No. 2011-22

AN ACT

HB 960

Amending the act of June 13, 1967 (P.L.31, No.21), entitled "An act to consolidate, editorially revise, and codify the public welfare laws of the Commonwealth," in public assistance, adding definitions; providing for fraud detection system, for administration of assistance programs and for copayments for subsidized child care; further providing for determination of eligibility; providing for verification system and for eligibility for persons with drug-related felonies; further providing for persons eligible for medical assistance, for medical assistance payments for institutional care, for reimbursement for certain medical assistance items and services, for payments for readmissions to a hospital paid through diagnosis-related groups and for medical assistance benefit packages, coverage, copayments, premiums and rates; in Statewide quality care assessment, further providing for the definition of "net patient revenue," for implementation, for calculation and notice of assessments under certain conditions, for restricted account limitations and for conditions for certain payments; and providing for inmate medical costs.

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

Section 1. Section 402 of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, is amended by adding definitions to read:

Section 402. Definitions.—As used in this article, unless the content clearly indicates otherwise:

"Applicant" means an individual who applies for assistance under this article.

* * *

"Recipient" means an individual who receives assistance under this article.

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"Residence" means permanent legal residence.

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Section 2. The act is amended by adding sections to read:

Section 403.1. Administration of Assistance Programs.—(a) The department is authorized to establish rules, regulations, procedures and standards consistent with law as to the administration of programs providing assistance, including regulations promulgated under subsection (d), that do any of the following:

(1) Establish standards for determining eligibility and the nature and extent of assistance.

(2) Authorize providers to condition the delivery of care or services on the payment of applicable copayments.

(3) Modify existing benefits, establish benefit limits and exceptions to those limits, establish various benefit packages and offer different packages to different recipients, to meet the needs of the recipients.

(4) Establish or revise provider payment rates or fee schedules, reimbursement models or payment methodologies for particular services.

(5) Restrict or eliminate presumptive eligibility.

(6) Establish provider qualifications.

(b) The department is authorized to develop and submit State plans, waivers or other proposals to the Federal Government and to take such other measures as may be necessary to render the Commonwealth eligible for available Federal funds or other assistance.

(c) Notwithstanding any other provision of law, the department shall take any action specified in subsection (a) as may be necessary to ensure that expenditures for State fiscal year 2011-2012 for assistance programs administered by the department do not exceed the aggregate amount appropriated for such programs by the act of June 30, 2011 (P.L.633, No.1A), known as the General Appropriation Act of 2011. The department shall seek such waivers or Federal approvals as may be necessary to ensure that actions taken pursuant to this section comply with applicable Federal law. During State fiscal year 2011-2012, the department shall not enter into a new contract for consulting or professional services, unless the department determines that:

(1) it does not have sufficient staff to perform the services and it would be more cost effective to contract for the services than to hire new staff to provide the services; or

(2) it does not have staff with the expertise required to perform the services.

(d) For purposes of implementing subsection (c), and notwithstanding any other provision of law, including section 814-A, the secretary shall promulgate regulations pursuant to section 204(1)(iv) of the act of July 31, 1968 (P.L.769, No.240), referred to as the "Commonwealth Documents Law," which shall be exempt from the following:

(1) Section 205 of the "Commonwealth Documents Law."

(2) Section 204(b) of the act of October 15, 1980 (P.L.950, No.164), known as the "Commonwealth Attorneys Act."

(3) The act of June 25, 1982 (P.L.633, No.181), known as the "Regulatory Review Act."

(e) The regulations promulgated under subsection (d) may be retroactive to July 1, 2011, and shall be promulgated no later than June 30, 2012.

Section 405.1A. Special Allowance Limitations.—Pursuant to section 403.1, no later than January 1, 2012, the department shall further reduce annual and lifetime limits for the RESET program, including moving and transportation expenses, by up to twenty-five percent, or eliminate any special allowances from the program, as provided under 55 Pa. Code Ch. 165 (relating to road to economic self-sufficiency through employment and training (RESET) program).

Section 408.3. Copayments for Subsidized Child Care.—(a) Notwithstanding any other provision of law or departmental regulation, the parent or caretaker of a child enrolled in subsidized child care shall pay a copayment for the subsidized child care as specified in a copayment schedule established by the department pursuant to this section.

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

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

(1) Copayments shall be based upon a sliding income scale taking into account Federal poverty income guidelines. Copayments shall be updated annually.

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

(i) for each child enrolled in subsidized child care;

(ii) based upon family size; or

(iii) in accordance with both subparagraphs (i) and (ii).

(3) Copayment amounts shall be a minimum of five dollars ($5) per week and may increase in incremental amounts as determined by the department taking into account annual family income.

(4) A family's annual copayment under either paragraph (1) or (2) shall not exceed:

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

(ii) eleven percent of the family's annual income if the family's annual income exceeds one hundred percent of the Federal poverty income guideline. Notwithstanding this subsection, beginning with State fiscal year 2012-2013, the department may adjust the annual copayment percentages specified in this subsection by promulgation of final-omitted regulations under section 204 of the act of July 31, 1968 (P.L.769, No.240), referred to as the "Commonwealth Documents Law."

(d) Notwithstanding subsection (a), a parent or caretaker copayment may be waived in accordance with department regulations.

Section 422.1. Fraud Detection System.—Within six months of the effective date of this section, the department shall establish uniform procedures to identify, investigate and resolve potential cases of fraud, misrepresentation or inadequate documentation prior to determining an applicant's eligibility for assistance. The procedures shall apply to all applicants and recipients of assistance. Procedures shall utilize the income eligibility verification system established in section 432.23.

Section 3. Section 432.2(b) and (c) of the act, amended or added July 15, 1976 (P.L.993, No.202) and April 8, 1982 (P.L.231, No.75), are amended to read:

Section 432.2. Determination of Eligibility.—* * *

(b) As a condition of eligibility for assistance, all applicants and recipients of assistance shall cooperate with the department in providing and verifying information necessary for the department to determine initial or continued eligibility in accordance with the provisions of this act. An individual applying for assistance shall complete an application containing such information required to establish eligibility and amount of grant. The application shall include, but not be limited to, the following information:

(1) Names of all persons to receive aid;

(2) Birth dates of all persons to receive aid;

(3) Social security numbers of all persons to receive aid, or proof of application for such social security number;

(4) Place of residence for all persons to receive aid;

(5) The names of any legally responsible relative living in the home;

(6) Any income or resources as defined in this act or in regulations promulgated pursuant to this act.

The department shall provide assistance as needed to complete the application and shall insure that all applicants or recipients have or promptly obtain a social security number. ***The department shall determine all elements of eligibility based upon the circumstances that exist at the applicant's place of residence prior to awarding assistance.***

(c) The department shall determine all elements of eligibility periodically ***based upon the circumstances that exist at the recipient's place of residence and*** in accordance with the provisions of this section: Provided, however, **[That]** ***that*** such determination shall not be less frequent than every six months. The department shall require the completion of a continuing application form at the time of redetermination ***recertifying the information required by subsection (b)*** and the provisions of section 432.15 shall be applicable to this subsection.

* * *

Section 4. The act is amended by adding sections to read:

Section 432.23. Verification System.—(a) The department shall establish a computerized income eligibility verification system to verify eligibility, eliminate duplication of assistance and deter fraud: Provided, however, that the department, in good faith, attempts to obtain the cooperation by Federal authorities or other states, or both; and further provided, that the data be accessible by the department. Subject to section 432.19, prior to authorizing assistance under section 432.2(b) or continuing assistance under section 432.2(c), the department shall match the social security number of each applicant and recipient with the following:

(1) Unearned income information maintained by the Internal Revenue Service.

(2) Employer quarterly reports of income and unemployment insurance benefit payment information maintained by the State Wage Information Collection Agency.

(3) Earned income information maintained by the Social Security Administration.

(4) Immigration status information maintained by the Citizenship and Immigration Services.

(5) Death register information maintained by the Social Security Administration.

(6) Prisoner information maintained by the Social Security Administration.

(7) Public housing and section 8 payment information maintained by the Department of Housing and Urban Development.

(8) National fleeing felon information maintained by the Federal Bureau of Investigation.

(9) Wage reporting and similar information maintained by states contiguous to this Commonwealth.

(10) Beneficiary Data Exchange (BENDEX) Title H database maintained by the Social Security Administration.

(11) Beneficiary Earnings Exchange Report (BEER) database maintained by the Social Security Administration.

(12) State New Hire database maintained by the Commonwealth.

(13) National New Hire database maintained by the Federal Government.

(14) State Data Exchange (SDX) database maintained by the Social Security Administration.

(15) Veterans Benefits and Veterans Medical (PARIS) maintained by the Department of Veterans Affairs with coordination through the Department of Health and Human Services.

(16) Child care subsidy payments maintained by the Commonwealth.

(17) Low-Income Energy Assistance Program Reporting Utility Expenses maintained by the Commonwealth.

(18) The database of all persons who currently hold a license, permit or certificate from a Commonwealth agency the cost of which exceeds one thousand dollars ($1,000).

(19) A database which is new, substantially similar to or a successor of a database set forth in this subsection.

(b) If a discrepancy results between the applicant's or a recipient's social security number and one or more of the databases set forth in subsection (a), the department shall review the applicant's or recipient's case using the following procedure:

(1) If the information discovered under subsection (a) does not result in ineligibility or modification of the amount or type of assistance, the department shall take no further action.

(2) If the information discovered under subsection (a) would result in ineligibility or modification of the amount or type of assistance, the department shall provide written notice to the applicant or recipient which shall describe in sufficient detail the circumstances of the discrepancy, opportunity for a hearing or review and the consequences of failing to take action. The applicant or recipient shall have ten business days to respond in writing to resolve the discrepancy. The department may request additional documentation as necessary.

(3) If the applicant or recipient does not respond to the notice, the department shall deny assistance. The department shall provide written notice of intent to discontinue assistance. Eligibility for assistance shall not be reestablished until the applicant or recipient complies with paragraph (2).

(4) If an applicant or recipient responds or disagrees with the findings of a match between his social security number and a database under subsection (a), the department shall reinvestigate the matter. If the department determines there has been an error, the department shall correct the error. If, after investigation, the department determines that there is no error, the department shall determine the effect on the applicant's or recipient's case and take appropriate action.

(5) If the applicant or recipient agrees with the findings of the match between the applicant's or recipient's social security number and one or more databases, the department shall determine the effect on the applicant's or recipient's case and take appropriate action.

(6) Written notice of the department's action under paragraph (4) or (5) shall be given to the applicant or recipient.

(c) (1) No later than one year after the effective date of this section and every year thereafter, the department shall provide a written report to the Governor, the General Assembly, the chairperson and minority chairperson of the Public Health and Welfare Committee of the Senate, the chairperson and minority chairperson of the Health Committee of the House of Representatives and the Inspector General detailing the results of the implementation of this section, including, but not limited to, the following information:

(i) The number of case closures.

(ii) The savings resulting from the use of the verification system.

(iii) A listing of the data required under subsection (a) that the department was unable to obtain or access, and a description of the department's efforts to obtain or access the data.

(iv) Any actions taken by the department to qualify the Commonwealth for continued or enhanced Federal funds and a description of why the action was necessary.

(2) The department shall also notify the chairperson and minority chairperson of the Public Health and Welfare Committee of the Senate and the chairperson and minority chairperson of the Health Committee of the House of Representatives of any changes in the information provided in subparagraphs (iii) and (iv) within sixty days.

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

"Discrepancy" means information regarding assets, income, resources or status of an applicant or recipient of assistance, derived from a database under subsection (a), that indicates that either:

(i) an applicant or recipient is ineligible to receive assistance under Federal or State law; or

(ii) the assets, income or resources of an applicant or recipient are at least, in terms of a dollar amount, ten percent greater than the dollar amount reflected in the information the department possesses about the applicant or recipient with respect to the applicant's or recipient's assets, income or resources.

Section 432.24. Eligibility for Persons with Drug-related Felonies.—(a) To the extent permitted by Federal law, a person who is otherwise eligible to receive public assistance shall not be denied assistance solely because he has been convicted of a felony drug offense, provided:

(1) He is complying with or has already complied with the obligations imposed by the criminal court.

(2) He is actively engaged in or has completed a court-ordered substance abuse treatment program and participates in periodic drug screenings for five years after the drug-related conviction or for the duration of probation, whichever is of longer duration.

(b) Under the screening for the drug test and retest program the department shall:

(1) Require a recipient be scheduled to be tested if he has either a felony conviction for a drug offense which occurred within five years or a

felony conviction for a drug offense for which he is presently on probation subject to the following conditions:

(i) An individual who is applying for public assistance is required to be tested and shall be tested at the time the application for public assistance is made.

(ii) A recipient already receiving public assistance as of the effective date of this section shall be scheduled to be tested in accordance with paragraph (2).

(2) Develop and implement a system for randomly testing no less than twenty percent of the individuals receiving public assistance benefits during each six-month period following the effective date of this section who are subject to testing for the presence of illegal drugs under this section.

(3) Deny public assistance to an individual who refuses to take the drug test or the drug retest required by this section and terminate the public assistance benefits for anyone who refuses to submit to the random drug test required by this section.

(c) An individual who takes the drug test or retest and fails it shall be subject to the following sanctions:

(1) For failing a drug test or retest the first time, an individual shall be provided an assessment for addiction and provided treatment for addiction as indicated by treatment criteria developed by the Single State Authority on Drugs and Alcohol. Assessments shall be conducted by the Single County Authority (SCA) on Drugs and Alcohol or a designee. Treatment recommended shall be provided by facilities licensed by the Division of Drug and Alcohol Program Licensure in the Department of Health. Medicaid eligibility and determinations shall be expedited to ensure access to assessment and addiction treatment through Medicaid. If the individual cooperates with the assessment and treatment, no penalty will be imposed. If the individual refuses to cooperate with the assessment and treatment, the public assistance shall be suspended for six months. The department must notify the individual of the failed drug test no later than seven days after receipt of the drug test results, and the suspension in public assistance will begin on the next scheduled distribution of public assistance and for every other distribution of public assistance until the suspension period lapses. After suspension, an individual may apply for public assistance, but shall submit to a retest.

(2) For failing a drug test or retest the second time, the public assistance to which the individual is entitled shall be suspended for twelve months. The department must notify the individual of the failed drug test no later than seven days after receipt of the drug test results, and the suspension in public assistance shall begin on the next scheduled distribution of public assistance and for every other distribution of public assistance until the suspension period lapses. After suspension, an individual may then reapply for public assistance, but shall submit to a retest.

(3) For failing a drug test or retest the third time, the individual shall no longer be entitled to public assistance.

(d) Nothing in this section shall be construed to render applicants or recipients who fail a drug test or drug retest ineligible for:

(1) a Commonwealth program that pays the costs for participating in a drug treatment program;

(2) a medical assistance program; or

(3) another benefit not included within the definition of public assistance as defined under this act.

(e) Notwithstanding any other provision in this section, the department shall, in its sole discretion, determine when it is cost effective to implement the provisions of this section.

(f) Within six months of the effective date of this section, the department shall submit a written report detailing the department's determination whether it is cost effective to implement the provisions of this section. Nothing in this section shall prohibit the department from implementation of this program prior to the issuance of the report. The report shall be submitted to the Governor, the General Assembly, the chairperson and minority chairperson of the Public Health and Welfare Committee of the Senate, the chairperson and minority chairperson of the Health Committee of the House of Representatives and the Inspector General.

(g) As used in this section, the following words and phrases shall have the meanings given to them in this subsection unless the context clearly indicates otherwise:

"Drug offense" means an offense resulting in a conviction for the possession, use or distribution of a controlled substance, or conspiracy to commit the offense, whether the offense occurred in this Commonwealth or in another jurisdiction.

"Drug test" means a urinalysis, blood test or another scientific study of an individual's body which has been conclusively found to detect the presence or prior use of an illegal drug or substance and for which the accuracy has been accepted in the scientific community.

"Public assistance" means Temporary Assistance to Needy Families (TANF), Federal food stamps, general assistance and State supplemental assistance.

Section 4.1. Section 441.1 of the act, added July 31, 1968 (P.L.904, No.273), is amended to read:

Section 441.1. Persons Eligible for Medical Assistance.—*(a)* The following persons shall be eligible for medical assistance:

(1) Persons who receive or are eligible to receive cash assistance grants under this article**[;]**.

(2) Persons who meet the eligibility requirements of this article for cash assistance grants except for citizenship, durational residence and any eligibility condition or other requirement for cash assistance which is prohibited under Title XIX of the Federal Social Security Act**[; and]**.

(3) The medically needy.

(4) Inmates of correctional institutions who meet the eligibility requirements under the Commonwealth's approved Title XIX State Plan who are receiving medical care in medical institutions, as defined in 42 CFR 435.1010 (relating to definitions relating to institutional status). The

State share of the medical care for inmates in county correctional institutions shall be contributed by the inmate's county of residence.

(5) Inmates of correctional institutions who do not qualify under paragraph (4) but who meet the income and resource eligibility requirements for general assistance, provided that such persons shall be eligible for general assistance-related medical assistance only for services provided by a disproportionate share hospital if the expenditures for such assistance qualify as an additional disproportionate share payment under the Commonwealth's approved Title XIX State Plan. For purposes of this section, a disproportionate share hospital is a hospital that receives a disproportionate share payment from the department because the hospital provides services to persons who have been determined to be low income under the income and resource standards for the general assistance program. The State share of the medical care for inmates of county correctional institutions shall be contributed by the inmates' county of residence.

(b) For purposes of this section, "correctional institution" means a State or county correctional institution or jail, group home, prerelease center, community corrections center, parole center or facility that houses a person convicted of a criminal offense or awaiting trial, sentencing or extradition in a criminal proceeding. The term does not include a facility or institution operated, supervised or licensed by the department.

Section 5. Section 443.1(1.1), (1.2), (7) and (8) of the act, amended June 30, 2007 (P.L.49, No.16), July 4, 2008 (P.L.557, No.44) and July 9, 2010 (P.L.336, No.49), are amended and the section is amended by adding paragraphs to read:

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

* * *

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

(i) If the Commonwealth's approved Title XIX State Plan for inpatient hospital services in effect for the period of July 1, 2010, through June 30, 2013, specifies a methodology for calculating payments that is different from the department's regulations or authorizes additional payments not specified in the department's regulations, such as inpatient disproportionate share payments and direct medical education payments, the department shall follow the methodology or make the additional payments as specified in the approved Title XIX State Plan.

(ii) Subject to Federal approval of an amendment to the Commonwealth's approved Title XIX State Plan, in making medical assistance fee-for-service payments to acute care hospitals for inpatient services provided on or after July 1, 2010, the department shall use payment methods and standards that provide for all of the following:

(A) Use of the All Patient Refined-Diagnosis Related Group (APR/DRG) system for the classification of inpatient stays into DRGs.

(B) Calculation of base DRG rates, based upon a Statewide average cost, which are adjusted to account for a hospital's regional labor costs, teaching status, capital and medical assistance patient levels and such other factors as the department determines may significantly impact the costs that a hospital incurs in delivering inpatient services and which may be adjusted based on the assessment revenue collected under Article VIII-G.

(C) Adjustments to payments for outlier cases where the costs of the inpatient stays ***either*** exceed ***or are below*** cost thresholds established by the department.

(iii) Notwithstanding subparagraph (i), the department may make additional changes to its payment methods and standards for inpatient hospital services consistent with Title XIX of the Social Security Act, including changes to supplemental payments currently authorized in the State plan based on the availability of Federal and State funds.

(1.2) Subject to section 813-G, for inpatient acute care hospital services provided under the physical health medical assistance managed care program during **[a]** ***State*** fiscal year **[in which an assessment is imposed under Article VIII-G]** ***2010-2011***, the following shall apply:

(i) For inpatient hospital services provided under a participation agreement between an inpatient acute care hospital and a medical assistance managed care organization in effect as of June 30, 2010, the medical assistance managed care organization shall pay, and the hospital shall accept as payment in full, amounts determined in accordance with the payment terms and rate methodology specified in the agreement and in effect as of June 30, 2010, during the term of that participation agreement. If a participation agreement in effect as of June 30, 2010, uses the department fee for service DRG rate methodology in determining payment amounts, the medical assistance managed care organization shall pay, and the hospital shall accept as payment in full, amounts determined in accordance with the fee for service payment methodology in effect as of June 30, 2010, including, without limitation, continuation of the same grouper, outlier methodology, base rates and relative weights, during the term of that participation agreement.

(ii) Nothing in subparagraph (i) shall prohibit payment rates for inpatient acute care hospital services provided under a participation agreement to change from the rates in effect as of June 30, 2010, if the change in payment rates is authorized by the terms of the participation agreement between the inpatient acute care hospital and the medical assistance managed care organization. For purposes of this act, any contract provision that provides that payment rates and changes to payment rates shall be calculated based upon the department's fee for service DRG payment methodology shall be interpreted to mean the department's fee for service medical assistance DRG methodology in place on June 30, 2010.

(iii) If a participation agreement between a hospital and a medical assistance managed care organization terminates during a fiscal year in which an assessment is imposed under Article VIII-G prior to the expiration of the term of the participation agreement, payment for services, other than

emergency services, covered by the medical assistance managed care organization and rendered by the hospital shall be made at the rate in effect as of the termination date, as adjusted in accordance with subparagraphs (i) and (ii), during the period in which the participation agreement would have been in effect had the agreement not terminated. The hospital shall receive the supplemental payment in accordance with subparagraph (v).

(iv) If a hospital and a medical assistance managed care organization do not have a participation agreement in effect as of June 30, 2010, the medical assistance managed care organization shall pay, and the hospital shall accept as payment in full, for services, other than emergency services, covered by the medical assistance managed care organization and rendered during a fiscal year in which an assessment is imposed under Article VIII-G, an amount equal to the rates payable for the services by the medical assistance fee for service program as of June 30, 2010. The hospital shall receive the supplemental payment in accordance with subparagraph (v).

(v) The department shall make enhanced capitation payments to medical assistance managed care organizations exclusively for the purpose of making supplemental payments to hospitals in order to promote continued access to quality care for medical assistance recipients. Medical assistance managed care organizations shall use the enhanced capitation payments received pursuant to this section solely for the purpose of making supplemental payments to hospitals and shall provide documentation to the department certifying that all funds received in this manner are used in accordance with this section. The supplemental payments to hospitals made pursuant to this subsection are in lieu of increased or additional payments for inpatient acute care services from medical assistance managed care organizations resulting from the department's implementation of payments under paragraph (1.1)(ii). Medical assistance managed care organizations shall in no event be obligated under this section to make supplemental or other additional payments to hospitals that exceed the enhanced capitation payments made to the medical assistance managed care organization under this section. Medical assistance managed care organizations shall not be required to advance the supplemental payments to hospitals authorized by this subsection and shall only make the supplemental payments to hospitals once medical assistance managed care organizations have received the enhanced capitation payments from the department.

(vi) Nothing in this subsection shall prohibit an inpatient acute care hospital and a medical assistance managed care organization from executing a new participation agreement or amending an existing participation agreement on or after July 1, 2010, in which they agree to payment terms that would result in payments that are different than the payments determined in accordance with subparagraphs (i), (ii), (iii) and (iv).

[(vii) As used in this paragraph, the term "medical assistance managed care organization" means a Medicaid managed care organization as defined in section 1903(m)(1)(a) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396b(m)(1)(a)) that is a party to a Medicaid managed care contract with the department, other than a behavioral health managed care organization that is a party to a medical assistance managed care contract with the department.]

(1.3) Subject to section 813-G, the department may adjust its capitation payments to medical assistance managed care organizations under the physical health medical assistance managed care program during State fiscal year 2011-2012 to provide additional funds for inpatient hospital services to mitigate the impact, if any, to the managed care organizations that may result from the changes to the department's payment methods and standards specified in paragraph (1.1)(ii). If the department adjusts a medical assistance managed care organization's capitation payments pursuant to this paragraph, the following shall apply:

(i) The medical assistance managed care organization shall provide documentation to the department identifying how the additional funds received pursuant to this subsection were used by the medical assistance managed care organization.

(ii) If the medical assistance managed care organization uses all of the additional funds received pursuant to this subsection to make additional payments to hospitals, the following shall apply:

(A) For inpatient hospital services provided under a participation agreement between an inpatient acute care hospital and the medical assistance managed care organization in effect as of June 30, 2010, the medical assistance managed care organization shall pay, and the hospital shall accept as payment in full, amounts determined in accordance with the payment terms and rate methodology specified in the agreement and in effect as of June 30, 2010, during the term of that participation agreement. If a participation agreement in effect as of June 30, 2010, uses the department fee-for-service DRG rate methodology in determining payment amounts, the medical assistance managed care organization shall pay, and the hospital shall accept as payment in full, amounts determined in accordance with the fee-for-service payment methodology in effect as of June 30, 2010, including, without limitation, continuation of the same grouper, outlier methodology, base rates and relative weights during the term of that participation agreement.

(B) Nothing in clause (A) shall prohibit payment rates for inpatient acute care hospital services provided under a participation agreement to change from the rates in effect as of June 30, 2010, if the change in payment rates is authorized by the terms of the participation agreement between the inpatient acute care hospital and the medical assistance managed care organization. For purposes of this act, any contract provision that provides that payment rates and changes to payment rates shall be calculated based upon the department's fee-for-service DRG payment methodology shall be interpreted to mean the department's fee-for-service medical assistance DRG methodology in place on June 30, 2010.

(C) For an out-of-network inpatient discharge of a recipient enrolled in a medical assistance managed care organization that occurs in State fiscal year 2011-2012, the medical assistance managed care organization shall pay, and the hospital shall accept as payment in full, the amount that the department's fee-for-service program would have paid for the discharge if the recipient were enrolled in the department's fee-for-service program and the discharge occurred on June 30, 2010.

(D) Nothing in this subparagraph shall prohibit an inpatient acute care hospital and a medical assistance managed care organization from executing a new participation agreement or amending an existing participation agreement on or after July 1, 2010, in which they agree to payment terms that would result in payments that are different from the payments determined in accordance with clauses (A), (B) and (C).

(1.4) Subject to section 813-G, for inpatient hospital services provided under the physical health medical assistance managed care program during State fiscal year 2012-2013, the following shall apply:

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

(B) For an out-of-network inpatient discharge of a recipient enrolled in a medical assistance managed care organization that occurs in State fiscal year 2012-2013, the medical assistance managed care organization shall pay, and the hospital shall accept as payment in full, the amount that the department's fee-for-service program would have paid for the discharge if the recipient were enrolled in the department's fee-for-service program.

(1.5) As used in paragraphs (1.2), (1.3) and (1.4), the following terms shall have the following meanings:

(i) "Emergency services" means emergency services as defined in section 1932(b) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396u-2(b)(2)(B)). the term shall not include post-stabilization care services as defined in 42 CFR 438.114(a)(1) (relating to emergency and poststabilization services).

(ii) "Medical assistance managed care organization" means a Medicaid managed care organization as defined in section 1903(m)(1)(a) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396b(m)(1)(a)) that is a party to a Medicaid managed care contract with the department, other than a behavioral health managed care organization that is a party to a medical assistance managed care contract with the department.

* * *

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

(i) For the fiscal year 2007-2008, the department shall apply a revenue adjustment neutrality factor and make adjustments to county and nonpublic nursing facility payment rates for medical assistance nursing facility services. The revenue adjustment factor shall limit the estimated aggregate increase in the Statewide day-weighted average payment rate over the three-year period commencing July 1, 2005, and ending June 30, 2008, from the Statewide day-weighted average payment rate for medical assistance nursing facility services in fiscal year 2004-2005 to 6.912% plus any percentage rate of increase permitted by the amount of funds appropriated for nursing facility services in the General Appropriation Act of 2007. Application of the

revenue adjustment neutrality factor shall be subject to Federal approval of any amendments as may be necessary to the Commonwealth's approved Title XIX State Plan for nursing facility services.

(ii) The department may make additional changes to its methodologies for establishing payment rates for county and nonpublic nursing facilities enrolled in the medical assistance program consistent with Title XIX of the Social Security Act, except that if during a fiscal year an assessment is implemented under Article VIII-A, the department shall not make a change under this subparagraph unless it adopts regulations as provided under section 814-A.

(iii) Subject to Federal approval of such amendments as may be necessary to the Commonwealth's approved Title XIX State Plan, the department shall do all of the following:

(A) For each fiscal year between July 1, 2008, and June 30, 2011, the department shall apply a revenue adjustment neutrality factor to county and nonpublic nursing facility payment rates. For each such fiscal year, the revenue adjustment neutrality factor shall limit the estimated aggregate increase in the Statewide day-weighted average payment rate so that the aggregate percentage rate of increase for the period that begins on July 1, 2005, and ends on the last day of the fiscal year is limited to the amount permitted by the funds appropriated by the General Appropriations Act for those fiscal years.

(B) In calculating rates for nonpublic nursing facilities for fiscal year 2008-2009, the department shall continue to include costs incurred by county nursing facilities in the rate-setting database, as specified in the department's regulations in effect on July 1, 2007.

(C) The department shall propose regulations that phase out the use of county nursing facility costs as an input in the process of setting payment rates of nonpublic nursing facilities. The final regulations shall be effective July 1, 2009, and shall phase out the use of these costs in rate-setting over a period of three rate years, beginning fiscal year 2009-2010 and ending on June 30, 2012.

(D) The department shall propose regulations that establish minimum occupancy requirements as a condition for bed-hold payments. The final regulations shall be effective July 1, 2009, and shall phase in these requirements over a period of two rate years, beginning fiscal year 2009-2010.

(iv) Subject to Federal approval of such amendments as may be necessary to the Commonwealth's approved Title XIX State Plan, for each fiscal year beginning on or after July 1, 2011, the department shall apply a revenue adjustment neutrality factor to county and nonpublic nursing facility payment rates so that the estimated Statewide day-weighted average payment rate in effect for that fiscal year is limited to the amount permitted by the funds appropriated by the General Appropriation Act for the fiscal year. The revenue adjustment neutrality factor shall remain in effect until the sooner of June 30, 2013, or the date on which a new rate-setting methodology for medical assistance nursing facility services which replaces the rate-setting methodology codified in 55 Pa. Code Chs. 1187

(relating to nursing facility services) and 1189 (relating to county nursing facility services) takes effect.

(8) As a condition of participation in the medical assistance program, before any county or nonpublic nursing facility increases the number of medical assistance certified beds in its facility or in the medical assistance program, whether as a result of an increase in beds in an existing facility or the enrollment of a new provider, the facility must seek and obtain advance written approval of the increase in certified beds from the department. The following shall apply:

(i) Before July 1, 2009, the department shall propose regulations that would establish the process and criteria to be used to review and respond to requests for increases in medical assistance certified beds, including whether an increase in the number of certified beds is necessary to assure that long-term living care and services under the medical assistance program will be provided in a manner consistent with applicable Federal and State law, including Title XIX of the Social Security Act.

(ii) Pending adoption of regulations, a nursing facility's request for advance written approval for an increase in medical assistance certified beds shall be submitted and reviewed in accordance with the process and guidelines contained in the statement of policy published in 28 Pa.B. 138.

(iii) The department may publish amendments to the statement of policy if the department determines that changes to the process and guidelines for reviewing and responding to requests for approval of increases in medical assistance certified beds will facilitate access to medically necessary nursing facility services or are required to assure that long-term living care and services under the medical assistance program will be provided in a manner consistent with applicable Federal and State law, including Title XIX of the Social Security Act. The department shall publish the proposed amendments in the Pennsylvania Bulletin and solicit public comments for thirty days. After consideration of the comments it receives, the department may proceed to adopt the amendments by publishing an amended statement of policy in the Pennsylvania Bulletin which shall include its responses to the public comments that it received concerning the proposed amendments.

(iv) This subparagraph shall apply to any requests for approval of an increase in medical assistance certified beds pending or submitted on or after the effective date of this subparagraph. This subparagraph shall expire upon the department's adoption of final regulations or **[September 30, 2011,]** ***June 30, 2012,*** whichever occurs first.

Section 6. Section 443.6 of the act is amended by adding a subsection to read:

Section 443.6. Reimbursement for Certain Medical Assistance Items and Services.—* * *

(g) The department shall establish benefit packages for dental and pharmacy services for medical assistance recipients twenty-one years of age or older, and any exceptions to such benefit packages as the department determines are appropriate. Notwithstanding any other provision of law, including this section, during State fiscal year 2011-2012, the department shall establish such benefit packages, limits and exceptions thereto by publication of one or more notices in the Pennsylvania Bulletin.

A notice shall describe the available benefit packages or limits and any exceptions thereto. The benefit packages, limits and exceptions thereto shall take effect as specified in the notice and remain in effect until changed by a subsequent notice issued on or before June 30, 2012, or thereafter by department regulation.

Section 6.1. Section 443.9 of the act, added July 4, 2008 (P.L.557, No.44), is amended to read:

Section 443.9. Payments for Readmission to a Hospital Paid Through Diagnosis-Related Groups.—All of the following shall apply to eligible recipients readmitted to a hospital within **[fourteen]** ***thirty*** days of the date of discharge:

(1) If the readmission is for the treatment of conditions that could or should have been treated during the previous admission, the department shall make no payment in addition to the hospital's original diagnosis-related group payment. If the combined hospital stay qualifies as an outlier, as set forth under the department's regulations, an outlier payment shall be made.

(2) If the readmission is due to complications of the original diagnosis and the result is a different diagnosis-related group with a higher payment, the department shall pay the higher diagnosis-related group payment rather than the original diagnosis-related group payment.

(3) If the readmission is due to conditions unrelated to the previous admission, the department shall consider the readmission as a new admission for payment purposes.

Section 7. Section 454(a) of the act, added July 7, 2005 (P.L.177, No.42), is amended to read:

Section 454. Medical Assistance Benefit Packages; Coverage, Copayments, Premiums and Rates.—(a) Notwithstanding any other provision of law to the contrary, the department shall promulgate regulations as provided in subsection (b) to establish provider payment rates; the benefit packages and any copayments for adults eligible for medical assistance under Title XIX of the Social Security Act (49 Stat 620, 42 U.S.C. § 1396 et seq.) and adults eligible for medical assistance in general assistance-related categories; and the premium ***or copayment*** requirements for disabled children whose family income is above two hundred percent of the Federal poverty income limit. **[The]** ***Subject to such Federal approval as may be necessary, the*** regulations shall authorize and describe the available benefit packages and any copayments and premiums***, except that the department shall set forth the copayment schedule for disabled children whose family income is above two hundred percent of the Federal poverty income limit by publishing a notice in the Pennsylvania Bulletin. The department may adjust such copayments for disabled children by notice published in the Pennsylvania Bulletin***. The regulations shall also specify the effective date for provider payment rates.

* * *

Section 8. The definition of "net inpatient revenue" in section 801-G of the act, added July 9, 2010 (P.L.336, No.49), is amended to read:

Section 801-G. Definitions.

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

* * *

"Net inpatient revenue." Gross charges for facilities for inpatient services less any deducted amounts for bad debt expense, charity care expense and contractual allowances as reported on **[the Medicare Cost Report for Federal Fiscal Year 2008 or to the Pennsylvania Health Care Cost Containment Council for Federal fiscal year 2008, if the Medicare Cost Report is not available, and validated by the department]** ***forms specified by the department and:***

(1) as identified in the hospital's records for the State fiscal year commencing July 1, 2007; or

(2) as identified in the hospital's records for the most recent State fiscal year, or part thereof, if amounts are not available under paragraph (1).

* * *

Section 9. Section 803-G(b) and (c) of the act, amended or added July 9, 2010 (P.L.336, No.49) and October 22, 2010 (P.L.829, No.84), are amended to read:

Section 803-G. Implementation.

* * *

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

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

(2) for fiscal years 2011-2012 and 2012-2013, an amount equal to **[2.84%]** ***3.22%*** of the net inpatient revenue of the covered hospital.

(c) Adjustments to assessment percentage.—The secretary may adjust the assessment percentage specified in subsection (b), **[subject to the following:**

(1) Before] ***provided that, before*** adjusting, the secretary shall publish a notice in the Pennsylvania Bulletin that specifies the proposed assessment percentage and identifies the aggregate impact on covered hospitals subject to the assessment. Interested parties shall have 30 days in which to submit comments to the secretary. Upon expiration of the 30-day comment period, the secretary, after consideration of the comments, shall publish a second notice in the Pennsylvania Bulletin announcing the assessment percentage.

[(2) The secretary may not adjust the assessment percentages to exceed 2.95% of the net inpatient revenue of covered hospitals.

(3) An adjustment in the assessment percentage shall be approved by the Governor.]

* * *

Section 10. Sections 804-G, 805-G(a) and (b) and 813-G of the act, added July 9, 2010 (P.L.336, No.49), are amended to read:

Section 804-G. Administration.

(a) Calculation and notice of assessment amount.—Using the assessment percentage established under section **[803-G(b)]** ***803-G*** and covered

hospitals' net inpatient revenue, the department shall calculate and notify each covered hospital of the assessment amount owed for the fiscal year. Notification pursuant to this subsection may be made in writing or electronically at the discretion of the department.

(a.1) Calculation of assessment with changes of ownership.—

(1) If a single covered hospital changes ownership or control, the department will continue to calculate the assessment amount using the hospital's net inpatient revenue for State fiscal year 2008-2009 or for the most recent State fiscal year, or part thereof, if the State fiscal year 2008-2009 amounts are not available. The covered hospital is liable for any outstanding assessment amounts, including outstanding amounts related to periods prior to the change of ownership or control.

(2) If two or more hospitals merge or consolidate into a single covered hospital as a result of a change in ownership or control, the department will calculate the covered hospital assessment amount using the combined net inpatient revenue for State fiscal year 2008-2009 or for the most recent State fiscal year, or part thereof, if the State fiscal year 2008-2009 amounts are not available, of any covered hospitals that were merged or consolidated into the single covered hospital. The single covered hospital is liable for any outstanding assessment amounts, including outstanding amounts related to periods prior to the change of ownership or control, of any covered hospital that was merged or consolidated.

(a.2) Calculation of assessment with closures or other changes in operation.—Except as provided in subsection (a.1)(2), a covered hospital that closes or that becomes an exempt hospital during a fiscal year is liable for both:

(1) The annual assessment amount for the fiscal year in which the closure or change occurs prorated by the number of days in the fiscal year during which the covered hospital was in operation.

(2) Any outstanding assessment amounts related to periods prior to the closure or change in operation.

(b) Payment.—A covered hospital shall pay the assessment amount due for a fiscal year in four quarterly installments. Payment of a quarterly installment shall be made on or before the first day of the second month of the quarter or 30 days from the date of the notice of the quarterly assessment amount, whichever day is later.

(c) Records.—Upon request by the department, a covered hospital shall furnish to the department such records as the department may specify in order ***for the department to validate the net inpatient revenue reported by the hospital or*** to determine the assessment for a fiscal year or the amount of the assessment due from the covered hospital or to verify that the covered hospital has paid the correct amount due.

(d) Underpayments and overpayments.—In the event that the department determines that a covered hospital has failed to pay an assessment or that it has underpaid an assessment, the department shall notify the covered hospital in writing of the amount due, including interest, and the date on which the amount due must be paid, which shall not be less than 30 days from the date of the notice. In the event that the department determines that a

covered hospital has overpaid an assessment, the department shall notify the covered hospital in writing of the overpayment and, within 30 days of the date of the notice of the overpayment, shall either refund the amount of the overpayment or offset the amount of the overpayment against any amount that may be owed to the department from the covered hospital.

Section 805-G. Restricted account.

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

(1) Making medical assistance payments to hospitals in accordance with section 443.1(1.1) and as otherwise specified in the Commonwealth's approved Title XIX State Plan.

(2) Making **[enhanced]** ***adjusted*** capitation payments to medical assistance managed care organizations for **[supplemental]** ***additional*** payments for inpatient hospital services in accordance with section 443.1(1.2), ***(1.3) and (1.4)***.

(3) Any other purpose approved by the secretary.

(b) Limitations.—

(1) For the first year of the assessment, the amount used for the medical assistance payments for hospitals and Medicaid managed care organizations may not exceed the aggregate amount of assessment funds collected for the year less $121,000,000.

(2) For the second year of the assessment, the amount used for the medical assistance payments for hospitals and medical assistance managed care organizations may not exceed the aggregate amount of assessment funds collected for the year less **[$59,000,000]** ***$109,000,000.***

[(3) For the first two years of the assessments, the aggregate amount used for the medical assistance payments for hospitals and Medicaid managed care organizations may not exceed the aggregate amount of assessment funds collected for the two years less $180,000,000.]

(4) For the third year of the assessment, the amount used for the medical assistance payment for hospitals and medical assistance managed care organizations may not exceed the aggregate amount of the assessment funds collected for the year less **[$51,500,000]** ***$109,000,000.***

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

* * *

Section 813-G. Conditions for payments.

The department **[and the medical assistance managed care organizations]** shall not be required to make payments as specified in section 443.1(1.1) **[and]**, (1.2), ***(1.3) and (1.4)*** and a covered hospital shall not be required to pay the Quality Care Assessment as specified in section 804-G(b) unless all of the following have occurred:

(1) The department receives Federal approval of a waiver under 42 CFR 433.68(e) (relating to permissible health care-related taxes) authorizing the department to implement the Quality Care Assessment as specified in this article.

(2) The department receives Federal approval of a State plan amendment authorizing the changes to its payment methods and standards specified in § 443.1(1.1)(ii).

(3) The department receives Federal approval of **[a waiver under section 1915(b) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396n(b)) for the HealthChoices Program and]** amendments to its medical assistance managed care organization contracts authorizing **[supplemental]** ***adjustments to its capitation*** payments **[for inpatient hospital services]** funded in accordance with section 805-G.

Section 11. The act is amended by adding an article to read:

ARTICLE XIV-A
INMATE MEDICAL COSTS

Section 1401-A. Definitions.

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

"Correctional institution." A State or county correctional institution or jail, group home, prerelease center, community corrections center, parole center or facility that houses a person convicted of a criminal offense or awaiting trial, sentencing or extradition in a criminal proceeding. The term does not include a facility or institution operated, supervised or licensed by the department.

"Drug." The term shall mean:

(1) Substances recognized in the official United States Pharmacopeia, or official National Formulary, or supplement to either of them.

(2) Substances intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in man or other animals.

(3) Substances, other than food, intended to affect the structure or function of the human body or other animal body.

(4) Substances intended for use as a component of an article specified in paragraph (1), (2) or (3), but not including devices or their components, parts or accessories.

"Health care facility." A health care facility as defined under section 802.1 of the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act, or an entity licensed as a hospital under this act.

"Health care provider." A health care facility or a person, including a corporation, university or other educational institution, licensed or approved by the Commonwealth to provide health care or professional medical services. The term shall include a physician, certified nurse midwife, podiatrist, certified registered nurse practitioner, physician assistant, chiropractor, hospital, ambulatory surgery center, nursing home or birth center.

"Inmate." A person committed to a term of imprisonment or otherwise confined under the custody of a State or county correctional institution.

"Inpatient care." The provision of medical, nursing, counseling or therapeutic services 24 hours a day in a hospital or other health care facility, according to individualized treatment plans.

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

"Outpatient care." The provision of medical, nursing, counseling or therapeutic services in a hospital or other health care facility on a regular and predetermined schedule according to individualized treatment plans.

"Prescription." A written or oral order issued by a duly licensed medical practitioner in the course of his professional practice for a controlled substance, other drug or device or medication which is dispensed for use by a consumer.

Section 1402-A. Inmate medical cost containment.

(a) Inpatient care.—A health care provider who provides inpatient care to an inmate shall not charge the State or county correctional institution or its medical services contractor more than the maximum allowable rate payable for the goods, services and supplies under the medical assistance program. This subsection shall include goods and services furnished by the health care provider to the inmate, including the cost of medications and prescription drugs.

(b) Outpatient care.—A health care provider who provides outpatient care to an inmate shall not charge the State or county correctional institution or its medical services contractor more than the maximum allowable rate payable for goods, services and supplies under the Medicare program. This subsection includes goods and services furnished by the health care provider to the inmate, including the cost of medications and prescription drugs.

(c) Limitation.—Nothing in this article shall be construed to prevent a health care provider from contracting with a correctional institution to provide outpatient care to inmates at rates higher than those established by this article.

Section 12. The addition of section 443.1(1.5)(i) of the act shall be retroactive to July 1, 2010.

Section 13. This act shall take effect July 1, 2011, or immediately, whichever is later.

APPROVED—The 30th day of June, A.D. 2011

TOM CORBETT