



AN ACT

1 Amending the act of June 13, 1967 (P.L.31, No.21), entitled "An
2 act to consolidate, editorially revise, and codify the public
3 welfare laws of the Commonwealth," further providing for
4 medical assistance payments for institutional care, for
5 reimbursement for certain medical assistance items and
6 services, for needs-based budgeting, for the definition of
7 "net patient revenue," for calculation and notice of
8 assessments under certain conditions, for restricted account
9 limitations and for conditions for certain payments.

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

12 Section 1. Section 443.1.(1.1), (1.2), (7) and (8) of the
13 act of June 13, 1967 (P.L.31, No.21), known as the Public
14 Welfare Code, amended June 30, 2007 (P.L.49, No.16), July 4,
15 2008 (P.L.557, No.44) and July 9, 2010 (P.L.336, No.49), are
16 amended and the section is amended by adding paragraphs to read:

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

21 * * *

1 (1.1) Subject to section 813-G, for inpatient acute care
2 hospital services provided during a fiscal year in which an
3 assessment is imposed under Article VIII-G, payments under the
4 medical assistance fee-for-service program shall be determined
5 in accordance with the department's regulations, except as
6 follows:

7 (i) If the Commonwealth's approved Title XIX State Plan for
8 inpatient hospital services in effect for the period of July 1,
9 2010, through June 30, 2013, specifies a methodology for
10 calculating payments that is different from the department's
11 regulations or authorizes additional payments not specified in
12 the department's regulations, such as inpatient disproportionate
13 share payments and direct medical education payments, the
14 department shall follow the methodology or make the additional
15 payments as specified in the approved Title XIX State Plan.

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

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

25 (B) Calculation of base DRG rates[,] which are based upon a
26 percentage of the Statewide average cost[, which are] determined
27 by the department and adjusted to account for a hospital's
28 regional labor costs, teaching status, capital and medical
29 assistance patient levels and such other factors as the
30 department determines may significantly impact the costs that a

1 hospital incurs in delivering inpatient services and which may
2 be adjusted based on the assessment revenue collected under
3 Article VIII-G.

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

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

13 (1.2) Subject to section 813-G, for inpatient acute care
14 hospital services provided under the physical health medical
15 assistance managed care program during [a] State fiscal year [in
16 which an assessment is imposed under Article VIII-G] 2010-2011,
17 the following shall apply:

18 (i) For inpatient hospital services provided under a
19 participation agreement between an inpatient acute care hospital
20 and a medical assistance managed care organization in effect as
21 of June 30, 2010, the medical assistance managed care
22 organization shall pay, and the hospital shall accept as payment
23 in full, amounts determined in accordance with the payment terms
24 and rate methodology specified in the agreement and in effect as
25 of June 30, 2010, during the term of that participation
26 agreement. If a participation agreement in effect as of June 30,
27 2010, uses the department fee for service DRG rate methodology
28 in determining payment amounts, the medical assistance managed
29 care organization shall pay, and the hospital shall accept as
30 payment in full, amounts determined in accordance with the fee

1 for service payment methodology in effect as of June 30, 2010,
2 including, without limitation, continuation of the same grouper,
3 outlier methodology, base rates and relative weights, during the
4 term of that participation agreement.

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

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

29 (iv) If a hospital and a medical assistance managed care
30 organization do not have a participation agreement in effect as

1 of June 30, 2010, the medical assistance managed care
2 organization shall pay, and the hospital shall accept as payment
3 in full, for services, other than emergency services, covered by
4 the medical assistance managed care organization and rendered
5 during a fiscal year in which an assessment is imposed under
6 Article VIII-G, an amount equal to the rates payable for the
7 services by the medical assistance fee for service program as of
8 June 30, 2010. The hospital shall receive the supplemental
9 payment in accordance with subparagraph (v).

10 (v) The department shall make enhanced capitation payments
11 to medical assistance managed care organizations exclusively for
12 the purpose of making supplemental payments to hospitals in
13 order to promote continued access to quality care for medical
14 assistance recipients. Medical assistance managed care
15 organizations shall use the enhanced capitation payments
16 received pursuant to this section solely for the purpose of
17 making supplemental payments to hospitals and shall provide
18 documentation to the department certifying that all funds
19 received in this manner are used in accordance with this
20 section. The supplemental payments to hospitals made pursuant to
21 this subsection are in lieu of increased or additional payments
22 for inpatient acute care services from medical assistance
23 managed care organizations resulting from the department's
24 implementation of payments under paragraph (1.1)(ii). Medical
25 assistance managed care organizations shall in no event be
26 obligated under this section to make supplemental or other
27 additional payments to hospitals that exceed the enhanced
28 capitation payments made to the medical assistance managed care
29 organization under this section. Medical assistance managed care
30 organizations shall not be required to advance the supplemental

1 payments to hospitals authorized by this subsection and shall
2 only make the supplemental payments to hospitals once medical
3 assistance managed care organizations have received the enhanced
4 capitation payments from the department.

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

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

20 (1.3) Subject to section 813-G, the department may adjust
21 its capitation payments to medical assistance managed care
22 organizations under the physical health medical assistance
23 managed care program during State fiscal year 2011-2012 to
24 provide additional funds for inpatient hospital services to
25 mitigate the impact, if any, to the managed care organizations
26 that may result from the changes to the department's payment
27 methods and standards specified in paragraph (1.1)(ii). If the
28 department adjusts a medical assistance managed care
29 organization's capitation payments pursuant to this paragraph,
30 the following shall apply:

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

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

9 (A) For inpatient hospital services provided under a
10 participation agreement between an inpatient acute care hospital
11 and the medical assistance managed care organization in effect
12 as of June 30, 2010, the medical assistance managed care
13 organization shall pay, and the hospital shall accept as payment
14 in full, amounts determined in accordance with the payment terms
15 and rate methodology specified in the agreement and in effect as
16 of June 30, 2010, during the term of that participation
17 agreement. If a participation agreement in effect as of June 30,
18 2010, uses the department fee for service DRG rate methodology
19 in determining payment amounts, the medical assistance managed
20 care organization shall pay, and the hospital shall accept as
21 payment in full, amounts determined in accordance with the fee
22 for service payment methodology in effect as of June 30, 2010,
23 including, without limitation, continuation of the same grouper,
24 outlier methodology, base rates and relative weights during the
25 term of that participation agreement.

26 (B) Nothing in clause (A) shall prohibit payment rates for
27 inpatient acute care hospital services provided under a
28 participation agreement to change from the rates in effect as of
29 June 30, 2010, if the change in payment rates is authorized by
30 the terms of the participation agreement between the inpatient

1 acute care hospital and the medical assistance managed care
2 organization. For purposes of this act, any contract provision
3 that provides that payment rates and changes to payment rates
4 shall be calculated based upon the department's fee for service
5 DRG payment methodology shall be interpreted to mean the
6 department's fee for service medical assistance DRG methodology
7 in place on June 30, 2010.

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

16 (D) Nothing in this subparagraph shall prohibit an inpatient
17 acute care hospital and a medical assistance managed care
18 organization from executing a new participation agreement or
19 amending an existing participation agreement on or after July 1,
20 2010, in which they agree to payment terms that would result in
21 payments that are different from the payments determined in
22 accordance with clauses (A), (B) and (C).

23 (1.4) Subject to section 813-G, for inpatient hospital
24 services provided under the physical health medical assistance
25 managed care program during State fiscal year 2012-2013, the
26 following shall apply:

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

30 (B) For an out-of-network inpatient discharge of a recipient

1 enrolled in a medical assistance managed care organization that
2 occurs in State fiscal year 2012-2013, the medical assistance
3 managed care organization shall pay, and the hospital shall
4 accept as payment in full, the amount that the department's fee-
5 for-service program would have paid for the discharge if the
6 recipient were enrolled in the department's fee-for-service
7 program.

8 (1.5) As used in paragraphs (1.2), (1.3) and (1.4), the
9 following terms shall have the following meanings:

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

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

22 * * *

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

1 (i) For the fiscal year 2007-2008, the department shall
2 apply a revenue adjustment neutrality factor and make
3 adjustments to county and nonpublic nursing facility payment
4 rates for medical assistance nursing facility services. The
5 revenue adjustment factor shall limit the estimated aggregate
6 increase in the Statewide day-weighted average payment rate over
7 the three-year period commencing July 1, 2005, and ending June
8 30, 2008, from the Statewide day-weighted average payment rate
9 for medical assistance nursing facility services in fiscal year
10 2004-2005 to 6.912% plus any percentage rate of increase
11 permitted by the amount of funds appropriated for nursing
12 facility services in the General Appropriation Act of 2007.
13 Application of the revenue adjustment neutrality factor shall be
14 subject to Federal approval of any amendments as may be
15 necessary to the Commonwealth's approved Title XIX State Plan
16 for nursing facility services.

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

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

28 (A) For each fiscal year between July 1, 2008, and June 30,
29 2011, the department shall apply a revenue adjustment neutrality
30 factor to county and nonpublic nursing facility payment rates.

1 For each such fiscal year, the revenue adjustment neutrality
2 factor shall limit the estimated aggregate increase in the
3 Statewide day-weighted average payment rate so that the
4 aggregate percentage rate of increase for the period that begins
5 on July 1, 2005, and ends on the last day of the fiscal year is
6 limited to the amount permitted by the funds appropriated by the
7 General Appropriations Act for those fiscal years.

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

13 (C) The department shall propose regulations that phase out
14 the use of county nursing facility costs as an input in the
15 process of setting payment rates of nonpublic nursing
16 facilities. The final regulations shall be effective July 1,
17 2009, and shall phase out the use of these costs in rate-setting
18 over a period of three rate years, beginning fiscal year
19 2009-2010 and ending on June 30, 2012.

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

25 (iv) Subject to Federal approval of such amendments as may
26 be necessary to the Commonwealth's approved Title XIX State
27 Plan, for each fiscal year beginning on or after July 1, 2011,
28 the department shall apply a revenue adjustment neutrality
29 factor to county and nonpublic nursing facility payment rates so
30 that the estimated Statewide day-weighted average payment rate

1 in effect for that fiscal year is limited to the amount
2 permitted by the funds appropriated by the General Appropriation
3 Act for the fiscal year.

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

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

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

25 (iii) The department may publish amendments to the statement
26 of policy if the department determines that changes to the
27 process and guidelines for reviewing and responding to requests
28 for approval of increases in medical assistance certified beds
29 will facilitate access to medically necessary nursing facility
30 services or are required to assure that long-term living care

1 and services under the medical assistance program will be
2 provided in a manner consistent with applicable Federal and
3 State law, including Title XIX of the Social Security Act. The
4 department shall publish the proposed amendments in the
5 Pennsylvania Bulletin and solicit public comments for thirty
6 days. After consideration of the comments it receives, the
7 department may proceed to adopt the amendments by publishing an
8 amended statement of policy in the Pennsylvania Bulletin which
9 shall include its responses to the public comments that it
10 received concerning the proposed amendments.

11 (iv) This subparagraph shall apply to any requests for
12 approval of an increase in medical assistance certified beds
13 pending or submitted on or after the effective date of this
14 subparagraph. This subparagraph shall expire upon the
15 department's adoption of final regulations or [September 30,
16 2011,] March 31, 2012, whichever occurs first.

17 Section 2. Section 443.6 of the act is amended by adding a
18 subsection to read:

19 Section 443.6. Reimbursement for Certain Medical Assistance
20 Items and Services.--* * *

21 (g) Notwithstanding any other provision of law, including
22 this section, the department shall establish benefit packages
23 for dental and pharmacy services for medical assistance
24 recipients 21 years of age or older, and any exceptions to such
25 benefit packages as the department determines are appropriate,
26 by publication of notice in the Pennsylvania Bulletin. The
27 notice shall describe the available benefit packages or limits
28 and any exceptions thereto.

29 Section 3. Section 709.1(a) and (b) of the act, added August
30 5, 1991 (P.L.315, No.30), are amended to read:

1 Section 709.1. Needs-Based Budgeting Process.--(a) Provider
2 submissions:

3 (1) Any department-licensed provider of community-based or
4 institutional placements purchased by a county with Federal or
5 State funds disbursed by the department under this article shall
6 submit to the department sufficient information in a form and
7 manner prescribed by the department to allow the department to
8 determine the extent to which the costs of those services may be
9 reimbursed with Federal and State funds.

10 (2) The department shall begin informing licensed providers
11 of the requirement to submit information pursuant to paragraph
12 (1) no later than January 1, 2012. The department shall inform
13 all licensed providers of the requirement to submit information
14 no later than January 1, 2014. During the period from January 1,
15 2012, through January 1, 2014, a licensed provider that receives
16 a written notice pursuant to this paragraph, sent on or before
17 January 1, shall provide the information required by paragraph
18 (1) no later than May 1 of the same year.

19 (3) Upon review of the information submitted under paragraph
20 (1), the department in consultation with counties, shall
21 determine which of those costs are reimbursable with Federal or
22 State funds and which are not. The department shall advise the
23 provider and the counties of that determination on or before
24 August 1 of the year in which that information is submitted. The
25 department's determinations regarding reimbursement with Federal
26 and State funds as of the effective date of this section shall
27 remain in effect for a licensed provider until the department
28 has completed a subsequent review and determination pursuant to
29 this subsection.

30 (4) The department's determination pursuant to paragraph (3)

1 shall take effect with the fiscal year beginning the year after
2 the department's determination and shall remain in effect for a
3 total of three fiscal years, except as otherwise provided in
4 this paragraph. A licensed provider may request a
5 redetermination due to a change in circumstances by submitting
6 the information required by paragraph (1) no later than May 1 of
7 the year preceding the fiscal year for which it requests a
8 redetermination. The department may give notice to a provider
9 that, due to a change in circumstances, the provider must
10 resubmit the information required by paragraph (1). A licensed
11 provider that receives a written notice pursuant to this
12 paragraph, sent on or before January 1, shall provide the
13 information required by paragraph (1) no later than May 1 of the
14 same year.

15 (b) County submissions:

16 (1) Prior to [September 15, 1991, and] August 15 each year
17 [thereafter] after calendar year 1991, counties shall submit to
18 the department a needs-based budget in a form prescribed by the
19 department containing their annual client and budget estimates
20 and a description of proposed changes in their annual plan for
21 the fiscal year beginning the following July 1.

22 [(b)] (2) Representatives of the department shall meet with
23 representatives of each of the counties to discuss the needs-
24 based budgets and proposed changes in annual plans and shall
25 make a thorough review of county submissions to ensure that the
26 county is seeking and obtains funding only for those costs which
27 are allowable expenditures under Federal and State law. County
28 submissions shall clearly distinguish funding supported by
29 section 704.1(a) from grants authorized by section 704.1(b). On
30 the basis of the discussions and review, the department shall

1 make its determination of each of the counties total costs and
2 reimbursable costs and the amount allowed each of the counties
3 in accordance with section 704.1(a).

4 * * *

5 Section 4. The definition of "net inpatient revenue" in
6 section 801-G of the act, added July 9, 2010 (P.L.336, No.49),
7 is amended to read:

8 Section 801-G. Definitions.

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

12 * * *

13 "Net inpatient revenue." Gross charges for facilities for
14 inpatient services less any deducted amounts for bad debt
15 expense, charity care expense and contractual allowances as
16 reported on [the Medicare Cost Report for Federal Fiscal Year
17 2008 or to the Pennsylvania Health Care Cost Containment Council
18 for Federal fiscal year 2008, if the Medicare Cost Report is not
19 available, and validated by the department] forms specified by
20 the department and:

21 (1) as identified in the hospital's books and records
22 for the State fiscal year commencing July 1, 2008; or

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

26 * * *

27 Section 5. Sections 804-G, 805-G(a) and (b) and 813-G of the
28 act, added July 9, 2010 (P.L.336, No.49), are amended to read:

29 Section 804-G. Administration.

30 (a) Calculation and notice of assessment amount.--Using the

1 assessment percentage established under section [803-G(b)] 803-G
2 and covered hospitals' net inpatient revenue, the department
3 shall calculate and notify each covered hospital of the
4 assessment amount owed for the fiscal year. Notification
5 pursuant to this subsection may be made in writing or
6 electronically at the discretion of the department.

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

8 (1) If a single covered hospital changes ownership or
9 control, the department will continue to calculate the
10 assessment amount using the hospital's net inpatient revenue
11 for State fiscal year 2008-2009 or for the most recent State
12 fiscal year, or part thereof, if the State fiscal year
13 2008-2009 amounts are not available. The covered hospital is
14 liable for any outstanding assessment amounts, including
15 outstanding amounts related to periods prior to the change of
16 ownership or control.

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

30 (a.2) Calculation of assessment with closures or other

1 changes in operation.--Except as provided in subsection (a.1)
2 (2), a covered hospital that closes or that becomes an exempt
3 hospital during a fiscal year is liable for both:

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

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

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

16 (c) Records.--Upon request by the department, a covered
17 hospital shall furnish to the department such records as the
18 department may specify in order for the department to validate
19 the net inpatient review reported by the hospital or to
20 determine the assessment for a fiscal year or the amount of the
21 assessment due from the covered hospital or to verify that the
22 covered hospital has paid the correct amount due.

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

1 department shall notify the covered hospital in writing of the
2 overpayment and, within 30 days of the date of the notice of the
3 overpayment, shall either refund the amount of the overpayment
4 or offset the amount of the overpayment against any amount that
5 may be owed to the department from the covered hospital.

6 Section 805-G. Restricted account.

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

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

15 (2) Making [enhanced] adjusted capitation payments to
16 medical assistance managed care organizations for
17 [supplemental] additional payments for inpatient hospital
18 services in accordance with section 443.1(1.2), (1.3) and
19 (1.4).

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

21 (b) Limitations.--

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

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

1 year less [\$59,000,000] \$145,731,000.

2 (3) For the first two years of the assessments, the
3 aggregate amount used for the medical assistance payments for
4 hospitals and Medicaid managed care organizations may not
5 exceed the aggregate amount of assessment funds collected for
6 the two years less [\$180,000,000] \$266,731,000.

7 (4) For the third year of the assessment, the amount
8 used for the medical assistance payment for hospitals and
9 medical assistance managed care organizations may not exceed
10 the aggregate amount of the assessment funds collected for
11 the year less [\$51,500,000] \$138,231,000.

12 (5) The amounts retained by the department pursuant to
13 paragraphs (1), (2), (3) and (4) and any additional amounts
14 remaining in the restricted accounts as a result of Federal
15 limitations on the payments described in subsection (a)(1)
16 and (2), shall be used for purposes approved by the secretary
17 under subsection (a)(3).

18 * * *

19 Section 813-G. Conditions for payments.

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

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

30 (2) The department receives Federal approval of a State

1 plan amendment authorizing the changes to its payment methods
2 and standards specified in § 443.1(1.1)(ii).

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

10 Section 6. This act shall take effect July 1, 2011, or
11 immediately, whichever is later.