No. 2001-77

AN ACT

HB 2

Establishing a special fund and account for money received by the Commonwealth from the Master Settlement Agreement with tobacco manufacturers; providing for home and community-based care, for tobacco use prevention and cessation efforts, for Commonwealth universal research enhancement, for hospital uncompensated care, for health investment insurance, for medical assistance for workers with disabilities, for regional biotechnology research centers, for the HealthLink Program, for community-based health care assistance programs, for PACE reinstatement and PACENET expansion, for medical education loan assistance and for percentage allocation and appropriation of moneys.

TABLE OF CONTENTS

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

CHAPTER 1
PRELIMINARY PROVISIONS

Section 101. Short title.

This act shall be known and may be cited as the Tobacco Settlement Act.

Section 102. Definitions.

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

"Fund." The Tobacco Settlement Fund established in section 303(a).

"Health Account." The Health Endowment Account for Long-Term Hope established in section 303(b).

"Health Venture Investment Account." The account established in section 303(c).

"Jurisdictional payment." A payment received by the Commonwealth resulting from a court retaining jurisdiction over the Escrow Agreement pursuant to section IX(b) of the Master Settlement Agreement.

"Master Settlement Agreement." The settlement agreement and related documents entered into on November 23, 1998, by the Commonwealth and leading United States tobacco product manufacturers approved by the Court of Common Pleas, Philadelphia County, on January 13, 1999.

"Strategic contribution payment." A payment received by the Commonwealth pursuant to section IX(c)(2) of the Master Settlement Agreement.

"Tobacco Settlement Fund." The Tobacco Settlement Fund established in section 303(a).

CHAPTER 3
HEALTH INVESTMENT

Section 301. Scope.

This chapter deals with health investment.

Section 302. Definitions.

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

"Accounts." The Health Endowment Account for Long-Term Hope established in section 303(b) and the Health Venture Investment Account established in section 303(c).

"Board." The Tobacco Settlement Investment Board established in section 304(a).

Section 303. Establishment of special fund and account.

(a) Tobacco Settlement Fund.—There is hereby established a special fund known as the Tobacco Settlement Fund. Except as provided in subsection (b), all payments received by the Commonwealth pursuant to the Master Settlement Agreement shall be deposited by the Treasury Department in the fund.

(b) Health Account.—There is hereby established within the fund the Health Endowment Account for Long-Term Hope. The following amounts shall be deposited by the Treasury Department into the account:

(1) The jurisdictional payment received by the Commonwealth pursuant to the Master Settlement Agreement.

(2) The strategic contribution payments received by the Commonwealth pursuant to the Master Settlement Agreement.

(3) Earnings derived from the investment of the money in the fund after deduction of investment expenses, including such earnings as may have accrued prior to the effective date of this chapter.

(4) Earnings derived from the investment of the money in the Health Account after deduction of investment expenses and the approved expenses of the board.

(5) Money received as a result of investments from the Health Venture Investment Account.

(c) Health Venture Investment Account.—There is hereby established within the fund the Health Venture Investment Account.

Section 304. Tobacco Settlement Investment Board.

(a) Establishment.—There is hereby established the Tobacco Settlement Investment Board, consisting of 11 members as follows: the Governor or a designee; the Secretary of the Budget; the State Treasurer or a designee; one member appointed by the President pro tempore of the Senate and one member appointed by the Minority Leader of the Senate; one member appointed by the Speaker of the House of Representatives and one member appointed by the Minority Leader of the House of Representatives; three members appointed by the Governor; and one member appointed by the State Treasurer. Legislative appointments shall serve at the pleasure of the appointing authority. Other appointed members shall serve for a term of four years and until a successor is appointed. Members of the board shall serve without compensation but shall be reimbursed for actual and reasonable expenses incurred in the performance of their official duties. The Governor shall select one member as chairperson, and the members of the board shall select one member as secretary.

(b) Professional personnel.—The board may employ investment advisors, fund managers and staff as the board deems advisable.

(c) Expenses.—All approved expenses of the board and related professional personnel expenses shall be paid and deducted from investment earnings of the Health Account. The board shall, through the Governor, submit to the General Assembly an annual budget covering its proposed administrative expenses. Concurrently with its annual budget request, the board shall submit to the General Assembly a list of proposed expenditures for the period covered by the budget request that the board intends to pay through the use of directed commissions, together with a list of the actual expenditures from the previous year actually paid by the board through the use of directed commissions. All such directed commission expenditures shall be made by the board for the exclusive benefit of the fund and the Health Account.

(d) Records and meetings.—The board shall keep a record of its proceedings, which shall be open to inspection by the public. Meetings of the board shall be conducted under 65 Pa.C.S. Ch. 7 (relating to open meetings).

Section 305. Investment of fund and accounts.

(a) Control and management.—Notwithstanding any other provision of law, the board shall have exclusive control and authority to manage, invest and reinvest money in the fund and the Health Account in accordance with this section, subject, however, to the exercise of that degree of judgment, skill and care under the circumstances then prevailing that persons of prudence, discretion and intelligence, who are familiar with investment matters, exercise in the management of their own affairs, not in regard to speculation but in regard to permanent disposition of the funds, considering the probable income to be derived from the investments and the probable safety of their capital. The board may hold, purchase, sell, lend, assign, transfer or dispose of any securities and investments, including equity securities, in which money in the fund or the accounts has been invested and of the proceeds of the investments, including any directed commissions that have accrued to the benefit of the fund or the accounts as a consequence of the investments, and of money belonging to the fund or the accounts subject to the standard of prudence in this section.

(b) Fiduciary status of board.—The members of the board and their professional personnel shall stand in a fiduciary relationship to the Commonwealth and its citizens regarding the investments of the money of the fund and the accounts and shall not profit, either directly or indirectly, with respect thereto.

(c) Custodian.—The State Treasurer shall be the custodian of the fund and the accounts. All investment draws from the fund or the accounts shall be made by the State Treasurer in accordance with requisitions signed by the secretary of the board and ratified by resolution of the board.

(d) Authorized investment vehicles for the fund and the Health Account.—The board may invest the money in the fund and the Health Account in investments that meet the standard of prudence set forth in subsection (a) by acquiring any type of interest in a business organization existing under the laws of any jurisdiction. The liability of the fund or the Health Account shall be limited to the amount of their investment under this subsection.

(e) Additional authorized investment vehicles for the Health Account.—The board in its prudent discretion may invest the money in the Health Account in venture capital investments, private placement investments or other alternative investments of any kind, structure or manner which meet the standard of prudence set forth in subsection (a). The liability of the Health Account shall be limited to the amount of its investment under this subsection.

(f) Authorized investment vehicles for the Health Venture Investment Account.—The board may invest the money in the Health Venture Investment Account in investments which meet the standard of prudence set forth in subsection (a) by becoming a limited partner in partnerships that make venture capital investments by acquiring equity interests or a combination of debt and equity interests in health care, biotechnology or any other health-related businesses that are expected to grow substantially in the future and in which the expected returns on investment are to come predominantly from increases in value of the equity interests and are not interests in or secured by real estate. The board may invest in one or more limited partnerships or comparable investment entities provided that the investment guidelines and strategies of each investment entity require that at least 70% of the investments will be made in companies located primarily in Pennsylvania or in companies willing to relocate significant business operations to Pennsylvania. The liability of the fund or the Health Venture Investment Account shall be limited to the amount of its investment under this section.

(g) Requirements for venture capital investments.—The following are the requirements to participate in a venture capital investment program undertaken by the board under subsection (e) or (f):

(1) Each general partner must:

(i) contribute 2% of the aggregate committee capital as a general partner; and

(ii) subordinate 5% of the board's contribution in terms of the distribution schedule, putting the general partner in a first loss position with respect to the board.

(2) The partnership must provide a preferred return of no less than 5% to all limited partners.

(3) The partnership must agree to operate under a prudent expert standard of care. The board shall adopt policies regarding cancellation of a contract with a general partner based on poor performance which may include policies relating to multiple instances of indemnification or substantial changes in principals.

(4) The board must be given a seat on any limited partner advisory/valuation committee.

(5) The board must be reimbursed for expenses for attending limited partner advisory/valuation committee meetings and partnership annual meetings.

(6) The partnership must issue to the board audited financial statements on the basis of Generally Accepted Accounting Principles.

(h) Legislative declaration.—The General Assembly finds and declares that authorized investments of the fund or the accounts made by or on behalf of the board under this section whereby the board becomes a joint owner, limited partner or stockholder in a company, corporation, limited partnership, association or other lawful business organization are outside

the scope of the original intent of and do not violate the prohibition set forth in section 8 of Article VIII of the Constitution of Pennsylvania.

Section 306. Use of Tobacco Settlement Fund.

(a) Annual report.—The Governor shall report on the fund in the annual budget which shall include the amounts appropriated to each program.

(b) Appropriations.—

(1) The General Assembly hereby appropriates funds in the fund in accordance with the following percentages based on actual funds received in each year or upon receipt of the final annual payment:

(i) Eight percent for deposit into the Health Account pursuant to this chapter, which shall be deposited immediately upon receipt.

(ii) Thirteen percent for home and community-based services pursuant to Chapter 5. For fiscal year 2001-2002, up to $13.5 million may be used for expanded counseling, area agency on aging training and education, assistive technology and for reducing waiting lists for services in the Department of Aging.

(iii) Twelve percent for tobacco use prevention and cessation programs pursuant to Chapter 7.

(iv) Eighteen percent for health and related research pursuant to section 906 and one percent for health and related research pursuant to section 909.

(v) Ten percent for the uncompensated care payment program pursuant to Chapter 11.

(vi) Thirty percent for health investment insurance pursuant to Chapter 13 and for the purchase of Medicaid benefits for workers with disabilities pursuant to Chapter 15.

(vii) Eight percent for the expansion of the PACENET program pursuant to Chapter 23.

(2) In addition, any Federal funds received for any of these programs is hereby specifically appropriated to those programs.

(c) Lapses.—Lapses shall be deposited in the Health Account except for the following:

(1) Lapses from moneys provided for the home and community-based care services shall be reallocated to the home and community-based care program for use in succeeding years.

(2) Lapses from moneys provided for the health investment insurance program shall be reallocated to the health investment insurance program for use in succeeding years.

Section 307. Use of Health Account.

Whenever the Governor determines that money from the Health Account is necessary to meet the extraordinary or emergency health care needs of the citizens of this Commonwealth, the Governor shall present a detailed spending proposal with a request for an appropriation and any necessary legislation to the chair and minority chair of the Appropriations Committee

of the Senate and the chair and minority chair of the Appropriations Committee of the House of Representatives. The General Assembly may, through approval of a separate appropriation bill by a vote of two-thirds of the members elected to the Senate and to the House of Representatives, appropriate money from the Health Account to meet the needs identified in the Governor's request. Any money appropriated under this section that lapses shall be returned to the Health Account.

Section 308. Annual report.

By November 30, 2002, and annually thereafter, the board shall submit a report to the Governor and to the chair and minority chair of the Appropriations Committee of the Senate and the chair and minority chair of the Appropriations Committee of the House of Representatives. The report shall provide an analysis of the status of the current investments and transactions made over the last fiscal year for the fund and the accounts.

CHAPTER 5
HOME AND COMMUNITY-BASED CARE

Section 501. Scope.

This chapter deals with home and community-based care.

Section 502. Definitions.

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

"Applicant." An individual who applies for services under this chapter and who meets all of the following:

(1) Legally resides in the United States.

(2) Is domiciled in this Commonwealth.

(3) Is 60 years of age or older.

"Assisted individual." An applicant who meets all of the following:

(1) Is domiciled in this Commonwealth for at least 30 days prior to requesting an assessment.

(2) Has been assessed by the department to be in need of care equivalent to the level of care provided by a nursing facility.

(3) Has monthly income at or below 300% of the Federal benefit rate.

(4) Exceeds the resource eligibility requirements for medical assistance under the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, but does not exceed a resource level determined by the department and the Department of Public Welfare which in no case shall be less than $40,000.

"Department." The Department of Aging of the Commonwealth.

"Enrolled provider." A provider who participates in the medical assistance program pursuant to the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.

"Federal benefit rate." The amount payable to a Supplemental Security Income (SSI) beneficiary under section 1611(b)(1) of the Social Security

Act (49 Stat. 620, 42 U.S.C. § 1382(b)(1)) who resides in his or her own home and has no income or resources.

"Funded individual." An applicant who meets all of the following:

(1) Has been assessed to be in need of care equivalent to the level of care provided by a nursing facility.

(2) Is financially eligible for medical assistance under the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.

"Home and community-based care services." An array of services designated by the Department of Aging and the Department of Public Welfare to maintain older Pennsylvanians in their homes.

"Nursing facility." A facility which is:

(1) licensed under the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act; and

(2) qualified to participate under Title XIX of the Federal Social Security Act.

Section 503. Home and community-based care services.

(a) Appropriations.—Appropriations from the fund to the Department of Public Welfare for home and community-based care services shall be used to pay enrolled providers for home and community-based care services provided to funded individuals in accordance with all applicable Federal and State requirements. Appropriations from the fund to the department shall be used for home and community-based care services to assisted individuals and for coordination of services provided under this chapter.

(b) Applicant responsibilities.—An applicant for home and community-based care services shall do all of the following:

(1) Request an assessment in accordance with procedures established by the department and the Department of Public Welfare.

(2) Cooperate with the Department of Public Welfare and the department, as applicable, in determining eligibility for home and community-based care services, including financial eligibility.

(c) Funded individual responsibilities.—An applicant who receives home and community-based care services as a funded individual shall notify the Department of Public Welfare of any change in resources or income as specified by the Department of Public Welfare.

(d) Assisted individual responsibilities.—An applicant who receives home and community-based care services as an assisted individual shall do all of the following:

(1) Pay a monthly copayment on a sliding scale developed by the department and the Department of Public Welfare based on resources and income. The monthly copayment shall not exceed the actual costs of the home and community-based care services to be received.

(2) Notify the department of any change in resources and monthly income as specified by the department.

(e) Department of Public Welfare responsibilities.—The Department of Public Welfare shall do all of the following:

(1) Determine the financial eligibility of applicants.

(2) Provide funding to enrolled providers for home and community-based care services to funded individuals.

(3) Notify the department of applicants determined to be assisted or funded individuals.

(4) In cooperation with the department, submit a report no later than November 30, 2002, and annually thereafter to the chair and minority chair of the Aging and Youth Committee of the Senate, the chair and minority chair of the Public Health and Welfare Committee of the Senate, the chair and minority chair of the Aging and Older Adult Services Committee of the House of Representatives, the chair and minority chair of the Health and Human Services Committee of the House of Representatives, the chair and minority chair of the Appropriations Committee of the Senate and the chair and minority chair of the Appropriations Committee of the House of Representatives. The report shall be made available for public inspection and posted on the publicly accessible World Wide Web site of the Department of Public Welfare. The report shall include:

(i) The number of applicants.

(ii) The number of assisted and funded individuals by county.

(iii) The total expenditure by county.

(iv) The scope and average cost of services provided to assisted and to funded individuals.

(v) The average expenditure per assisted and per funded individual.

(vi) The average copayment amount per assisted individual.

(vii) Any other information deemed necessary by the Department of Public Welfare.

(f) Department responsibilities.—The department shall do all of the following:

(1) Coordinate the collection of copayments from assisted individuals for home and community-based care services.

(2) Provide funding to entities designated by the department to provide home and community-based care services to assisted individuals.

(3) Assist the Department of Public Welfare in the recruitment of providers.

(4) Facilitate the transition of assisted individuals who become eligible for home and community-based care services as funded individuals.

(g) Limitations.—

(1) In no case shall the total aggregate amount of payments to enrolled providers under this chapter exceed Federal appropriations and State appropriations from the fund to the Department of Public Welfare for home and community-based care services.

(2) In no case shall the total aggregate amount of payments to entities that provide home and community-based care services to assisted individuals under this chapter exceed Federal appropriations and State appropriations from the fund to the department for home and community-based care services.

(3) In no case shall the creation of this program be considered an entitlement to home and community-based care services.

Section 504. Accountability.

Three years after the effective date of this chapter, the Department of Public Welfare, in cooperation with the department, shall conduct a performance review of the program to provide home and community-based services under this chapter. The performance review shall be based upon the report prepared under section 503(e)(4) and shall include the following:

(1) The strategic goals and objectives for the program.

(2) Whether these strategic goals and objectives were achieved.

(3) The specific methodology for evaluating the results, along with any proposed recommendations for improvement.

CHAPTER 7
TOBACCO USE PREVENTION AND CESSATION EFFORTS

Section 701. Scope.

This chapter deals with tobacco use prevention and cessation efforts.

Section 702. Definitions.

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

"Committee." The Tobacco Use Prevention and Cessation Advisory Committee established in section 705.

"Department." The Department of Health of the Commonwealth.

"Primary contractor." A person located in this Commonwealth that develops, implements or monitors tobacco use prevention and cessation programs in a service area. The term includes:

(1) a for-profit or nonprofit organization, including a community foundation, that provides tobacco use prevention and cessation programs;

(2) an entity created under the act of April 14, 1972 (P.L.221, No.63), known as the Pennsylvania Drug and Alcohol Abuse Control Act;

(3) a municipality or a municipal health department created pursuant to the act of August 24, 1951 (P.L.1304, No.315), known as the Local Health Administration Law;

(4) an institution of higher education; and

(5) a hospital established under the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

"Program." The comprehensive tobacco use prevention and cessation program established under section 703, the goal of which is to promote

tobacco use prevention and cessation efforts that eliminate or reduce disease, disability and death, related to tobacco use among residents of this Commonwealth, utilizing the "Best Practices for Comprehensive Tobacco Control Programs," or a successor program, of the National Centers for Disease Control and Prevention.

"Secretary." The Secretary of Health of the Commonwealth.

"Service area." A geographic area designated by the Department of Health under section 704.

"Service provider." A person located in this Commonwealth that is selected by the primary contractor to receive a grant to provide tobacco use prevention and cessation programs. The term includes:

(1) a for-profit or nonprofit organization that provides tobacco use prevention and cessation programs;

(2) an entity created under the act of April 14, 1972 (P.L.221, No.63), known as the Pennsylvania Drug and Alcohol Abuse Control Act;

(3) a municipality or a municipal health department created under the act of August 24, 1951 (P.L.1304, No.315), known as the Local Health Administration Law;

(4) an institution of higher education;

(5) a hospital established under the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act; and

(6) a school district or intermediate unit.

Section 703. Tobacco use prevention and cessation program.

(a) Establishment.—There is hereby established in the department a tobacco use prevention and cessation program. Appropriations from the fund to the department for the program shall be used to implement the program.

(b) Components.—The program shall include the following:

(1) Statewide, community and school programs designed to reduce tobacco use.

(2) Chronic disease programs to reduce the burden of tobacco-related diseases, including prevention and early detection.

(3) Enforcement of applicable laws related to tobacco access.

(4) Efforts designed to counter tobacco influences and increase health-related messages.

(5) Tobacco cessation programs, with a priority for serving the uninsured and low-income populations.

(6) Monitoring program accountability by requiring the evaluation and documentation of or by conducting research regarding the effectiveness of the program and program results.

(7) Administration and management to facilitate the coordination of State and local programs.

Section 704. Powers and duties of department.

The department has the following powers and duties:

(1) To administer the program in a manner which provides Statewide and local services to Commonwealth residents.

(2) To annually establish program priorities for the Commonwealth in consultation with the committee.

(3) On a Statewide basis, to award grants and enter into contracts to implement the priorities established under paragraph (2). The department shall set specific goals with measurable objectives to monitor the reduction of tobacco consumption under related programs developed by Statewide grant recipients.

(4) To divide this Commonwealth into no more than 67 service areas in order to provide for the effective and geographically dispersed delivery of the program. The department shall foster collaboration among geographic regions of this Commonwealth.

(5) To enter into contracts under section 708 with at least one and no more than two primary contractors in each service area.

(6) To approve plans submitted by primary contractors, which shall include specific goals with measurable objectives to be met by the primary contractors for each service area.

(7) To coordinate, monitor and evaluate the program funded under this chapter to ensure compliance with priorities and goals and to ensure delivery of program services in all geographic areas of this Commonwealth. The program shall be coordinated with other efforts to prevent and reduce exposure to and consumption of tobacco.

(8) To determine the level of tobacco use in this Commonwealth and each of the service areas and monitor changes in the level of tobacco use in this Commonwealth and each of the service areas based on available information.

(9) To pursue grants for tobacco use prevention and cessation as provided in section VI(g) of the Master Settlement Agreement. All money awarded to the department under this paragraph shall be listed in the report under paragraph (10).

(10) To prepare and submit a report no later than November 30, 2002, and annually thereafter to the chair and minority chair of the Public Health and Welfare Committee of the Senate and the chair and minority chair of the Health and Human Services Committee of the House of Representatives. The annual report shall be made available for public inspection and posted on the department's publicly accessible World Wide Web site. The report shall include the activities of the department in implementing this chapter, including:

(i) Identification of Statewide grant recipients and the grant amount awarded to each recipient.

(ii) Identification of the primary contractor and all service providers in each service area and the grant amounts awarded to each contractor and each provider.

(iii) Identification of program priorities under paragraph (2).

(iv) The goals of each primary contractor and whether its goals have been met.

(v) The information and methodology derived from the implementation of paragraph (8), along with any recommendations for further reductions in the level of tobacco use.

(vi) Applications made and grants received under paragraph (9).

Section 705. Committee.

(a) Establishment.—There is established in the department the Tobacco Use Prevention and Cessation Advisory Committee.

(b) Membership.—The committee is comprised of the following:

(1) The secretary or a designee, who shall serve as chairperson.

(2) Four members appointed by the secretary.

(3) One member appointed by the President pro tempore of the Senate and one member appointed by the Minority Leader of the Senate.

(4) One member appointed by the Speaker of the House of Representatives and one member appointed by the Minority Leader of the House of Representatives.

(c) Qualifications.—Members appointed to the committee must possess expertise in community, clinical or public health practices or in programs related to tobacco use prevention and cessation.

(d) Terms.—

(1) The secretary shall serve ex officio.

(2) A member under subsection (b)(2) shall serve a term of four years.

(3) A member under subsection (b)(3) shall serve a term of four years but may be removed at the pleasure of the appointing authority.

(4) A member under subsection (b)(4) shall serve a term of two years but may be removed at the pleasure of the appointing authority.

(5) An appointment to fill a vacancy shall be for the period of the unexpired term or until a successor is named.

(e) Meetings.—The committee shall meet as needed, but at least twice a year, to perform the duties provided for in this chapter. A majority of the members of the committee constitutes a quorum. A majority of the members of the committee has authority to act upon any matter properly before it. The committee is authorized to establish rules for its operation and shall hold at least one public hearing annually. Meetings of the committee shall be conducted under 65 Pa.C.S. Ch. 7 (relating to open meetings).

(f) Expenses.—Members shall receive no payment for their services. Members who are not employees of State government shall be reimbursed for necessary and reasonable expenses incurred in the course of their official duties.

(g) Powers and duties.—The committee has the following powers and duties:

(1) Collect and review information relating to tobacco use prevention and cessation.

(2) Make annual recommendations to the department regarding tobacco use prevention and cessation program priorities. Consideration shall be given to:

(i) prevention and cessation programs operating in minority communities and among other demographic groups and demographic regions which suffer from disproportionately high rates of lung cancer or other tobacco-related diseases;

(ii) efforts which would lower tobacco use among school-age children; and

(iii) the delivery of cessation services by approved "health care practitioners" as defined in section 103 of the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

(3) Make annual recommendations to the department on the evaluation procedures to be used in approving primary contractors and service providers.

Section 706. Primary contractors.

(a) Applicants.—In order to be a primary contractor, an applicant must submit a plan to the department which demonstrates the ability of the primary contractor to develop, implement and monitor the program in a service area. Priority may be given to primary contractors that have experience in providing or coordinating tobacco use prevention and cessation services.

(b) Department.—The department shall review plans submitted under subsection (a) and shall enter into a contract with the primary contractor selected to provide the program in each service area.

(c) Grants.—The primary contractor shall award grants to service providers to implement the program for the service area. The grants must be approved by the department.

(d) Duties of primary contractor.—The primary contractor shall do all of the following:

(1) Develop a proposed plan, subject to department approval, which meets the tobacco use prevention and cessation needs in the service area and the goals and priorities established under section 704(2).

(2) Award grants to service providers to implement the program in the service area in accordance with the plan developed and approved under paragraph (1). Priority may be given to service providers who have experience in providing tobacco use prevention and cessation services. In a service area with multiple service providers, no individual service provider shall receive more than 50% of the funds awarded to the primary contractor unless otherwise approved by the department.

(3) Establish tobacco reduction goals for each service provider in the service area consistent with the plan adopted under paragraph (1).

(4) Ensure that service providers are meeting the priorities and goals set forth in the plan.

(5) Coordinate the plan with other health-related programs to prevent or reduce tobacco use by individuals receiving services from these programs.

(6) Increase participation in the program by schools in the service area.

(7) Solicit input from health care providers, community organizations, public officials and other individuals and groups regarding the plan for each service area.

(8) Coordinate efforts with local law enforcement to enforce existing tobacco restrictions.

(9) Prepare and submit reports as required by the department which shall include all of the following:

(i) Identification of service providers and grant amounts for each service provider by service area by fiscal year.

(ii) Identification of specific local goals for the program to be met by service providers for each service area.

(iii) Details of the spending plan by service area.

(iv) Identification of indicators used to evaluate whether specific goals have been met.

Section 707. Service providers.

(a) Applications.—Service providers must apply to the primary contractor in their service area for a grant to deliver program services in accordance with section 706. An application to be a service provider must include a description of the purpose of the service and the manner in which the service will reduce or prevent tobacco use. The application shall include the method by which the service provider proposes to be evaluated.

(b) Service provider annual report.—A service provider awarded a grant under this chapter shall annually report to the primary contractor and to the department all of the following:

(1) Expenditures made with the grant awards.

(2) Whether the goals set by the primary contractor have been met and the methodology utilized to measure program results.

(3) Any other information deemed necessary by the primary contractor or the department.

Section 708. Contracts and purposes.

(a) Contracts.—Contracts with primary contractors and Statewide contractors shall be for a period not to exceed three years. Contracts shall be awarded in accordance with 62 Pa.C.S. (relating to procurement) and may be awarded on a multiple-award basis. Funding for multiyear contracts shall be subject to the availability of funds as appropriated by the General Assembly.

(b) Purpose.—Funds allocated under this chapter shall be used for all of the following:

(1) At least 70% shall be used for grants to primary contractors to develop local programs.

(2) The remaining funds shall be used for compliance with Federal requirements under the act of December 21, 2000 (Public Law 106-554, 114 Stat. 2763), and for Statewide efforts consistent with the priorities established under section 704(2). After June 30, 2002, no more than one-half of the funds set aside under this paragraph shall be used for countermarketing media campaigns. Media campaigns prepared for television or radio may be conducted through public or private media outlets. All funds used for such campaigns shall be spent to the greatest extent possible on efforts that have been proven successful in other states.

(c) Limitations.—The aggregate amount of contracts and grants in any fiscal year may not exceed the amount of the appropriation to the department for the tobacco prevention program in that fiscal year. The provision of a grant under this chapter shall not constitute an entitlement derived from the Commonwealth or a claim on any other funds of the Commonwealth.

(d) Restrictions.—A tobacco company or an agent or subsidiary of a tobacco company may not be awarded a contract or grant as a Statewide contractor, primary contractor or service provider.

Section 709. Accountability.

(a) Audits.—Contracts with Statewide contractors and primary contractors and grants to service providers shall be subject to audit as provided by law. Contracts with Statewide contractors and primary contractors and grants to service providers shall be subject to an annual audit by the department. Audits of these contracts and grants are to be conducted in accordance with generally accepted government auditing standards.

(b) Review procedures.—Any Statewide contractor, primary contractor or service provider that receives a contract or a grant under this chapter shall be subject to a performance review by the department. As appropriate, the performance review shall be based upon information submitted to the department that includes the following:

(1) The contractor's or service provider's strategic goals and objectives for the use of grant moneys for tobacco use prevention and cessation.

(2) The contractor's or service provider's annual performance plan setting forth how these strategic goals and objectives are to be achieved and the specific methodology for evaluating results, along with any proposed methods for improvement.

(3) The contractor's or service provider's annual performance report setting forth the specific results in achieving its strategic goals and objectives for tobacco use prevention and cessation, including any changes in the incidence of tobacco use among target populations.

(4) The progress made in achieving expected program priorities and goals.

(5) Any other information deemed necessary by the department.

(c) Penalty.—If an audit or performance review indicates that a Statewide contractor, a primary contractor or a service provider failed to comply with contract requirements or meet performance goals, contractors and providers may be subject to a reduction in or ineligibility for future contract or grant funding.

Section 710. Miscellaneous provisions.

Notwithstanding any other provisions of this chapter, the department or a primary contractor, with the approval of the department, may award grants that promote healthy lifestyles through education programs which incorporate tobacco use prevention and cessation services. Education programs may include Internet or computer-based instruction and health and fitness guidance relating to healthy life choices and the dangers of tobacco use in conjunction with developmental and instructional programs for school athletic coaches and school athletes.

CHAPTER 9
COMMONWEALTH UNIVERSAL RESEARCH ENHANCEMENT

Section 901. Scope.

This chapter deals with Commonwealth universal research enhancement efforts.

Section 902. Definitions.

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

"Advisory committee." The Health Research Advisory Committee established in section 903(b).

"Applicant." Any of the following located in this Commonwealth:

(1) A person.

(2) An institution.

(3) An entity established under the act of August 24, 1951 (P.L.1304, No.315), known as the Local Health Administration Law.

"Biomedical research." Comprehensive research pertaining to the application of the natural sciences to the study and clinical practice of medicine at an institution, including biobehavioral research related to tobacco use.

"Clinical research." Patient-oriented research which involves direct interaction and study of the mechanisms of human disease, including therapeutic interventions, clinical trials, epidemiological and behavioral studies and the development of new technology.

"Department." The Department of Health of the Commonwealth.

"Health services research." Any of the following:

(1) Research on the promotion and maintenance of health, including biobehavioral research.

(2) Research on the prevention and reduction of disease.

(3) Research on the delivery of health care services to reduce health risks and transfer research advances to community use.

"Infrastructure." Equipment, supplies, nonprofessional personnel, laboratory or building construction or renovations, or the development, acquisition or maintenance of technology, including training, used to conduct research.

"Institution." Any of the following located in this Commonwealth:

(1) A nonprofit entity that conducts research.

(2) A hospital that conducts research and is established under the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

(3) An institution of higher education that conducts research.

"NIH." The National Institutes of Health.

"Peer review." A process approved by the Department of Health or the National Institutes of Health in which a review panel which includes the applicant's professional peers reviews and evaluates research grant applications using a rating system of scientific and technical merit.

"Research." Biomedical, clinical and health services research which may include infrastructure.

"Secretary." The Secretary of Health of the Commonwealth.

Section 903. Health research program.

(a) Program establishment.—

(1) There is established in the department a health research program which shall be known as the Commonwealth Universal Research Enhancement Program. Appropriations from the fund to the department shall be used to fund research projects and related infrastructure by eligible applicants. This includes:

(i) biomedical research;

(ii) clinical research; and

(iii) health services research.

(2) Funds appropriated for the program may be used to conduct peer reviews and performance reviews.

(b) Advisory committee.—

(1) There is hereby established in the department the Health Research Advisory Committee.

(2) The committee is comprised of the following:

(i) The secretary or a designee, who shall serve as chairperson.

(ii) Four members appointed by the Governor.

(iii) One member appointed by the President pro tempore of the Senate and one member appointed by the Minority Leader of the Senate.

(iv) One member appointed by the Speaker of the House of Representatives and one member appointed by the Minority Leader of the House of Representatives.

(3) Members appointed to the committee by the Governor must possess expertise in health care or research, with representation by institution-based research specialists, practicing clinicians, clinical investigators and public health professionals.

(4) Terms are as follows:

(i) The secretary shall serve ex officio.

(ii) A member under paragraph (2)(ii) shall serve a term of six years.

(iii) A member under paragraph (2)(iii) shall serve a term of four years but may be removed at the pleasure of the appointing authority.

(iv) A member under paragraph (2)(iv) shall serve a term of two years but may be removed at the pleasure of the appointing authority.

(v) An appointment to fill a vacancy shall be for the period of the unexpired term or until a successor is appointed and qualified.

(5) The committee shall meet as needed, but at least twice a year, to fulfill the purposes provided for in this chapter. A majority of the members of the committee constitutes a quorum. A majority of the members of the committee has authority to act upon any matter properly before it. The committee is authorized to establish rules for its operation and shall hold public hearings, as necessary, to obtain public input and make recommendations to the department regarding research priorities, evaluation and accountability procedures and related issues. Meetings of the committee shall be conducted under 65 Pa.C.S. Ch. 7 (relating to open meetings).

(6) Members shall receive no payment for their services. Members who are not employees of State government shall be reimbursed for necessary and reasonable expenses incurred in the course of their official duties.

Section 904. Department responsibilities.

The department has the following powers and duties:

(1) Administer the health research program established under this chapter.

(2) Establish, in conjunction with the Health Research Advisory Committee, the research priorities of the Commonwealth. In developing these research priorities, the national health promotion and disease prevention objectives established by the United States Department of Health and Human Services, as applied to this Commonwealth, shall be considered. The priorities shall include the identification of critical research areas, disparities in health status among various Commonwealth populations, expected research outcomes and benefits and disease prevention and treatment methodologies. The priorities shall be reviewed annually and revised as necessary.

(3) Except as provided in section 905(f) and (g), review applications and award research grants to applicants consistent with the priorities

established under paragraph (2). Research grants may be awarded for a period not to exceed four years for each project.

(4) Develop and implement peer review procedures to be used for the review of grant applications for projects funded pursuant to section 906(2) and (3).

(5) Publish an annual report on all research funded under this chapter. The report shall include:

(i) the aggregate amount of research grants awarded to each applicant;

(ii) the name and address of each principal investigator that received a grant;

(iii) the project title and purpose;

(iv) the name and employer of each participating researcher;

(v) the expected research outcomes and benefits;

(vi) the amount of each research grant awarded;

(vii) an anticipated disbursement schedule by fiscal year for each grant awarded;

(viii) a report of expenditures by grant by fiscal year; and

(ix) a detailed summary of the research completed that year.

(6) The report under paragraph (5) shall be provided to the chair and minority chair of the Public Health and Welfare Committee and the chair and minority chair of the Appropriations Committee of the Senate and the chair and minority chair of the Health and Human Services Committee and the chair and minority chair of the Appropriations Committee of the House of Representatives no later than November 30, 2002, and annually thereafter. The annual report shall be made available for public inspection and posted on the department's publicly accessible World Wide Web site.

Section 905. Peer review procedures.

(a) Peer review required.—Except for infrastructure and for projects funded under section 906(1), research funded under this chapter shall be peer reviewed and selected in accordance with this section.

(b) Prior peer review.—Research which has received peer review by the National Institutes of Health, the Centers for Disease Control or another Federal agency may be approved and ranked for funding by the department consistent with the priorities established under section 904(2).

(c) Department peer review.—Research which has not received peer review as provided in subsection (b) shall be subject to peer review by the department in accordance with subsection (d) prior to being considered for funding under section 906(2) and (3).

(d) Peer review panels.—The department shall establish peer review panels in various disciplines, as necessary, to review research grant proposals which are consistent with the priorities established under section 904(2). A panel shall be composed of at least three nationally recognized physicians, scientists or researchers from the same or similar discipline as

the research grant proposal under review. Members of a peer review panel may be residents of other states. In no case shall a member of a peer review panel be an employee of an applicant whose grant proposal is under its review.

(e) Panel review factors.—A review panel shall determine eligibility for grant funding based on the highest-ranked peer review scores through a rating system consistent with Federal rating standards as developed by the department. A panel shall review and rank research projects eligible for funding in a manner which recognizes scientific and technical merit on the basis of scientific need, scientific method, research design, adequacy of the facility and qualifications of the research personnel.

(f) Ethical standards.—No research funded under this chapter shall be permitted until a memorandum of understanding between the applicant and the secretary has been executed specifying that the research to be performed and all individuals performing such research shall be subject to Federal ethical and procedural standards of conduct as prescribed by the NIH on the date the memorandum of understanding is executed. Research funded under this act shall observe the Federal ethical and procedural standards regulating research and research findings, including publications and patents, which are observed under NIH extramural funding requirements and NIH grants policy statements and applicable sections of 45 CFR Pt. 74 (relating to uniform administrative requirements for awards and subawards to institutions of higher education, hospitals, other nonprofit organizations, and commercial organizations; and certain grants and agreements with States, local governments and Indian tribal governments) and Pt. 92 (relating to uniform administrative requirements for grants and cooperative agreements to State and local governments).

(g) Ethics Advisory Board.—

(1) The Ethics Advisory Board shall be composed of six individuals who are not officers or employees of the Commonwealth. The secretary shall make appointments to the board from among individuals with qualifications and experience to provide advice and recommendations regarding ethical matters in research. The members of the board shall include one attorney, one ethicist, one practicing physician, one theologian, one scientist with experience in biomedical research and one scientist with experience in behavioral research. In no case shall a member of the board be an officer, director, employee or paid consultant of an applicant whose grant proposal is under review.

(i) A majority of the board shall consist of four members.

(ii) Members of the board shall serve at the pleasure of the secretary.

(iii) The secretary shall designate an individual from among the members of the board to serve as the chair of the board.

(iv) A member of the board shall receive no payment for service but shall be reimbursed by the department for necessary and

reasonable expenses incurred in the course of the member's official duties.

(v) An annual report setting forth a summation of the board activities as well as each board decision shall be submitted no later than November 30 of each year to the chair and minority chair of the Public Health and Welfare Committee of the Senate and to the chair and minority chair of the Health and Human Services Committee of the House of Representatives and shall be made available to the public.

(2) The board shall be convened by the secretary to advise and make recommendations when a research project may be denied due to ethical considerations, consistent with the standards set forth in subsection (f) that are in effect on the date the board is convened.

(i) The department shall notify the research applicant of the initiation of an ethics review. The applicant shall have the opportunity to provide comment on the ethical considerations of the project to the board. The board may receive other comments or information to assist in its review.

(ii) The board shall have access to all relevant information possessed by the department regarding the research project.

(iii) Within 60 days of initiating its review, the board shall submit to the secretary a report with its findings and recommendations regarding the ethical considerations of the research project.

(3) Funding for a research project under this chapter shall be denied by the secretary based on a finding of improper ethical considerations by a majority of the board.

(4) As used in this subsection, the following words and phrases shall have the meanings given to them in this paragraph:

"Board." The Ethics Advisory Board.

"Ethical considerations." Matters concerning whether the proposed conduct of or subject of the research is medically, sociologically and legally moral and proper.

(h) Final selection.—Based on the procedures set forth in this section and the rankings established by the relevant peer review panel, the department shall award research grants to selected applicants. In making these awards, the department shall avoid unnecessary duplication, ensure relevance to the appropriate research priority, encourage collaboration between applicants and provide for the development of a complementary Statewide research program.

Section 906. Use of funds.

Research projects conducted under this section shall be consistent with the priorities established under section 904(2). Funds under this section shall be allocated for the following purposes:

(1) Seventy percent of the funds appropriated under this section shall be used to fund research pursuant to section 908.

(2) Fifteen percent of the funds appropriated under this section shall be used to fund clinical and health services research projects by eligible applicants.

(3) Fifteen percent of the funds appropriated under this section shall be used to fund other research projects by eligible applicants.

Section 907. Applications.

(a) General rule.—An application for a research grant under section 906 must include all of the following, as applicable:

(1) The name and address of the applicant.

(2) The identification of participating researchers.

(3) The description of the purpose and methodology of the research project.

(4) An accounting of proposed expenditures, to include salary expenses, capital equipment and construction or renovation.

(5) The expected research outcomes and benefits.

(6) An explanation of the project's evaluative procedures.

(7) A list of other proposed funding sources being sought by the applicant for the research project.

(8) Any other information deemed necessary by the department.

(b) Report.—An applicant receiving a research grant under this chapter shall report annually to the department on the progress of the research project or as often as the department deems necessary. The results of the research and other information deemed necessary by the department shall be reported to the department upon conclusion of the research project in accordance with section 910.

(c) Limitations.—

(1) An applicant for a research grant under section 906 may not expend more than 50% of its grant for infrastructure.

(2) The award of a research grant shall not constitute an entitlement derived from the Commonwealth or a claim on any funds of the Commonwealth.

Section 908. National Institutes of Health funding formula.

(a) Eligibility.—An institution that conducts research in this Commonwealth and has received funding from the National Institutes of Health during each of the three immediately preceding Federal fiscal years shall be eligible to receive a grant pursuant to section 906(1). For one year from the effective date of this act, an institution that has immediately succeeded, by asset acquisition, the research function of another institution that received National Institutes of Health funding during any of the four immediately preceding fiscal years shall be considered eligible to receive a grant pursuant to section 906(1).

(b) Fund distribution.—Funds under this section shall be distributed to eligible institutions as follows:

(1) Twenty percent shall be distributed to each institution that receives more than $175,000,000 as an average amount from the

National Institutes of Health during the three immediately preceding Federal fiscal years.

(2) Seventeen percent shall be distributed to each institution that receives more than $175,000,000 in federally sponsored research and development obligations in the immediately available preceding Federal fiscal year as reported by the National Science Foundation and receives more than $60,000,000 as an average amount from the National Institutes of Health during the three immediately preceding Federal fiscal years.

(3) The remaining funds shall be distributed to eligible institutions based on the percentage calculated by dividing an institution's average award from the National Institutes of Health for the three immediately preceding Federal fiscal years by the sum of the average annual award from the National Institutes of Health for all Pennsylvania-based eligible institutions during the three immediately available preceding Federal fiscal years.

(4) An institution is not eligible to receive funds under more than one paragraph of this subsection.

(c) Additional requirements.—An institution that receives $400,000 or more pursuant to this section shall include the following information with its application under section 907(a):

(1) A plan for the timely licensure or commercial development of research results conducted under this section, including its management of intellectual property.

(2) Standard forms of agreement developed by the institution for use in the licensing of research results.

(3) A plan to establish affiliations, exchanges, partnerships or other cooperative efforts with postsecondary educational institutions to provide programs to train students and health professionals in the biomedical field.

(4) A description of the training opportunities provided for researchers employed by the institution relating to the licensing and commercial development of research.

(5) Outreach efforts directed toward informing businesses and business organizations regarding recent developments in research being conducted by the institutions.

(6) A plan for collaboration with an applicant, an institution, a regional biomedical research center under Chapter 17 or a for-profit corporation or other business entity to participate in the development of research.

Section 909. National Cancer Institute funding formula.

(a) Eligibility.—An institution that conducts research in this Commonwealth and has received funding from the National Cancer Institute during each of the three immediately preceding Federal fiscal years shall be eligible to receive a grant under this section.

(b) Fund distribution.—Funds shall be distributed to an eligible institution based on the percentage calculated by dividing that institution's average award from the National Cancer Institute for the three immediately available preceding Federal fiscal years by the sum of the average annual award from the National Cancer Institute for all Pennsylvania-based eligible institutions during the three immediately available preceding Federal fiscal years.

(c) Ineligibility.—An institution that receives funding pursuant to section 908(b)(1) and (2) shall be ineligible for funding under this section.

(d) Requirements.—An institution that receives a grant pursuant to this section shall comply with all applicable requirements of this chapter.

Section 910. Accountability procedures.

(a) Requirements.—An applicant that receives a research grant under this chapter shall be subject to a performance review by the department upon completion of a research project or more often as deemed necessary by the department. The performance review shall be based on an evaluation process developed by the department in consultation with the advisory committee. Information shall be submitted by research grant recipients and shall include, as applicable, the following:

(1) The progress made in achieving expected research goals and objectives.

(2) The extent of clinical activities initiated and completed, detailing the number of treatment, prevention and diagnostic studies; the number of hospitals and health care professionals; the number of subjects relative to targeted goals; and the extent of penetration of the studies throughout the region or this Commonwealth.

(3) The number of peer-reviewed publications and the number of licenses and patents filed, including commercial development opportunities.

(4) Any changes in risk factors, services provided, incidence of disease, death from disease, stage of disease at the time of diagnosis or other relevant measures of the outcome, impact and effectiveness of the research being conducted.

(5) Any major discoveries, new drugs and new approaches for prevention, diagnosis and treatment which are attributable to the completed research project.

(6) Any other information deemed necessary by the department.

(b) Penalty.—Notwithstanding any other provision of this chapter, an applicant that receives an unfavorable review by the department under subsection (a) may be subject to a reduction in or ineligibility for research grant funding under this chapter.

CHAPTER 11
HOSPITAL UNCOMPENSATED CARE

Section 1101. Scope.

This chapter deals with hospital uncompensated care.

Section 1102. Definitions.

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

"Bad debt expense." The cost of care for which a hospital expected payment from the patient or a third-party payor, but which the hospital subsequently determines to be uncollectible.

"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.

"Children's Health Insurance Program." The insurance program established by Article XXIII of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

"Council." The Health Care Cost Containment Council established under the act of July 8, 1986 (P.L.408, No.89), known as the Health Care Cost Containment Act.

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

"Emergent medically necessary services." Immediate medical care consistent with the definition of emergency service as set forth in section 2116 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

"Extraordinary expenses." The cost of hospital inpatient services provided to an uninsured patient which exceeds twice the hospital's average cost per stay for all patients.

"Hospital." A health care facility licensed as a hospital pursuant to the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act, or pursuant to Article X of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.

"Inpatient day." A billing unit corresponding to each day an individual stays in a hospital as a patient.

"Insurer." Any insurance company, association, reciprocal, health maintenance organization, fraternal benefits society or a risk-bearing preferred provider organization that offers health care benefits and is subject to regulation under the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, or the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act. The term includes an entity and its subsidiaries that operate subject to the provisions of 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

"Medical assistance." The State program of medical assistance established under Article IV(f) of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.

"Medical assistance day." An inpatient day provided by a hospital to a patient enrolled in the State program of medical assistance established under the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, or for a similar program in other states.

"Medicare SSI day." An inpatient day provided by a hospital to a patient enrolled in both Medicare Part A and Supplemental Security Income (SSI) as determined by the Centers for Medicare and Medicaid Services.

"Net patient revenue." The estimated net realized amounts from patients, third-party payors and others for health care services rendered, including estimated retroactive adjustments due to future audits, reviews, settlements and investigations. Retroactive adjustments are accrued on an estimated basis in the period the relative services are rendered and adjusted in future periods as adjustments become known. This amount shall be equal to the amount presented in the most current audited financial statement as filed with the council.

"Publicly funded health care program." Care or services rendered by a government entity or any facility thereof or health care services for which payment is made directly or indirectly by a government entity, including, but not limited to, Medicare and medical assistance, or by their fiscal intermediary.

"Qualified hospital." An eligible hospital which has an uncompensated care score at or exceeding the median score of all eligible hospitals.

"Uncompensated care." The cost of care provided to patients financially unable or unwilling to pay for services provided by a hospital. This cost shall be determined by the council utilizing reported data and the hospital's cost-to-charge ratio and shall include charity care expense and bad debt expense.

"Uninsured." An individual who has no health insurance coverage, whose coverage does not reimburse for the medically necessary services provided by a hospital or who does not receive benefits under a publicly funded health care program.

Section 1103. Hospital uncompensated care payments.

(a) Program establishment.—There is established in the department the Hospital Uncompensated Care Program. Appropriations from the fund to the department for the Hospital Uncompensated Care Program pursuant to section 1106(b) shall be used to annually compensate hospitals in accordance with section 1104 for a portion of the uncompensated care provided to patients.

(b) Department responsibilities.—The department has the following powers and duties:

(1) Administer the Hospital Uncompensated Care Program.

(2) Determine the eligibility of hospitals on an annual basis in accordance with section 1104(b). Notice of eligibility shall be published in the Pennsylvania Bulletin by April 1 for the forthcoming fiscal year.

(3) Calculate uncompensated care scores for eligible hospitals under section 1104(c).

(4) Calculate and make payments to qualified hospitals under section 1104(d) on an annual basis.

(5) Seek Federal matching funds under medical assistance to supplement payments made under section 1104.

(6) Prepare and submit a report no later than November 30, 2002, and annually thereafter to the chair and minority chair of the Public Health and Welfare Committee and the chair and minority chair of the Appropriations Committee of the Senate and the chair and minority chair of the Health and Human Services Committee and the chair and minority chair of the Appropriations Committee of the House of Representatives. The annual report shall be made available for public inspection and posted on the department's publicly accessible World Wide Web site. The report shall list all of the following:

(i) The name and address of each eligible hospital.

(ii) The name, address and payment amount for each qualified hospital.

(iii) The health system affiliation of each qualified hospital.

(iv) The uncompensated care score for each qualified hospital.

(v) The methodology utilized to compute the uncompensated care score for each eligible hospital.

(7) No later than June 30, 2003, the department shall contract with an independent entity to evaluate the payment methodology to determine the extent to which payments under this section are made to hospitals with the greatest uncompensated care burden. The report shall contain recommendations to the Governor, the department and the General Assembly concerning the payment methodology.

(c) Information collection.—The department shall:

(1) Collect data and information as necessary to determine hospital eligibility for payment under this chapter, including the department's medical assistance data for medical assistance inpatient days percentage, the uncompensated care percentage and net patient revenue data from the council and data from the Centers for Medicare and Medicaid Services or their designee regarding Medicare SSI days percentage.

(2) Contact the appropriate data source if there is missing data and obtain the necessary information.

(d) Reporting requirements.—

(1) Within 60 days of the effective date of this chapter, the department in consultation with the council shall establish an advisory committee comprised of nine individuals with expertise in hospital administration, hospital finance and reimbursement and hospital patient

accounts management, including a representative of the department and representative of the council. The purpose of the advisory committee shall be to assist the department and the council in improving the accuracy, consistency and timeliness of the information collected and used to determine payments to hospitals under the Hospital Uncompensated Care Program. The advisory committee shall make recommendations to the department concerning the information that is required to more accurately measure the amount of bad debt expense incurred and charity care expense provided by hospitals to uninsured patients in this Commonwealth.

(2) Within 180 days of the effective date of this chapter, the department shall develop and provide public notice to hospitals of the uniform reporting requirements for uncompensated care which shall address both charity care expense and bad debt expense components. The uniform reporting requirements for charity care expense shall incorporate the recommendations of the advisory committee and address the following:

(i) Patient eligibility for other public or private coverage.

(ii) Income eligibility threshold based on family size.

(iii) Consideration of other resources available to a patient or responsible party.

(iv) Patient or responsible party employment status and earning capacity.

(v) Other financial obligations of the patient or responsible party.

(vi) Other sources of funds available to the hospital such as endowments or donations specified for charity care.

The uniform reporting requirements for bad debt expense shall incorporate the recommendations of the advisory committee and shall address hospital collection procedures for unpaid patient responsibility, including deductibles, coinsurance, copayments and noncovered services. Patients are presumed to be able to pay for medically necessary services until and unless information is obtained to indicate an inability or refusal to pay.

(3) For fiscal years beginning on or after January 1, 2002, hospitals shall report uncompensated care information to the council in accordance with the reporting requirements set forth in this section in order to receive payments under the Hospital Uncompensated Care Program.

Section 1104. Eligibility and payment.

(a) Determination of eligibility.—The department shall determine the eligibility of each hospital from information collected under section 1103.

(b) Requirements for hospitals.—A hospital is eligible to apply for payment from the Hospital Uncompensated Care Program if the hospital has a plan in place to serve the uninsured and:

(1) Accepts all individuals regardless of the ability to pay for emergent medically necessary services within the scope of the hospital's service.

(2) Seeks collection of a claim, including collection from an insurer or payment arrangements with the person who is responsible for payment of the care rendered.

(3) Attempts to obtain health care coverage for patients, including assisting patients in applying for medical assistance, the Children's Health Insurance Program or the Adult Basic Coverage Insurance Program established in section 1303(a), when applicable.

(4) Ensures that an emergency admission or treatment is not delayed or denied pending determination of coverage or requirement for prepayment or deposit.

(5) Posts adequate notice of the availability of medical services and the obligations of hospitals to provide free services.

(6) Provides data to the council in accordance with section 1103.

(c) Uncompensated care scoring.—The department shall annually calculate the uncompensated care score of each eligible hospital from collected data. If information necessary to determine the uncompensated care score of an eligible hospital is unavailable due to the refusal of the hospital to provide the information, the hospital shall not be eligible for payment from the Hospital Uncompensated Care Program. If the department determines that such data cannot be provided after due diligence, the department shall use the average of the collected data. An eligible hospital's uncompensated care score shall be the sum of the following, using three-year average data as determined by the department:

(1) The amount of uncompensated care provided as a percentage of net patient revenue based on the most recent hospital financial analysis data reported to the council in accordance with the act of July 8, 1986 (P.L.408, No.89), known as the Health Care Cost Containment Act.

(2) The number of Medicare SSI days as a percentage of total inpatient days based on the most recent data available to the department.

(3) The number of medical assistance days as a percentage of total inpatient days based on the most recent data available to the department.

(d) Payment calculation.—A payment to a qualified hospital shall be calculated as follows:

(1) Multiplying each qualified hospital's uncompensated care score by the three-year average of its total reported inpatient days.

(2) Dividing the product under paragraph (1) for each qualified hospital by the sum of the products under paragraph (1) for all qualified hospitals.

(3) Multiplying the quotient under paragraph (2) by the moneys available for the Hospital Uncompensated Care Program.

(e) Limitations.—Except as stated in section 1106:

(1) In no case shall the sum of payments to a qualified hospital under this section and payments under the medical assistance program exceed the aggregate cost of the inpatient and outpatient services furnished to:

(i) recipients entitled to medical benefits under Title XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396 et seq.);

(ii) recipients entitled to medical benefits under section 441.1 of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code; and

(iii) patients receiving uncompensated care.

(2) In no case shall payments made under this section in a fiscal year exceed the amount of money available to the department for the Hospital Uncompensated Care Program for that fiscal year.

(3) In no case shall payment under this section constitute an entitlement derived from the Commonwealth or a claim on any other funds of the Commonwealth.

(4) In no case shall payment under this section to a qualified hospital exceed the hospital's annual uncompensated care amount as provided in the council's most recently published hospital financial report.

(f) Three-year average.—For purposes of this section, for fiscal years up to and including 2002-2003, the term "three-year average" shall be determined by the department. For fiscal years 2003-2004 and thereafter, the term "three-year average" shall be the average of the immediately preceding three years.

(g) Mergers and separations.—The department shall combine payments for hospitals which have merged into a single entity. The department shall fairly allocate payments for a hospital which separated into two or more entities, as appropriate.

Section 1105. Reimbursement for extraordinary expense.

(a) Program establishment.—There is established in the department a Hospital Extraordinary Expense Program. Appropriations to the department for the Hospital Extraordinary Expense Program pursuant to section 1106(b) shall be used to reimburse hospitals for extraordinary expenses in treating the uninsured on an inpatient hospital basis.

(b) Department responsibilities.—The department has the following powers and duties:

(1) Administer the Hospital Extraordinary Expense Program.

(2) Collect the data necessary to administer this section, including data from the council.

(3) Contact the appropriate data source if there is missing data and obtain the necessary information.

(4) Determine the eligibility of hospitals from information collected under paragraph (2).

(5) Pay eligible hospitals by October 1 of each fiscal year an amount consistent with subsection (d).

(6) Seek Federal matching funds under the medical assistance program to supplement payments under this chapter.

(7) Prepare and submit a report no later than November 30, 2002, and annually thereafter to the chair and minority chair of the Public Health and Welfare Committee and the chair and minority chair of the Appropriations Committee of the Senate and the chair and minority chair of the Health and Human Services Committee and the chair and minority chair of the Appropriations Committee of the House of Representatives. The annual report shall also be made available for public inspection and be posted on the department's publicly accessible World Wide Web site. The report shall list all of the following:

(i) The name, address and payment amount for each eligible hospital.

(ii) The health system affiliation of each eligible hospital.

(iii) The methodology and data utilized to determine the eligibility of each hospital.

(c) Eligibility.—

(1) Except as provided in paragraph (3), a hospital may receive payment under this section if the hospital does not qualify for payment under section 1104 and the hospital provided uncompensated care to a patient with extraordinary expenses in the most recent fiscal year for which data is available.

(2) A hospital receiving payment under this section shall meet all the requirements of section 1104(b).

(3) A hospital may elect to receive payment under this section in lieu of payment under section 1104.

(d) Payment methodology.—Payment to a hospital under this section shall equal the lesser of the cost of:

(1) the extraordinary expense claim; or

(2) the prorated amount of each hospital's percentage of extraordinary expense costs as compared to all eligible hospitals' extraordinary expense costs, as applied to the total funds available in the Hospital Extraordinary Expense Program for the fiscal year.

(e) Limitations.—Except as provided in section 1106:

(1) In no case shall payments to a hospital under this section exceed the aggregate cost of services furnished to patients with extraordinary expenses.

(2) In no case shall the aggregate amount of extraordinary expense payments in any fiscal year exceed the amount of the appropriation to the department for the Hospital Extraordinary Expense Program. The provision of extraordinary expense payments under this section shall not constitute an entitlement derived from the Commonwealth or a claim on any other funds of the Commonwealth.

Section 1106. Amounts.

(a) General rule.—The total amount of funds received by a hospital under this chapter shall not exceed the uncompensated care amount reported to the council.

(b) Allocation.—Of the funds appropriated for this chapter, 85% shall be used for payments to hospitals under section 1103, and 15% shall be used for payments to hospitals under section 1105.

Section 1107. Federal funds.

The department shall seek to maximize any Federal funds, including Title XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396 et seq.), available for the Hospital Uncompensated Care Program and the Hospital Extraordinary Expense Program.

Section 1108. Penalties.

(a) Assessment.—The department may assess an administrative penalty against a hospital which negligently violates a requirement set forth in this chapter.

(b) Amount.—The amount of the penalty shall be:

(1) not more than $25,000 for a hospital with less than 100 beds; and

(2) not more than $50,000 for a hospital with at least 100 beds.

(c) Procedure.—A penalty under this section is subject to 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).

CHAPTER 13
HEALTH INVESTMENT INSURANCE

Section 1301. Scope.

This chapter deals with health investment insurance.

Section 1302. Definitions.

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

"Benefit package." Insurance coverage which provides the benefits set forth in section 1303(f)(2) for eligible adults.

"Contractor." An insurer or other entity or its subsidiaries operating under 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations), or both.

"Department." The Insurance Department of the Commonwealth.

"Eligible adult." A low-income adult who meets all of the following:

(1) Legally resides within the United States.

(2) Has been domiciled in this Commonwealth for at least 90 days prior to enrollment.

(3) Is not covered by a health insurance plan, a self-insurance plan or a self-funded plan.

(4) Has not been covered by a health insurance plan, a self-insurance plan or a self-funded plan during the three months immediately

preceding the determination of eligibility except when one of the following apply:

(i) The low-income adult is eligible to receive benefits pursuant to the act of December 5, 1936 (2nd Sp.Sess., 1937 P.L.2897, No.1), known as the Unemployment Compensation Law.

(ii) The low-income adult was covered under one of the above plans but at the time of application for coverage is no longer employed and is ineligible to receive benefits pursuant to the Unemployment Compensation Law.

(iii) The low-income adult is the spouse of a person who meets either of the exceptions set forth in subparagraph (i) or (ii) and both the eligible adult and the spouse are low income and applying for coverage.

(5) Is ineligible for medical assistance or Medicare.

"Hospital." A hospital as defined and licensed under the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

"Insurer." An insurance company, association, reciprocal, health maintenance organization, fraternal benefit society or a risk-bearing preferred provider organization that offers health care benefits and is subject to regulation under the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, or the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

"Low-income adult." An individual who is at least 19 years of age but less than 65 years of age and whose household income is less than 200% of the Federal poverty level at the time of eligibility determination.

"Medical assistance." The State program of medical assistance established under the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.

"Medicare." The Federal program established under Title XVIII of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1395 et seq.).

"Offeror." An insurer that submits a proposal in response to the department's request for proposals issued pursuant to section 1303(f).

"Preexisting condition." A disease or physical condition for which medical advice or treatment has been received prior to the effective date of coverage.

"Program." The adult basic coverage insurance program established in section 1303.

Section 1303. Adult basic coverage insurance program.

(a) Program establishment.—There is established in the department an adult basic coverage insurance program. Fund appropriations to the department for the program shall be used for contracts to provide basic health care insurance for eligible adults and outreach activities. The department shall, to the greatest extent practicable, ensure that all eligible adults in this Commonwealth have access to the program established in this section.

(b) Eligible adult responsibilities.—An eligible adult seeking to purchase adult basic coverage insurance shall:

(1) Submit an application to the department.

(2) Pay to the department or its contractor an amount of $30 per month of coverage. Beginning January 1, 2003, the monthly payment amount shall be adjusted based on the annual change in the Consumer Price Index for the 12 preceding months for which data is available. Notification of any change in the monthly payment amount shall be provided to eligible adults participating in the program.

(3) Be responsible for any required copayments for health care services rendered under the benefit package in subsection (f)(2).

(4) Notify the department or its contractor of any change in the eligible adult's income.

(c) Purchase of insurance.—An eligible adult's payment to the department or its contractor under subsection (b)(2) shall be used to purchase the benefit package and shall be received in a timely manner. The appropriations for the program shall be used by the department to pay the difference between the premium cost of the benefit package and the eligible adult's payment. Subsidization of the benefit package is contingent upon the amount of the appropriations to the program and limited to eligible adults in compliance with subsection (b). Nothing under this section shall constitute an entitlement derived from the Commonwealth or a claim on any funds of the Commonwealth.

(d) Potential waiting list.—The department shall maintain a waiting list of eligible adults who have applied for adult basic coverage insurance but who are not enrolled due to insufficient appropriations. An eligible adult on the waiting list may purchase the benefit package at the monthly per member premium cost negotiated by the department.

(e) Department responsibilities.—The department shall:

(1) Administer the adult basic coverage insurance program on a Statewide basis.

(2) Enter into contracts for health care insurance in accordance with 62 Pa.C.S. (relating to procurement). The department may award contracts on a multiple award basis.

(3) Conduct monitoring, oversight and audits of executed contracts for enforcement purposes.

(4) Ensure that the eligibility of enrolled individuals receiving subsidization of the benefit package is redetermined on an annual basis.

(5) In consultation with appropriate Commonwealth agencies, monitor, review and evaluate the insurer's benefit package for the adequacy, accessibility and availability of the services required under subsection (f).

(6) In consultation with appropriate Commonwealth agencies, establish and coordinate the development, implementation and supervision of an outreach plan.

(7) Prepare and submit, by November 30, 2002, and annually thereafter a report to the chair and minority chair of the Banking and Insurance Committee of the Senate and to the chair and minority chair of the Insurance Committee of the House of Representatives regarding the number of eligible adults purchasing the adult basic coverage insurance, with a geographic distribution; the insurers participating in the program; the scope of the services being provided, the level of outreach; the cost of the insurance; and the amount an eligible adult contributes toward the insurance, including any copayments and adjustments due to the Consumer Price Index adjustment factor under subsection (b)(2). The annual report shall be made available for public inspection and posted on the department's publicly accessible World Wide Web site.

(f) Request for proposals.—In accordance with subsection (e)(2), the department shall issue a request for proposals for the adult basic coverage insurance. The request shall require:

(1) An offeror to assure that if selected as a contractor it will do all of the following:

(i) Ensure that eligible adults have access to primary health care physicians and nurse practitioners.

(ii) Contract with qualified, cost-effective providers, which may include primary health care physicians, nurse practitioners, clinics and health maintenance organizations, to provide health care for eligible adults in a manner that best manages the costs of the services and utilizes other appropriate medical cost-management methods.

(iii) Ensure that the individual applying for coverage is an eligible adult. If a review of the individual's application for coverage indicates that the individual is not eligible for adult basic coverage insurance but may be eligible for medical assistance, the application for benefits and all accompanying documentation shall be promptly transmitted to the appropriate county assistance office for a determination of eligibility for medical assistance or other Federal, State and local resources available to the individual.

(iv) Not prohibit enrollment based upon a preexisting condition nor exclude a diagnosis or treatment for the condition based on the condition's preexistence.

(v) Provide the benefit package to eligible adults consistent with the scope and duration requirements of the request for proposals.

(vi) Provide an insurance identification card to each eligible adult covered under a contract executed under this section. The card shall not identify the eligible adult as low income.

(vii) Require each primary care physician providing primary care services under this section to make necessary arrangements for admission to hospitals and for necessary specialty care.

(viii) Not pay any claim on behalf of an eligible adult unless all other Federal, State and local resources are first utilized.

(2) A benefit package with scope and duration determined by the department that includes:

(i) Preventive care.

(ii) Physician services.

(iii) Diagnosis and treatment of illness or injury, including all medically necessary covered services related to the diagnosis and treatment of sickness and injury and other conditions provided on an ambulatory basis, such as laboratory tests, x-rays, wound dressing and casting to immobilize fractures.

(iv) Inpatient hospitalization.

(v) Outpatient hospital services.

(vi) Emergency accident and emergency medical care.

(g) Proposals.—Upon publication of a request for proposals, an entity and its subsidiaries that operate subject to the provisions of 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations), or both, shall submit a proposal to the department to carry out the purposes of this section. Upon publication of a request for proposals, an insurer doing business in this Commonwealth may submit a proposal to the department to carry out the purposes of this section.

(h) Reviewing, scoring and selection of proposals.—The department shall review and score the proposals on the basis of all of the requirements for the adult basic coverage insurance program. The department may include such other criteria in the request for proposals and in the scoring and selection of the proposals that the department, in the exercise of its administrative duties under this section, deems necessary; however, the department shall:

(1) Select, to the greatest extent practicable, offerors that contract with providers to provide health care services on a cost-effective basis. The department shall select offerors that use appropriate cost-management methods that enable the program to provide coverage to the maximum number of eligible adults and that, whenever possible, pursue and utilize available public and private funds.

(2) Select, to the greatest extent practicable, only offerors that comply with all procedures relating to coordination of benefits as required by the department and the Department of Public Welfare.

(3) Select offerors that limit administrative expenses to no more than 10% of the amount of any contract. If after the first two full years of operation any contractor presents documented evidence that administrative expenses are in excess of 10% of the amount of the contract, the department may make an additional payment, not to exceed 1% of the amount of the contract, for future administrative expenses to the contractor to the extent that the department finds the expenses reasonable and necessary.

(i) Negotiations.—The department shall not negotiate a contract for a period in excess of three years.

(j) Limitation.—In no case shall the total aggregate amount of annual contracts entered into pursuant to this section exceed the amount of the aggregate annual appropriations to the department for the adult basic coverage insurance program.

Section 1304. Accountability.

Three years after the effective date of this chapter, the Insurance Department shall conduct a performance review of the insurance contractors selected to provide services under the Adult Basic Coverage Insurance Program. The performance review shall be based on the report prepared pursuant to section 1303(e)(7) and shall include the following: the strategic goals and objectives for the program, a determination of whether the strategic goals and objectives were achieved by the contractors and specific methodology for evaluating the results along with any proposed recommendations for improvement.

CHAPTER 15
MEDICAL ASSISTANCE FOR WORKERS WITH DISABILITIES

Section 1501. Scope.

This chapter deals with medical assistance for workers with disabilities.

Section 1502. Definitions.

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

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

"Medical assistance." The State program of medical assistance established under the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.

"Medicare." The Federal program established under Title XVIII of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1395 et seq.).

"Monthly income." The monthly income of an individual as determined by the Department of Public Welfare when determining eligibility for medical assistance.

"Worker with a disability." An individual who meets all of the following:

(1) is at least 16 years of age but less than 65 years of age;

(2) is employed and receiving compensation;

(3) is eligible to receive Supplemental Security Income except for earnings and resources that exceed the limit established in section 1905 of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396d(q)(2)(B));

(4) has monthly income below 250% of the Federal poverty income guidelines; and

(5) has countable resources equal to or less than $10,000.

"Worker with a medically improved disability." An individual who meets all of the following:

(1) is at least 16 years of age but less than 65 years of age;

(2) is employed at least 40 hours per month and is earning at least the applicable minimum wage under section 6 of the Fair Labor Standards Act of 1938 (52 Stat. 1060, 29 U.S.C. § 206);

(3) was previously a worker with a disability and participated in medical assistance;

(4) has monthly income below 250% of the Federal poverty income guidelines; and

(5) has countable resources equal to or less than $10,000.

Section 1503. Medical assistance benefits for workers with disabilities and workers with medically improved disabilities.

(a) Program establishment.—There is established in the department a medical assistance purchase program for workers with disabilities and workers with medically improved disabilities. Appropriations to the department from the fund for the program shall be used by the department to provide medical assistance to a worker with a disability or a worker with a medically improved disability.

(b) Worker with a disability or worker with a medically improved disability responsibilities.—A worker with a disability or a worker with a medically improved disability seeking to purchase medical assistance benefits shall:

(1) Pay to the department or its designee 5% of the worker's monthly income in a manner to be determined by the department.

(2) Notify the department or its designee of any change in the worker's monthly income in a manner to be determined by the department.

(3) Failure of a worker with a disability or a worker with a medically improved disability to make payments in accordance with paragraph (1) will result in the termination of medical assistance coverage.

(c) Provision of benefits.—Upon receipt of a worker's payment under subsection (b)(1), the department or its designee shall provide to the worker medical assistance benefits at the categorically needy level as defined by the department.

(d) Department responsibilities.—The department shall:

(1) Administer the medical assistance purchase program.

(2) Prepare and submit by November 30, 2002, and annually thereafter a report to the chair and minority chair of the Public Health and Welfare Committee of the Senate and the chair and minority chair of the Health and Human Services Committee of the House of Representatives on the number of individuals purchasing medical benefits, the average amount paid for the benefits and any other information deemed necessary by the department. The annual report shall be made available for public inspection and posted on the department's publicly accessible World Wide Web site.

CHAPTER 17
REGIONAL BIOTECHNOLOGY RESEARCH CENTERS

Section 1701. Scope.

This chapter deals with regional biotechnology research centers.

Section 1702. Definitions.

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

"Biomedical research." Comprehensive research pertaining to the application of the natural sciences to the study and clinical practice of medicine at an institution, including biobehavioral research related to tobacco use.

"Clinical research." Patient-oriented research which involves direct interaction and study of the mechanisms of human disease, including therapeutic interventions, clinical trials, epidemiological and behavioral studies and the development of new technology.

"Collaborative research." Peer-reviewed biomedical, clinical or health services research conducted jointly by two or more applicants that cooperate to identify priorities and conduct research which provides for the sharing of infrastructure, resources and expertise.

"Department." The Department of Community and Economic Development of the Commonwealth.

"Health services research." Any of the following:

(1) Research on the promotion and maintenance of health, including biobehavioral research.

(2) Research on the prevention and reduction of disease.

(3) Research on the delivery of health care services to reduce health risks and transfer research advances to community use.

"Intellectual property." Includes:

(1) any idea, invention, trade secret, process, program, data, formula, patent, license, copyright or trademark; and

(2) an application, right or registration relating to any idea, invention, trade secret, process, program, data, formula, patent, license, copyright or trademark.

"NIH." The National Institutes of Health.

"Research." Biomedical, clinical, collaborative and health services research.

Section 1703. Regional biotechnology research centers.

(a) Establishment of centers.—The department, in consultation with the Department of Health, shall establish three regional biotechnology research centers to facilitate research through the sharing of funds and infrastructure.

(b) Nonprofit corporations to own and operate centers.—The department shall seek applicants for the purpose of forming a nonprofit corporation to own and operate regional biotechnology research centers.

(c) Board of directors.—Each nonprofit corporation shall establish a board of directors consisting of at least seven but not more than 15 members. The Secretary of Community and Economic Development and the Secretary of Health or their designees shall be ex officio members of each board of directors. The board of directors shall include representatives of the for-profit and nonprofit institutions and organizations participating in the research center as well as other representatives of local, civic or community groups.

(d) Board chair.—The Secretary of Community and Economic Development shall appoint the initial chair of the board of directors who shall serve a term of two years. All subsequent board chairs shall be selected by the members of the board of directors and shall serve a term of two years.

(e) Functions of centers.—The regional biotechnology research centers shall develop and implement biotechnology research projects which promote and coordinate research in this Commonwealth in order to:

(1) Create or enhance research and related industries in Pennsylvania.

(2) Develop high quality and commercially useful products or intellectual property.

(3) Attract venture capital investments.

(4) Attract and retain prominent scientists.

(5) Encourage training and educational programs.

(6) Develop regional research specialties.

(7) Implement the commercial development of new research discoveries.

(f) Application.—The board of directors of each regional biotechnology research center shall submit an application to the department which includes the following:

(1) A listing of the for-profit and nonprofit institutions and organizations that will comprise the nonprofit corporation and that will own and operate the research center.

(2) The names and affiliations of the members of the board of directors for the nonprofit corporation.

(3) The proposed programs, activities and categories of research to be conducted at the center.

(4) The plans for marketing the research center to regional institutions and corporations to build awareness and encourage participation.

(5) The proposed location of the research center.

(6) A proposed budget for the first year of operations of the research center, including projected infrastructure costs and projections on permanent staff to be employed at the research center.

(7) The anticipated health, scientific, commercial and economic development outcomes to be achieved by the research center.

(8) The amount of funds, infrastructure or other resources to be contributed by each participant to the research center.

(9) Any other information deemed necessary by the department.

(g) Agreement with department.—The board of directors of each biotechnology research center shall reach an agreement with the department regarding all of the following:

(1) The amount of capital to be raised from the for-profit and nonprofit institutions and organizations prior to disbursement of any State funds.

(2) The process for allowing access to and commercialization of intellectual property.

(3) The portion of biotechnology research center earnings which will be returned to the Health Account due to intellectual property or products which are developed as a result of research conducted through the research center. All proceeds derived from royalty agreements shall be divided equally between the regional research center and the Health Account.

(h) Contributions and ongoing funding.—In order to participate in research or product development at a regional biotechnology research center, financial or other substantially equivalent contributions to the research being conducted shall be made at a level established by the department. The board of directors shall develop revenue sources, including royalty agreements, to fund ongoing operations of the biotechnology research center.

(i) Personnel.—A regional biotechnology research center may hire personnel to coordinate research projects.

(j) Review and report.—

(1) Each regional biotechnology research center shall be subject to an annual performance review by the department.

(2) Each regional biotechnology research center shall, by November 30, 2002, and annually thereafter, prepare and submit a report to the department, the Department of Health, the chair and minority chair of the Appropriations Committee of the Senate, the chair and minority chair of the Appropriations Committee of the House of Representatives, the chair and minority chair of the Community and Economic Development Committee of the Senate and the chair and minority chair of the Commerce and Economic Development Committee of the House of Representatives. This report shall be in a form and manner developed by the department working in cooperation with the Department of Health and shall include the following:

(i) The current members of the board of directors for the research center.

(ii) A description of the research facilities, including space and equipment.

(iii) The research center's current policies for the management and development of intellectual property and ownership of inventions and products created during the course of research conducted through the center.

(iv) The research center's policies on conflicts of interest and the handling of confidential material.

(v) A listing of all organizations and for-profit and nonprofit institutions utilizing the services of the research center during the prior year.

(vi) A listing of any licenses or other contractual obligations in effect or anticipated for the intellectual property developed at the research center during the prior year.

(vii) A listing of any inventions, any patent applications or patents issued, any products or other intellectual property developed as a result of research conducted through the research center during the prior year.

(viii) A copy of the annual operating budget for the year, with a listing of the sources of all funds, including financial and in-kind services, personnel, equipment or other material donations and contributions by all parties involved in the research center; grants obtained by or through the research center; Federal funds leveraged and expenditures made, including infrastructure expenditures; and administrative and staffing costs.

Section 1704. Applicability of standards regarding funded research.

Each regional biotechnology research center established under this chapter and for-profit and nonprofit institutions and organizations participating in the research center shall execute a memorandum of understanding with the Secretary of Health which specifies that research performed or coordinated by and projects promoted and coordinated by the regional biotechnology research center shall be subject to Federal ethical and procedural standards of conduct prescribed by the NIH on the date the memorandum of understanding is executed. Research centers funded under this chapter shall observe the Federal ethical and procedural standards regulating research and research findings, including publications and patents, which are observed under NIH extramural funding requirements and NIH grants policy statements and applicable sections of 45 CFR Pt. 74 (relating to uniform administrative requirements for awards and subawards to institutions of higher education, hospitals, other nonprofit organizations, and commercial organizations; and certain grants and agreements with States, local governments and Indian tribal governments) and Pt. 92 (relating to uniform administrative requirements for grants and cooperative agreements to State and local governments).

CHAPTER 19
HEALTHLINK

Section 1901. Scope.

This chapter deals with the HealthLink Program.

Section 1902. Definitions.

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

"Department." The Department of Health of the Commonwealth.

"Hospital." A health care facility providing medical and surgical services and licensed as a hospital by the Department of Health under the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

"Program." The HealthLink Program established in section 1903.

Section 1903. HealthLink Program.

(a) Program established.—The HealthLink Program is hereby established as a medical and surgical equipment grant program for hospitals eligible under subsection (c).

(b) Program description.—The program shall provide grants for the purchase of medical and surgical equipment used in the diagnosis and treatment of patients and for reimbursement of expenses related to the purchase of such equipment.

(c) Eligibility.—To be eligible for a grant under the program, a hospital must meet all of the following:

(1) Be located in a county of the sixth, seventh or eighth class.

(2) Submit an application to the department describing the equipment to be purchased and its intended purpose.

(3) Provide matching funds in the amount of 100% of the amount of the grant.

(d) Department duties.—The department shall:

(1) Administer the program and award grants from the account by establishing procedures and utilizing forms as may be necessary to implement the program. A grant to an individual hospital under the program shall not exceed $500,000. A grant may be extended over two State fiscal years at the request of the grant recipient.

(2) Audit each grant recipient to ensure that funds are used in accordance with program requirements. Grant recipients shall provide information relating to the expenditure of moneys in the format specified by the department.

(3) Report to the Governor and the chair and minority chair of the Public Health and Welfare Committee of the Senate and the chair and minority chair of the Health and Human Services Committee of the House of Representatives on the grants awarded, the impact on the grantees and the amount of funds spent. The report shall be due November 30, 2002. The report shall be made available for public inspection and posted on the department's publicly accessible World Wide Web site.

Section 1904. Duties.

A hospital eligible for a grant under this chapter shall agree to provide medically necessary services to individuals regardless of the individual's ability to pay for such services and be a participating provider with the Department of Public Welfare for services provided to persons eligible for medical assistance.

CHAPTER 21
COMMUNITY-BASED HEALTH CARE ASSISTANCE

Section 2101. Scope.

This chapter deals with community-based health care assistance.

Section 2102. Definitions.

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

"Collaborative." An entity located in this Commonwealth that provides an integrated delivery system for coordinating health care and outreach efforts under this chapter.

"Community-based health care provider." Any of the following nonprofit health care centers located in this Commonwealth which provide primary health care services:

(1) A "federally qualified health center" as defined by section 1861(aa)(4) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1395x(aa)(4)).

(2) A "rural health clinic," as defined by section 1861(aa)(2) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1395x(aa)(2)), certified by Medicare.

(3) A freestanding hospital clinic serving a federally designated health care professional shortage area.

(4) A free or partial-pay health clinic which provides services by volunteer medical providers.

"Department." The Department of Health of the Commonwealth.

Section 2103. Community-Based Health Care Assistance Program.

(a) Establishment.—There is established in the department the Community-Based Health Care Assistance Program. Subsection (c) shall be administered by the department with the advice of the Insurance Department and the Department of Public Welfare. Appropriations from the fund to the department shall be used to implement the program.

(b) Purpose.—The purpose of the program is to support community-based health care providers and collaboratives in locating, assessing and managing health care for low-income Pennsylvanians and to improve access to and the delivery of preventative, curative and palliative health care to these individuals.

(c) Grants for coordination and outreach.—A grant, not to exceed $350,000, shall be available to a community-based health care provider or a collaborative that meets all of the following:

(1) Identify and assess the general health status of low-income individuals with or at risk for chronic diseases and provide enrollment assistance to these individuals for available health benefit insurance programs.

(2) Provide case management services to low-income individuals to improve their physical health, behavioral health and social condition and to reduce medical complications.

(3) Refer and coordinate care for individuals who require additional health care services.

(4) Reduce the inappropriate use of hospital emergency departments and hospital inpatient stays by persons who are chronically ill.

(5) Educate patients, medical providers, caregivers and the community on the coordinated management of chronic diseases.

(6) Develop regional, nonprofit, community-based integrated delivery systems capable of carrying out the purposes and goals specified in this subsection.

(d) Grants for resources.—Grants shall be available to community-based health care providers to increase access and to improve the delivery and quality of health care by developing and maintaining necessary community-based health care resources. A grant under this subsection shall not exceed $100,000.

(e) Application.—An application for a grant under this section shall be evaluated by the department to determine its merit in achieving the purposes set forth in subsections (c) and (d) through the strategic goals and objectives set forth in the application. The department shall provide applications for grants under this section to all known community-based health care providers and collaboratives. A grant under this section may be extended over two State fiscal years at the request of the community-based health care provider or collaborative.

(f) Report.—

(1) A community-based health care provider or collaborative receiving a grant under this section shall report to the department, as specified by the department, on all of the following:

(i) The progress of its efforts to improve the delivery and management of health care to low-income persons, as measured by the goals and objectives developed by the department.

(ii) Documentation of the reduction of unnecessary and redundant health care services to such persons.

(iii) The data necessary for evaluation of the programs as defined by the department.

(2) The department shall provide a report to the chair and minority chair of the Public Health and Welfare Committee of the Senate and the

chair and minority chair of the Health and Human Services Committee of the House of Representatives. The report shall be due November 30, 2002. The report shall include a list of the grants awarded, the impact on the entities which received the grants, the impact of the grant on improving the delivery and quality of health care in the community and the amount of funds spent. The report shall be made available for public inspection and posted on the department's publicly accessible World Wide Web site.

CHAPTER 23
PACE REINSTATEMENT AND PACENET EXPANSION

Section 2301. Scope.

This chapter deals with PACE reinstatement and PACENET expansion.

Section 2302. Definitions.

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

"Department." The Department of Aging of the Commonwealth.

"Income." All income from whatever source derived, including, but not limited to, salaries, wages, bonuses, commissions, income from self-employment, alimony, support money, cash public assistance and relief, the gross amount of any pension or annuities, including railroad retirement benefits, all benefits received under State unemployment insurance laws and veterans' disability payments, all interest received from the Federal Government or any state government or any instrumentality or political subdivision thereof, realized capital gains, rentals, workers' compensation and the gross amount of loss of time insurance benefits, life insurance benefits and proceeds, except the first $5,000 of the total of death benefits payments, and gifts of cash or property, other than transfers by gift between members of a household, in excess of a total value of $300, but shall not include surplus food or other relief in kind supplied by a government agency or property tax rebate.

"Program." The Pharmaceutical Assistance Contract for the Elderly Needs Enhancement Tier program established under section 519(a) of the act of August 26, 1971 (P.L.351, No.91), known as the State Lottery Law.

"Qualified individual." A resident of this Commonwealth for no less than 90 days who meets all of the following:

(1) Is not an eligible claimant as defined under section 502 of the act of August 26, 1971 (P.L.351, No.91), known as the State Lottery Law.

(2) Is 65 years of age or older.

(3) Has an annual income which is not less than $16,001 and not more than $17,000 in the case of a single person, and not less than $19,201 and not more than $20,200 in the case of the combined income of persons married to each other. A person may, in reporting income to the department, round the amount of each source of income and the

income total to the nearest whole dollar. Any amount which is less than 50¢ shall be eliminated.

(4) Is not otherwise qualified for public assistance under the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.

(5) Applies for pharmaceutical assistance under the act of August 26, 1971 (P.L.351, No.91), known as the State Lottery Law.

Section 2303. Additional eligibility.

A qualified individual shall be eligible for participation in the program.

Section 2304. Deductibles and copayments.

Upon enrollment in the program, a qualified individual shall be required to meet the annual deductible and to satisfy the copayment provisions of the program in section 519(c) and (d) of the act of August 26, 1971 (P.L.351, No.91), known as the State Lottery Law. To qualify for the deductible set forth in section 519(c), the prescription drug must be purchased for the use of the qualified individual from a provider as that term is defined in Chapter 5 of the State Lottery Law.

Section 2305. Application of other PACENET provisions.

Any other provisions of Chapter 5 of the act of August 26, 1971 (P.L.351, No.91), known as the State Lottery Law, which apply to the PACENET program shall apply to the expansion of the PACENET program contained in this chapter.

Section 2306. PACE reinstatement.

Notwithstanding any other provision of law to the contrary, persons who, as of December 31, 2000, were enrolled in the PACE program established pursuant to the act of August 14, 1991 (P.L.342, No.36), known as the former Lottery Fund Preservation Act, shall remain eligible for the PACE program if the maximum income limit is exceeded due solely to a Social Security cost-of-living adjustment. Any person whose PACE eligibility has been terminated for this cause shall be retroactively reinstated commencing on the effective date of this section. Eligibility in the PACE program pursuant to this section shall expire on December 31, 2002.

Section 2307. Limitations.

The receipt of benefits pursuant to the program under this chapter shall not constitute an entitlement derived from the Commonwealth or a claim on any funds of the Commonwealth.

Section 2308. PACE study.

The Secretary of Aging shall conduct a study of the PACE and PACENET program established under Chapters 5 and 7 of the act of August 26, 1971 (P.L.351, No.91), known as the State Lottery Law. The study shall be conducted by an advisory committee comprised of the Secretary of Aging, the Secretary of Public Welfare, senators appointed by the Majority Leader of the Senate and the Minority Leader of the Senate, representatives appointed by the Majority Leader of the House of Representatives and the Minority Leader of the House of Representatives and other members as selected by the Secretary of Aging. The committee shall review methods and

practices to reduce the cost of these programs to the Commonwealth, including best price, Federal upper limits, therapeutic interchangeability and step therapy. The Secretary of Aging shall submit recommendations to the General Assembly by October 1, 2001.

CHAPTER 25
PENNSYLVANIA MEDICAL EDUCATION LOAN ASSISTANCE

Section 2501. Scope.

This chapter deals with medical education loan assistance.

Section 2502. Definitions.

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

"Accredited medical college." An institution of higher education located in this Commonwealth that is accredited by the Liaison Committee on Medical Education to provide courses in medicine and empowered to grant professional and academic degrees in medicine as defined in the act of December 20, 1985 (P.L.457, No.112), known as the Medical Practice Act of 1985.

"Agency." The Pennsylvania Higher Education Assistance Agency.

"Approved institution of higher learning." An institution of higher learning located in this Commonwealth and approved by the agency.

"Approved nursing program." An institution located in this Commonwealth and accredited to grant professional and academic degrees or diplomas in nursing as defined in the act of May 22, 1951 (P.L.317, No.69), known as The Professional Nursing Law.

"Degree in medicine." A degree from an accredited medical college that qualifies the degree recipient to be licensed as a physician.

"Designated area." Any of the following:

(1) A geographic area of this Commonwealth that is designated by the Secretary of Health as having a shortage of physicians.

(2) A geographic area of this Commonwealth designated by the United States Department of Health and Human Services as a medically underserved area or designated to have a medically underserved population.

"Eligible applicant." An individual who holds an undergraduate degree from an institution of higher learning and is enrolled in:

(1) an accredited medical college; or

(2) an approved institution of higher learning for purposes of obtaining a graduate degree in biomedicine or life sciences.

"Guarantor." An insurance company or not-for-profit guarantor whose primary purpose is to provide default coverage and loss prevention services to an offeror of unsecured student loans.

"Offeror." An institution that makes unsecured loans to eligible students in cooperation with the agency.

"Nursing school applicant." An individual who is a resident of this Commonwealth and is enrolled in an approved nursing program.

"Physician." An individual licensed to practice medicine and surgery within the scope of the act of December 20, 1985 (P.L.457, No.112), known as the Medical Practice Act of 1985, or the act of October 5, 1978 (P.L.1109, No.261), known as the Osteopathic Medical Practice Act.

"Registered nurse." An individual licensed to practice professional nursing under the act of May 22, 1951 (P.L.317, No.69), known as The Professional Nursing Law.

Section 2503. Pennsylvania Medical Education Loan Assistance Program.

The agency shall establish and administer the Pennsylvania Medical Education Loan Assistance Program as set forth in sections 2504 and 2505 to provide financial assistance to individuals who acquire the required degree or diploma in medicine, professional nursing, biomedicine or life sciences and to recruit these individuals to practice their professions in Pennsylvania.

Section 2504. Loan guarantor program.

(a) Establishment of program.—The agency shall administer a loan guarantor program on a Statewide basis. The agency shall utilize funds in the Medical School Loan Account to encourage eligible applicants to attend an accredited medical college or an approved institution of higher learning.

(b) Loan Guarantor Program.—The Loan Guarantor Program shall provide for the following:

(1) Life of loan servicing.

(2) Contracting for insurance with a guarantor, approved by the agency, which offers a low-cost loan with competitive interest rates and loan fees to eligible applicants.

(3) Predetermining the eligibility of applicants who receive a loan from an offeror to attend an accredited medical school or an approved institution of higher learning that is insured by a guarantor.

(4) Evaluating the benefit package of a guarantor for adequacy, accessibility and availability of funds necessary to provide adequate loss prevention.

(c) Low-cost loans.—An eligible applicant shall apply to an offeror for a low-cost loan to attend an accredited medical college or an approved institution of higher learning. A low-cost loan made under this subsection shall be guaranteed by an approved guarantor through a contract with the agency. Low-cost loans made under this subsection shall provide reduced interest rates and loan fees to eligible applicants compared to loans made for the same purpose that are not guaranteed by this chapter.

(d) Loan requirements.—Loans provided under this section shall cover up to 100% of the actual cost of tuition, room and board at an accredited medical college or an approved institution of higher learning and the actual cost of course-required textbooks and supplies for the recipient.

(e) Default.—If a recipient fails to repay a loan received under this section, the agency shall collect the loan pursuant to one of the following:

(1) Section 4.3 of the act of August 7, 1963 (P.L.549, No.290), referred to as the Pennsylvania Higher Education Assistance Agency Act.

(2) A process established by the applicable guarantors.

(3) Any other collection procedure or process deemed appropriate by the agency.

(f) Medical Education Loan Loss Account.—An account is hereby established within the agency to receive funds appropriated for purposes of this section. Moneys in the account are hereby appropriated to the agency to provide the loan guarantor program. When funds in the account are expended, no additional loans shall be offered.

(g) Interest rate reduction.—The agency or an offeror may modify loans under this section to further reduce interest rates as follows:

(1) The agency or the offeror may reduce the interest rate of the loan by not less than 1% if the loan recipient, upon completion of a graduate degree in biomedicine or life sciences or upon licensure as a physician, agrees to practice medicine or be employed to conduct research on a full-time basis in Pennsylvania for a period of three consecutive years.

(2) The agency or the offeror may reduce the interest rate of the loan by not less than 2% if the loan recipient, upon licensure as a physician, agrees to practice medicine for not less than three consecutive years in a designated area.

(h) Contract.—In addition to the requirements of subsection (g), in order to be eligible for an interest rate reduction, a loan recipient shall enter into a contract with the agency or an offeror or its assigns at the time the loan is made. The contract shall include the following:

(1) The loan recipient practicing in a designated area shall agree to treat patients eligible for medical assistance and Medicare.

(2) The loan recipient shall permit the agency or the offeror to monitor the recipient's practice or employment to determine compliance with the terms of the contract and this chapter.

(3) The agency shall certify compliance with the terms of the contract.

(4) Upon the loan recipient's death or total or permanent disability, the agency or the offeror shall nullify the service obligation of the recipient.

(5) If the loan recipient is convicted of or pleads guilty or no contest to a felony or if the licensing board has determined that the recipient has committed an act of gross negligence in the performance of service obligations or has suspended or revoked the license to practice, the agency or the offeror shall terminate the loan recipient's participation in the program and seek repayment of the amount of the loan on the date of the conviction, determination, suspension or revocation.

(6) A loan recipient who fails to comply with a contract shall pay to the agency or the offeror the amount of loan received under the original contract as of the time of default. Providing false information or misrepresentation on an application or verification of service shall constitute default.

(i) Accountability.—Three years after the effective date of this chapter, the agency shall conduct a performance review of the program and services provided. The performance review shall include the following:

(1) the goals and objectives of the program;

(2) a determination of whether the goals and objectives were achieved by the agency participating guarantor and offeror;

(3) the specific methodology used to evaluate the results; and

(4) recommendations for improvement.

Section 2505. Loan forgiveness program.

(a) Establishment of program.—The agency shall administer a loan forgiveness program for nursing school applicants on a Statewide basis. The agency may provide loan forgiveness as provided in subsection (b) for recipients of loans who by contract with the agency agree to practice professional nursing in this Commonwealth upon attainment of the required license.

(b) Loan forgiveness.—Agency-administered, federally insured student loans for higher education provided to a nursing school applicant may be forgiven by the agency as follows:

(1) The agency may forgive 50% of the loan, not to exceed $50,000, if a loan recipient enters into a contract with the agency that requires the recipient upon successful completion of an approved nursing program and licensure as a registered nurse to practice nursing in this Commonwealth for a period of not less than three consecutive years.

(2) Loan forgiveness awards made pursuant to paragraph (1) shall be forgiven over a period of three years at an annual rate of 33 1/3% of the award and shall be made from funds appropriated for this purpose.

(3) The contract entered into with the agency pursuant to paragraph (1) shall be considered a contract with the Commonwealth and shall include the following terms:

(i) An unlicensed recipient shall apply for a registered nurse's license to practice in this Commonwealth at the earliest practicable opportunity upon successfully completing a degree in nursing.

(ii) Within six months after licensure, a recipient shall engage in the practice of nursing in this Commonwealth according to the terms of the loan forgiveness award.

(iii) The recipient shall agree to practice on a full-time basis.

(iv) The recipient shall permit the agency to determine compliance with the terms of the contract.

(v) Upon the recipient's death or total or permanent disability, the agency shall nullify the service obligation of the recipient.

(vi) If the recipient is convicted of or pleads guilty or no contest to a felony or if the licensing board has determined that the recipient has committed an act of gross negligence in the performance of service obligations or has suspended or revoked the license to practice, the agency shall have the authority to terminate the recipient's service in the program and demand repayment of the amount of the loan as of the date of the conviction, determination, suspension or revocation.

(vii) Loan recipients who fail to begin or complete the obligations contracted for shall pay to the agency the amount of the loan received under the terms of the contract pursuant to this section. Providing false information or misrepresentation on an application or verification of service shall be deemed a default. Determination as to the time of default shall be made by the agency.

(4) Notwithstanding 42 Pa.C.S. § 8127 (relating to personal earnings exempt from process), the agency may seek garnishment of wages in order to collect the amount of the loan following default under paragraph (3)(vii).

Section 2506. Limitations.

The receipt of a loan under this chapter shall not constitute an entitlement derived from the Commonwealth or a claim on any funds of the Commonwealth.

Section 2507. Regulations.

The agency may adopt regulations as are necessary to carry out the provisions of this chapter.

CHAPTER 27
MISCELLANEOUS PROVISIONS

Section 2701. Definitions.

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

"Participating manufacturer." As defined in the Master Settlement Agreement.

"Released claim." As defined in the Master Settlement Agreement.

Section 2702. Disbursement to counties.

(a) Counties.—If a county maintains or financially supports an action at law or in equity against a participating manufacturer for a released claim, no money available as a result of the Master Settlement Agreement shall be disbursed to any entity within the county until the action is withdrawn or dismissed.

(b) Other political subdivisions.—If a political subdivision other than a county maintains or financially supports an action at law or in equity against a participating manufacturer for a released claim, no money available as a result of the Master Settlement Agreement shall be disbursed

to any entity in the county in which the political subdivision is located until the action is withdrawn or dismissed.

Section 2703. Prohibition.

(a) General rule.—Recipients of funds under this act are prohibited from using these funds for lobbying activities.

(b) Definition.—As used in this section, the term "lobbying activities" means efforts to influence State or local legislative action or administrative action. The term includes direct or indirect communication.

CHAPTER 51
APPROPRIATIONS

Section 5101. One-time appropriations for 2001-2002.

(a) Tobacco settlement funds.—The following sums, or as much thereof as may be necessary, are hereby specifically appropriated from the Tobacco Settlement Fund for the fiscal year 2001-2002:

(1) Governor.—The following amounts are appropriated to the Governor:

	Federal	State
For transfer to the Tobacco Endowment Account.		
State appropriation		25,783,000

(2) Department of Community and Economic Development.—The following amounts are appropriated to the Department of Community and Economic Development:

	Federal	State
For transfer to the Health Venture Investment Account pursuant to section 305(f) and (g).		
State appropriation		60,000,000
For regional biotechnology research centers pursuant to Chapter 17.		
State appropriation		100,000,000

(3) Department of Health.—The following amounts are appropriated to the Department of Health:

	Federal	State
For grants for the purchase of medical and surgical equipment pursuant to Chapter 19.		
State appropriation		20,000,000
For grants for the community-based health care assistance program pursuant to Chapter 21.		
State appropriation		25,000,000

(4) Department of Public Welfare.—The following amounts are appropriated to the

Department of Public Welfare:	Federal	State
For hospital uncompensated care pursuant to sections 1103 and 1104.		
State appropriation		15,000,000

(5) Pennsylvania Higher Education Assistance Agency.—The following amounts are appropriated to the Pennsylvania Higher Education Assistance Agency:

	Federal	State
For low-cost loans to medical school students and graduate students in biomedicine or life sciences pursuant to Chapter 25.		
State appropriation		5,000,000
For low-cost loans and loan forgiveness for nursing school students pursuant to Chapter 25.		
State appropriation		3,000,000

(b) Federal funds.—In addition, any Federal funds received for any programs referred to in subsection (a) are hereby specifically appropriated to those programs.

(c) Lapsing.—All appropriations in this section shall lapse on June 30, 2002, except for the following:

The appropriations to the Department of Health for grants for the purchase of medical and surgical equipment pursuant to Chapter 19 and grants for the community-based health care assistance program pursuant to Chapter 21 shall lapse on June 30, 2003.

(d) Transfer—The sum of $68,508,000 is transferred from the fund to the General Fund for health-related programs.

Section 5102. Sunset.

Section 5101 shall expire June 30, 2003.

Section 5103. Effective date.

This act shall take effect July 1, 2001, or immediately, whichever is later.

APPROVED—The 26th day of June, A.D. 2001.

THOMAS J. RIDGE