The amount assessed
22 after administrative hearing or a waiver of the administrative
23 hearing shall be payable to the Commonwealth of Pennsylvania and
24 shall be collectible in any manner provided by law for the
25 collection of debts. If any provider liable to pay such penalty
26 neglects or refuses to pay the same after demand, such failure
27 to pay shall constitute a judgment in favor of the Commonwealth
28 in the amount of the penalty, together with the interest and any
29 costs that may accrue.

30 (4) Money collected by the department under this section

1 shall be placed in a special restricted receipt account and
2 shall be first used to defray the expenses incurred by residents
3 relocated under this act. Any moneys remaining in this account
4 shall annually be remitted to the department for enforcing the
5 provisions of this article. Fines collected pursuant to this act
6 shall not be subject to the provisions of 42 Pa.C.S. § 3733
7 (relating to deposits into account).

8 (c) The penalties prescribed under this section may be
9 imposed in addition to each other and to any other applicable
10 criminal, civil, or administrative penalty, action or sanction
11 otherwise provided by law.

12 Section 16. Subarticle (c) of Article X of the act is
13 repealed:

14 [(c) Registration Provisions

15 Section 1070. Definitions.--As used in this article.--

16 "Child day care" means care in lieu of parental care given
17 for part of the twenty-four hour day to children away from their
18 own homes.

19 "Family day care home" means any home in which child day care
20 is provided at any one time to four through six children who are
21 not relatives of the caregiver.

22 Section 1071. Operation Without Registration Certificate
23 Prohibited.--No individual shall operate a family day care home
24 without a registration certificate issued therefor by the
25 department.

26 Section 1072. Application for Registration Certificate.--(a)
27 Any individual desiring to secure a registration certificate
28 shall submit an application therefor to the department upon
29 forms prepared and furnished by the department, and, at the same
30 time, shall certify in writing that he/she and the facility

1 named in the application are in compliance with applicable
2 department regulations.

3 (b) Application for renewal of the registration certificate
4 shall be made every two years in the same manner as application
5 for the original registration certificate.

6 (c) No application fee shall be required to register a
7 family day care home.

8 Section 1073. Issuance of Registration Certificate.--Upon
9 receipt of an application and the applicant's written
10 certification of compliance with applicable department
11 regulations, the department shall issue a registration
12 certificate to the applicant for the premises named in the
13 application. A registration certificate shall be issued for a
14 period of two years.

15 Section 1074. Visitation and Inspection.--The department or
16 authorized agent of the department shall have the right to
17 enter, visit and inspect on a random sample basis, upon
18 complaint, or upon request of the caregiver, any family day care
19 home registered or requiring registration under this article and
20 shall have free and full access to the premises, where children
21 are cared for, all records of the premises which relate to the
22 children's care, and to the children cared for therein and full
23 opportunity to speak with or observe such children.

24 Section 1075. Records.--Every individual who operates a
25 family day care home registered under this article shall keep
26 and maintain such records as required by the department.

27 Section 1076. Regulations.--The department is hereby
28 authorized and empowered to adopt regulations establishing
29 minimum and reasonable standards for the operation of family day
30 care homes and the issuance of registration certificates. These

1 regulations will establish the minimum standards of safety and
2 care which will be required in family day care homes and will
3 recognize the vital role which parents and guardians play in
4 monitoring the care provided in family day care homes.

5 Section 1077. Technical Assistance.--The department may
6 offer and provide upon request technical assistance to
7 caregivers to assist them in complying with department
8 regulations.

9 Section 1078. Operation Without Registration Certificate.--
10 No individual shall operate a family day care home without
11 having a registration certificate. Any individual operating a
12 family day care home without a registration certificate, after
13 being notified that such a registration is required, shall upon
14 conviction pay a fine of not less than twenty dollars (\$20) nor
15 more than one hundred dollars (\$100) and costs of prosecution.
16 Each day of operating without a registration certificate shall
17 constitute a separate offense.

18 Section 1079. Denial, Nonrenewal, or Revocation.--(a)
19 Whenever a caregiver does not certify compliance or whenever
20 upon inspection the department observes noncompliance with
21 applicable department regulations, the department shall give
22 written notice thereof to the offending person. Such notice
23 shall deny issuance of a registration certificate, deny renewal
24 of a registration certificate, or shall require the offending
25 person to take action to bring the facility into compliance with
26 regulations.

27 (b) The department shall refuse to issue or renew a
28 registration certificate or shall revoke a registration
29 certificate for any of the following reasons:

30 (1) Noncompliance with department regulations.

(2) Fraud or deceit in the self-certification process.

(3) Lending, borrowing, or using the registration certificate of another caregiver, or in any way knowingly aiding the improper issuance of a registration certificate.

(4) Gross incompetence, negligence, or misconduct in operating the facility.

(5) Mistreating or abusing children cared for in the facility.

Section 1080. Emergency Closure.--If the department, or authorized agent of the department observes a condition at a family day care home which places the children cared for therein in immediate life-threatening danger, the department shall maintain an action in the name of the Commonwealth for an injunction or other process restraining or prohibiting the operation of the facility.]

Section 17. The definition of "eligible permanent legal custodian" in section 1302 of the act, amended June 30, 2012 (P.L.668, No.80), is amended and the section is amended by adding definitions to read:

Section 1302. 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:

* * *

"Eligible permanent legal custodian." A relative or kin:

(1) whose home is approved pursuant to applicable regulations for placement of foster children;

(2) with whom an eligible child has resided for at least six months, which need not be consecutive; and

(3) who meets the requirements [for employment in child-

care services pursuant to] to be approved as a foster parent under 23 Pa.C.S. § 6344 (relating to [information relating to prospective child-care personnel] employees having contact with children; adoptive and foster parents).

* * *

"Sibling." An individual who has at least one parent in common with another individual, whether by blood, marriage or adoption, regardless of whether or not there is a termination of parental rights or parental death. The term includes biological, adoptive, step and half siblings.

* * *

"Successor permanent legal custodian." A relative or kin:

(1) with whom an eligible child resides for any period of time;

(2) who has been named as a successor in a permanent legal custodianship agreement executed by an eligible child's previous eligible permanent legal custodian; and

(3) who meets the requirements for employment in child-care services and approval as a foster or adoptive parent under 23 Pa.C.S. § 6344 (relating to employees having contact with children; adoptive and foster parents).

Section 18. Sections 1303(a.1) and 1303.2(a) of the act, added June 30, 2012 (P.L.668, No.80), are amended to read:

Section 1303. Kinship Care Program.

* * *

(a.1) Relative notification.--Except in situations of family or domestic violence, the county agency shall exercise due diligence to identify and notify all grandparents and other adult relatives to the fifth degree of consanguinity or affinity to the parent or stepparent of a dependent child and each parent

1 who has legal custody of a sibling of a dependent child within
2 30 days of the child's removal from the child's home when
3 temporary legal and physical custody has been transferred to the
4 county agency. The notice must explain all of the following:

5 (1) Any options under Federal and State law available to
6 the relative to participate in the care and placement of the
7 child, including any options that would be lost by failing to
8 respond to the notice.

9 (2) The requirements to become a foster parent,
10 permanent legal custodian or adoptive parent.

11 (3) The additional supports that are available for
12 children removed from the child's home.

13 * * *

14 Section 1303.2. Permanent legal custodianship subsidy and
15 reimbursement.

16 (a) Amount.--The amount of permanent legal custodianship
17 subsidy for maintenance costs to a permanent legal custodian or
18 a successor permanent legal custodian shall not exceed the
19 monthly payment rate for foster family care in the county in
20 which the child resides.

21 * * *

22 Section 19. ~~(Reserved).~~ THE REGULATIONS PERTAINING TO <--
23 ISSUANCE OF A CERTIFICATE OF REGISTRATION FOR A FAMILY CHILD-
24 CARE HOME UNDER 55 PA. CODE § 3290.11 ARE ABROGATED INSOFAR AS
25 THEY ARE INCONSISTENT WITH THIS ACT.

26 Section 20. The requirement that a family ~~child-care~~ CHILD- <--
27 CARE home be licensed as a facility as defined in section 1001
28 of the act shall apply upon expiration of the family ~~child-care~~ <--
29 CHILD-CARE home's current certificate of registration. <--

30 Section 21. This act shall take effect as follows:

1 (1) The following provisions shall take effect in 60
2 days:

3 (i) The addition of section 405.1B.

4 (ii) The amendment of section 432.4 of the act.

5 (2) Except as set forth in paragraph (3), the addition
6 of Article VIII-I of the act shall take effect on July 1,
7 2016, or immediately, whichever is later.

8 (3) The addition of sections 801-I, 806-I and 807-I(2)
9 of the act shall take effect immediately.

10 (4) The following provisions shall take effect
11 immediately:

12 (i) This section.

13 (ii) The remainder of this act.