AMENDMENTS TO HOUSE BILL NO. 1322

Sponsor:

Printer's No. 2453

Amend Bill, page 1, lines 1 through 4, by striking out all of said lines and inserting

Amending the act of June 13, 1967 (P.L.31, No.21), entitled "An act to consolidate, editorially revise, and codify the public welfare laws of the Commonwealth," as follows:
In public assistance:
establishing the Keystone Education Yields Success Program; and
further providing for copayments for subsidized child care, for identification and proof of residence, for medical assistance payments for institutional care, for other medical assistance payments, for mileage reimbursement and paratransit services for individuals receiving methadone treatment.
In children and youth:
further providing for payments to counties for services to children, for providers submission and for limits on reimbursement to counties.
Repealing provisions relating to Medicaid managed care organization assessments.
In Statewide quality care assessment:
further providing for definitions, for implementation, for administration, for restricted account and for expiration.
Providing for managed care organization assessments.
In departmental powers and duties as to supervision, further providing for definitions.
In departmental powers and duties as to licensing:
further providing for definitions, for fees, for provisional license for violation and penalty;
repealing provisions relating to registration.
In family finding and kinship care:
further providing for definitions, for the Kinship Care Program and for permanent legal custodianship subsidy and reimbursement.
Making a related repeal.
Providing for the licensing of family child-care homes.

Amend Bill, page 1, lines 7 through 10, by striking out all of said lines and inserting

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) Nothing in this section shall create or provide an

individual with an entitlement to services or benefits. Services under this section shall only be available to individuals enrolled in the KEYS program to the extent that funds are available.

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

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 based on a percentage of the family's annual income 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] on a sliding [income] scale based on a percentage of the family's annual income 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] shall increase in incremental amounts, based on a percentage of the family's annual income, as determined by the department [taking into account annual family income].

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

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

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

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

(4) [A] Subject to subsection (e), 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[.], but is not more than two

hundred fifty percent of the Federal poverty income guideline;

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

(iv) beginning after July 1, 2017, fifteen percent of the family's annual income if the family's annual income exceeds two hundred seventy-five percent of the Federal poverty income guideline, but is not more than three hundred percent of the Federal poverty income guideline or eighty-five percent of the State median income, whichever is lower.

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

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

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

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

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

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

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

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

for the copayment deduction if:

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

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

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

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

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

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

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

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

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

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

Amend Bill, page 2, line 19, by striking out "has collected" and inserting

is receiving

Amend Bill, page 2, line 20, by striking out "Commonwealth shall notify" and inserting

department may not authorize general assistance until it receives verification that the public assistance is scheduled to close in

Amend Bill, page 2, line 21, by striking out "of the change in residency of the applicant"

Amend Bill, page 3, line 16, by striking out all of said line and inserting

Section 5. Section 443.1(1.1) introductory paragraph and (i), (1.4) and (6) of the act, amended June 30, 2007 (P.L.49, No.16) and July 9, 2013 (P.L.369, No.55), are amended and paragraph (7) is amended by adding a subparagraph 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, [2016] 2018, 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.

* * *

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

(A) The department may adjust its capitation payments to medical assistance managed care organizations to provide additional funds for inpatient and outpatient 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, 2013-2014, 2014-2015 [or], 2015-2016, 2016-2017 and 2017-2018, 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 was enrolled in the department's fee-for-service program.

(C) Nothing in this paragraph 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, 2013.

* * *

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

(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:

* * *

(vi) Subject to Federal approval of such amendments as may be necessary to the Commonwealth's approved Title XIX State Plan, for fiscal year 2015-2016, the department shall make up to four medical assistance day-one incentive payments to qualified nonpublic nursing facilities. The department shall determine the nonpublic nursing facilities that qualify for the medical assistance day-one incentive payments and calculate the payments using the total Pennsylvania medical assistance (PA MA) days and total resident days as reported by nonpublic nursing facilities under Article VIII-A. The department's determination and calculations under this subparagraph shall be based on the nursing facility assessment quarterly resident day reporting forms, as determined by the department. The department shall not retroactively revise a medical assistance day-one incentive payment amount based on a nursing facility's late submission or revision of the department's report after the dates designated by the department. The department, however, may recoup payments based on an audit of a nursing facility's report. The following shall apply:

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

(I) The nursing facility shall have an overall occupancy rate of at least eighty-five percent during the resident day

quarter. For purposes of determining a nursing facility's overall occupancy rate, a nursing facility's total resident days, as reported by the facility under Article VIII-A, shall be divided by the product of the facility's licensed bed capacity, at the end of the quarter, multiplied by the number of calendar days in the quarter.

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

(III) The nursing facility shall be a nonpublic nursing facility for a full resident day quarter prior to the applicable quarterly reporting due dates, as determined by the department.

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

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

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

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

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

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

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

* * *

(1.1) Rates established by the department for observation services provided by or furnished under the direction of a physician and furnished by a hospital. Payment for observation services shall be made in an amount specified by the department by notice in the Pennsylvania Bulletin and shall be effective for dates of service on or after July 1, 2016. Payment for observation services shall be subject to conditions specified in the department's regulations, including regulations adopted by the department to implement this paragraph. Pending adoption of regulations implementing this paragraph, the conditions for

payment of observation services shall be specified in a medical assistance bulletin.

* * *

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

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

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

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

Section 472. Other Computations Affecting Counties.--To compute for each month the amount expended as medical assistance for public nursing home care on behalf of persons at each public medical institution operated by a county, county institution district or municipality and the amount expended in each county for aid to families with dependent children on behalf of children in foster family homes or child-caring institutions, plus the cost of administering such assistance. From such total amount the department shall deduct the amount of Federal funds properly received or to be received by the department on account of such expenditures, and shall certify the remainder increased or decreased, as the case may be, by any amount by which the sum certified for any previous month differed from the amount which should have been certified for such previous month, and by the proportionate share of any refunds of such assistance, to each appropriate county, county institution district or municipality. The amounts so certified shall become obligations of such counties, county institution districts or municipalities to be paid to the department for assistance: Provided, however, That for fiscal year 1979-80 and thereafter, the obligations of the counties shall be the amounts so certified representing aid to dependent children foster care as computed above plus one-tenth of the amount so certified above for public nursing home care: And provided further, That as to public nursing home care, for fiscal year 2005-2006 and thereafter, the obligations of the counties shall be the amount so certified above, less nine-tenths of the non-Federal share of payments made by the department during the fiscal year to county homes for public nursing care at rates established in accordance with section 443.1(5) and (7).

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

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

(g) [The] Except as provided by an executive approval or appropriation under the act of April 9, 1929 (P.L.343, No.176),

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

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

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

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

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

(5) Upon approval by the department of the county's final cumulative report for its expenditures for the fiscal year, twelve and one-half percent of the amount of State funds allocated to the county under section 709.3, adjusted by the amount of overspending or underspending of State funds in the previous quarters.

* * *

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

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

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

* * *

Section 704.3. Provider Submissions.--(a) For fiscal [year] years 2013-2014, 2014-2015 and 2015-2016, a provider shall submit documentation of its costs of providing services; and the department shall use such documentation, to the extent necessary, to support the department's claim for Federal funding

and for State reimbursement for allowable direct and indirect costs incurred in the provision of out-of-home placement services.

* * *

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

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

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

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

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

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

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

(c.1) The department shall reimburse counties with funds appropriated in the fiscal year in which the department is to make the reimbursement payment for child welfare services on the earliest date under section 704.1. The aggregate reimbursement for child welfare services provided during a fiscal year shall not exceed the amount specified as the aggregate child welfare needs-based budget allocation by the General Assembly as necessary to fund child welfare services in the General Appropriation Act for that fiscal year.

(d) For the purpose of this section, an appropriation shall be considered equivalent to the aggregate child welfare needs if it is equivalent to the result obtained by calculating the aggregate child welfare needs minus the county share of Youth Development Center costs and minus the Social Security Act Title

IV-B funding, provided, however, an appropriation shall be deemed equivalent if it is equal to eighty-two percent of the result in 1991-1992, ninety percent of the result in 1992-1993 and ninety-five percent of the result in 1993-1994.

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

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

[ARTICLE VIII-F

MEDICAID MANAGED CARE ORGANIZATION ASSESSMENTS

Section 801-F. Definitions.

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

"Assessment percentage." The rate assessed pursuant to this article on every Medicaid managed care organization.

"Assessment period." The time period identified in the contract.

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

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

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

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

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

"Medicaid managed care organization." 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 of Public Welfare. The term shall include a county Medicaid managed care organization and a permitted assignee of a Medicaid managed care contract but shall not include an assignor of a Medicaid managed care contract.

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

"Social Security Act." 49 Stat. 620, 42 U.S.C. § 301 et seq.

Section 802-F. Authorization.

The department shall implement an assessment on each Medicaid managed care organization, subject to the conditions and

requirements specified in this article.
Section 803-F. Implementation.
The assessment shall be implemented on an annual basis, through periodic submissions not to exceed five times per year by Medicaid managed care organizations, as a health care-related fee as defined in section 1903(w)(3)(B) of the Social Security Act, or any amendments thereto, and may be imposed and is required to be paid only to the extent that the revenues generated from the assessment qualify as the State share of program expenditures eligible for Federal financial participation.
Section 804-F. Assessment percentage.
(a) Amount.--The assessment percentage shall be uniform for all Medicaid managed care organizations, determined in accordance with this section and implemented by the department as approved by the Governor after notification to and in consultation with the Medicaid managed care organizations. The assessment percentage shall be subject to the maximum aggregate amount that may be assessed pursuant to 42 CFR 433.68(f)(3)(i) (relating to permissible health care-related taxes) or any subsequent maximum established by Federal law.
(b) Notice.--Subject to the provisions of subsection (c), the department shall notify each Medicaid managed care organization of a proposed assessment percentage. Medicaid managed care organizations shall have 30 days from the date of the proposed assessment percentage notice to provide written comments to the department regarding the proposed assessment. Upon expiration of the 30-day comment period, the department, after consideration of the comments, shall provide each Medicaid managed care organization with a second notice announcing the assessment percentage. Once effective, an assessment percentage will remain in effect until the department notifies each Medicaid managed care organization of a new assessment percentage in accordance with the notice provisions contained in this section.
(c) Initial assessment.--The initial assessment percentage may be imposed retroactively to the beginning of an assessment period beginning on or after July 1, 2004. Once effective, the initial assessment percentage will remain in effect until the department notifies each Medicaid managed care organization of a new assessment percentage in accordance with the notice provisions contained in this section.
Section 805-F. Calculation and payment.
Using the assessment percentage established under section 804-F, each Medicaid managed care organization shall calculate the assessment amount for each assessment period on a report form specified by the contract and shall submit the completed report form and total amount owed to the department on a due date specified by the contract. The Medicaid managed care organization shall report net operating revenue for purposes of the assessment calculation as specified in the contract.

Section 806-F. Use of assessment proceeds.

No Medicaid managed care organization shall be guaranteed a repayment of its assessment in derogation of 42 CFR 433.68(f) (relating to permissible health care-related taxes), provided, however, in each fiscal year in which an assessment is implemented, the department shall use the assessment proceeds to maintain actuarially sound rates as defined in the contract for the Medicaid managed care organizations to the extent permissible under Federal and State law or regulation and without creating a guarantee to hold harmless, as those terms are used in 42 CFR 433.68(f).

Section 807-F. Records.

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

Section 808-F. Payment of assessment.

In the event that the department determines that a Medicaid managed care organization has failed to pay an assessment or that it has underpaid an assessment, the department shall provide written notification to the Medicaid managed care organization within 180 days of the original due date 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 Medicaid managed care organization has overpaid an assessment, the department shall notify the Medicaid managed care organization in writing of the overpayment, and, within 30 days of the date of the notice of the overpayment, the Medicaid managed care organization shall advise the department to either authorize a refund of the amount of the overpayment or offset the amount of the overpayment against any amount that may be owed to the department by the Medicaid managed care organization.

Section 809-F. Appeal rights.

A Medicaid managed care organization that is aggrieved by a determination of the department relating to the assessment may file a request for review of the decision of the department by the Bureau of Hearings and Appeals within the department, which shall have exclusive primary jurisdiction in such matters. The procedures and requirements of 67 Pa.C.S. Ch. 11 (relating to medical assistance hearings and appeals) shall apply to requests for review filed pursuant to this section except that, in any such request for review, a Medicaid managed care organization

may not challenge the assessment percentage determined by the department pursuant to section 804-F.

Section 810-F. Enforcement.

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

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

(2) When a Medicaid managed care organization fails to submit a report form concerning the calculation of the assessment or to furnish records to the department as required by this article, the department may impose a penalty against the Medicaid managed care organization in the amount of $1,000 per day for each day the report form or required records are not submitted or furnished to the department. If the $1,000 per day penalty is imposed, it shall commence on the first day after the date for which a report form or records are due.

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

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

Section 811-F. Time periods.

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

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

* * *

"Exempt hospital." Any of the following:

(1) A Federal veterans' affairs hospital.
(2) A hospital that provides care, including inpatient hospital services, to all patients free of charge.
(3) A private psychiatric hospital.
(4) A State-owned psychiatric hospital.
(5) A critical access hospital.
(6) A long-term acute care hospital.
(7) A free-standing acute care hospital organized primarily for the treatment of and research on cancer in which at least 30% of the inpatient admissions had cancer as the principal diagnosis based on Pennsylvania Health Care Cost Containment Council CY 2014 inpatient discharge data. For the purposes of meeting this definition, only discharges with ICD-9-CM principal diagnoses codes of 140 through 239, V58.0, V58.1, V66.1, V66.2 or 990 are considered.

* * *

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

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

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

* * *

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

Section 803-G. Implementation.

* * *

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

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

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

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

(c) Adjustments to assessment percentage.--The secretary may adjust the assessment percentage specified in subsection (b), provided that, before [adjusting] implementing an adjustment, the secretary shall publish a notice in the Pennsylvania Bulletin that specifies the proposed assessment percentage and identifies the aggregate impact on covered hospitals subject to

the assessment. Interested parties shall have 30 days in which to submit comments to the secretary. Upon expiration of the 30-day comment period, the secretary, after consideration of the comments, shall publish a second notice in the Pennsylvania Bulletin announcing the assessment percentage.

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

* * *

Section 804-G. Administration.

* * *

(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:

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

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

(iii) the most recent State fiscal year, or part thereof, if the [State fiscal year 2010-2011] net inpatient revenue amounts specified in subparagraphs (i) and (ii) 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 owed by the single covered hospital resulting from the merger or consolidation using the merged or consolidated hospitals' combined net inpatient revenue for:

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

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

(iii) the most recent State fiscal year, or part thereof, if the [State fiscal year 2010-2011] net inpatient revenue amounts specified in subparagraphs (i) and (ii) 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.

* * *

(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 electronically 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.

* * *

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

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 for inpatient services in accordance with section 443.1(1.1), and outpatient services, including for observation services in accordance with section 443.3(a)(1.1), and as otherwise specified in the Commonwealth's approved Title XIX State Plan.

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

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

(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 $109,000,000.

(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 $109,000,000.

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

(4.2) For State fiscal [year] years 2015-2016, 2016-2017 and 2017-2018, 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 [$140,000,000] $220,000,000.

(5) The amounts retained by the department pursuant to paragraphs (1), (2), (4), (4.1) and (4.2) 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).

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

Section 815-G. Expiration.

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

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

ARTICLE VIII-I

MANAGED CARE ORGANIZATION ASSESSMENTS

Section 801-I. Definitions.

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

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

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

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

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

"Department." The Department of Human Services of the

Commonwealth.

"Fixed fee." The assessment amount imposed on a per member per month basis as specified under section 803-I(b).

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

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

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

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

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

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

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

"Medicaid managed care organization." 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 contract with the department. The term includes a county Medicaid managed care organization and a permitted assignee of a contract. The term does not include an assignor of a contract.

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

(1) A Medicare Advantage plan.

(2) A TRICARE or other health care plan provided through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) as defined under 10 U.S.C. § 1072.

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

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

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

Section 802-I. Authorization.

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

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

eligible for Federal financial participation.

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

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

(4) In the event that the department determines that a managed care organization has failed to pay an assessment or that it has underpaid an assessment, the department shall notify the managed care organization in writing of the amount due, including interest, and the date on which the amount due must be paid. The date the amount is due shall not be less than 30 days from the date of the notice.

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

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

Section 803-I. Assessment amount.

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

(b) Fixed fee.--Beginning July 1, 2016, and ending June 30, 2020, the managed care organization shall be assessed a fixed fee of $13.48 for each unduplicated member for each month the member is enrolled for any period of time with the managed care organization.

(c) Adjustments.--The secretary may make further adjustments to the fixed fee specified under subsection (b) for all or part of the fiscal year so long as the assessment does not exceed the maximum limit specified under subsection (d). Before adjusting the fixed fee, the secretary shall publish a notice in the Pennsylvania Bulletin that specifies the proposed adjusted fixed fee and identifies the estimated aggregate impact on managed care organizations. 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 adjusted fixed fee.

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

(e) Limited review.--

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

(2) Any assessments implemented under this article or forms or reports required to be completed by managed care organizations under this article shall not be subject to the act of July 31, 1968 (P.L.769, No.240), referred to as the Commonwealth Documents Law, the act of October 15, 1980 (P.L.950, No.164), known as the Commonwealth Attorneys Act, and the act of June 25, 1982 (P.L.633, No.181), known as the Regulatory Review Act.

Section 804-I. No hold harmless.

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

Section 805-I. Restricted account.

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

Section 806-I. Access to information and records.

(a) Reports and access.--A managed care organization shall report such information and shall provide access to and shall

furnish such records to the department, without charge, as the department may specify in order for the department to:

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

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

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

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

Section 807-I. Remedies.

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

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

(2) If a managed care organization fails to file a report or to furnish records to the department as required by this article, the department shall impose a penalty against the managed care organization in the amount of $1,000 per day for each day the report or required records are not submitted or furnished to the department. If the penalty under this paragraph is imposed, it shall commence on the first day after the date for which a report form or records are due.

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

provider or managed care service entity.

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

Section 808-I. Liens.

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

Section 809-I. Appeal rights.

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

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

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

Section 810-I. Tax exemption provisions superseded.

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

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

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

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

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

Section 811-I. Expiration.

The assessment authorized under this article shall expire

June 30, 2020.

Section 812-I. Coordination with other agencies.

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

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

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

"Child day care" means care in lieu of parental care given for part of the twenty-four hour day to a child under sixteen years of age, away from the child's home, but does not include child day care furnished in a place of worship during religious services.

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

* * *

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

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

* * *

"Facility" means an adult day care center, child day care center, family [day] child care home, boarding home for children, mental health establishment, personal care home, assisted living residence, nursing home, hospital or maternity home, as defined herein, except to the extent that such a facility is operated by the State or Federal governments or those supervised by the department, or licensed pursuant to the act of July 19, 1979 (P.L.130, No.48), known as the "Health Care Facilities Act."

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

* * *

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

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

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

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

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

Section 1008. Provisional License.--(a) When there has been substantial but not complete compliance with all the applicable statutes, ordinances and regulations and when the applicant has taken appropriate steps to correct deficiencies, the department shall issue a provisional license [for a specified period of not more than six months which may be renewed three times. Upon full compliance, a regular license shall be issued immediately].

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

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

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

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

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

(1) For a first offense, the person commits a summary

offense and shall, upon conviction, be sentenced to pay a fine not less than twenty-five dollars ($25) nor more than three hundred dollars ($300), costs of prosecution, and if in default of payment thereof, to imprisonment for not less than ten days nor more than thirty days.

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

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

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

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

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

(3) Any provider charged with violation of this subsection shall have thirty days to pay the assessed penalty in full, or, if the provider wishes to contest either the amount of the penalty or the fact of the violation, the party shall forward the assessed penalty to the Secretary of Human Services for placement in an escrow account with the State Treasurer. If, through administrative hearing or judicial review of the proposed penalty, it is determined that no violation occurred or that the amount of the penalty shall be reduced, the secretary

shall within thirty days remit the appropriate amount to the provider with any interest accumulated by the escrow deposit. Failure to forward the payment to the secretary within thirty days shall result in a waiver of rights to contest the fact of the violation or the amount of the penalty. The amount assessed after administrative hearing or a waiver of the administrative hearing shall be payable to the Commonwealth of Pennsylvania and shall be collectible in any manner provided by law for the collection of debts. If any provider liable to pay such penalty neglects or refuses to pay the same after demand, such failure to pay shall constitute a judgment in favor of the Commonwealth in the amount of the penalty, together with the interest and any costs that may accrue.

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

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

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

[(c) Registration Provisions

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

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

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

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

Section 1072. Application for Registration Certificate.--(a) Any individual desiring to secure a registration certificate shall submit an application therefor to the department upon forms prepared and furnished by the department, and, at the same time, shall certify in writing that he/she and the facility named in the application are in compliance with applicable department regulations.

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

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

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

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

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

Section 1076. Regulations.--The department is hereby authorized and empowered to adopt regulations establishing minimum and reasonable standards for the operation of family day care homes and the issuance of registration certificates. These regulations will establish the minimum standards of safety and care which will be required in family day care homes and will recognize the vital role which parents and guardians play in monitoring the care provided in family day care homes.

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

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

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

(b) The department shall refuse to issue or renew a registration certificate or shall revoke a registration

certificate for any of the following reasons:

(1) Noncompliance with department regulations.

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

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

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

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

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

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

Section 1302. Definitions.

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

* * *

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

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

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

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

* * *

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

* * *

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

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

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

(3) who meets the requirements for employment in child-care services and approval as a foster or adoptive parent

under 23 Pa.C.S. § 6344 (relating to employees having contact with children; adoptive and foster parents).

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

Section 1303. Kinship Care Program.

* * *

(a.1) Relative notification.--Except in situations of family or domestic violence, the county agency shall exercise due diligence to identify and notify all grandparents and other adult relatives to the fifth degree of consanguinity or affinity to the parent or stepparent of a dependent child and each parent who has legal custody of a sibling of a dependent child within 30 days of the child's removal from the child's home when temporary legal and physical custody has been transferred to the county agency. The notice must explain all of the following:

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

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

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

* * *

Section 1303.2. Permanent legal custodianship subsidy and reimbursement.

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

* * *

Section 19. (Reserved).

Section 20. The requirement that a family child care home be licensed as a facility as defined in section 1001 of the act shall apply upon expiration of the family child care home's current certificate of registration.

Section 21. This act shall take effect as follows:

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

(i) The addition of section 405.1B.

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

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

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

(4) The following provisions shall take effect immediately:

(i) This section.

(ii) The remainder of this act.