

AMENDMENTS TO HOUSE BILL NO. 254

Sponsor:

Printer's No. 2734

1 Amend Bill, page 1, line 4, by inserting after "WELFARE,"
2 further
3 Amend Bill, page 1, line 4, by inserting after "for"
4 determining whether applicants are
5 Amend Bill, page 1, lines 5 through 9, by striking out
6 "ESTABLISHMENT OF " in line 5, all of lines 6 through 8 and "TAX
7 EXEMPTION AND FOR CESSATION" in line 9 and inserting
8 medical assistance payments for institutional care; and
9 providing for Statewide Quality Care Assessment
10 Amend Bill, page 1, lines 12 through 17; pages 2 through 7,
11 lines 1 through 30; page 8, lines 1 through 23, by striking out
12 all of said lines on said pages and inserting
13 Section 1. Section 215 of the act of June 13, 1967 (P.L.31,
14 No.21), known as the Public Welfare Code, added December 17,
15 2009 (P.L.598, No.54), is amended to read:
16 Section 215. Determining Whether Applicants are Veterans.--
17 (a) The department shall make a good faith effort to determine
18 whether an applicant for cash, medical or energy assistance is a
19 veteran. While in the process of making its determination, the
20 department shall dispense benefits to the applicant, if
21 otherwise eligible.
22 (b) As a condition of eligibility to receive cash, medical
23 or energy assistance, unless there is good cause not to do so,
24 an applicant who is a veteran shall be required to contact a
25 veteran service officer accredited and recognized by the United
26 States Department of Veterans Affairs, the Department of
27 Military and Veterans Affairs or the county director of veterans
28 affairs in which the applicant resides in order to determine the
29 applicant's eligibility for veteran's benefits or to file a
30 veteran claims packet. The department shall develop a standard
31 form to be used by a veteran service officer to verify the
32 applicant's eligibility for veteran's benefits and make this

1 form available on its official website.

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

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

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

14 "Veteran claims packet" means an application requesting a
15 determination or entitlement or evidencing a belief in
16 entitlement to a benefit as provided for in 38 CFR (relating to
17 pensions, bonuses, and veterans' relief) or 51 Pa.C.S. (relating
18 to military affairs).

19 Section 2. Section 443.1 introductory paragraph and (1) of
20 the act, amended June 30, 2007 (P.L.49, No.16), are amended and
21 the section is amended by adding paragraphs to read:

22 Section 443.1. Medical Assistance Payments for Institutional
23 Care.--The following medical assistance payments shall be made
24 [in] on behalf of eligible persons whose institutional care is
25 prescribed by physicians:

26 (1) Payments as determined by the department for inpatient
27 hospital care consistent with Title XIX of the Social Security
28 Act (49 Stat. 620, 42 U.S.C. § 1396 et seq.). To be eligible for
29 such payments, a hospital must be qualified to participate under
30 Title XIX of the Social Security Act and have entered into a
31 written agreement with the department regarding matters
32 designated by the secretary as necessary to efficient
33 administration, such as hospital utilization, maintenance of
34 proper cost accounting records and access to patients' records.
35 Such efficient administration shall require the department to
36 permit participating hospitals to utilize the same fiscal
37 intermediary for this Title XIX program as such hospitals use
38 for the Title XVIII program[;].

39 (1.1) Subject to section 813-G, for inpatient acute care
40 hospital services provided during a fiscal year in which an
41 assessment is imposed under Article VIII-G, payments under the
42 medical assistance fee-for-service program shall be determined
43 in accordance with the department's regulations, except as
44 follows:

45 (i) If the Commonwealth's approved Title XIX State Plan for
46 inpatient hospital services in effect for the period of July 1,
47 2010, through June 30, 2013, specifies a methodology for
48 calculating payments that is different from the department's
49 regulations or authorizes additional payments not specified in
50 the department's regulations, such as inpatient disproportionate
51 share payments and direct medical education payments, the

1 department shall follow the methodology or make the additional
2 payments as specified in the approved Title XIX State Plan.

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

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

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

20 (C) Adjustments to payments for outlier cases where the
21 costs of the inpatient stays exceed cost thresholds established
22 by the department.

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

29 (1.2) Subject to section 813-G, for inpatient acute care
30 hospital services provided under the physical health medical
31 assistance managed care program during a fiscal year in which an
32 assessment is imposed under Article XIII-G, the following shall
33 apply:

34 (i) For inpatient hospital services provided under a
35 participation agreement between an inpatient acute care hospital
36 and a medical assistance managed care organization in effect as
37 of June 30, 2010, the medical assistance managed care
38 organization shall pay, and the hospital shall accept as payment
39 in full, amounts determined in accordance with the payment terms
40 and rate methodology specified in the agreement and in effect as
41 of June 30, 2010, during the term of that participation
42 agreement. If a participation agreement in effect as of June 30,
43 2010, uses the department fee for service DRG rate methodology
44 in determining payment amounts, the medical assistance managed
45 care organization shall pay, and the hospital shall accept as
46 payment in full, amounts determined in accordance with the fee
47 for service payment methodology in effect as of June 30, 2010,
48 including, without limitation, continuation of the same grouper,
49 outlier methodology, base rates and relative weights, during the
50 term of that participation agreement.

51 (ii) Nothing in subparagraph (i) shall prohibit payment

1 rates for inpatient acute care hospital services provided under
2 a participation agreement to change from the rates in effect as
3 of June 30, 2010, if the change in payment rates is authorized
4 by the terms of the participation agreement between the
5 inpatient acute care hospital and the medical assistance managed
6 care organization. For purposes of this act, any contract
7 provision that provides that payment rates and changes to
8 payment rates shall be calculated based upon the department's
9 fee for service DRG payment methodology shall be interpreted to
10 mean the department's fee for service medical assistance DRG
11 methodology in place on June 30, 2010.

12 (iii) If a participation agreement between a hospital and a
13 medical assistance managed care organization terminates during a
14 fiscal year in which an assessment is imposed under Article
15 VIII-G prior to the expiration of the term of the participation
16 agreement, payment for services, other than emergency services,
17 covered by the medical assistance managed care organization and
18 rendered by the hospital shall be made at the rate in effect as
19 of the termination date, as adjusted in accordance with
20 subparagraphs (i) and (ii), during the period in which the
21 participation agreement would have been in effect had the
22 agreement not terminated. The hospital shall receive the
23 supplemental payment in accordance with subparagraph (v).

24 (iv) If a hospital and a medical assistance managed care
25 organization do not have a participation agreement in effect as
26 June 30, 2010, the medical assistance managed care organization
27 shall pay, and the hospital shall accept as payment in full for
28 services, other than emergency services, covered by the medical
29 assistance managed care organization and rendered during a
30 fiscal year in which an assessment is imposed under Article
31 XIII-G an amount equal to the rates payable for the services by
32 the medical assistance fee for service program as of June 30,
33 2010. The hospital shall receive the supplemental payment in
34 accordance with subparagraph (v).

35 (v) The department shall make enhanced capitation payments
36 to medical assistance managed care organizations exclusively for
37 the purpose of making supplemental payments to hospitals in
38 order to promote continued access to quality care for medical
39 assistance recipients. Medical assistance managed care
40 organizations shall use the enhanced capitation payments
41 received pursuant to this section solely for the purpose of
42 making supplemental payments to hospitals and shall provide
43 documentation to the department certifying that all funds
44 received in this manner are used in accordance with this
45 section. The supplemental payments to hospitals made pursuant to
46 this subsection are in lieu of increased or additional payments
47 for inpatient acute care services from medical assistance
48 managed care organizations resulting from the department's
49 implementation of payments under paragraph (1.1)(ii). Medical
50 assistance managed care organizations shall in no event be
51 obligated under this section to make supplemental or other

1 additional payments to hospitals that exceed the enhanced
2 capitation payments made to the medical assistance managed care
3 organization under this section. Medical assistance managed care
4 organizations shall not be required to advance the supplemental
5 payments to hospitals authorized by this subsection and shall
6 only make the supplemental payments to hospitals once medical
7 assistance managed care organizations have received the enhanced
8 capitation payments from the department.

9 (vi) Nothing in this subsection shall prohibit an inpatient
10 acute care hospital and a medical assistance managed care
11 organization from executing a new participation agreement or
12 amending an existing participation agreement on or after July 1,
13 2010, in which they agree to payment terms that would result in
14 payments that are different than the payments determined in
15 accordance with subparagraphs (i), (ii), (iii) and (iv).

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

24 * * *

25 Section 3. The act is amended by adding an article to read:

26 ARTICLE VIII-G

27 STATEWIDE QUALITY CARE ASSESSMENT

28 Section 801-G. Definitions.

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

32 "Assessment." The fee, known as the Quality Care Assessment,
33 authorized to be implemented under this article on every covered
34 hospital.

35 "Bad debt expense." The cost of care for which a hospital
36 expected payment from the patient or a third-party payer, but
37 which the hospital subsequently determines to be uncollectible,
38 as further described in the Medicare Provider Reimbursement
39 Manual published by the United States Department of Health and
40 Human Services.

41 "Charity care expense." The cost of care for which a
42 hospital ordinarily charges a fee but which is provided free or
43 at a reduced rate to patients who cannot afford to pay but who
44 are not eligible for public programs, and from whom the hospital
45 did not expect payment in accordance with the hospital's charity
46 care policy, as further described in the Medicare Provider
47 Reimbursement Manual published by the United States Department
48 of Health and Human Services.

49 "Contractual allowance." The difference between what a
50 hospital charges for services and the amounts that certain
51 payers have agreed to pay for the services as further described

1 in the Medicare Provider Reimbursement Manual published by the
2 United States Department of Health and Human Services.

3 "Covered hospital." A hospital other than an exempt hospital.

4 "Critical access hospital." Any hospital that has qualified
5 under section 1861(mm)(1) of the Social Security Act (49 Stat.
6 620, 42 U.S.C. § 1395x(mm)(1)) as a critical access hospital
7 under Medicare.

8 "Exempt hospital." Any of the following:

9 (1) A Federal veterans' affairs hospital.

10 (2) A hospital that provides care, including inpatient
11 hospital services, to all patients free of charge.

12 (3) A private psychiatric hospital.

13 (4) A State-owned psychiatric hospital.

14 (5) A critical access hospital.

15 (6) A long-term acute care hospital.

16 "Hospital." A facility licensed as a hospital under 28
17 Pa.Code Pt. IV Subpt. B (relating to general and special
18 hospitals).

19 "Long-term acute care hospital." A hospital or unit of a
20 hospital whose patients have a length of stay of greater than 25
21 days, and that provide specialized acute care of medically
22 complex patients who are critically ill.

23 "Medical assistance managed care organization." A Medicaid
24 managed care organization as defined in section 1903(m)(1)(a) of
25 the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396b(m)(1)
26 (a)) that is a party to a Medicaid managed care contract with
27 the department. The term shall not include a behavioral health
28 managed care organization that is a party to a Medicaid managed
29 care contract with the department.

30 "Net inpatient revenue." Gross charges for facilities for
31 inpatient services less any deducted amounts for bad debt
32 expense, charity care expense and contractual allowances as
33 reported on the Medicare Cost Report for Federal Fiscal Year
34 2008 or to the Pennsylvania Health Care Cost Containment Council
35 for Federal fiscal year 2008, if the Medicare Cost Report is not
36 available, and validated by the department.

37 "Program." The Commonwealth's medical assistance program as
38 authorized under Article IV.
39 Section 802-G. Authorization.

40 In order to generate additional revenues for the purpose of
41 assuring that medical assistance recipients have access to
42 hospital services, the department shall implement a monetary
43 assessment, known as the Quality Care Assessment, on each
44 covered hospital subject to the conditions and requirements
45 specified in this article, including section 813-G.
46 Section 803-G. Implementation.

47 (a) Health care-related fee.--The assessment authorized
48 under this article, once imposed, shall be implemented as a
49 health care-related fee as defined under section 1903(w)(3)(B)
50 of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396b(w)
51 (3)(B)) or any amendments thereto and may be collected only to

1 the extent and for the periods that the secretary determines
2 that revenues generated by the assessment will qualify as the
3 State share of program expenditures eligible for Federal
4 financial participation.

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

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

10 (2) for fiscal years 2011-2012 and 2012-2013, an amount
11 equal to 2.84% of the net inpatient revenue of the covered
12 hospital.

13 (c) Adjustments to assessment percentage.--The secretary may
14 adjust the assessment percentage specified in subsection (b)
15 (2), subject to the following:

16 (1) Before adjusting, the secretary shall publish a
17 notice in the Pennsylvania Bulletin that specifies the
18 proposed assessment percentage and identifies the aggregate
19 impact on covered hospitals subject to the assessment.
20 Interested parties shall have 30 days in which to submit
21 comments to the secretary. Upon expiration of the 30-day
22 comment period, the secretary, after consideration of the
23 comments, shall publish a second notice in the Pennsylvania
24 Bulletin announcing the assessment percentage.

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

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

30 (d) Maximum amount.--In each year in which the assessment is
31 implemented, the assessment shall be subject to the maximum
32 aggregate amount that may be assessed under 42 CFR 433.68(f)(3)
33 (i) (relating to permissible health care-related taxes) or any
34 other maximum established under Federal law.

35 (e) Limited review.--Except as permitted under section 810-
36 G, the secretary's determination of the assessment percentage
37 pursuant to subsection (b) shall not be subject to
38 administrative or judicial review under 2 Pa.C.S. Chs. 5 Subch.
39 A (relating to practice and procedure of Commonwealth agencies)
40 and 7 Subch. A (relating to judicial review of Commonwealth
41 agency action), or any other provision of law; nor shall any
42 assessments implemented under this article or forms or reports
43 required to be completed by covered hospitals pursuant to this
44 article be subject to the act of July 31, 1968 (P.L.769,
45 No.240), referred to as the Commonwealth Documents Law; the act
46 of October 15, 1980 (P.L.950, No.164), known as the Commonwealth
47 Attorneys Act; and the act of June 25, 1982 (P.L.633, No.181),
48 known as the Regulatory Review Act.
49 Section 804-G. Administration.

50 (a) Calculation and notice of assessment amount.--Using the
51 assessment percentage established under section 803-G(b) and

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

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

12 (c) Records.--Upon request by the department, a covered
13 hospital shall furnish to the department such records as the
14 department may specify in order to determine the assessment for
15 a fiscal year or the amount of the assessment due from the
16 covered hospital or to verify that the covered hospital has paid
17 the correct amount due.

18 (d) Underpayments and overpayments.--In the event that the
19 department determines that a covered hospital has failed to pay
20 an assessment or that it has underpaid an assessment, the
21 department shall notify the covered hospital in writing of the
22 amount due, including interest, and the date on which the amount
23 due must be paid, which shall not be less than 30 days from the
24 date of the notice. In the event that the department determines
25 that a covered hospital has overpaid an assessment, the
26 department shall notify the covered hospital in writing of the
27 overpayment and, within 30 days of the date of the notice of the
28 overpayment, shall either refund the amount of the overpayment
29 or offset the amount of the overpayment against any amount that
30 may be owed to the department from the covered hospital.

31 Section 805-G. Restricted account.

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

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

40 (2) Making enhanced capitation payments to medical
41 assistance managed care organizations for supplemental
42 payments for inpatient hospital services in accordance with
43 section 443.1(1.2).

44 (3) Any other purpose approved by the secretary.

45 (b) Limitations.--

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

51 (2) For the second year of the assessment, the amount

1 used for the medical assistance payments for hospitals and
2 medical assistance managed care organizations may not exceed
3 the aggregate amount of assessment funds collected for the
4 year less \$59,000,000.

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

10 (4) For the third year of the assessment, the amount
11 used for the medical assistance payment for hospitals and
12 medical assistance managed care organizations may not exceed
13 the aggregate amount of the assessment funds collected for
14 the year less \$51,500,000.

15 (5) The amounts retained by the department shall be used
16 for purposes approved by the secretary under subsection (a)
17 (3).

18 (c) Lapse.--Funds in the Quality Care Assessment Account
19 shall not lapse to the General Fund at the end of a fiscal year.
20 If this article expires, the department shall use any remaining
21 funds for the purposes stated in this section until the funds in
22 the Quality Care Assessment Account are exhausted.

23 Section 806-G. No hold harmless.

24 No covered hospital shall be directly guaranteed a repayment
25 of its assessment in derogation of 42 CFR 433.68(f) (relating to
26 permissible health care-related taxes), except that, in each
27 fiscal year in which an assessment is implemented, the
28 department shall use the funds received under this article for
29 the purposes outlined under section 805-G to the extent
30 permissible under Federal and State law or regulation and
31 without creating an indirect guarantee to hold harmless, as
32 those terms are used under 42 CFR 433.68(f)(i). The secretary
33 shall submit to the United States Department of Health and Human
34 Services any State Medicaid plan amendments that are necessary
35 to make the payments authorized under section 805-G.

36 Section 807-G. Federal waiver.

37 To the extent necessary in order to implement this article,
38 the department shall seek a waiver under 42 CFR 433.68(e)
39 (relating to permissible health care-related taxes) from the
40 Centers for Medicare and Medicaid Services of the United States
41 Department of Health and Human Services. The department shall
42 not implement the assessment until approval of the waiver is
43 obtained. Upon approval of the waiver, the assessment shall be
44 implemented retroactive to the first day of the fiscal year to
45 which the waiver applies.

46 Section 808-G. Tax exemption.

47 (a) General rule.--Notwithstanding any exemptions granted by
48 any other Federal, State or local tax or other law, no covered
49 hospital other than an exempt hospital shall be exempt from the
50 assessment.

51 (b) Interpretation.--The assessment imposed under this

1 article shall be recognized by the Commonwealth as uncompensated
2 goods and services under the act of November 26, 1997 (P.L.508,
3 No.55), known as the Institutions of Purely Public Charity Act,
4 and shall be considered a community benefit for purposes of any
5 required or voluntary community benefit report filed or prepared
6 by a covered hospital.

7 Section 809-G. Remedies.

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

11 (1) When a covered hospital fails to pay an assessment
12 or penalty in the amount or on the date required by this
13 article, the department shall add interest at the rate
14 provided in section 806 of the act of April 9, 1929 (P.L.343,
15 No.176), known as The Fiscal Code, to the unpaid amount of
16 the assessment or penalty from the date prescribed for its
17 payment until the date it is paid.

18 (2) When a covered hospital fails to file a report or to
19 furnish records to the department as required by this
20 article, the department shall impose a penalty against the
21 covered hospital in the amount of \$1,000, plus an additional
22 amount of \$200 per day for each additional day that the
23 failure to file the report or furnish the records continues.

24 (3) When a covered hospital that is a medical assistance
25 provider, or that is related through common ownership or
26 control as defined in 42 CFR 413.17(b) (relating to cost to
27 related organizations) to a medical assistance provider,
28 fails to pay all or part of an assessment or penalty within
29 60 days of the date that payment is due, the department may
30 deduct the unpaid assessment or penalty and any interest owed
31 thereon from any medical assistance payments due to the
32 covered hospital or to any related medical assistance
33 provider until the full amount is recovered. Any such
34 deduction shall be made only after written notice to the
35 covered hospital and medical assistance provider and may be
36 taken in installments over a period of time, taking into
37 account the financial condition of the medical assistance
38 provider.

39 (4) Within 60 days after the end of each calendar
40 quarter, the department shall notify the Department of Health
41 of any covered hospital that has assessment, penalty or
42 interest amounts that have remained unpaid for 90 days or
43 more. The Department of Health shall not renew the license of
44 any such covered hospital until the department notifies the
45 Department of Health that the covered hospital has paid the
46 outstanding amount in its entirety or that the department has
47 agreed to permit the covered hospital to repay the
48 outstanding amount in installments and that, to date, the
49 covered hospital has paid the installments in the amount and
50 by the date required by the department.

51 (5) The secretary may waive all or part of the interest

1 or penalties assessed against a covered hospital pursuant to
2 this article for good cause as shown by the covered hospital.

3 Section 810-G. Request for review.

4 A covered hospital that is aggrieved by a determination of
5 the department as to the amount of the assessment due from the
6 covered hospital or a remedy imposed pursuant to section 809-G
7 may file a request for review of the decision of the department
8 by the Bureau of Hearings and Appeals, which shall have
9 exclusive jurisdiction in such matters. The procedures and
10 requirements of 67 Pa.C.S. Ch. 11 (relating to medical
11 assistance hearings and appeals) shall apply to requests for
12 review filed pursuant to this section, except that in any such
13 request for review, a covered hospital may not challenge an
14 assessment percentage determined by the secretary pursuant to
15 section 803-G(b) but only whether the department correctly
16 determined the assessment amount due from the covered hospital
17 using the assessment percentage in effect for the fiscal year. A
18 notice of review filed pursuant to this section shall not
19 operate as a stay of the covered hospital's obligation to pay
20 the assessment amount due for a fiscal year as specified in
21 section 804-G(b).

22 Section 811-G. Liens.

23 Any assessments implemented and interest and penalties
24 assessed against a covered hospital under this article shall be
25 a lien on the real and personal property of the covered hospital
26 in the manner provided by section 1401 of the act of April 9,
27 1929 (P.L.343, No.176), known as The Fiscal Code, may be entered
28 by the department in the manner provided by section 1404 of The
29 Fiscal Code and shall continue and retain priority in the manner
30 provided in section 1404.1 of The Fiscal Code.

31 Section 812-G. Regulations.

32 The department may issue such regulations and orders as may
33 be necessary to implement the Quality Care Assessment program in
34 accordance with the requirements of this article.

35 Section 813-G. Conditions for payments.

36 The department and the medical assistance managed care
37 organizations shall not be required to make payments as
38 specified in section 443.1(1.1) and (1.2) and a covered hospital
39 shall not be required to pay the Quality Care Assessment as
40 specified in section 804-G(b) unless all of the following have
41 occurred:

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

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

49 (3) The department receives Federal approval of a waiver
50 under section 1915(b) of the Social Security Act (49 Stat.
51 620, 42 U.S.C. § 1396n(b)) for the HealthChoices Program and

1 amendments to its medical assistance managed care
2 organization contracts authorizing supplemental payments for
3 inpatient hospital services funded in accordance with section
4 805-G.

5 Section 814-G. Report.

6 Not later than 180 days prior to the expiration date
7 specified in section 815-G, the department shall prepare and
8 submit a report to the chair and minority chair of the Public
9 Health and Welfare Committee of the Senate, the chair and
10 minority chair of the Appropriations Committee of the Senate,
11 the chair and minority chair of the Health and Human Services
12 Committee of the House of Representatives and the chair and
13 minority chair of the Appropriations Committee of the House of
14 Representatives. The report shall include the following:

15 (1) The name, address and amount of assessment for each
16 covered hospital subject to the Quality Care Assessment.

17 (2) The total amount of assessment revenue collected for
18 each year.

19 (3) The amount of assessment paid by each covered
20 hospital, including any interest and penalties paid.

21 (4) The name and address of each hospital receiving
22 supplemental payments instituted as a result of the Quality
23 Care Assessment.

24 (5) The payment amount and type of supplemental payment
25 received by each hospital.

26 (6) The total amount of fee-for-service inpatient acute
27 care payment made to each hospital.

28 (7) The number of medical assistance patient days and
29 discharges by hospital.

30 (8) Any proposed changes to the payment methodologies
31 and standards.

32 Section 815-G. Expiration.

33 This article shall expire June 30, 2013.

34 Section 816-G. Retroactive applicability.

35 This article shall apply retroactively to July 1, 2010.

36 Section 4. This act shall take effect immediately.