AN ACT

To consolidate, editorially revise, and codify the public welfare laws of the Commonwealth.

Compiler's Note: Section 1101 of Act 45 of 1999 provided that Act 45 shall not repeal or in any way affect Act 21.

Compiler's Note: See section 6 of Act 84 of 2010 in the appendix to this act for special provisions relating to continuation of prior law.

Compiler's Note: See the preamble to Act 32 of 2023 in the appendix to this act for special provisions relating to findings and declarations.

TABLE OF CONTENTS

Article I
Preliminary Provisions

Article II
General Powers and Duties
of the Department of Public Welfare

Article III
State Institutions in the Department of

Public Welfare

(a) General Provisions

(b) General Hospitals

(c) Geriatric Centers

(d) Youth Development Centers for Delinquent Juveniles

(e) Forestry Camps for Delinquent Juveniles

Article IV
Public Assistance

(a) Legislative Intent; Definitions

(b) Departmental Powers and Duties as to Public Assistance

(f) Medical Assistance

(g) Special Provisions Respecting Assistance

Article V-A
Health Care Outcomes

Article VI
The Aged

Article VII

Children and Youth

(a) Departmental Powers and Duties as to Public Child Welfare

(b) Departmental Powers and Duties as to Delinquency

(c) Interstate Compact on Juveniles

(d) Interstate Placement of Children

Article VIII-D
Senior Care and Services Study Commission

ARTICLE VIII-E
HOSPITAL ASSESSMENTS

ARTICLE VIII-F
MEDICAID MANAGED CARE ORGANIZATION ASSESSMENTS
(Repealed)

ARTICLE VIII-G
STATEWIDE QUALITY CARE ASSESSMENT

ARTICLE VIII-H
PENNSYLVANIA TRAUMA SYSTEMS STABILIZATION
(Repealed)

ARTICLE VIII-I
MANAGED CARE ORGANIZATION ASSESSMENTS

Article IX
Departmental Powers and Duties as to Supervision

Article X
Departmental Powers and Duties as to Licensing

(a) Licensing Provisions

Article XI
Mental Health: Departmental Powers and Duties; Commissioner of Mental Health; Interstate Compact; Reciprocal Agreements; Research Foundation

Article XIV
Fraud and Abuse Control

Article XIV-A
Inmate Medical Costs

Article XIV-B
Human Services Block Grant Program

Article XIV-C
Pennsylvania eHealth Partnership Program

ARTICLE XIV-D
PENNSYLVANIA RURAL HEALTH REDESIGN CENTER AUTHORITY

SUBARTICLE A
PRELIMINARY PROVISIONS

SUBARTICLE B
PENNSYLVANIA RURAL HEALTH REDESIGN CENTER AUTHORITY

SUBARTICLE C
PARTICIPATION IN GLOBAL BUDGET MODEL

SUBARTICLE D
DATA COLLECTION AND CONFIDENTIALITY

SUBARTICLE E
PENNSYLVANIA RURAL HEALTH REDESIGN CENTER FUND

Article XV
Repeals; Effective Date

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

ARTICLE I
PRELIMINARY PROVISIONS

Section 101. Short Title.--This act shall be known and may be cited as the Human Services Code.
(101 amended Dec. 28, 2015, P.L.500, No.92)
Section 102. Definitions.--Subject to additional definitions contained in subsequent articles of this act, the following words when used in this act shall have, unless the context clearly indicates otherwise, the meanings given them in this section:

"Department" means the Department of Human Services of this Commonwealth.

"Secretary" means the Secretary of Human Services of this Commonwealth.

(102 amended September 24, 2014, P.L.2458, No.132)

Section 103. Redesignation.--(a) The Department of Public Welfare shall be known as the Department of Human Services.

(b) A reference to the Department of Public Welfare in a statute or a regulation shall be deemed a reference to the Department of Human Services.

(c) In order to provide an efficient and cost-minimizing transition, licenses, contracts, deeds and any other official actions of the Department of Public Welfare shall not be affected by the use of the designation of the department as the Department of Human Services. The department may continue to use the name Department of Public Welfare on badges, licenses, contracts, deeds, stationery and any other official documents until existing supplies are exhausted. The Department of Public Welfare may substitute the title "Department of Human Services" for "Department of Public Welfare" on its documents and materials on such schedule as it deems appropriate.

(d) The Department of Human Services shall not replace existing signage at department locations with the redesignated name until the signs are worn and in need of replacement. This transition shall be coordinated with changes in administration.

(e) The department shall continue to use the name Department of Public Welfare on its computer systems until the time of routine upgrades in each computer system in the department. The change in name shall be made at the time of the routine upgrade to the department computer systems.

(103 added September 24, 2014, P.L.2458, No.132)

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

ARTICLE II
GENERAL POWERS AND DUTIES OF THE DEPARTMENT OF PUBLIC WELFARE

Section 201. State Participation in Cooperative Federal Programs.--The department shall have the power and its duties shall be:

(1) With the approval of the Governor, to act as the sole agency of the State when applying for, receiving and using Federal funds for the financing in whole or in part of programs in fields in which the department has responsibility.

(2) With the approval of the Governor, to develop and submit State plans or other proposals to the Federal government, to promulgate regulations, establish and enforce standards and to take such other measures as may be necessary to render the Commonwealth eligible for available Federal funds or other assistance. Notwithstanding anything to the contrary in the act of July 31, 1968 (P.L.769, No.240), referred to as the Commonwealth Documents Law, the department may omit notice of proposed rulemaking and promulgate regulations as final when a delay of thirty days or less in the final adoption of regulations will result in the loss of Federal funds or when a delay of thirty days or less in adoption would require the replacement of Federal funds with State funds.

(3) To make surveys and inventories of existing facilities and services as required in connection with such State plans, and to assess the need for construction, modernization or

additional services and to determine priorities with respect thereto.

(4) To conduct investigations of activities related to fraud, misuse or theft of public assistance moneys, medical assistance moneys or benefits, or Federal food stamps, committed by any person who is or has been participating in or administering programs of the department, or by persons who aid or abet others in the commission of fraudulent acts affecting welfare programs.

(5) To collect data on its programs and services, including efforts aimed at preventative health care, to provide the General Assembly with adequate information to determine the most cost-effective allocation of resources in the medical assistance program.

(6) To submit on a biannual basis a report to the General Assembly regarding the medical assistance population, which shall include aggregate figures, delineated on a monthly basis, for the number of individuals to whom services were provided, the type and incidence of services provided by procedure and the cost per service as well as total expenditures by service.

(201 amended June 16, 1994, P.L.319, No.49)

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Compiler's Note: Section 16 of Act 49 of 1994, which amended section 201, provided that the Department of Public Welfare shall report to the General Assembly, no later than six months from the effective date of Act 49, on the policies and procedures instituted to implement section 201(5), as well as the nature of the information to be provided.

Section 201.1. Federal Funds for Legal Services.--In addition to the areas of expenditures for legal services authorized by section 220 of the act of June 30, 1995 (P.L.749, No.5A), known as the General Appropriation Act of 1995, Federal funds appropriated for fiscal year July 1, 1995, through June 30, 1996, may only be used for the following: termination of employment and unemployment compensation; insurance; health care; discrimination due to age, race, sex or handicap; wage and pension claims; taxation; wills and estates; Social Security; disability; and debtor-creditor issues.

(201.1 added June 30, 1995, P.L.129, No.20)

Section 202. Approval of Plans and Mortgages.--The department shall have the power, and its duty shall be:

(1) To approve or disapprove all plans for the erection or substantial alteration of any State or supervised institution as defined in section 901 receiving aid from the Commonwealth.

(2) To investigate, and report to the Auditor General, upon every application to the Auditor General made by any institution, corporation, or unincorporated association, desiring to give a mortgage under the provisions of the act of April 29, 1915 (P.L.201), entitled "An act making mortgages, given by benevolent, charitable, philanthropic, educational, and eleemosynary institutions, corporations, or unincorporated associations, for permanent improvements and refunding purposes, prior liens to the liens of the Commonwealth for the appropriation of moneys; providing a method for the giving of such mortgages, and fixing the duties of the Auditor General and Board of Public Charities in connection therewith."

Section 203. Promotion of Local Planning Bodies.--The department shall have the power to assist in the establishment

of local social welfare planning bodies, such as councils of social agencies.

Section 204. Consultation to Local Agencies.--The department shall have the power to provide consultation to local public officials and voluntary organizations in the establishment and operation of public and private social welfare programs in fields in which the department has responsibility.

Section 205. Grants and Subsidies to Local Agencies.--On the basis of formulae which include public or voluntary support, the department shall have the power to disburse Federal and State funds, appropriated for the purpose, as grants and subsidies to programs in fields in which the department has responsibility if they meet the department's standards.

Section 205.1. County Human Services Consolidated Planning and Reporting (Unconstitutional).

(205.1 added June 30, 2012, P.L.668, No.80; addition declared unconstitutional 2018)

2018 Unconstitutionality: The addition of section 205.1 by Act 80 of 2012 was declared unconstitutional on July 18, 2018, by the Supreme Court of Pennsylvania in Washington v. Commonwealth, Department of Public Welfare, 188 A.3d 1135 (Pa. 2018). The Legislative Reference Bureau effectuated the 2018 unconstitutionality.

Section 206. Purchase of Services.--The department shall have the power:

(1) Whenever the General Assembly shall have appropriated money to the department for public welfare purposes, to purchase necessary services for individuals entitled to such services at rates not exceeding those charged the general public or actual cost; such services may be purchased directly from agencies or institutions conforming to minimum standards established by the department or by law or the department may reimburse local public agencies which purchase such services from such agencies or institutions. Except for day care services, this clause shall not be interpreted to include the direct provision by the department of services to dependent or neglected children.

(2) To establish rules and regulations not inconsistent with law prescribing minimum standards of plant, equipment, service, administration and care and treatment for agencies and institutions furnishing service to individuals paid for, in whole or in part, by money appropriated to the department by the General Assembly, and when not otherwise established by law, fixing per diem or other rates for services furnished by such agencies or institutions.

Section 207. Payment to Certain Facilities from Special Appropriations.--The department shall have the power, and its duty shall be, whenever the General Assembly shall have specifically appropriated money to the department for the purpose, to issue requisitions upon the Auditor General for warrants, to be drawn by the Auditor General upon the State Treasurer, in favor of such hospitals, homes and institutions as shall conform to at least the minimum standards of plant, equipment, service, administration and care and treatment necessary for the proper care and treatment of patients or inmates, as required by the rules and regulations of the department, or established by law, in amounts computed upon the per diem rates of payment established by law for free care and treatment to indigent, sick, injured or crippled persons.

Section 208. Reciprocal Agreements on Interstate Transfer and Support of Indigent Persons.--With respect to persons of

the classes provided for in Article IV relating to public assistance herein and with respect to persons for whom the counties and the county institution districts are responsible under other provisions of law, the department, subject to the approval of the Attorney General, is authorized to enter into reciprocal agreements with corresponding agencies of other states regarding the interstate transportation of poor and indigent persons and to arrange with the proper officials in this State for the acceptance, transfer and support of persons receiving public aid in other states in accordance with the terms of such reciprocal agreements. This State shall not, nor shall any political subdivision of this State, be committed to the support of persons who are not, in the opinion of the department entitled to public support by the laws of this State. All such reciprocal agreements respecting persons for whom the counties and the county institution districts are responsible under other provisions of law, entered into by the department, shall be binding upon the counties and the county institution districts of this State.

Compiler's Note: Section 502 of Act 164 of 1980 provided that the powers and duties of the Attorney General and/or the Department of Justice contained in section 9 were transferred to the Office of General Counsel.

Section 209. Consent to Care in a Public Institution.--(a) It shall be unlawful for any person, public official, corporation, association or institution to bring or send or cause to be brought or sent into the Commonwealth of Pennsylvania an inmate of any public institution outside of the Commonwealth of Pennsylvania for the purpose of placing such inmate in any public institution administered or supervised by the department, without first obtaining the written consent of the department.

(b) Any person who shall violate the provisions of this section shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay a fine not exceeding one hundred dollars ($100), or undergo imprisonment for a term not exceeding six months, or both.

Section 210. Training Program; Purpose and Method; Contract for Employment.--(210 repealed with exceptions Nov. 21, 1973, P.L.338, No.114)

Section 211. State Plan for Regulating and Licensing Personal Care Homes and Assisted Living Residences.--(Hdg. amended July 25, 2007, P.L.402, No.56) (a) In accordance with the statutory authority and responsibility vested in the department to regulate nonprofit homes for adults which provide personal care and services and to license for profit personal care homes for adults, pursuant to Articles IX and X, the department shall develop and implement a State plan for regulating and licensing said facilities as defined by section 1001 of this act.

(b) In developing rules and regulations for the State plan, the department shall:

(1) Distinguish between personal care homes serving less than eight persons and personal care homes serving more than eight persons.

(2) By July 1, 1981 adopt rules relating to the conduct of owners and employes of personal care homes relative to the endorsement or delivery of public or private welfare, pension or insurance checks by a resident of a personal care home.

(3) Not regulate or require the registration of boarding homes which merely provide room, board and laundry services to persons who do not need personal care home services.

(c) Within three months following the effective date of this act, the department shall submit to the General Assembly for comment and review, and publish in the Pennsylvania Bulletin in accordance with the provisions of the Commonwealth Documents Law relating to the publication of regulations, a preliminary State plan for regulating and licensing personal care homes.

(d) The preliminary plan shall include, but is not limited to, the following:

(1) Coordination of the department's statutory responsibilities with those of other State and local agencies having statutory responsibilities relating to personal care homes, with particular attention given to the Department of Labor and Industry, the Department of Environmental Resources, the Department of Aging and the Pennsylvania Human Relations Commission. The Department of Labor and Industry shall promulgate rules and regulations applicable to personal care homes on a Statewide basis consistent with size distinctions set forth in subsection (b) pertaining to construction and means of egress.

(2) Recommendations for changes in existing State law and proposed legislation to:

(i) Resolve inconsistencies that hinder the department's implementation of the State plan.

(ii) Promote the cost efficiency and effectiveness of visitations and inspections.

(iii) Delegate to other State and local agencies responsibility for visitations, inspections, referral, placement and protection of adults residing in personal care homes.

(iv) Evaluate the State's fire and panic laws as applied to personal care homes.

(3) Recommendations for implementation of fire safety and resident care standards relating to personal care homes by cities of the first class, second class and second class A.

(4) A programmatic and fiscal impact statement regarding the effect of the plan on existing residential programs for the disabled, including but not limited to skilled nursing homes, intermediate care facilities, domiciliary care homes, adult foster care homes, community living arrangements for the mentally retarded and group homes for the mentally ill and the effect of the plan on recipients of Supplemental Security Income.

(5) Cost analysis of the entire plan and of all regulations that will be proposed pursuant to the plan.

(6) Number of personnel at the State, regional and county level required to inspect personal care homes and monitor and enforce final rules and regulations adopted by the department.

(7) Process for relocating residents of personal care homes whose health and safety are in imminent danger.

(e) If the department deems that it is in the best interest of the Commonwealth to develop a plan for implementation on a phased basis, the department shall submit a detailed schedule of the plan to the General Assembly which shall be part of the preliminary State plan.

(f) Within six months of the effective date of this act, the department shall adopt a final State plan which shall be submitted and published in the same manner as the preliminary plan.

(g) The final plan shall include the information required in the preliminary plan and, in addition, the cost to operators of personal care homes for compliance with the regulations.

(h) At no time may the department change, alter, amend or modify the final State plan, except in emergency situations, without first publishing such change in the Pennsylvania Bulletin in accordance with the Commonwealth Documents Law relating to publication of regulations and without first submitting the proposed change to the General Assembly for comment and review. In an emergency, the department may change, alter, amend or modify the State plan without publishing the change or submitting the change to the General Assembly; but, within thirty days, the department shall submit and publish the change as otherwise required.

(i) The State plan shall not apply to any facility operated by a religious organization for the care of clergymen or other persons in a religious profession.

(j) Prior to January 1, 1985, department regulations shall not apply to personal care homes in which services are integrated with, are under the same management as, and on the same grounds as a skilled nursing or intermediate care facility licensed for more than twenty-five beds and having an average daily occupancy of more than fifteen beds. Prior to January 1, 1985 the department may require registration of such facilities and may visit such facilities for the purpose of assisting residents and securing information regarding facilities of this nature.

(k) Any regulations by the department relating to the funding of residential care for the mentally ill or mentally retarded adults and any regulations of the Department of Aging relating to domiciliary care shall use as their base, regulations established in accordance with this section. Supplementary requirements otherwise authorized by law may be added.

(l) The department shall annually conduct at least one onsite unannounced inspection of each personal care home and each assisted living residence. Additional announced or unannounced inspections may be conducted by the department as the department deems necessary. When developing regulations under this act, the department may provide for an abbreviated annual licensure visit when a residence has established a history of exemplary compliance. ((l) amended July 25, 2007, P.L.402, No.56)

(m) Regulations specifically related to personal care homes or personal care home services adopted prior to the effective date of this act shall remain in effect until superseded by a final plan adopted in accordance with this section.

(211 amended Dec. 21, 1988, P.L.1883, No.185)

Compiler's Note: See the preamble and sections 8, 9, 10 and 11 of Act 56 of 2007 for special provisions relating to legislative findings, construction of law, Legislative Budget and Finance Committee report and assisted living residence licenses.

Compiler's Note: The Department of Environmental Resources, referred to in subsec. (d), was abolished by Act 18 of 1995. Its functions were transferred to the Department of Conservation and Natural Resources and the Department of Environmental Protection.

Section 212. Intra-Governmental Council on Long-Term Care.--(212 repealed Nov. 24, 2015, P.L.232, No.64)

Section 213. Personal Care Home and Assisted Living Residence Administrators.--(Hdg. amended July 25, 2007, P.L.402, No.56) (a) After December 31, 1990, all personal care homes shall identify and appoint a personal care home administrator or administrators who meet the qualifications provided in this section.

(a.1) All assisted living residences shall identify and appoint an administrator or administrators who meet the qualifications provided in this section for personal care home administrators and any additional standards pertaining to the operations of assisted living residences as the department may establish by regulation. ((a.1) added July 25, 2007, P.L.402, No.56)

(b) A personal care home administrator shall:

(1) be at least twenty-one years of age and be of good moral character; and

(2) have knowledge, education and training in all of the following:

(i) fire prevention and emergency planning;

(ii) first aid, medications, medical terminology and personal hygiene;

(iii) local, State and Federal laws and regulations;

(iv) nutrition, food handling and sanitation;

(v) recreation;

(vi) mental illness and gerontology;

(vii) community resources and social services; and

(viii) staff supervision, budgeting, financial record keeping and training; or

(3) be a licensed nursing home administrator. The department may establish separate standards of knowledge and training for licensed nursing home administrators who wish to operate a personal care home.

(c) The department shall promulgate regulations requiring orientation and training for all direct care staff and regulations requiring qualifications for administrators in a personal care home or assisted living residence. Such regulations for assisted living direct care staff and administrators shall meet or exceed the requirements for direct service staff and administrators in a personal care home. ((c) amended July 25, 2007, P.L.402, No.56)

(d) By June 1, 1989, the department shall by regulation develop such standards for knowledge, education or training to meet the standards of this section.

(e) If not otherwise available, the department shall schedule, and offer at cost, training and educational programs for a person to meet the knowledge, educational and training requirements established by this act.

(213 added Dec. 21, 1988, P.L.1883, No.185)

Compiler's Note: See the preamble and sections 8, 9, 10 and 11 of Act 56 of 2007 for special provisions relating to legislative findings, construction of law, Legislative Budget and Finance Committee report and assisted living residence licenses.

Section 214. Job Training.--(a) The department shall establish, implement and administer a pilot job training program with the ultimate goal of securing economic self-sufficiency for welfare recipients. The program shall utilize Federal and State funds available to the department for job training programs.

(b) The pilot program shall consist of three projects located in three separate counties in different geographical

regions representing rural, suburban and urban populations of this Commonwealth. In selecting sites for projects, preference shall be given to areas of persistent unemployment and widespread failure or closure of existing dominant industries.

(c) The goal of the pilot program shall be to match trainees with existing job vacancies which pay wages and benefits based on a forty-hour work week and which are sufficient to ensure the financial security of the trainee and any dependents to enable that trainee and dependents to remain free of any State assistance for at least one year.

(d) The pilot program shall include provisions to:

(1) Ensure that contracts with training, placement and other service providers are performance based, with payments derived from successful placements of welfare recipients into adequate employment.

(2) Reward client initiative by directing child-care, training and other program resources to welfare recipients who are actively working toward self-sufficiency.

(3) Make receipt of benefits and/or incentives contingent on recipients meeting of individualized obligations such as attendance at training sessions and pursuit of job opportunities.

(e) The department may contract with an employer, a nonprofit association, corporation or government agency or any combination thereof.

(f) Payments by the department to a project operator shall be scheduled so that twenty-five percent of the contract price is paid during training, twenty-five percent is paid upon completion of training, twenty-five percent after the trainee is employed continuously for a period of at least six months and twenty-five percent after the trainee is employed continuously for a period of at least one year.

(g) The department shall be required to analyze the pilot program, measuring its results against the goals under this section as well as comparing it to other Federal and State job training programs. A report on the evaluation shall be submitted to the Governor and the General Assembly detailing the findings and recommendations of the evaluation no later than two years following implementation of the pilot program. The report shall include, but not be limited to:

(1) Cost-effectiveness in the use of job training resources.

(2) Rate of job placements.

(3) Reduction of welfare enrollment.

(4) Rate of in-migration and out-migration in the program area.

(h) An employer may not contract a program participant to another employer unless the program participant is the sole recipient of any additional wages, benefits or compensation that may result from the contract.

(i) The department shall promulgate regulations to implement the provisions of this section.

(214 added June 30, 1995, P.L.129, No.20)

Compiler's Note: See section 11 of Act 20 of 1995 in the appendix to this act for special provisions relating to waiver of Federal law and regulations and other approvals by Federal Government necessary for implementation of programs added by Act 20.

Compiler's Note: Section 14 of Act 20 of 1995, which added section 214, provided that section 214 shall take effect in 120 days.

Section 215. Determining Whether Applicants are Veterans.--(a) The department shall make a good faith effort to determine whether an applicant for cash, medical or energy assistance is a veteran. While in the process of making its determination, the department shall dispense benefits to the applicant, if otherwise eligible.

(b) As a condition of eligibility to receive cash, medical or energy assistance, unless there is good cause not to do so, an applicant who is a veteran shall be required to contact a veteran service officer accredited and recognized by the United States Department of Veterans Affairs, the Department of Military and Veterans Affairs or the county director of veterans affairs in which the applicant resides in order to determine the applicant's eligibility for veteran's benefits or to file a veteran claims packet. The department shall develop a standard form to be used by a veteran service officer to verify the applicant's eligibility for veteran's benefits and make this form available on its official website.

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

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

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

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

(215 amended July 9, 2010, P.L.336, No.49)

Section 216. Coordinated Service Delivery Pilot Program.--(a) To the extent permitted by Federal law, the department, in consultation with the Department of Education, shall establish a pilot program at a school entity or entities within the city of the first class to assist in the coordinated delivery of education services and human services to students and their families for the purposes of promoting and implementing innovative research-based practices within selected school entities. Coordination shall be based upon joint planning between the department, the Department of Education and a school entity's comprehensive assessments of the need to provide services, coordinate service delivery, close gaps in services and coordinate to address the provision of needed services. In order to assist in the coordinated delivery of education services and human services to students and their families, the pilot program may consider the following:

(1) A school entity assisting students and their families in applying for and receiving education services and human services.

(2) An expanded school day for the purpose of providing opportunities for increased instructional time, tutoring by staff, pupils and volunteers, an environment conducive to learning before and after the regular school day and personalized instruction and mentoring.

(3) Other best practices as determined by the department and the Department of Education.

(b) A school entity participating in the pilot program shall submit reports to the department containing such information and in the form and by the deadline prescribed by the department.

(c) As used in this section, the term "school entity" shall mean any public school, including a charter school or cyber charter school or area vocational-technical school operating within this Commonwealth.

(216 added June 22, 2018, P.L.258, No.40)

ARTICLE III
STATE INSTITUTIONS IN THE DEPARTMENT OF PUBLIC WELFARE

(a) General Provisions

Section 301. Definition.--As used in this article:

"State institutions" means and includes all hospitals for the mentally ill or any other institutions for mentally retarded or epileptic persons, or for juvenile delinquents and dependents, and charitable institutions, within this Commonwealth, maintained in whole by the Commonwealth, and whose boards of trustees are departmental administrative boards within the department.

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Section 302. Supervision.--The department shall have supervision over all State institutions as provided in Article IX.

Section 303. Determination of Capacity; Type of Persons Received.--With regard to State institutions, the department shall have the power and its duty shall be:

(1) To determine the capacity of such institutions;

(2) Except as otherwise provided by law, to determine and designate the type of persons to be received by such institutions, the proportion of each type to be received therein and the districts from which persons shall be received by such institutions.

Section 304. Payment of Costs.--With regard to State institutions, the department shall have the power and its duty shall be to issue requisitions upon the Auditor General for warrants, to be drawn by the Auditor General upon the State Treasurer, in favor of such institutions, for the payment, out of moneys specifically appropriated to the department for the purpose, of the expenses of administering, operating, maintaining and developing such State institutions.

Section 305. Contracts.--With regard to State institutions, the department shall have the power and its duty shall be to require the submission to the department of any contract for repairs, alterations or equipment, which any such State institution desires to make and to approve or disapprove such proposed contract. No such contract shall be valid, without the approval of the department as evidenced by the signature of the secretary.

Section 306. Stores or Canteens.--With regard to State institutions, the department shall have the power to authorize the construction of separate buildings, or the addition to or improvement of existing buildings, for the purpose of operating and conducting therein a store or canteen for the convenience and benefit of the inmates or patients of such institutions,

out of moneys appropriated therefor by the General Assembly, or from moneys derived from the operation of any such stores, or from grants or gifts offered for such particular purpose.

Whenever any such construction, addition, or improvement is made for such purpose, the same shall become the property of the Commonwealth, regardless of the source of the funds used in connection therewith.

Section 307. Utility Services.--For the purpose of providing utility services for State institutions, the department may execute such agreements and contracts as it may deem necessary therefor with any political subdivision or any authority to provide utility services, and for defraying the Commonwealth's share of the expenses and charges to be incurred in establishing and contracting with an authority or political subdivision for the purpose of acquiring, holding, constructing, improving, maintaining, and operating sewage systems, water supply systems, electric power, gas, steam, or other utility systems.

Payment of the costs of such expenses, charges and services shall be made from appropriations to the department for such purposes, in accordance with the agreement made by the department.

Section 308. Leases.--The department shall have the power to lease, for a period not to exceed ten years, with the right to renewal for one further term not to exceed ten years, on such terms as may be considered reasonable by the secretary, a portion of the lands of the Commonwealth at any institution under its supervision to any municipality or municipalities adjacent thereto for the use by the municipality or municipalities in common with the State institution for disposal of garbage, refuse and ashes, by depositing them in compact layers of controlled depth and width in trenches or depressions and covering each layer promptly on all sides with a compact layer of clean earth or other inorganic material of sufficient thickness to exclude rodents and to prevent the escape of odors or outbreak of fires, such method of disposal being commonly known as sanitary land fill.

Section 309. Religious Ministration.--Residents of all State institutions in the department shall have the right to religious freedom, and to be visited by a clergyman of any denomination. Religious services rendered by a clergyman shall be personal to the patient desiring them, and shall not interfere with the established order of religious services in the State institution.

Section 310. Ex Officio Visitation.--The Governor, the judges of the several courts of the Commonwealth and the members of the Legislature shall have the right by virtue of their office to visit State institutions.

Section 316. Boards of Trustees of General Hospitals; Powers and Duties.--The board of trustees of each of the State general hospitals shall have general direction and control of the property and management of such institution. It shall have the power, and its duty shall be:

(1) Subject to the approval of the Governor, to elect a superintendent of the hospital, who shall, subject to the authority of the board, administer the institution in all its departments;

(2) On nomination by the superintendent from time to time, to appoint such officers and employes as may be necessary;

(3) To fix the salaries of its employes in conformity with the standards established by the Executive Board;

(4) Subject to the approval of the secretary, to make such bylaws, rules, and regulations for the management of the institution as it may deem wise.

(5) When only a part of a hospital is used as a geriatric center, the responsibilities of the board of trustees of such hospital shall continue to extend to the entire institution.

Section 317. Boards of Trustees of Other State Institutions; Powers and Duties.--(a) The powers and duties of the boards of trustees of each State institution within the department caring for the mentally ill, feebleminded, mentally retarded, mentally deficient, geriatric center patients and juvenile delinquents, shall be only as defined in this section:

(1) To advise, assist and make recommendations to the superintendent with respect to the management and operation of the institution and with respect to any plans or programs for its improvement.

(2) To keep under review all matters pertaining to the welfare and well-being of patients and juvenile delinquents and to make recommendations to the superintendent with respect thereto.

(3) To advise and make recommendations to the Commissioner of Mental Health or the secretary, as the case may be, with regard to the selection and appointment of a superintendent in case of a vacancy.

(4) To advise and make recommendations to the superintendent with regard to his selection of employes of the institution.

(5) To develop and further means and methods of establishing proper relations and understanding between the institution (and its program) and the community in which it is located; and, to provide liaison between the institution and the community in order better to serve the interests and needs of both.

(6) To make recommendations to the Advisory Committee for Mental Health and Mental Retardation Advisory Committee for the Aging, and the Advisory Committee for Children and Youth, as the case may be, on matters of policy and program emerging from their intimate knowledge and experience of mental health, geriatric and juvenile delinquency programs in operation. ((6) amended Oct. 19, 1967, P.L.459, No.216)

(b) The provisions of this section shall be applicable to the boards of trustees in all of the State mental institutions, geriatric centers and youth development centers within the department caring for mentally ill, feeble-minded, mentally retarded, mentally deficient, and geriatric center patients and juvenile delinquents, as the case may be. ((b) amended Oct. 19, 1967, P.L.459, No.216)

(b) General Hospitals

Section 321. Purposes.--The State general hospitals are declared to be hospitals for the care and treatment of the ill, without any restrictions other than those now or hereafter imposed by law upon all general hospitals, and except as each individual institution is restricted by the limitations of its facilities and equipment.

Section 322. Charges.--The department shall have the power and its duty shall be, subject to the approval of the proper board of trustees, to fix and establish charges for all services rendered by any State general hospital.

Section 323. Gifts and Donations.--Gifts or donations to State general hospitals shall be used only for the purpose specified by the donor or, if no purpose is specified, such gifts or donations may be used for such hospital for such

purposes as the board of trustees of such hospital may determine.

The department shall not withhold any moneys allocated or fail to allocate any money to any State general hospital for the reason that such hospital has received a gift or donation from another source.

(c) Geriatric Centers

Section 331. Purposes.--The department shall have the power to provide in State institutions to be known as geriatric centers either or both of the following:

(1) Public nursing home care as defined in Article IV relating to public assistance for persons who are sixty-five years of age or over and who because they continue to need medical or other necessary health care, are admitted immediately upon discharge from State mental institutions;

(2) Inpatient or outpatient diagnostic, screening or preventive services for persons for whom, because of physical or mental infirmity usually associated with senescence, admission is being sought in an institution providing long-term care and the cost of whose care in the long-term institution will be paid wholly or partially from funds administered by the department. Geriatric centers shall not constitute, nor shall they be operated as, institutions for tuberculosis or mental diseases.

Section 332. Conversion of Institutions.--With the approval of the Governor, the secretary may convert any State general hospital or distinct part of such hospital to a geriatric center as provided in this article. The department may also convert all or part of any State mental institution to a geriatric center.

Section 333. Charges.--Charges for care in a geriatric center shall be established by the department.

(d) Youth Development Centers for Delinquent Juveniles

Section 341. Purposes.--The purpose of the youth development centers is to promote and safeguard the social well-being and general welfare of minors of this Commonwealth by providing social services and facilities for the rehabilitation of delinquent minors who require care, guidance and control.

Section 342. Appointment of Superintendent.--The secretary shall appoint a superintendent of each youth development center.

Section 343. Commitments, Transfer of Juveniles.--(a) The board of trustees shall receive into custody in the State facilities assigned to their jurisdiction by the department for care, guidance and control, those minors under the age of eighteen years committed by juvenile courts. Such minors may remain committed until they attain the age of twenty-one years.

(b) ((b) repealed Aug. 3, 1977, P.L.155, No.41)

Section 344. Employment of Juveniles.--(a) Whenever, in the judgment of the superintendent of a youth development center, the rehabilitation of a committed minor will be served by his full or partial employment off the grounds of the center, the superintendent may consent to such employment; provided, that the terms of employment do not violate applicable labor or wage laws and that the minor returns to the center, or to his foster boarding home, each day after work.

(b) From the net earnings of a minor, employed as permitted by this section, the superintendent of the youth development

center shall transmit twenty-five percent thereof to the Department of Revenue for deposit in the State Treasury as partial compensation for the State's share in the cost of his care and shall transmit twenty-five percent to the county from which he was committed as similar partial compensation. The superintendent shall allow the minor reasonable pocket money from the balance and shall conserve the remainder to be paid to the minor on his release or discharge.

Section 345. Release with Counseling.--Whenever, in the judgment of the superintendent of a youth development center, a committed minor is ready for release, but is in need of continued counseling from the center, the superintendent shall so advise the court. If the court approves, the minor shall be released and the center shall provide counseling to him until the court approves its discontinuance or his discharge.

Section 346. Care and Maintenance; Charges.--(346 repealed July 9, 1976, P.L.846, No.148)

(e) Forestry Camps for Delinquent Juveniles

Compiler's Note: Section 302(h) of Act 18 of 1995, which created the Department of Conservation and Natural Resources and renamed the Department of Environmental Resources as the Department of Environmental Protection, provided that the Department of Conservation and Natural Resources shall exercise the powers and duties conferred upon the Department of Forests and Waters by subarticle (e).

Section 351. Purpose.--It is hereby declared to be the legislative intent to promote the welfare of this Commonwealth by making available facilities for the rehabilitation, reeducation, treatment and training of male youth.

Section 352. Facilities.--The Department of Forests and Waters, at the request of the department shall provide and maintain facilities to be used for forest conservation and for the education and training of male youth. In cooperation with the Fish Commission and with the Game Commission, the Department of Forests and Waters shall plan useful projects for conservation, recreation, dams or flood control in State forests and State park lands, and shall supply personnel to supervise work on these projects.

Compiler's Note: The name of the Pennsylvania Fish Commission, referred to in this section, was changed to the Pennsylvania Fish and Boat Commission by Act 39 of 1991. See 30 Pa.C.S. § 308 (relating to designation of commission).

Section 353. Selection, Acceptance and Return of Campers; Commitment Order.--The department may select as campers young men fifteen to eighteen years of age, who have been committed to any youth development center or whose commitment as campers is recommended by a classification and assignment center of the department and whose rehabilitation will be furthered by forestry work.

The department may also accept as campers, boys, fifteen to eighteen years of age, who have been committed to an institution and whose transfer to a camp is recommended by the institution and approved by the committing juvenile court. The department may return campers to the institution from which they were received for reasons of health, security or morale. The committing juvenile court shall be notified promptly of such

action and a full explanation in writing shall be provided the committing court and the institution. No forestry camp shall receive a boy as a camper unless an order of commitment accompanies him. When a boy is transferred from a forestry camp to an institution, the order of commitment shall accompany him.

Section 354. Reimbursing the State; Compensating Campers.--(354 repealed July 9, 1976, P.L.846, No.148)

ARTICLE IV
PUBLIC ASSISTANCE

(a) Legislative Intent; Definitions

Section 401. Legislative Intent.--(a) It is hereby declared to be the legislative intent to promote the self-sufficiency of all the people of the Commonwealth.

(b) It is further declared to be the legislative intent that no recipient of cash or medical assistance shall be entitled to indefinite cash or medical assistance unless it can be established that:

(1) the person is permanently disabled and unable to work; or

(2) the person is required to be in the home full time to care for a dependent adult or child who requires constant attention and supervision and there is no other adult in the household capable of providing such care.

(401 amended May 16, 1996, P.L.175, No.35)

Section 402. Definitions.--As used in this article, unless the context clearly indicates otherwise:: (Intro. par. amended June 28, 2019, P.L.43, No.12)

"Access device." An electronic benefit transfer card that is issued by the department to convey public assistance benefits to a recipient. (Def. added Oct. 24, 2018, P.L.777, No.125)

"Applicant" means an individual who applies for assistance under this article. (Def. added June 30, 2011, P.L.89, No.22)

"Assistance" means money, services and payment for medical coverage for needy persons who are residents of Pennsylvania, are in need of assistance and meet all conditions of eligibility.

"Assistance group" means one or more related or nonrelated individuals who occupy a common residence, or would occupy a common residence if they were not homeless, and whose needs and eligibility for assistance are considered together in determining eligibility for cash assistance or medical assistance. If eligible for cash assistance or medical assistance, the assistance group shall be limited to assistance that accords with standards established by the department.

"Benefits" shall mean assistance.

"Community service" means nonpaid work for a unit of Federal, State or local government or a nonprofit organization arranged by the cash assistance recipient. The organization receiving the work must agree to report to the appropriate county assistance office regarding the number of hours worked per week by the cash assistance recipient.

"General assistance" (Def. deleted by amendment June 28, 2019, P.L.43, No.12)

"General assistance-related categorically needy medical assistance" means medical assistance for persons who meet the requirements under section 432(3). (Def. added June 28, 2019, P.L.43, No.12)

"Grant diversion" means the use of all or a portion of a recipient's cash assistance grant and food stamp grant as a

wage supplement to an employer, as further set forth in section 405.5. Such a supplement shall be limited to a twelve-month period. An employer must agree to continue the employment of the recipient as part of the regular work force beyond the supplement period if the recipient demonstrates satisfactory performance.

"Home Health Care" means intermittent or part time nursing services or other therapeutic services furnished by a home health agency qualified to participate under Title XVIII of the Federal Social Security Act.

"Job readiness/preparation" means training that prepares the recipient for the workplace by teaching interviewing techniques, preparation of resumes and employer expectations. This activity may also include instruction in basic life skills and career exploration.

"Job search" means the activity of seeking full-time or part-time employment with required documentation of attempts to secure employment.

"Job skills training" means preparation that is designed to provide a recipient with the knowledge necessary to perform the duties of a specific job.

"Medical assistance transportation program" means the program funded in part by the Department of Public Welfare that provides transportation to medical services for medical assistance patients who have no other transportation available to them. (Def. added Dec. 22, 2011, P.L.561, No.121)

"Methadone" means a synthetic opioid agonist which binds with opioid receptors in the brain to initiate drug actions that mimic the effects of opiates. (Def. added Dec. 22, 2011, P.L.561, No.121)

"Mileage reimbursement" means the reimbursement provided to an individual who uses a personal vehicle in order for the individual to receive methadone treatment at a licensed provider of service. (Def. added Dec. 22, 2011, P.L.561, No.121)

"Narcotic treatment program" means a program for chronic drug users that either administers or dispenses agents under a narcotic treatment physician's order for detoxification or maintenance purposes or provides a comprehensive range of medical and rehabilitative services to alleviate adverse medical, psychological or physical effects incident to an addiction to narcotics, or both. (Def. added Dec. 22, 2011, P.L.561, No.121)

"On-the-job training" means employment experience that combines a subsidized period of employment with instruction necessary to perform specific job functions in which the recipient is hired by the employer, who is reimbursed up to fifty percent of the wages paid during the contracted subsidy period. The training is to be provided to recipients who do not have the related education or specific work experience required for the job.

"Paratransit service" means any personal transportation service operating on a nonfixed route basis, excluding mileage reimbursement or volunteer-driven rides. (Def. added Dec. 22, 2011, P.L.561, No.121)

"Protective payments" means payments with respect to any dependent child which are made to another individual who (as determined in accordance with standards prescribed by the department) is interested in or connected with the welfare of such child or relative, or made on behalf of such child or relative directly to a person furnishing food, living accommodations, or other goods, services, or items to or for

such child. Whenever possible, the protective payee shall be a public child welfare agency.

"Recipient" means an individual who receives assistance under this article. (Def. added June 30, 2011, P.L.89, No.22)

"RESET" means the Road to Economic Self-sufficiency through Employment and Training Program established in section 405.1(a.1).

"Residence" means permanent legal residence. (Def. added June 30, 2011, P.L.89, No.22)

"State supplemental assistance" means assistance granted under the provisions of section 432(2).

"Subsidized employment" means work in which all or a portion of the wages paid to the recipient are provided to the employer either as a reimbursement for the extra costs of training or as an incentive to hire the recipient, including, but not limited to, grant diversion as set forth in section 405.5.

"Vocational education" means a specific curriculum of training provided by an accredited training organization which is designed to prepare a recipient for a specific occupation.

"Work experience" means subsidized employment of not more than six months' duration which is combined with classroom study or other training program.

"Work-related activity" means participation in any one or a combination of the following education or training activities:

(i) subsidized employment;

(ii) work experience;

(iii) on-the-job training;

(iv) community service;

(v) workfare;

(vi) job search, whether independent or assisted, and job readiness/preparation activities;

(vii) vocational education training or job skills training;

(viii) any employment and training program funded or approved by the department that provides one-stop access to intensive case management, training, education, job readiness training, job search and individual job development that leads to job placement;

(ix) any employment and training program funded or approved by the department that provides activities for a cash assistance applicant or recipient to achieve rapid attachment to the work force;

(x) in the case of a recipient eighteen years of age or older and less than twenty-two years of age, general education that is necessary for the recipient to obtain employment, a high school diploma or a certificate of high school equivalency, subject to the recipient maintaining satisfactory progress as defined by the school or educational program; and

(xi) additional activities as specified by the department in regulations.

(402 amended May 16, 1996, P.L.175, No.35)

2018 Unconstitutionality: The amendment or addition of section 402 introductory paragraph and the definitions of "general assistance" and "general assistance-related categorically needy medical assistance" by Act 80 of 2012, were declared unconstitutional on July 18, 2018, by the Supreme Court of Pennsylvania in Washington v. Commonwealth, Department of Public Welfare, 188 A.3d 1135 (Pa. 2018). The Legislative Reference Bureau effectuated the 2018 unconstitutionality.

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

(b) Departmental Powers and Duties as to Public Assistance

Section 403. Uniformity in Administration of Assistance; Regulations as to Assistance.--(a) The department is responsible for maintaining uniformity in the administration of public welfare, including general assistance, throughout the Commonwealth.

(b) The department shall establish rules, regulations and standards, consistent with the law, as to eligibility for assistance and as to its nature and extent. The department is authorized to seek waivers from the Federal Government to enhance consistency between Federal program standards, requirements or procedures. This shall not be interpreted to require the department to seek waivers to achieve consistency among standards, requirements or procedures in Federal programs, except as specifically required under other provisions in this article. Whenever possible, except for residency requirements for general assistance, and consistent with State law, the department shall establish rules, regulations and standards for general assistance consistent with those established for aid to families with dependent children. In no instance shall the rules, regulations and standards established for general assistance provide for assistance greater than that provided for aid to families with dependent children. If three or more general assistance recipients reside together in the same household, their income eligibility and cash assistance shall be no greater than income eligibility and cash assistance from aid to families with dependent children for a household of the same size. The secretary or a written designee is the only person authorized to adopt regulations, orders, or standards of general application to implement, interpret, or make specific the law administered by the department. The secretary shall issue interim regulations whenever changes in Federal laws and regulations supersede existing statutes. In adopting regulations, orders, or standards of general application, the secretary shall strive for clarity of language which may be readily understood by those administering assistance and by those who apply for or receive assistance. For the purpose of this subsection, the term "household" does not include single-room occupancy residences, rooming houses, nonprofit residential programs or personal care facilities receiving charitable funding or Federal, State or local government funding.

(c) Whenever a recipient of public assistance, as a prerequisite to receiving assistance or otherwise, has been required to encumber in favor of the Commonwealth any property, or to give any bond, note or other obligation in any sum to secure the repayment of moneys received as assistance or for any other purposes, and such bonds, notes, judgments, mortgages, or other obligations are thereafter assigned by the Commonwealth to any third party, the assignee shall not be entitled to collect, and the person liable for the payment of the lien or obligation shall not be liable for the payment of, any amount greater than the amount the assignee paid for the assignment, notwithstanding the face amount of such lien or obligation. This provision shall not be effective as to the collection of

interest accruing after the date of the assignment or costs of collection.

(d) No general assistance shall be paid to any full-time student at a college or university who has not participated in a Federally subsidized program for dependent children within the previous five years.

(e) Beginning no later than December 31, 1982, the department shall conduct annual quality control reviews of the general assistance caseload in accordance with a methodology and scope determined by the department.

(f) No general assistance shall be paid to initial applicants who voluntarily terminate their employment until thirty days after the date of termination.

(g) Regulations which authorize payment for purchase of an automobile, for parts for an automobile or for repair of an automobile for a recipient of public assistance shall provide that the payment shall be made jointly to the seller of the automobile or parts or the garage or mechanic which made the repairs and the recipient.

(403 amended May 16, 1996, P.L.175, No.35)

Compiler's Note: See sections 19 and 20 of Act 35 of 1996 in the appendix to this act for information relating to request for necessary waivers and notice of approval.

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

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

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

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

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

(5) Restrict or eliminate presumptive eligibility.

(6) Establish provider qualifications.

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

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

(1) it does not have sufficient staff to perform the services and it would be more cost effective to contract for

the services than to hire new staff to provide the services; or

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

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

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

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

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

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

(403.1 added June 30, 2011, P.L.89, No.22)

Section 403.2. General Assistance-Related Categorically Needy and Medically Needy Only Medical Assistance Programs.--(a) Subject to subsection (b) and notwithstanding any other provision of law, the general assistance cash assistance program shall cease August 1, 2019.

(b) The general assistance-related categorically needy medical assistance program shall continue, including, but not limited to, the eligibility and work and work-related requirements under this article. The general assistance-related medical assistance program for the medically needy only shall continue.

(403.2 reenacted and amended June 28, 2019, P.L.43, No.12)

2018 Unconstitutionality: The addition of section 403.2 by Act 80 of 2012 was declared unconstitutional on July 18, 2018, by the Supreme Court of Pennsylvania in Washington v. Commonwealth, Department of Public Welfare, 188 A.3d 1135 (Pa. 2018). The Legislative Reference Bureau effectuated the 2018 unconstitutionality.

Section 404. Regulations for Protection of Information.--(a) The department shall have the power to make and enforce regulations:

(1) To protect the names of applicants for and recipients of public assistance from improper publication, and to restrict the use of information furnished to other agencies or persons to purposes connected with the administration of public assistance. Upon request by any adult resident of the Commonwealth, the department may furnish the address and amount of assistance with respect to persons about whom inquiry is made; but, information so obtained shall not be used for commercial or political purposes; and, no information shall be furnished regarding any person's application for, or receipt of, medical assistance.

(2) To protect the rights and interests of persons about whom personal or confidential information is in its possession.

(b) The regulations shall not prevent or interfere with investigations by proper authorities as to the rights of persons to receive assistance or as to the amounts of assistance received.

(404 amended July 31, 1968, P.L.904, No.273)

Section 404.1. Identification Numbers on Checks.--Beginning no later than December 31, 1982, the department shall place or

cause to be placed the social security number of the recipient on each check issued for cash assistance under this article.

(404.1 added Apr. 8, 1982, P.L.231, No.75)

Section 405. Regulations as to Employment, Work-Related Activities, and Training.--The department shall establish rules, regulations and standards for administration of the requirements for employment or work-related activities and training for employable recipients of assistance. The conditions applicable to work performed by employable recipients of general assistance shall be the same as those pertaining to recipients of assistance for which Federal financial participation is available to the Commonwealth, except that if Federal law limits the applicability of these conditions to recipients for whom Federal financial participation is available, the conditions pertaining to recipients of general assistance shall remain applicable.

(405 amended May 16, 1996, P.L.175, No.35)

Section 405.1. Establishment of RESET.--(a.1) There is established a program within the department, which shall be known as the Road to Economic Self-sufficiency through Employment and Training (RESET). RESET shall be designed to enable recipients of cash assistance to secure permanent full-time unsubsidized jobs, entry level jobs or part-time jobs which can establish a work history, preferably in the private sector, with wages and benefits that lead to economic independence and self-sufficiency as soon as practicable, within the constraints of available funds.

(a.2) In accordance with RESET, the following requirements shall apply:

(1) As a condition of eligibility or continuing eligibility for cash assistance, every individual who is not exempt under subsection (a.3) shall seek employment, accept any offer of employment and maintain employment.

(2) As a condition of eligibility or continuing eligibility for cash assistance, a nonexempt applicant or recipient who is not employed for an average of at least twenty hours per week shall be required to participate in a work-related activity.

(3) A nonexempt applicant's initial work-related activity shall be to conduct an independent job search for a period not to exceed eight weeks. A person who is on the effective date of this subsection a nonexempt recipient shall be required to conduct an independent job search within eight weeks of the recipient's next redetermination of eligibility. The applicant or recipient must document such efforts and present the documentation to the appropriate county assistance office upon request. Failure to comply with the requirements of this section shall result in the imposition of the sanctions set forth in section 432.3. ((3) amended June 30, 2012, P.L.668, No.80; amendment declared unconstitutional 2018)

(4) If the initial job search period concludes without the applicant or recipient obtaining full-time employment or employment for an average of at least twenty hours per week, the county assistance office, in consultation with the applicant or recipient, shall assess the additional measures that may be necessary for the applicant or recipient to seek and obtain employment, including the type of work-related activities that will be used to meet the ongoing work-related activity requirement. These measures shall be incorporated into the applicant's or recipient's agreement of mutual responsibility pursuant to section 405.3.

(5) An applicant or recipient may fulfill the work-related activity requirement following the initial job search and

consultation with the county assistance office by participating in any one or a combination of vocational education, general education, English-as-a-second-language study or job skills training, as necessary, for a maximum of twelve months. For a recipient or applicant who is eighteen years of age or older and less than twenty-two years of age and who has not earned a high school diploma or its equivalent, pursuit of a high school diploma or a certificate of high school equivalency can fulfill the work-related activity requirement for a maximum of twenty-four months.

(6) A recipient who has received assistance for twenty-four months, whether those months are consecutive or interrupted, must work, participate in subsidized employment, work experience, on-the-job training, community service or workfare for an average of at least twenty hours per week. Information indicating noncompliance with the minimum twenty-hour per week requirement shall be cause for a review of eligibility.

(a.3) An applicant or recipient may be exempt from the requirements of subsection (a.2) if any of the following apply:

(1) The applicant or recipient has been assessed by a physician or psychologist as having a verified physical or mental disability which temporarily or permanently precludes the applicant or recipient from any form of employment or work-related activity. The verification of the physical or mental disability shall be established by written documentation in a form prescribed by the department and shall be based on acceptable clinical and laboratory diagnostic techniques, rather than a statement of symptoms by the applicant or recipient. The department may also require the applicant or recipient to submit to an independent examination as a condition of receiving assistance. An applicant or recipient with a verified physical or mental disability that is temporary in nature must pursue appropriate treatment as a condition of receiving assistance.

(2) The applicant or recipient is a specified relative caring for a child who is under six years of age and for whom alternate child care arrangements are unavailable.

(3) The applicant or recipient is under eighteen years of age. An applicant or recipient under this clause shall be required to pursue a high school diploma or a certificate of high school equivalency.

(a.4) An applicant or recipient who is exempt under subsection (a.3) shall be required to comply with subsection (a.2) as follows:

(1) An applicant or recipient who is exempt under subsection (a.3)(1) shall be required to comply with subsection (a.2) when the condition which caused the person to be unable to be employed ceases as follows:

(i) If the condition ceases during the first twenty-two months that the recipient receives cash assistance, whether those months are consecutive or interrupted, the recipient shall be required to comply with subsection (a.2) immediately.

(ii) If the condition ceases after the recipient has received cash assistance for twenty-two months or more, whether those months are consecutive or interrupted, the recipient shall be required to comply with subsection (a.2) within eight weeks.

(2) An applicant or recipient who is exempt under subsection (a.3)(2) shall be required to comply with subsection (a.2) as soon as alternate child care arrangements are available.

(3) Upon attaining eighteen years of age, the recipient who is exempt under subsection (a.3)(3) shall be required to comply with subsection (a.2).

(b) Any applicant or recipient exempted from subsection (a.2) may participate in employment and work-related activities.

(c) No applicant or recipient subject to the requirements of subsection (a.2) shall refuse to accept a bona fide offer of employment or training.

In order to be a bona fide offer of employment, there must be reasonable assurances that:

(1) Appropriate standards for the health, safety, minimum wage and other conditions applicable to the performance of work and training in the employment are established and will be maintained.

(2) The offer of employment will not result in any displacement of employed workers.

(3) With respect to such employment, the conditions of work, training, education, and employment are reasonable in the light of such factors as the type of work, geographical region, and a proficiency of the participant.

(4) The employment is not available due to labor dispute, strike or lock-out.

(d) Any applicant or recipient who wilfully fails to fulfill the obligations pursuant to subsection (a.2) shall be ineligible for cash assistance in accordance with section 432.3.

(h) No department or agency of the Commonwealth and no vendor delivering social services funded in whole or in part by contracts with or grants from the Department of Public Welfare shall discriminate in any manner including employment or job placement against any person because that person is or was an applicant for or recipient of assistance.

(i) Pursuant to the authorization provided to the states under section 115(d)(1)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193, 21 U.S.C. § 862a(d)(1)(A)), the Commonwealth elects to exempt all individuals domiciled in this Commonwealth from application of section 115(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (21 U.S.C. § 862a(a)). After approval of benefits, the department shall refer all affected individuals for assessment and treatment under the act of April 14, 1972 (P.L.221, No.63), known as the "Pennsylvania Drug and Alcohol Abuse Control Act." This subsection shall not be construed to alter or supersede any other provision of this section. ((i) added Dec. 23, 2003, P.L.237, No.44)

(405.1 amended May 16, 1996, P.L.175, No.35)

2018 Unconstitutionality: The amendment of section 405.1 (a.2)(3) by Act 80 of 2012 was declared unconstitutional on July 18, 2018, by the Supreme Court of Pennsylvania in Washington v. Commonwealth, Department of Public Welfare, 188 A.3d 1135 (Pa. 2018). The Legislative Reference Bureau effectuated the 2018 unconstitutionality.

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Compiler's Note: Section 13 of Act 20 of 1995 provided that all references in the Public Welfare Code to the Community Work Program shall be deemed to be references to the Workfare Program.

Section 405.1A. Special Allowance Limitations.--Pursuant to section 403.1, no later than January 1, 2012, the department shall further reduce annual and lifetime limits for the RESET program, including moving and transportation expenses, by up to twenty-five percent, or eliminate any special allowances

from the program, as provided under 55 Pa. Code Ch. 165 (relating to road to economic self-sufficiency through employment and training (RESET) program).

(405.1A added June 30, 2011, P.L.89, No.22)

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 coursework 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.

(405.1B added Dec. 28, 2015, P.L.500, No.92)

Section 405.2. Workfare Program.--(Hdg. amended June 30, 1995, P.L.129, No.20) (a) The department shall enter into cooperative agreements to establish workfare projects with departments, agencies or institutions of the Commonwealth or any political subdivision located within the Commonwealth or any agency of the Federal Government or department-approved nonprofit organizations or established for-profit temporary help organizations for temporary placement with private, nonprofit or for-profit employers. Participating for-profit temporary help organizations shall recover their costs and profit from fees charged to employers. The department shall

assign to these work projects cash assistance recipients who are able to work but have been unable to secure employment. In instances when workfare projects are not available for all recipients, priority shall be given to general assistance recipients for referral to available projects. ((a) amended June 30, 1995, P.L.129, No.20)

(b) Every individual who has not received a bona fide offer of training or employment under section 405.1 shall, as a condition of continuing eligibility for cash assistance, report to and work in an available workfare project established under this section unless such individual is exempt from the registration requirements of section 405.1. Such individual shall be required to work that number of hours which when multiplied by the applicable minimum wage equals the amount of cash assistance such person receives: Provided, however, That:

(1) such work shall not exceed forty hours per week; and

(2) the parent or other caretaker of a child between the ages of six and fourteen who is personally providing care for the child with only very brief and infrequent absences from the child shall not be required to participate in workfare projects except on days and at times when the child is in school or when there are adequate day-care arrangements available for the child at no cost to the recipient. ((b) amended June 30, 1995, P.L.129, No.20)

(c) Workfare projects established under this section must be approved by the department. To qualify for approval, a work site must conform to appropriate health and safety standards. Cash assistance recipients shall not be assigned to work opportunities available due to a labor dispute, strike, or lockout and shall not be assigned to perform work so as to cause the layoff, downgrading or prevention of return to work of an available competent employe. Cash assistance recipients shall be assigned to workfare projects within twenty-five miles of their place of residence unless the department determines that a greater distance is not a hardship. ((c) amended June 30, 1995, P.L.129, No.20)

(d) A person who without good cause fails or refuses to accept assignment to and participate in a workfare project shall be terminated from assistance pursuant to section 432.3. ((d) amended June 30, 1995, P.L.129, No.20)

(e) The department shall propose initial rules and regulations for the administration of this section prior to the effective date of this section. Neither initial rules and regulations nor any promulgated thereafter with regard to this section shall take effect without the approval of the General Assembly. The department's proposed initial rules and regulations shall be submitted to, and approved or disapproved by, the Senate and the House of Representatives in the same manner as provided for the consideration of reorganization plans provided for by the act of April 7, 1955 (P.L.23, No.8), known as the "Reorganization Act of 1955." In the event that the General Assembly disapproves the proposed rules and regulations, then the department shall submit new rules and regulations within thirty days.

(f) Workmen's compensation insurance premiums shall be the responsibility of the entity which provides the employment opportunity.

(g) An independent performance evaluation shall be performed on the community work experience program. A report on the evaluation shall be submitted to the Governor and the General Assembly no later than March 31, 1995, and shall include, but not be limited to, the following information:

(1) The number of persons eligible for and actively participating in the program.

(2) A review of the program implementation process, including the number and type of community work projects approved by the department, designated by county.

(3) Problems with achieving broader participation in the program.

(4) Program adjustments and resulting program activity.

(5) An examination of the extent to which public assistance recipients become employed, especially at the point of program enrollment and during program participation.

(6) An examination of the extent to which the existence of a program requirement appears to discourage employables from remaining on public assistance.

(7) The number of persons who have been disqualified from cash assistance for noncompliance with the program.

((g) added June 16, 1994, P.L.319, No.49)

(405.2 added Apr. 8, 1982, P.L.231, No.75)

Compiler's Note: Section 13 of Act 20 of 1995, which amended section 405.2, provided that all references in the Public Welfare Code to the Community Work Program shall be deemed to be references to the Workfare Program.

Compiler's Note: See section 11 of Act 20 of 1995 in the appendix to this act for special provisions relating to waiver of Federal law and regulations and other approvals by Federal Government necessary for the implementation of the programs added by Act 20.

Section 405.3. Responsibilities and Obligations of Department, Applicants and Recipients.--(a) Subject to Federal approval, only where necessary, each adult applicant or recipient of cash assistance or other person who is required to sign an application for assistance shall be required as a condition of eligibility to enter into a mutual agreement with the department that will set forth the responsibilities and obligations to be undertaken by the recipient to achieve self-sufficiency, the time frames within which each obligation is to be completed, the penalties for failure to comply and the actions to be taken by the department to support the efforts of the applicant or recipient. Where appropriate, these obligations shall include, but not be limited to:

(1) Providing timely and accurate information required under section 432.2.

(2) Cooperating in the determination of paternity and enforcement of support obligations as required under section 432.7.

(3) Seeking and participating in an educational program leading to a high school diploma or its equivalent, job training or work-related activities as required under section 405.1(a.2).

(4) Maintaining employment as a condition for receiving cash assistance as required under section 405.1(a.2).

(5) Obtaining prenatal care consistent with nationally recognized standards.

(6) Maintaining the health and well-being of his or her children, including:

(i) ensuring that children attend school and pursue a high school diploma or its equivalent;

(ii) ensuring that children receive immunizations, appropriate health screenings and necessary medical treatment, consistent with nationally recognized standards;

(iii) performing any other appropriate activity based on an assessment of the education level, parenting skills and

history of parenting activities and involvement of each parent who is applying for assistance;

(iv) meeting other requirements as established by the department.

(7) Fulfilling obligations for remaining free of alcohol and illegal drugs if it is determined that a person has an ongoing substance-abuse problem that presents a barrier to employment. These obligations include:

(i) participating in, maintaining compliance with and satisfactorily completing a drug and alcohol program licensed or approved by the Department of Health or administered by an agency of the Federal Government; or

(ii) providing proof of substance-free status by submitting to periodic drug testing by a licensed drug and alcohol treatment provider or appropriate authorized licensed practitioner and testing substance free.

(8) Fulfilling all obligations for payment of day-care fees for care provided.

(9) Fulfilling all obligations for payment of support service fees for which allowances have been provided.

(d) Nothing in this section shall be interpreted as requiring the department to develop or offer employment, education, training, work-related activities or work experience programs.

(e) Any person who is required to sign an application for assistance and fails or refuses without good cause to enter into or cooperate in the completion of an agreement of mutual responsibility shall be ineligible for cash assistance.

(f) Penalties shall be imposed on an applicant or recipient of cash assistance who fails to comply with the obligations set forth in the agreement of mutual responsibility. Penalties shall include disqualification from receiving assistance as follows:

(1) Sanctions for failure to comply with employment and work-related requirements as set forth in section 432.3(a)(1) and (2).

(2) Sanctions for failure to cooperate with child support requirements as set forth in section 432.7A.

(3) Sanctions for failure to disclose truthful and accurate information as set forth in section 481.

(4) Sanctions for failure to cooperate with other aspects of the agreement of mutual responsibility shall include discontinuance or reduction of cash assistance, in addition to other penalties established by the department.

(405.3 amended May 16, 1996, P.L.175, No.35)

Section 405.4. Task Force on Job Creation.--(405.4 expired June 30, 1995. See Act 49 of 1994)

Section 405.5. Grant Diversion.--(a) Public assistance recipients who have not secured unsubsidized employment may be placed in subsidized employment with any employer approved by the department. The department may convert the cash assistance and food stamp assistance of participating recipients and their dependents, if any, into subsidies for participating employers if the department determines it is cost effective to do so.

(b) Employers may be reimbursed as follows:

(1) In the first six months of a recipient's employment, the employer reimbursement may be equal to the lesser of:

(i) the total of the recipient's cash assistance plus food stamp assistance; or

(ii) fifty percent of the employer's share of Social Security taxes, unemployment insurance and worker's compensation premiums paid on behalf of the recipient and the wages paid to the recipient up to the State minimum wage.

(2) In the next six months of a recipient's employment, the employer reimbursement may be equal to the lesser of:

(i) the total amount of the recipient's cash assistance plus food stamp assistance; or

(ii) twenty-five percent of the employer's share of Social Security taxes, unemployment insurance and worker's compensation premiums paid on behalf of the participating recipient and the wages paid to the recipient up to the State minimum wage.

(c) Program recipients are considered probationary employes for the employer's established probationary period for new hires performing the same or similar work. Thereafter, the recipient will be considered a permanent hire.

(d) Each employer who participates in the subsidized employment project shall as a minimum:

(1) Pay all participating recipients a wage rate that is at least equal to the rate established by the employer for an employe with similar background, training or experience who is performing the same or similar work. Nothing in this clause shall grant an employer the right to pay a participating recipient less than the State minimum wage.

(2) Not discriminate against participating recipients in any benefits provided to other new employes. The department shall ensure that there is no duplication of benefits.

(3) Schedule recipients for a minimum of twenty hours per week of work.

(4) Sign a worksite contract outlining the specific job offered to the recipient and agreeing to abide by all requirements of the program. While the worksite contract shall ensure the recipient's fair treatment and safety, the paperwork which is to be completed by the employer shall be kept to a minimum.

(5) Not have any other individual on layoff from the same or any substantially equivalent job and not have terminated any regular employe or otherwise reduced its work force with the intent of filling the position with a recipient.

(e) The department shall maximize the use of Federal grants and apportionments of the cash assistance program, the food stamp program, employment-related child care and the programs under the Job Training Partnership Act (Public Law 97-300, 29 U.S.C. § 1501 et seq.) and any other Federal or private funding sources to support this subsidized employment program.

(f) The program will be administered and operated by the department, which will solicit vendors to provide the local operation, administration and case management for the program. The program shall be available Statewide.

(g) Recipients eligible for enrollment in this program must be receiving cash assistance at the time of enrollment.

(h) The maximum number of recipients to be placed with any single employer shall be limited to one recipient for employers with fewer than ten employes and to ten percent of an employer's total number of employes for employers with more than ten employes. The department may exceed these limits for employers that demonstrate a long-term commitment to the successful integration of recipients into the labor force by continuing to employ participating recipients for at least one year after the grant diversion subsidy payments cease.

(i) An employer may terminate the employment of a participating recipient at any time. The department may deem ineligible for participation in the grant diversion program any employer that consistently terminates the employment of participating recipients during or soon after the end of the grant diversion period.

(405.5 added May 16, 1996, P.L.175, No.35)

Section 406. Receipt and Allocation of Funds.--The department shall have the duty:

(1) To receive and to supervise the disbursement of funds, provided by the Federal government or from any other source for use in this Commonwealth, for assistance.

(2) To allocate to the several assistance programs funds with which to provide assistance and funds for administrative expenses, and as may be needed, from time to time, to keep reasonable emergency funds in the hands of local boards, which shall be used, subject to the rules, regulations and standards of the department, by the Executive Director for the furnishing of assistance and pensions respectively in emergency cases, upon application to him, or under the direction of any member of the local board.

Section 407. Supervision of County Boards.--The department shall have the power to exercise general supervision of the county boards of public assistance, and establish for such boards, rules, regulations and standards.

Section 408. Meeting Special Needs; Work Supports and Incentives.--(a) The department shall take measures not inconsistent with the purposes of this article; and when other funds or facilities for such purposes are inadequate or unavailable to provide for special needs of individuals eligible for assistance; to relieve suffering and distress arising from disabilities and infirmities; to promote their rehabilitation; to help them if possible to become self-dependent; and, to cooperate to the fullest extent with other public agencies empowered by law to provide rehabilitative or similar services.

(b) The department may provide assistance to recipients for child care when the department has determined that, without such services, the recipient would be exempt from compliance with the conditions of the agreement of mutual responsibility or work requirements or when a former recipient who is employed has ceased to receive cash assistance for a reason other than a sanction for noncompliance with an eligibility condition. In establishing the time limits and levels of access to child care funds, the department shall take into account availability, costs and the number of assistance groups needing services within the geographic area and shall seek to provide essential services to the greatest number of recipients. ((b) amended June 22, 2018, P.L.258, No.40)

(c) The department may provide assistance to recipients for transportation and work support when the department has determined that without such services the recipient would be exempt from compliance with the conditions of the agreement of mutual responsibility or work requirements. In establishing the time limits and levels of access to transportation and work support, the department shall take into account availability, costs and the number of recipients needing services within the geographic area and shall seek to provide essential services to the greatest number of recipients.

(408 amended May 16, 1996, P.L.175, No.35)

Section 408.1. Rental Payments to Housing Authorities.--If upon the petition of any housing authority created under the laws of this Commonwealth and after a hearing, the county board finds that a tenant of a housing project of the housing authority who is a recipient of public assistance owes the authority rent, in an amount equal to or greater than three monthly rental payments, then the board shall notify the department to deduct an amount equal to one and one-third monthly rental payments from each monthly assistance payment

and pay the amounts deducted to the housing authority until such time as all the rent owed is paid. The department shall make the deductions required by this section to the fullest extent not inconsistent with Federal statute or regulation and shall make every effort to obtain a waiver of any inconsistent Federal requirement. If the provisions of this section are held to be invalid by the court, then the remaining provisions of this act shall not be affected and shall be given the full force and effect of law.

(408.1 added Apr. 8, 1982, P.L.231, No.75)

Section 408.2. Education Savings Accounts.--(a) Any individual or family receiving assistance under this act may establish an interest-bearing savings account at a bank or other financial institution for the purpose of paying for tuition, books and incidental expenses at any vocational school or any community college, college or university. Any funds deposited in this account and any interest earned thereon shall be exempt from consideration, subject to Federal approval, in any calculations under any assistance program administered by the department for as long as the funds and interest remain on deposit in the account.

(b) Subject to Federal approval, any amounts withdrawn from the account for the purpose stated in subsection (a) shall be exempt from consideration in any calculations under any assistance program administered by the department. The department shall promulgate regulations to establish penalties for any amounts withdrawn from any accounts for any other purpose.

(c) Any tuition account established and any college savings bond purchased under the provisions of the act of April 3, 1992 (P.L.28, No.11), known as the "Tuition Account Program and College Savings Bond Act," shall be deemed to meet the requirements of this section.

(408.2 added June 16, 1994, P.L.319, No.49)

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 on a sliding 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 shall increase in incremental amounts, based on a percentage of the family's annual income, as determined by the department.

(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) 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;

(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 forth 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 forth 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 forth 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 forth 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 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.

(408.3 amended Dec. 28, 2015, P.L.500, No.92)

Section 409. Collection of Information; Reports.--The department shall have the duty:

(1) To gather and study current information constantly, and to report, at least annually, to the Governor, as to the nature and need of assistance, as to the amounts expended under the supervision of each county board, and as to the work of each county board, and to cause such reports to be published for the information of the public.

(2) To report, at least annually, to the Governor, as to the cost of living in the various counties, as related to the standards of assistance and the amounts expended for assistance, and to cause such reports to be published for the information of the public.

Section 410. Cooperation with Other Agencies.--The department shall have the duty:

(1) To cooperate with other agencies, including any agency of the United States or of another state, in all matters concerning the powers and duties of the department under this article and particularly in projects for child welfare, for the relief of persons in areas of special need, and for the care of transient and homeless persons.

(2) To make such reports, in such form and containing such information as the Department of Health, Education and Welfare of the United States government, or any other agency of the United States may, from time to time, require and shall comply with the provisions that such department or agency may, from time to time, find necessary to insure the correctness and verification of such reports.

Section 411. Contracts for Medical Services.--The department may contract with one or more nonprofit corporations authorized by law to operate nonprofit hospital plans, nonprofit medical, osteopathic and dental service plans or nonprofit dental service plans for the purpose of providing medical services, including inpatient hospital care, to persons who are eligible for such services as assistance.

Section 412. Appointment of Protective Payees.--The department may appoint a protective payee to take charge of the expenditure of assistance granted any person under this article when, consistent with Federal regulations, such protective payee is necessary. In any such case, payment shall be made direct to the protective payee. A protective payee shall serve without compensation, and shall be subject to such rules, regulations and accounting as the department shall prescribe.

Wherever possible, the protective payee shall be a public child welfare agency.

(412 amended July 15, 1976, P.L.993, No.202)

Section 413. Purchase of Credit Reports.--Whenever the department deems it necessary and advisable, it may purchase credit reports and other services on a fee basis for the purpose of supplementing the investigation of eligibility for assistance.

Section 414. Assistance Recipient Identification Program.--(a) The department is authorized to create, in geographic areas where the department determines it to be cost effective, a program to be known as the Assistance Recipient Identification Program.

(b) The purpose of the program is to eliminate duplication of assistance to recipients, to deter fraud and to assist law enforcement officials in their duties.

(d) A person currently receiving or applying for assistance shall participate in the program. The person shall be identified using available technological means that may include, but are not limited to, two-digit fingerimaging.

(e) The department, wherever feasible, shall work with neighboring states to execute agreements between each of those states and the Commonwealth to implement compatible computer cross-matching identification systems.

(f) It is a violation for a person in the program to acquire or attempt to acquire duplication of assistance.

(g) Absent a court order, only the department, the Pennsylvania State Police and the Pennsylvania Board of Probation and Parole, the chief of a local municipal police department or his designee within the department, including the sheriff's office in counties of the second class, and the designated officials of neighboring states with whom the department executes agreements under subsection (e) shall have access to records under this program.

(h) The department shall make a report to the General Assembly no later than March 1, 1996, and every two years thereafter. Each report shall include:

(1) Caseload data before implementation of this section as well as after one year for comparison purposes to judge the program's effectiveness at fraud deterrence.

(2) Attempts at and instances of multiple enrollment by persons.

(3) Analysis of the cost-effectiveness of the project.

(4) Recommendations regarding whether the program should be discontinued, expanded or otherwise modified.

(i) As used in this section, the term "program" means the Assistance Recipient Identification Program.

(414 amended June 30, 1995, P.L.129, No.20)

Compiler's Note: See section 11 of Act 20 of 1995 in the appendix to this act for special provisions relating to waiver of Federal law and regulations and other approvals by Federal Government necessary for the implementation of the programs added by Act 20.

(c) County Boards of Assistance; Establishment

Section 415. Establishment of County Boards; Expenses.--For each county of the Commonwealth, there is hereby established a county board of assistance, to be known as the County Board of Assistance and referred to in this Article IV as the "county board," which shall be composed of men and women, to be appointed by the Governor. Each appointment by the Governor shall bear the endorsement of the Senator of the district in which the nominee resides. In the case of a vacancy in that senatorial district, the nominee shall be endorsed by the Senator of an adjacent district. The county boards shall be composed as far as possible of persons engaged or interested in business, social welfare, labor, industry, education or public administration. The members of the county boards shall serve without compensation, but shall be reimbursed for necessary expenses. No member of a county board shall hold office in any political party. Not all of the members of a county board shall belong to the same political party.

(415 amended Dec. 17, 2009, P.L.598, No.54)

Compiler's Note: Section 9(c) of Act 173 of 1978 provided that section 415 is repealed insofar as it is inconsistent with 1 Pa.C.S. § 2301(b) (relating to equality of rights based on sex).

Section 416. Composition of County Boards; Terms; Officers.--(a) Each county board shall be composed of a minimum of eleven members in counties of the first and second classes, and of a minimum of seven members in other counties. There shall be a maximum of fifteen members on any county board and, in addition thereto, the Governor shall appoint as ex officio members two county commissioners, one from each political party. Any vacancy caused by the expiration of a term shall be filled by an appointment, in the manner above provided, for a term of three years, and any vacancy, otherwise caused, shall be filled for the duration of the unexpired term by appointment, in the same manner. Any member of a county board who has served all or any portions of three consecutive three-year terms, as above specified, shall be ineligible for further reappointment until after one full term has passed.

(b) Each county board shall organize annually and elect from among its members a chairman, vice-chairman and a secretary.

(d) County Boards; Powers and Duties

Section 417. Personnel.--Each county board shall:

(1) In accordance with the Civil Service Act, appoint, transfer, lay off, suspend and remove its employes who shall, on behalf of the county board and under the supervision of the Executive Director, provide assistance in the territory under the jurisdiction of the county board in accordance with law.

(2) Determine the number of its employes and direct and supervise their services so as to attain the maximum degree of efficiency.

(3) From time to time, appoint such board of review as it sees fit and proper, to hear and determine appeals by employes from orders of demotion and of removal.

Section 418. Conformity with Departmental Regulations; Recommendations.--Each county board shall conform to the rules, regulations and standards, established by the department, and may make recommendations to the department as to rules, regulations and standards as to eligibility for assistance, and as to the nature and extent of assistance.

Section 419. Administration of Assistance and Related Functions.--Each county board shall:

(1) Administer public assistance in the county, and determine the eligibility for assistance of applicants and continued eligibility for assistance of persons receiving the same in accordance with law and rules, regulations and standards established by the department.

(2) Take measures to promote the welfare and self-dependency of individuals and families eligible for assistance by helping them to secure rehabilitative, remedial or other constructive aid, through local community resources, or in the absence or inadequacy of such resources, through direct provision of such aid, in accordance with rules, regulations and standards adopted by the department.

(3) With the approval of the secretary, supervise the administration of and promote any other public function related to assistance, or the work of the department, or of the county board, which may be committed to the county board by a political subdivision of the Commonwealth.

Section 420. Reports and Budget Requests.--Each county board shall submit reports and budget requests to the department as required and shall study, report and interpret its policies, problems and work, to the department and to the public.

Section 421. Community Work and Training Programs.--Each county board shall administer community work and training programs in accordance with law and the rules, regulations and standards established by the department.

Section 422. Encouragement of Employment.--Each county board shall encourage employable recipients of assistance to accept full or part-time employment.

(422 amended Apr. 8, 1982, P.L.231, No.75)

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

utilize the income eligibility verification system established in section 432.23.

(422.1 added June 30, 2011, P.L.89, No.22)

Section 423. Hearing Appeals of Recipients.--(a) Each county board shall hear and determine appeals from actions of its employes affecting the rights of those applying for or receiving assistance. Any person applying for or receiving assistance of any type covered by the public assistance provisions of the Federal Social Security Act, may appeal to the department from any decision of the county board, refusing or discontinuing his assistance, in whole or in part. In every such appeal, an opportunity for a fair hearing shall be granted, and the decision of the department on such appeal shall be final, except as otherwise hereinafter provided. All such appeals shall be in accordance with rules and regulations established by the department. If the appellant is already receiving assistance and requests a fair hearing within the timely notice period, assistance shall not be terminated until a decision is rendered in the hearing except in those appeals where the sole issue is one of State or Federal law or policy or change in State or Federal law or policy. In appeals where the sole issue is one of State or Federal law or policy or change in State or Federal law or policy, assistance shall be terminated when the decision is rendered by the county board of assistance. Assistance granted pending a fair hearing is subject to recovery by the department if the department action is sustained.

(b) Notwithstanding anything to the contrary in Title 2 of the Pennsylvania Consolidated Statutes (relating to administrative law and procedure), the department may make an adjudication solely on the basis of written submissions if the sole question presented by the appellant is one of State or Federal law.

(423 amended Apr. 8, 1982, P.L.231, No.75)

Section 424. Appointment of Committees.--Each county board may:

(1) Appoint labor review committees, composed of representative citizens of the county, who shall serve without compensation, and whose duty it shall be to pass on the eligibility of any applicant for or recipient of general assistance who shall refuse an offer of employment and whose case shall be referred to such a committee by the county board.

(2) Appoint committees of the county board or of local citizens in various communities of the county, as circumstances may require, to cooperate with the county board in (i) supplying information as to the eligibility of persons for assistance; (ii) recommending local policies; and (iii) stimulating local employment; and, on petition of fifty or more residents of any community, it shall be mandatory upon the county board to appoint a committee to function in such community.

Section 425. Furnishing Information.--Upon request by any adult resident of the Commonwealth, any county board shall furnish the address and amount of assistance with respect to persons receiving assistance about whom inquiry is made, but such information shall not be used for commercial or political purposes.

Section 426. Employment of Credit Rating Agencies.--As need may require each county board may employ the services of commercial credit rating agencies for the purpose of determining eligibility for general assistance.

Section 427. Receipt and Expenditure of Contributions.--Each county board may receive and spend contributions from any source

for purposes related to assistance, or to the work of the department.

(e) Assistance Other Than Medical Assistance
(Hdg. amended July 31, 1968, P.L.904, No.273)

Section 431. Application.--Every person applying for public assistance shall be required to sign a statement setting forth his financial status and such other facts as may be required by the department, in order to determine whether such person is entitled to public assistance. Every such applicant shall make affidavit that the facts set forth in such statement are true and correct. Every person employed in the administration of public assistance shall have power to administer oaths for the purpose of carrying into effect the provisions of this section.

(431 amended July 31, 1968, P.L.904, No.273)

Section 432. Eligibility.--Except as hereinafter otherwise provided, and subject to the rules, regulations, and standards established by the department, both as to eligibility for assistance and as to its nature and extent, needy persons of the classes defined in clauses (1), (2), and (3) shall be eligible for assistance:

(1) Persons for whose assistance Federal financial participation is available to the Commonwealth as aid to families with dependent children or as other assistance, and which assistance is not precluded by other provisions of law.

(2) Persons who are eligible for State supplemental assistance.

(i) State supplemental assistance shall be granted to persons who receive Federal supplemental security income for the aged, blind and disabled pursuant to Title XVI of the Federal Social Security Act.

(ii) State supplemental assistance shall also be granted to persons who are aged, blind and disabled, as defined in Title XVI of the Federal Social Security Act, and whose income, pursuant to the standards and income disregards of Title XVI of the Social Security Act, is less than the combined income of the Federal payments under the supplemental security income program and the State supplemental assistance payments established pursuant to the provisions of this act.

(iii) In establishing the amounts of the State supplemental assistance, the department shall consider the funds certified by the Budget Secretary as available for State supplemental assistance, pertinent Federal legislation and regulation, the cost-of-living and the number of persons who may be eligible.

(iv) Beneficiaries of State supplemental assistance shall be eligible for cash State financial assistance to cover the cost of special needs as defined by statute and regulations promulgated under this act.

(v) After the amounts of assistance payments have been determined by the department with the approval of the Governor and General Assembly, the amounts of assistance payments shall not be reduced as a consequence of assistance increases, including but not limited to cost-of-living increases, provided through Federal legislation.

(vi) After the amounts of assistance payments have been determined by the department with the approval of the Governor and General Assembly, the amounts of assistance payments shall not be increased without the approval of the General Assembly in accordance with the procedure established by the act of April 7, 1955 (P.L.23, No.8) known as the "Reorganization Act of

1955," and a message to the General Assembly from the Governor for the purposes of executing such function shall be transmitted as in other cases under the Reorganization Act.

(3) Other persons who are citizens of the United States, or lawfully admitted aliens who are eligible for general assistance.

(i) Persons who may be eligible for general assistance for an indeterminate period as a result of medical, social or related circumstances shall be limited to:

(A) A child who is under age eighteen or who is eighteen through twenty years of age and attending a secondary or equivalent vocational or technical school full-time and may reasonably be expected to complete the program before reaching twenty-one years of age.

(B) Persons who are parents residing in two-parent households with their child who is under thirteen years of age unless the child is thirteen years of age or older and has a verified disability. Every possible effort shall be made by the department to place these persons in the AFDC program.

(C) A person who has been assessed by a physician or psychologist as having a verified physical or mental disability which temporarily or permanently precludes him or her from any gainful employment. The verification of the physical or mental disability must be established by written documentation in a form prescribed by the department and must be based on acceptable clinical and laboratory diagnostic techniques, rather than a statement of symptoms by the applicant or recipient. The department may also require the applicant or recipient to submit to an independent examination as a condition of receiving assistance. An applicant or recipient with a verified physical or mental disability which is temporary in nature shall pursue appropriate treatment as a condition of receiving assistance.

(D) A person who is a nonparental caretaker of a child under thirteen years of age or a caretaker of another person because of illness or disability. Such child or other person must be a member of the household and the caretaker must be a person whose presence is required in the home to care for another person as determined in accordance with department regulations. Assistance shall not be granted to a person under this clause if there is another adult in the household who is capable of providing the care without general assistance being required.

(E) A person who is currently undergoing active treatment for substance abuse in a drug and alcohol program licensed or approved by the Department of Health or administered by an agency of the Federal Government. A person shall only qualify for general assistance under this clause if the treatment program precludes the person from any form of employment in accordance with standards established by the department. No individual shall qualify for general assistance under this clause for more than nine months in a lifetime.

(F) A pregnant woman whose pregnancy has been medically verified.

(G) A person who is a victim of domestic violence and who is receiving protective services as defined by the department. No individual shall qualify for general assistance under this provision for more than nine months in that person's lifetime.

(ii) General assistance shall continue as long as the person remains eligible. Redeterminations shall be conducted on at least an annual basis, and persons shall be required to seek employment, accept any offer of employment and maintain employment as conditions of eligibility except as otherwise exempt under section 405.1(a.3).

(iv) No transitionally needy assistance shall be initially authorized after June 30, 1995. Any person receiving transitionally needy general assistance as of the effective date of this subclause may continue to receive that assistance until sixty days of assistance are exhausted in accordance with subclause (iii). Transitionally needy assistance received after June 30, 1993, shall be applied to the total period of assistance. Transitionally needy general assistance shall cease on the earlier of:

(A) the date of the final issuance of assistance; or

(B) August 29, 1995.

(4) Assistance shall not be granted (i) to or in behalf of any person who disposed of his real or personal property, of the value of five hundred dollars ($500), or more, without fair consideration, within two years immediately preceding the date of application for assistance unless he is eligible for State supplemental assistance; or (ii) to an inmate of a public institution.

(5) (i) Assistance may be granted only to or in behalf of a resident of Pennsylvania. Needy persons who do not meet the residence requirements stated in this clause and who are transients or without residence in any state, may be granted assistance up to seven days in the form of vendor payments, all in accordance with rules, regulations, and standards established by the department.

(ii) Cash assistance for applicants and recipients of aid to families with dependent children who have resided in this Commonwealth for less than twelve months shall not exceed the lesser of the maximum assistance payment that would have been received from the applicant's or recipient's state of prior residence or the maximum assistance payment available to the applicant or recipient in this Commonwealth.

(6) Aid to families with dependent children shall not be paid to any family for any month in which any caretaker relative with whom the child is living is, on the last day of such month, participating in a strike, and no individual's needs shall be included in determining the amount of aid payable for any month to a family if, on the last day of such month, such individual is participating in a strike.

(8) A person who does not meet a definitive condition for aid to families with dependent children solely because of the person's refusal to cooperate in establishing eligibility for aid to families with dependent children shall also be ineligible for general assistance.

(9) Assistance may not be granted to any person who has been sentenced for a felony or misdemeanor offense and who has not otherwise satisfied the penalty imposed on that person by law. Notwithstanding any provisions in 18 Pa.C.S. Ch. 91 (relating to criminal history record information), the cooperative agreements provided for in this clause shall provide the department with access to the central repository within the Pennsylvania State Police in order to carry out the objectives of this section. The Pennsylvania State Police and the Pennsylvania Board of Probation and Parole shall have access to the records of the Assistance Recipient Identification Program under section 414 within the department in order to carry out the objectives of section 414. For cash assistance applicants and recipients, the department shall enter into cooperative agreements with the Pennsylvania State Police and the Pennsylvania Board of Probation and Parole to ensure that no cash assistance is granted to a person who has been sentenced for a felony or misdemeanor offense. For this purpose, the

department may access and provide information available pursuant to section 414. As used in this clause, "satisfied the penalty" means completed the period of incarceration or extension thereof and paid all fines, costs and restitution. Nothing in this clause shall be deemed to exclude from cash assistance any person who has been paroled from a term of imprisonment, or any person who is in compliance with all terms of probation, and who has made either full payment of all fines, costs and restitution or is in compliance with an approved payment plan.

(10) Assistance shall not be granted to any applicant or recipient who is under eighteen years of age and who has never been married and is pregnant and/or caring for a dependent child unless the minor parent is residing with a parent, legal guardian or other adult relative or in an adult-supervised supportive living arrangement approved by the department. In the event that the minor parent is residing with a parent, legal guardian or other adult relative or in an adult-supervised supportive living arrangement approved by the department, assistance shall be paid to the parent, legal guardian or other adult with whom the minor parent is residing. Exceptions to this subsection will be granted by the department if it is determined that an exception would best serve the health and safety of the minor parent and the child or if the minor parent can present evidence that the parent, legal guardian or other adult:

(i) refuses or is unable to allow the minor parent or child to live in his or her home;

(ii) poses an emotional or physical threat to the minor parent or child;

(iii) has physically or sexually abused the minor parent or the minor parent's child or any other child in the household or poses a risk of doing so;

(iv) has exhibited neglect of the minor parent or the minor parent's child; or

(v) has spent the minor parent's assistance in an improper manner.

If the minor parent does not meet any of the exceptions set forth in this clause and the parents or legal guardian live within this Commonwealth or another state, the minor parent and child may be given a one-time allowance solely for the limited purpose of reuniting that minor parent and child with a parent, legal guardian or other adult relative at their place of residence. The amount of the allowance shall be limited to the least expensive mode of transportation available.

(11) A person who is ineligible for general assistance or medical assistance under this act shall be ineligible for assistance under the act of June 24, 1937 (P.L.2017, No.396), known as the "County Institution District Law," and the act of August 9, 1955 (P.L.323, No.130), known as "The County Code."

(432 amended May 16, 1996, P.L.175, No.35)

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Compiler's Note: Section 20 of Act 49 of 1994, which amended paragraph (3) and added paragraph (8), provided that regulations promulgated by the Department of Public Welfare prior to December 31, 1995, for the purpose of implementing paragraphs (3) and (8) shall not be subject to the act of June 25, 1982 (P.L.633, No.181), known as the Regulatory Review Act. Such regulations shall be subject, however, to review for form and legality by the

Attorney General and the General Counsel under sections 204(b) and 301(10) of the act of October 15, 1980 (P.L.950, No.164), known as the Commonwealth Attorneys Act.

Section 432.1. Continued Absence From the Home.--Where an application for aid to families with dependent children is based upon deprivation of parental support or care due to the continued absence of a parent from the home, such deprivation exists when the nature of the absence, for any reason, interrupts or terminates the parent's functioning as a provider of maintenance, physical care or guidance for the child and the known or indefinite duration of the absence precludes continuing the parent's performance of his function as a provider. Absence alone shall not constitute deprivation.

It shall be the duty of the department to verify the continued absence of the parent from the home from information regarding the absent parent supplied by the applicant on his application, or by requiring the applicant to provide, where known, the name, social security number, description, employer and present or last known address of the absent parent upon request.

(432.1 added July 15, 1976, P.L.993, No.202)

Section 432.2. Determination of Eligibility.--(a) Prior to determination of eligibility, the department shall conduct a personal interview with the applicant, or with the caretaker relatives of the needy children.

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

(1) Names of all persons to receive aid;

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

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

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

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

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

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

((b) amended June 30, 2012, P.L.668, No.80; amendment declared unconstitutional 2018)

(c) The department shall determine all elements of eligibility periodically based upon the circumstances that exist at the recipient's place of residence and in accordance with the provisions of this section: Provided, however, that such determination shall not be less frequent than every six months. The department shall require the completion of a continuing application form at the time of redetermination recertifying the information required by subsection (b) and the provisions of section 432.15 shall be applicable to this subsection. ((c) amended June 30, 2011, P.L.89, No.22)

(d) Each applicant shall provide, under penalty of fraud, the information necessary to complete such application. The applications used by the department shall contain, at the end thereof, in large type, a statement in the form approved by the Attorney General that the applicant understands that he has an obligation to report in accordance with section 432.14 of this act any changes in income or resources, composition of the assistance unit, addresses or any other factor which may affect eligibility, and that the declarations in the application are correct and complete to the best of the applicant's knowledge or belief when made. This declaration shall be signed by the applicant of assistance or any person completing the application for an applicant unable to do so himself.

(e) The caseworker shall insure that the applicant understands his rights and duties under this act and shall certify on each application that he has explained such rights and duties to the applicant or recipient.

(432.2 added July 15, 1976, P.L.993, No.202)

2018 Unconstitutionality: The amendment of section 432.2(b) by Act of 80 of 2012 was declared unconstitutional on July 18, 2018, by the Supreme Court of Pennsylvania in Washington v. Commonwealth, Department of Public Welfare, 188 A.3d 1135 (Pa. 2018). The Legislative Reference Bureau effectuated the 2018 unconstitutionality.

Section 432.3. Failure to Comply with Employment and Work-Related Activity Requirements.--(a) An applicant or recipient who is not exempt from participation in the employment or work-related activity requirements set forth in section 405.1(a.2) and who without good cause: (i) voluntarily terminates employment or reduces earnings; (ii) fails to apply for work at such time and in such manner as the department may prescribe; or (iii) fails or refuses to accept referral to and participate in a work-related activity, or refuses to accept referral to and work in and retain employment in which the applicant or recipient is able to engage, provided such employment conforms to the standards established for a bona fide offer of employment, shall be disqualified from receiving assistance as follows:

(1) A minimum of thirty days for the first violation and continuing thereafter until such time as he or she is willing to comply with the requirements of section 405.1; a minimum of sixty days for the second violation and continuing thereafter until such time as he or she is willing to comply with the requirements of section 405.1; and permanently for a third violation.

(2) If the reason for the disqualification occurs during the first twenty-four months that cash assistance is received, whether those months are consecutive or interrupted, only the individual is disqualified. If the reason for the disqualification occurs after the individual has received assistance for more than twenty-four months, whether those months are consecutive or interrupted, the disqualification is imposed on the entire assistance group.

((a) amended June 30, 2012, P.L.668, No.80; amendment declared unconstitutional 2018)

(b) In addition to or in lieu of the sanctions set forth in subsection (a)(1) and (2), the cash assistance grant of an employed person who voluntarily, without good cause, reduces his or her earnings by not fulfilling the twenty-hour per week work requirement set forth in section 405.1(a.2) shall be reduced by the dollar value of the income that would have been

earned if the recipient had fulfilled those employment responsibilities.

(432.3 amended May 16, 1996, P.L.175, No.35)

2018 Unconstitutionality: The amendment of section 432.3(a) by Act 80 of 2012 was declared unconstitutional on July 18, 2018, by the Supreme Court of Pennsylvania in Washington v. Commonwealth, Department of Public Welfare, 188 A.3d 1135 (Pa. 2018). The Legislative Reference Bureau effectuated the 2018 unconstitutionality.

Section 432.4. Identification and Proof of Residence.--(a) All persons applying for assistance shall provide acceptable identification and proof of residence. A person shall be deemed to be a resident when he or she documents his or her residency and that residency is verified by the department. Verification may include, but is not limited to the production of rent receipts, mortgage payment receipts, utility receipts, bank accounts or enrollment of children in local schools. General assistance applicants must establish that they have been residents of the Commonwealth for at least twelve months immediately preceding their application and they are not receiving assistance from any other state. General assistance applicants shall disclose, in their application, all states in which they have resided and in which they have collected a form of public assistance in the last five years. The provisions of this subsection shall not apply to General Assistance applicants who can establish that they moved to this Commonwealth to escape an abusive living situation. The department shall adopt rules governing the proof required to establish that the applicant has moved to this Commonwealth to escape an abusive living situation.

(a.1) When a general assistance applicant provides information that the applicant is receiving a form of public assistance in another state, the department may not authorize general assistance until it receives verification that the public assistance is scheduled to close in the other state.

(b) For the purpose of determining eligibility for assistance, the continued absence of a recipient from the Commonwealth for a period of thirty days or longer shall be prima facie evidence of the intent of the recipient to have changed his residence to a place outside the Commonwealth.

(c) If a recipient is prevented by illness or other good cause from returning to the Commonwealth at the end of thirty days, and has not acted to establish residence elsewhere, he shall not be deemed to have lost his residence in the Commonwealth.

(d) When a recipient of aid to families with dependent children or general assistance is absent from the United States for a period in excess of thirty days, his aid shall thereafter be suspended whenever need cannot be determined for the ensuing period of his absence.

(e) Beginning no later than September 1, 1994, the department shall collect information on all general assistance applicants to determine how long they have been residents of this Commonwealth. The department shall report its findings to the Governor and the General Assembly no later than December 31, 1995. Based on its findings, the department may make recommendations to the Governor and the General Assembly on changes to the residency requirement for general assistance recipients.

(432.4 amended Dec. 28, 2015, P.L.500, No.92)

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Compiler's Note: Section 20 of Act 49 of 1994, which amended section 432.4, provided that regulations promulgated by the Department of Public Welfare prior to December 31, 1995, for the purpose of implementing section 432.4 shall not be subject to the act of June 25, 1982 (P.L.633, No.181), known as the Regulatory Review Act. Such regulations shall be subject, however, to review for form and legality by the Attorney General and the General Counsel under sections 204(b) and 301(10) of the act of October 15, 1980 (P.L.950, No.164), known as the Commonwealth Attorneys Act.

Section 432.5. Resources.--(a) Real and personal property which an applicant or recipient owns or in which he or she has an interest are resources which must be considered in determining initial and continuous eligibility for assistance, subject to the limitations and exceptions hereinafter proscribed.

(b) An applicant or recipient may retain real property owned by that person, or in conjunction with any other person without reference to its value if such real property serves as the home of such applicant or recipient.

(c) Other property in excess of two hundred fifty dollars ($250) for a single person applying for or receiving assistance and other property in excess of one thousand dollars ($1,000) for assistance groups with more than one person shall be considered an available resource. The following items shall not be considered an available resource, unless such consideration is required under Federal law or regulations:

(1) Wedding and engagement rings, family heirlooms, clothing and children's toys.

(2) Household furnishings, personal effects and other items used to provide, equip, and maintain a household for the applicant and recipient.

(3) Equipment and material which are necessary to implement employment, rehabilitation, or self care plan for the applicant or recipient.

(4) One motor vehicle per assistance group as follows:

(i) When the difference between the fair market value, according to a standard guide resource available to the automobile industry and consumers that determines the value of new and used automobiles, and the amount owed on the purchase price of the vehicle is less than forty thousand dollars ($40,000).

(ii) Subparagraph (i) shall apply to the extent permitted by Federal law.

(5) Retroactive assistance payments received as a result of a prehearing conference or a fair hearing decision.

((c) amended Oct. 24, 2018, P.L.777, No.125)

(d) In the case of any nonresident real property, the applicant or recipient must take adequate steps to offer such property for sale on the open market or convert it to cash, with such sums being considered an available resource. The applicant or recipient shall acknowledge the liability of the property for reimbursement.

(e) Personal property which is not excluded from consideration in determining eligibility shall be considered immediately convertible to cash and available to meet current living expenses. Where such personal property cannot be readily converted into cash, or where it is in the form of a frozen

asset, eligibility criteria shall be met provided that the owner take adequate steps to convert the property into cash, offering such personal property for sale on the open market, and acknowledging the liability of the property for reimbursement.

(f) Where assistance has been received in good faith, but the recipient in fact owns excess property or has not met the requirements of the department, such recipient shall be considered to have been ineligible for assistance during the period for which any excess property would have supported that recipient at the rate of the assistance granted. In such case, subject to the provisions of section 432.16, recipient shall repay the amount of assistance received during such period of ineligibility.

(g) For the purpose of determining a recipient's eligibility for assistance, individual lottery winnings of six hundred dollars ($600) or more shall be considered an available resource. Lottery winnings shall be calculated on a prorated basis over a twelve-month period following receipt of such winnings. ((g) added Oct. 24, 2018, P.L.777, No.125)

(432.5 amended May 16, 1996, P.L.175, No.35)

Section 432.6. Support From Legally Responsible Relatives.--(432.6 repealed Dec. 16, 1997, P.L.549, No.58)

Section 432.7. Determination of Paternity and Enforcement of Support Obligations.--(432.7 repealed Dec. 16, 1997, P.L.549, No.58)

Section 432.7A. Protective Payments Imposed for Failure to Cooperate.--(432.7A repealed Dec. 16, 1997, P.L.549, No.58)

Section 432.8. Garnishment of Wages of Commonwealth Employes.--(432.8 repealed Dec. 16, 1997, P.L.549, No.58)

Section 432.9. Central Registry.--(432.9 repealed Dec. 16, 1997, P.L.549, No.58)

Section 432.10. Maximum Withholding Exemptions.--(432.10 repealed Apr. 8, 1982, P.L.231, No.75)

Section 432.11. Access to State Records.--(432.11 repealed Dec. 16, 1997, P.L.549, No.58)

Section 432.12. Determination of Need.--(a) In determining need for aid to families with dependent children, the gross income of all members of the assistance group who are fourteen years of age or older shall be considered except the gross income of a member of the assistance group who is between the ages of fourteen and twenty-one, is a full or part-time student, and is not employed full time or income which is specifically excluded by Federal or State law. Fifty percent of gross earned income shall be disregarded when determining eligibility for recipients. Any changes to that percentage shall be promulgated as regulations and shall be subject to the availability of Federal and State funds for cash assistance, as certified by the Secretary of the Budget.

In determining need for general assistance, the department shall take into consideration the gross income which is not excluded by Federal or State law, excluding that amount equal to the expenses reasonably attributable to the earning of income up to twenty-five dollars ($25) per month, of all members of the assistance group who are fourteen years of age or older. The deduction shall be considered to cover all transportation expenses related to employment, all child and adult care related to employment, all other expenses attributed to employment such as but not limited to union dues, uniforms and the like, and all deductions over which the employe has no control such as but not limited to Federal and State income tax. In addition to said work related expenses, a work incentive equal to the first twenty dollars ($20) plus fifty percent of the next sixty

dollars ($60) may be deducted from the gross monthly wages of each employed recipient of general assistance for a period not to exceed four months. The general assistance grant shall be computed on the remainder.

(b) Income as used in subsection (a) includes assistance in cash or in kind (other than the rental value of living accommodations), as defined by the department in accordance with Federal law and regulations.

(c) In establishing financial eligibility and the amount of the assistance payment in both the aid to families with dependent children program and the general assistance program, the department may consider the income of certain individuals as if it were actually available to the assistance group residing in the household notwithstanding the fact that the income may not be actually available to other household members. Income of stepparents living in a household shall be considered available to the assistance group by the department. The department may choose to consider income on either a prospective or retrospective basis in determining eligibility and the amount of the assistance payment. The applicant or recipient shall as a necessary condition of eligibility:

(1) provide all information necessary to income determination; and

(2) take all actions necessary to obtain unconditionally available income including applying for unemployment compensation to the extent permitted by Federal law. Income shall be considered unconditionally available if the applicant or recipient has only to claim or accept such income, including any type of governmental benefits, social insurance, private pension or benefits plan, or offers of private contributions, including contributions from relatives not in the nature of disaster relief.

(432.12 amended May 16, 1996, P.L.175, No.35)

Section 432.13. Income Averaging.--For purposes of determining eligibility for assistance, the income of any person under a contract of employment on an annual basis who works and receives income from such contract in fewer than twelve months, but more than eight months, shall be prorated over the period of the contract. This provision shall apply only to such persons whose annual income, when averaged over a twelve-month period, is expected to be in excess of that set forth in the minimum basic standards of adequate care for the appropriate number of persons dependent upon such income.

(432.13 added July 15, 1976, P.L.993, No.202)

Section 432.14. Reporting Responsibility.--(a) It shall be the duty of the department to insure that every applicant for, or recipient of, assistance be notified not less frequently than semiannually as to the provisions of eligibility and his responsibility for reporting information concerning changes in circumstances which may affect the amount of grant. After such notification has been provided, the department shall require the recipient to formally acknowledge, on a form prescribed for such purpose, that the provisions of eligibility and reporting obligations have been explained to him and were understood.

(b) Each applicant for or recipient or payee of such assistance shall be responsible for reporting accurately and within a reasonable specified period those facts required of him pursuant to the explanation provided by the department.

(432.14 added July 15, 1976, P.L.993, No.202)

Section 432.15. Quarterly Earnings Determination.--The department shall transmit to the Office of Employment Security the social security number of all persons over sixteen years

of age who receive assistance during the second prior quarter. The Office of Employment Security shall determine the amount of wages reported by employers for the amount of unemployment compensation insurance benefits which have been paid during the second and third prior quarters to persons with those social security numbers and shall return such information, excluding zero wage reports, to the department. The department shall compare such wage reports with earnings reported by recipients, take prompt action to resolve discrepancies, and shall refer promptly for investigation any cases of suspected fraud.

(432.15 amended Apr. 8, 1982, P.L.231, No.75)

Section 432.16. Recoupment of Prior Overpayments and Retroactive Correction of Underpayments.--(a) In accordance with Federal law and regulations, the department shall establish procedures for recoupment of prior overpayments.

(1) The recoupment of overpayments may be made from income, liquid resources, or assistance payments. However, in no case shall the combined income, liquid resources, or assistance payment be less than ninety percent of the amount payable to an assistance unit of the same composition with no income. Recoupment may be from: (i) the assistance unit which was overpaid, (ii) any assistance unit of which a member of the overpaid assistance unit has subsequently become a member, or (iii) any individual members of the overpaid assistance unit whether or not currently a recipient. If the Commonwealth recovers from individuals who are no longer recipients, recovery shall be made by appropriate action under State law against the income or resources of those individuals.

(2) The department shall, prior to effecting any reduction of a current grant, advise the recipient of the proposed reduction by timely and adequate notice.

(b) The department shall be permitted to recoup overpayments in accordance with the provisions of subsection (a) concurrent with a suit for restitution provided that the extent of liability for restitution shall be reduced by the amount of overpayments recouped.

(c) The department shall establish procedures for retroactive correction of underpayments caused by administrative error provided that:

(1) retroactive corrective payments shall be limited to the twelve months preceding the month in which the underpayment first becomes known to the department;

(2) retroactive payments to correct improper denial of assistance shall be made for up to twelve months prior to the month in which the error first becomes known to the department, but in no case earlier than the date of application; and

(3) for the purposes of determining continued eligibility and the amount of assistance, such retroactive corrective payments shall not be considered as income or as a resource in the month in which paid nor in the next following month.

(d) In cases which have both an underpayment and an overpayment, the department will offset one against the other in correcting the payment.

(432.16 amended Apr. 8, 1982, P.L.231, No.75)

Section 432.17. Timely and Adequate Notice Defined.--The department shall provide timely and adequate notice in all cases of intended action to discontinue, terminate, suspend or reduce an assistance grant except in those cases where adequate notice alone would be consistent with the requirements of Federal law or regulation.

"Timely notice" means notice which is mailed ten days before the intended change would be effective.

"Adequate notice" means a written notice that includes a statement of what action the agency intends to take, the reasons for the intended action, the specific regulations or statutes supporting such action, an explanation of the individual's right to request an evidentiary and an administrative hearing on the propriety of the intended action and the circumstances under which assistance is continued if a hearing is requested. Adequate notice shall be sent not later than the date of action.

(432.17 added July 15, 1976, P.L.993, No.202)

Section 432.18. Assistance Payments; Lost, Stolen, Destroyed or not Received.--In the event that a recipient of assistance does not receive an assistance check, or if such check is lost, stolen or destroyed after receipt but before it is cashed, the county office after a period of three days may authorize a one-time grant from the county disbursement, provided that the following conditions are met:

(1) The recipient reports the nonreceipt of the check, loss, or theft of an unendorsed check or destruction of an endorsed check. The report of a loss or theft of a check shall be accompanied by a sworn statement to that effect under penalty of fraud. The county board shall immediately stop payment on the check after receipt of its copy of the signed statement.

(2) The check was sent to the recipient.

(3) The recipient shall be instructed on his liability, should the lost, stolen, destroyed or nonreceived check come into his possession, to return such check immediately to the county office and that cashing or attempting to cash such check constitutes fraud.

(432.18 added July 15, 1976, P.L.993, No.202)

Section 432.19. Verification of Eligibility.--All conditions of eligibility for assistance shall be verified prior to authorization of assistance or during a redetermination of a recipient's eligibility unless the verification is pending from a third party and the applicant has cooperated in the verification attempt in accordance with department standards or unless certification of cooperation is pending with the domestic relations section pursuant to section 432.6. Initial authorization of assistance shall not be delayed more than thirty days after application. If the applicant establishes eligibility, assistance will be initially authorized effective with the date that all conditions of eligibility are verified. Except when prohibited by Federal law, it shall be a condition of eligibility for assistance that an applicant or recipient consent to the disclosure of information about the age, residence, citizenship, employment, applications for employment, income and resources of the applicant or recipient which is in the possession of third parties. Such consent shall be effective to empower any third party to release information requested by the department. Except in cases of suspected fraud, the department shall attempt to notify the applicant or recipient prior to contacting a third party for information about that applicant or recipient.

(432.19 amended May 16, 1996, P.L.175, No.35)

Section 432.20. Prohibition on Grant or Assistance for Moving Costs.--The department shall not provide in any manner specific grants or assistance to any person to pay for or offset the cost of such person's moving expenses, except when the move is necessary to secure gainful permanent employment or is required due to a verifiable health reason. Assistance shall not be provided to any assistance unit for more than one move in any twelve-month period, and shall not exceed two hundred dollars ($200).

(432.20 added Apr. 8, 1982, P.L.231, No.75)

Section 432.21. Requirement that Certain Federal Benefits be Primary Sources of Assistance.--(a) All recipients or applicants for assistance in this Commonwealth shall cooperate with the department in identifying the eligibility of such recipients or applicants for Federal Social Security Supplemental Security Income (SSI), Federal Social Security Retirement, Survivor's and Disability Income benefits (RSDI) or other Federal programs as the primary source of financial assistance for such persons. Any person who, without good cause, fails to cooperate with the department in an effort to establish such person's eligibility for SSI, RSDI or other Federal benefits shall have his assistance terminated, or if he has not previously received assistance, shall thereby be rendered ineligible for such assistance for a period of sixty days by reason of his noncooperation.

(b) All applicants for or recipients of assistance shall reimburse the department for any public assistance grants made to them in months for which SSI, RSDI or other Federal benefits are awarded them, as a condition of eligibility for assistance.

(432.21 added Apr. 8, 1982, P.L.231, No.75)

Section 432.22. Aliens.--A person who is not a citizen of the United States shall be ineligible for assistance unless specifically required by Federal law.

(432.22 added May 16, 1996, P.L.175, No.35)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(20) Lottery winners database maintained by the Pennsylvania State Lottery. ((20) added Oct. 24, 2018, P.L.777, No.125)

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

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

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

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

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

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

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

(c) (1) No later than one year after the effective date of this section and every year thereafter, the department shall provide a written report to the Governor, the General Assembly, the chairperson and minority chairperson of the Public Health and Welfare Committee of the Senate, the chairperson and minority chairperson of the Health Committee of the House of

Representatives and the Inspector General detailing the results of the implementation of this section, including, but not limited to, the following information:

(i) The number of case closures.

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

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

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

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

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

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

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

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

(432.23 added June 30, 2011, P.L.89, No.22)

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

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

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

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

(1) Require a recipient be scheduled to be tested if he has either a felony conviction for a drug offense which occurred within five years or a felony conviction for a drug offense for which he is presently on probation subject to the following conditions:

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

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

(2) Develop and implement a system for randomly testing no less than twenty percent of the individuals receiving public assistance benefits during each six-month period following the

effective date of this section who are subject to testing for the presence of illegal drugs under this section.

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

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

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

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

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

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

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

(2) a medical assistance program; or

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

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

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

Welfare Committee of the Senate, the chairperson and minority chairperson of the Health Committee of the House of Representatives and the Inspector General.

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

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

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

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

(432.24 added June 30, 2011, P.L.89, No.22)

Section 432.25. Eligibility for Individuals Convicted of Drug Distribution.--(a) (1) Notwithstanding sections 405.1 and 432.24, to the extent permitted by Federal law, no individual who, after the effective date of this section, has been convicted under section 13(a)(14), (30) or (37) of the act of April 14, 1972 (P.L.233, No.64), known as "The Controlled Substance, Drug, Device and Cosmetic Act," when the amount of controlled substances involved is equivalent to or greater than the amount of controlled substances set forth in 18 Pa.C.S. § 7508(a)(1)(iii), (2)(iii), (3)(iii), (4)(iii), (7)(iii) or (8)(iii) (relating to drug trafficking sentencing and penalties) while receiving public assistance shall be eligible for public assistance unless:

(i) the individual is complying with or has already complied with the obligations imposed by the criminal court; and

(ii) the individual is actively engaged in or has completed a court-ordered substance abuse treatment program, as applicable, and participates in periodic drug tests for ten years after the drug-related conviction or for the duration of probation, whichever is of longer duration.

(2) Upon a second or subsequent conviction under section 13(a)(14), (30) or (37) of "The Controlled Substance, Drug, Device and Cosmetic Act" when the amount of controlled substances involved is equivalent to or greater than the amount of controlled substances set forth in 18 Pa.C.S. § 7508(a)(1)(iii), (2)(iii), (3)(iii), (4)(iii), (7)(iii) or (8)(iii), the individual shall be suspended from receiving public assistance for a period of ten years to the extent permitted by Federal law. After the ten-year suspension, the individual may apply for public assistance.

(b) An individual who takes a drug test pursuant to subsection (a)(1)(ii) and fails the test shall be subject to the following sanctions to the extent permitted by Federal law:

(1) For failing a drug test the first time, an individual shall be provided an assessment for addiction and provided treatment for addiction as indicated by treatment criteria developed by the Single State Authority on Drugs and Alcohol. Assessments shall be conducted by the Single County Authority (SCA) on Drugs and Alcohol or a designee. Treatment recommended shall be provided by facilities licensed by the Division of Drug and Alcohol Program Licensure in the Department of Drug and Alcohol Programs or by a licensed physician. Medicaid

eligibility and determinations shall be expedited to ensure access to assessment and addiction treatment through Medicaid. If the individual cooperates with the assessment and treatment, no penalty shall be imposed. If the individual refuses to cooperate with the assessment and treatment, the public assistance shall be suspended for six months. The department must notify the individual of the failed drug test no later than seven days after receipt of the drug test results, and the suspension in public assistance will begin on the next scheduled distribution of public assistance and for every other distribution of public assistance until the suspension period lapses. After suspension, an individual may apply for public assistance but shall submit to a retest.

(2) For failing a drug test or retest the second time, the individual shall be suspended from receiving public assistance for a period of ten years. After the ten-year suspension, an individual may apply for public assistance but shall submit to a retest.

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

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

(2) a medical assistance program; or

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

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

(e) This section shall not apply to benefits which are afforded to the minor children of those individuals who are denied eligibility to receive public assistance benefits under subsection (a).

(f) As used in this section, the term "public assistance" means Temporary Assistance to Needy Families (TANF), general assistance and State supplemental assistance.

(432.25 added Oct. 24, 2018, P.L.777, No.125)

Section 432.26. Eligibility for Violators of Sexual Offender Registration.--Subject to Federal approval, an individual required to register as a convicted sexual offender pursuant to 42 Pa.C.S. § 9799.13 (relating to applicability) who is not compliant with the registration requirements imposed upon the individual by 42 Pa.C.S. §§ 9799.15 (relating to period of registration), 9799.19 (relating to initial registration) and 9799.25 (relating to verification by sexual offenders and Pennsylvania State Police) shall not be eligible for assistance until the individual can prove compliance with the applicable registration requirements. The eligibility for assistance of minor children living in the household shall not be affected by an individual being deemed ineligible for assistance by this section. The department may promulgate regulations necessary to effectuate compliance with the registration requirements for individuals it considers transient or homeless to include any address or location where public assistance funds are to be sent on behalf of an eligible individual.

(432.26 added Oct. 24, 2018, P.L.777, No.125)

Section 433. Special Eligibility Provision.--No person shall be rendered ineligible for public assistance solely by reason of his receiving care in a foster home or public nursing home under the provisions of acts relative to the powers and duties of counties or of county institution districts.

Section 434. Diminishment of Welfare Payment.--To the extent permitted by Federal law and regulations, assistance granted under this article shall be diminished by amounts the recipient obtains by cashing an assistance check at a gambling casino, racetrack, bingo hall or other establishment which derives more than fifty percent of its gross revenues from gambling.

(434 added May 16, 1996, P.L.175, No.35)

Section 434.1. Agreements With Federal Authorities.--The department is authorized to enter into agreements with Federal authorities for the Federal administration of the State supplemental assistance program. If required for Federal administration the department may make payments of the State's obligation with regard to State supplemental assistance prior to the month in which payments to eligible individuals will be made by the Federal authorities.

(434.1 added Dec. 12, 1973, P.L.403, No.143)

Section 434.2. Prohibition against Duplicate Payments and Expedited Authorization.--In no case shall duplicate payments be made on behalf of an aid to families with dependent children or general assistance child. Notwithstanding any provision of this act, a child, formerly in the custody of a parent or other caregiver who is no longer exercising care and control of the child, shall be eligible for expedited authorization of cash assistance benefits.

(434.2 added June 30, 1995, P.L.129, No.20)

Section 435. Care by Other Public Bodies.--Notwithstanding any other provisions of law, no public body shall provide without charge any maintenance, care or service which an individual is entitled to receive as assistance under the provisions of this article but this section shall not be construed to preclude any such public body from supplementing such assistance.

Section 436. Repayments of State Supplemental Assistance not Required; Relative Contributions not Necessary for Eligibility Determination.--Notwithstanding any other provision of law, no repayment shall be required of any State supplemental assistance paid to any person for which he was eligible; and with respect to the determination of eligibility for such assistance, no relative shall be required to contribute to the cost of such assistance.

(436 added Dec. 12, 1973, P.L.403, No.143)

Section 437. Reports to General Assembly.--Two copies of all reports required by the national center for social statistics of the Department of Health, Education and Welfare shall be furnished to the Senate Public Health and Welfare Committee and the Health and Welfare Committee of the House of Representatives when they are submitted to the Federal Government. Similar reports prepared concerning general assistance, the State Blind Pension and State supplemental assistance shall be similarly furnished to the committees.

(437 added July 15, 1976, P.L.993, No.202)

(f) Medical Assistance

(Hdg. amended July 31, 1968, P.L.904, No.273)

Compiler's Note: Section 19 of Act 49 of 1994 provided that nothing in Act 49 shall be construed as limiting the authority of the Department of Public Welfare to continue the general assistance basic health care plan.

Section 441. Medical Assistance for the Aged; Benefits.

(441 repealed July 31, 1968, P.L.904, No.273)

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

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

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

(3) The medically needy.

(4) Inmates of correctional institutions who meet the eligibility requirements under the Commonwealth's approved Title XIX State Plan who are receiving medical care in medical institutions, as defined in 42 CFR 435.1010 (relating to definitions relating to institutional status). The State share of the medical care for inmates in county correctional institutions shall be contributed by the inmate's county of residence.

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

(b) ((b) repealed July 5, 2012, P.L.1050, No.122)

(c) Except as provided under subsection (a)(4) and (5), upon notification of incarceration, the department shall temporarily suspend, for a period of not more than two years, medical assistance for a recipient who becomes incarcerated in a correctional institution. The suspension of medical assistance shall cease and the recipient shall continue to receive medical assistance upon notification of an inmate's release from the correctional institution, subject to the eligibility requirements under the Commonwealth's approved Title XIX State Plan. ((c) added July 8, 2016, P.L.480, No.76)

(d) Notwithstanding subsection (c), upon notification from a correctional institution of an inmate's release and the department's receipt of an inmate's application, the department shall determine the inmate's eligibility for medical assistance. Except as provided under subsection (a)(4) and (5), medical assistance may not be provided until the date of the inmate's release. ((d) added July 8, 2016, P.L.480, No.76)

(441.1 amended June 30, 2011, P.L.89, No.22)

Section 441.2. Medical Assistance Eligibility.--Medical assistance shall not be granted to or in behalf of any person who disposed of his real or personal property, of the value of five hundred dollars ($500), or more, without fair consideration, within two years immediately preceding the date of application for medical assistance unless he is eligible for State supplemental assistance or unless he can clearly show that the transfer was not primarily for the purpose of acquiring or retaining eligibility for assistance.

(441.2 added July 15, 1976, P.L.993, No.202)

Section 441.3. Use of Medical Expenses to Establish Eligibility for Medical Assistance.--Notwithstanding any other provision of law to the contrary, in determining eligibility for retroactive and prospective medical assistance, only medical expenses incurred on or after the first day of the third month before the month of application may be deducted from countable income, provided that the expenses were not previously deducted in determining eligibility for medical assistance and are not subject to payment by another party, including medical assistance.

(441.3 added July 7, 2005, P.L.177, No.42)

Section 441.4. Reasonable Limits on Allowable Income Deductions for Medical Expenses When Determining Payment Toward the Cost of Long-Term Care Services.--(a) When determining a recipient's payment toward the cost of long-term care services, long-term care medical expenses incurred six months or more prior to application for medical assistance shall be disallowed as a deduction, and medical and remedial expenses that were incurred as a result of a transfer of assets penalty shall be limited to zero unless application of these limits would result in undue hardship.

(b) As used in this section, the term "undue hardship" shall mean that either:

(1) denial of medical assistance would deprive the individual of medical care and endanger the individual's health or life; or

(2) the individual or a financially dependent family member would be deprived of food, shelter or the necessities of life.

(441.4 reenacted Oct. 22, 2010, P.L.829, No.84)

Section 441.5. Penalty Period for Asset Transfer.--(a) Pursuant to section 1917(c) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396p(c)), the department shall impose a penalty of ineligibility for all ineligible days, whether for full months or for a partial month's period of ineligibility, or both, when an applicant, recipient or spouse of an applicant or a recipient of the services set forth in subsection (b) transfers assets for less than fair market value within or after the look-back period as defined in section 1917(c) of the Social Security Act. Transfers totaling five hundred dollars ($500) or less in a calendar month shall not be subject to the penalty.

(b) The ineligibility period set forth in subsection (a) shall apply to all of the following:

(1) Nursing facility services.

(2) Services equivalent to those provided in a nursing facility.

(3) Home- and community-based services furnished under a waiver granted under section 1915(c) or (d) of the Social Security Act (42 U.S.C. § 1396n(c) or (d)).

(441.5 added July 7, 2005, P.L.177, No.42)

Section 441.6. Treatment of Life Estates, Annuities and Other Contracts in Determining Medical Assistance Eligibility.--(a) As a condition of eligibility for medical assistance, every applicant or recipient who owns a life estate in property with retained rights to revoke, amend or redesignate the remainderman must exercise those rights as directed by the department. The acceptance of medical assistance shall be an assignment by operation of law to the department of any right to revoke, amend or redesignate the remainderman of a life estate in property.

(b) Any provision in any annuity or other contract for the payment of money owned by an applicant or recipient of medical assistance, or owned by a spouse or other legally responsible relative of such applicant or recipient, that has the effect of limiting the right of such owner to sell, transfer or assign the right to receive payments thereunder or restricts the right to change the designated beneficiary thereunder is void.

(c) In determining eligibility for medical assistance, there shall be a rebuttable presumption that any annuity or contract to receive money is marketable without undue hardship.

(d) Upon approval by the Federal Government of any required State plan amendment implementing this subsection and notwithstanding subsections (b) and (c), a commercial annuity or contract purchased by or for an individual using that individual's assets will not be considered an available resource if the annuity meets all of the following conditions:

(1) Is an irrevocable guaranteed annuity.

(2) Guarantees to pay out principal and interest in equal monthly installments with no balloon payment to the individual so that payments are paid out over the actuarial life expectancy of the annuitant, as set forth in life expectancy tables approved by the department.

(3) Names the department as the residual beneficiary of any funds remaining due under the annuity at time of death of the annuitant, not to exceed the amount of medical assistance expended on the individual during his or her lifetime.

(4) Is issued by an insurance company licensed and approved to do business in this Commonwealth.

(e) This section applies to all annuity, life insurance and other contracts entered into on or after the effective date of this section and to life estates owned by any individual who applies or reapplies for medical assistance on or after the effective date of this section.

(441.6 added July 7, 2005, P.L.177, No.42)

Section 441.7. Income for the Community Spouse.--(a) When a community spouse has income below the monthly maintenance needs allowance as determined under the department's regulations and Title XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396 et seq.), the institutionalized spouse may transfer additional resources to the community spouse only in accordance with this section.

(b) The institutionalized spouse may transfer income to the community spouse in an amount equal to the difference between:

(1) The community spouse's monthly maintenance needs allowance; and

(2) The community spouse's income from all sources.

(c) Resources of the institutionalized spouse may be used to purchase an annuity in accordance with this subsection. The following shall apply:

(1) The annuity purchased may provide the community spouse with monthly income equal to the difference between:

(i) the community spouse's monthly maintenance needs allowance; and

(ii) the community spouse's income from all sources if the community spouse survives the institutionalized spouse.

(2) The annuity purchased to provide income for the community spouse must meet all of the following conditions:

(i) Be actuarially sound.

(ii) Be guaranteed.

(iii) Pay in equal monthly payments so that payments are paid out over the actuarial life expectancy of the annuitant,

as set forth in life expectancy tables approved by the department.

(iv) Name the department as the contingent beneficiary in the event that the community spouse predeceases the expiration of the guaranteed period of the annuity, not to exceed the amount of all medical assistance expended on behalf of the institutionalized spouse.

(3) If an annuity is purchased and the community spouse's income from all sources, including the annuity, is less than the monthly maintenance needs allowance, the institutionalized spouse may transfer sufficient income to bring the community spouse's income up to the monthly maintenance needs allowance.

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

"Community spouse" means the spouse of an institutionalized spouse.

"Institutionalized spouse" means an individual who is:

(1) in a medical institution;

(2) in a nursing facility or receiving services equivalent to those provided in a nursing facility; or

(3) receiving home- and community-based services in lieu of nursing facility care pursuant to a waiver granted under section 1915(c) or (d) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396n(c) or (d)).

(441.7 added July 7, 2005, P.L.177, No.42)

Section 441.8. Eligibility for Home- and Community-Based Services.--As a condition of eligibility for home- and community-based services, an applicant shall be subject to all medical and financial eligibility requirements for medical assistance including:

(1) Medical eligibility for the payment of nursing facility care or the equivalent level of care in a medical institution.

(2) Financial eligibility requirements under Federal and State law, including the provisions of sections 1917 and 1924 of the Social Security Act (49 Stat. 620, 42 U.S.C. §§ 1396p and 1396r-5).

(3) All other eligibility requirements for medical assistance under Federal and State law.

(441.8 added July 7, 2005, P.L.177, No.42)

Section 441.9. Verification of Eligibility.--(a) Except as set forth in subsection (b), income shall be verified prior to authorization of medical assistance or during a redetermination of a recipient's eligibility unless the verification is pending from a third party and the applicant has cooperated in the verification attempt in accordance with department regulations.

(b) Notwithstanding subsection (a), the department may authorize medical assistance for pregnant women, children, the elderly or people with disabilities if third-party, automated sources of verification are used to verify income within sixty days of the date of authorization.

(c) Except as prohibited by Federal law, it shall be a condition of eligibility for medical assistance that an applicant or recipient consent to the disclosure of information about the age, residence, citizenship, employment, applications for employment, income and resources of the applicant or recipient which is in the possession of third parties. Consent shall be effective to authorize a third party to release information requested by the department. Except in a case of suspected fraud, the department shall attempt to notify the applicant or recipient prior to contacting a third party for information about the applicant or recipient.

(441.9 added July 7, 2005, P.L.177, No.42)

Section 442. Medical Assistance for the Aged; Eligibility. (442 repealed July 31, 1968, P.L.904, No.273)

Section 442.1. The Medically Needy; Determination of Eligibility.--(a) A person shall be considered medically needy if that person meets the requirements of clauses (1), (2) and (3):

(1) Resides in Pennsylvania continuously for ninety days immediately preceding the effective date of eligibility, except for persons eligible for federally funded categories of medical assistance.

(2) Meets the standards of financial and nonfinancial eligibility established by the department with the approval of the Governor. In establishing these standards the department shall take into account:

(i) the funds certified by the Budget Secretary as available for medical assistance for the medically needy;

(ii) pertinent Federal legislation and regulations; and

(iii) the cost of living.

(3) Complies with subclause (ii): (Intro. par. amended June 28, 2019, P.L.43, No.12)

(i) ((i) deleted by amendment June 28, 2019, P.L.43, No.12).

(ii) Is not eligible for cash assistance but is:

(A) a child under twenty-one years of age;

(B) a custodial parent of a dependent child under twenty-one years of age;

(C) a person fifty-nine years of age or older;

(D) a refugee for whom Federal financial participation is available;

(E) a pregnant woman;

(F) a person with a disability who is receiving Social Security disability benefits, who has been referred to the Social Security Administration for a determination of eligibility for Supplemental Security Income or who is under review for a disability by the department based upon Social Security disability criteria; or

(G) a person who verifies employment of at least one hundred hours per month earning at least the minimum wage.

((3) amended June 30, 2012, P.L.668, No.80; amendment declared unconstitutional 2018)

(c) Medical assistance benefits can be authorized retroactively for an eligible person who requests coverage for an unpaid medical expense which was incurred during a period up to three months prior to the month of application. In determining eligibility, all income received or expected to be received in a six-month period shall be counted even if the person requests medical assistance coverage for less than six months. If retroactive medical assistance coverage is requested, the six-month period can combine both retroactive and prospective periods. Medical assistance coverage can continue as long as the need exists, but no longer than the six-month period from which income is counted.

(442.1 amended May 16, 1996 P.L.175, No.35)

2018 Unconstitutionality: The amendment of section 442.1(a)(3) by Act 80 of 2012 was declared unconstitutional on July 18, 2018, by the Supreme Court of Pennsylvania in Washington v. Commonwealth, Department of Public Welfare, 188 A.3d 1135 (Pa. 2018). The Legislative Reference Bureau effectuated the 2018 unconstitutionality.

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Compiler's Note: Section 20 of Act 49 of 1994, which amended section 442.1, provided that regulations promulgated by the Department of Public Welfare prior to December 31, 1995, for the purpose of implementing section 442.1 shall not be subject to the act of June 25, 1982 (P.L.633, No.181), known as the Regulatory Review Act. Such regulations shall be subject, however, to review for form and legality by the Attorney General and the General Counsel under sections 204(b) and 301(10) of the act of October 15, 1980 (P.L.950, No.164), known as the Commonwealth Attorneys Act.

Section 442.2. Additional Services for Certain Medically Needy Recipients.--In addition to other services provided to the medically needy:

(1) Persons who receive or are eligible for chronically needy general assistance pursuant to section 432(3)(i) shall receive coverage for prescribed medications.

(2) Recipients in general assistance-related categories whose benefits are funded at least in part by the Federal Government may receive such additional medical benefits as are federally funded. The department shall publish notice of such additional services in the Pennsylvania Bulletin.

(442.2 added June 16, 1994, P.L.319, No.49)

Compiler's Note: Section 20 of Act 49 of 1994, which added section 442.2, provided that regulations promulgated by the Department of Public Welfare prior to December 31, 1995, for the purpose of implementing section 442.2 shall not be subject to the act of June 25, 1982 (P.L.633, No.181), known as the Regulatory Review Act. Such regulations shall be subject, however, to review for form and legality by the Attorney General and the General Counsel under sections 204(b) and 301(10) of the act of October 15, 1980 (P.L.950, No.164), known as the Commonwealth Attorneys Act.

Section 442.3. Eligibility Redetermination of Persons on Medical Assistance.--(a) Unless the medical assistance recipient is a member of the class of persons described in subsection (b), the department shall make an eligibility redetermination every six months.

(b) Persons not subject to an eligibility redetermination every six months are:

(i) Persons receiving long-term care services.

(ii) Persons who are receiving medical assistance in an elderly or disabled category.

(iii) Pregnant women.

(iv) Children under one year of age.

(v) Children living with relatives other than a parent when the adult's income does not affect eligibility.

(vi) Children in foster care or adoption assistance programs.

(vii) Persons receiving Extended Medical Coverage (EMC).

(c) During the fiscal year beginning July 1, 2005, the department shall perform eligibility determinations in accordance with this section for at least 50% of the persons not described in subsection (b). For fiscal years beginning after June 30, 2006, the department shall perform eligibility determinations for at least 95% of the persons not described in subsection (b).

(d) Nothing in this section shall be construed to limit the department in determining the number or frequency of redeterminations of any person on assistance.

(442.3 added July 7, 2005, P.L.177, No.42)

Section 443. Purchased Hospital Care; Benefits. (443 repealed July 31, 1968, P.L.904, No.273)

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) Payments as determined by the department for inpatient hospital care consistent with Title XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396 et seq.). To be eligible for such payments, a hospital must be qualified to participate under Title XIX of the Social Security Act and have entered into a written agreement with the department regarding matters designated by the secretary as necessary to efficient administration, such as hospital utilization, maintenance of proper cost accounting records and access to patients' records. Such efficient administration shall require the department to permit participating hospitals to utilize the same fiscal intermediary for this Title XIX program as such hospitals use for the Title XVIII program. ((1) amended July 9, 2010, P.L.336, No.49)

(1.1) Subject to section 813-G, for inpatient 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: ((Intro. par. amended Dec. 28, 2015, P.L.500, No.92)

(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, 2028, 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. (i) amended Oct. 23, 2023, P.L.63, No.15)

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

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

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

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

(iii) Notwithstanding subparagraph (i), the department may make additional changes to its payment methods and standards

for inpatient hospital services consistent with Title XIX of the Social Security Act, including changes to supplemental payments currently authorized in the State plan based on the availability of Federal and State funds.

((1.1) amended June 30, 2011, P.L.89, No.22)

(1.2) Subject to section 813-G, for inpatient acute care hospital services provided under the physical health medical assistance managed care program during State fiscal year 2010-2011, the following shall apply:

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

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

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

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

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

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

(vii) ((vii) deleted by amendment).

((1.2) amended June 30, 2011, P.L.89, No.22)

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

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

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

(A) For inpatient hospital services provided under a participation agreement between an inpatient acute care hospital and the medical assistance managed care organization in effect as of June 30, 2010, the medical assistance managed care organization shall pay, and the hospital shall accept as payment in full, amounts determined in accordance with the payment terms and rate methodology specified in the agreement and in effect as of June 30, 2010, during the term of that participation agreement. If a participation agreement in effect as of June

30, 2010, uses the department fee-for-service DRG rate methodology in determining payment amounts, the medical assistance managed care organization shall pay, and the hospital shall accept as payment in full, amounts determined in accordance with the fee-for-service payment methodology in effect as of June 30, 2010, including, without limitation, continuation of the same grouper, outlier methodology, base rates and relative weights during the term of that participation agreement.

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

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

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

((1.3) added June 30, 2011, P.L.89, No.22)

(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, 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, 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.

((1.4) amended Dec. 28, 2015, P.L.500, No.92)

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

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

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

((1.5) added June 30, 2011, P.L.89, No.22)

(1.6) Notwithstanding any other provision of law or departmental regulation to the contrary, the department shall make separate fee-for-service APR/DRG payments for medically necessary inpatient acute care general hospital services provided for normal newborn care and for mothers' obstetrical delivery. ((1.6) added July 9, 2013, P.L.369, No.55)

(2) The cost of skilled nursing and intermediate nursing care in State-owned geriatric centers, institutions for the mentally retarded, institutions for the mentally ill, and the cost of skilled and intermediate nursing care provided prior to June 30, 2004, in county homes which meet the State and Federal requirements for participation under Title XIX of the Social Security Act and which are approved by the department. This cost in county homes shall be as specified by the regulations of the department adopted under Title XIX of the Social Security Act and certified to the department by the Auditor General; elsewhere the cost shall be determined by the department;

(3) Rates on a cost-related basis established by the department for skilled nursing home or intermediate care in a non-public nursing home, when furnished by a nursing home licensed or approved by the department and qualified to participate under Title XIX of the Social Security Act and provided prior to June 30, 2004;

(4) Payments as determined by the department for inpatient psychiatric care consistent with Title XIX of the Social Security Act. To be eligible for such payments, a hospital must be qualified to participate under Title XIX of the Social Security Act and have entered into a written agreement with the department regarding matters designated by the secretary as necessary to efficient administration, such as hospital utilization, maintenance of proper cost accounting records and access to patients' records. Care in a private mental hospital provided under the fee for service delivery system shall be limited to thirty days in any fiscal year for recipients aged twenty-one years or older who are eligible for medical assistance under Title XIX of the Social Security Act and for recipients aged twenty-one years or older who are eligible for general assistance-related medical assistance. Exceptions to the thirty-day limit may be granted under section 443.3. Only persons aged twenty-one years or under and aged sixty-five years or older shall be eligible for care in a public mental hospital. This cost shall be as specified by regulations of the department adopted under Title XIX of the Social Security Act and certified to the department by the Auditor General for county and non-public institutions;

(5) After June 30, 2004, and before June 30, 2007, payments to county and nonpublic nursing facilities enrolled in the

medical assistance program as providers of nursing facility services shall be calculated and made as specified in the department's regulations in effect on July 1, 2003, except that if the Commonwealth's approved Title XIX State Plan for nursing facility services in effect for the period of July 1, 2004, through June 30, 2007, specifies a methodology for calculating county and nonpublic nursing facility payment rates that is different than the department's regulations in effect on July 1, 2003, the department shall follow the methodology in the Federally approved Title XIX State plan.

(6) For public nursing home care provided on or after July 1, 2005, the department 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). ((6) amended Dec. 28, 2015, P.L.500, No.92)

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

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

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

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

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

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

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

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

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

(iv) Subject to Federal approval of such amendments as may be necessary to the Commonwealth's approved Title XIX State Plan, for each fiscal year beginning on or after July 1, 2011, the department shall apply a revenue adjustment neutrality factor to county and nonpublic nursing facility payment rates so that the estimated Statewide day-weighted average payment rate in effect for that fiscal year is limited to the amount permitted by the funds appropriated by the General Appropriation Act for the fiscal year. The revenue adjustment neutrality factor shall remain in effect until the sooner of June 30, 2022, or the date on which a new rate-setting methodology for medical assistance nursing facility services which replaces the rate-setting methodology codified in 55 Pa. Code Chs. 1187 (relating to nursing facility services) and 1189 (relating to county nursing facility services) takes effect. ((iv) amended June 28, 2019, P.L.168, No.19)

(v) Subject to Federal approval of such amendments as may be necessary to the Commonwealth's approved Title XIX State Plan, for fiscal year 2013-2014, the department shall make quarterly medical assistance day-one incentive payments to qualified nonpublic nursing facilities. The department shall determine the nonpublic nursing facilities that qualify for the quarterly 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 available on October 31, January 31, April 30 and July 31. 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 its report after these dates. 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 85% 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 65% 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 of October 31, January 31, April 30 and July 31.

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

(I) The total funds appropriated for payments under this subparagraph shall be divided by four.

(II) To establish the quarterly per diem rate, 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.

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

(C) For fiscal year 2013-2014, the State funds available for the nonpublic nursing facility medical assistance day-one incentive payments shall equal eight million dollars ($8,000,000).

((v) added July 9, 2013, P.L.369, No.55)

(vi) Subject to Federal approval of such amendments as may be necessary to the Commonwealth's approved Title XIX State Plan, for fiscal years 2015-2016, 2016-2017, 2018-2019, and 2019-2020, 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) The following shall apply:

(I) For fiscal years 2015-2016, 2016-2017 and 2018-2019, the State funds available for the nonpublic nursing facility medical assistance day-one incentive payments shall equal eight million dollars ($8,000,000).

(II) For fiscal years 2019-2020, the State funds available for the nonpublic nursing facility medical assistance day-one incentive payments shall equal sixteen million dollars ($16,000,000).

((vi) amended June 28, 2019, P.L.43, No.12)

(vii) For each fiscal year beginning on or after fiscal year 2020-2021, an additional annual payment equal to one hundred thirty dollars ($130) per eligible Medicaid ventilator or tracheostomy day shall be paid to qualified medical assistance nonpublic and county nursing facilities on a quarterly basis. The department will obtain all necessary approvals and take all steps required to ensure the distribution of these payments to all qualifying nursing facilities under both the fee-for-service program and the managed long-term services and supports program. The following shall apply:

(A) A nonpublic or county nursing facility will qualify for the payment if, during any quarter of the year, the facility had:

(I) a minimum of ten medical assistance recipient residents who received medically necessary ventilator care or tracheostomy care according to the most recently available Picture Date CMI Report; and

(II) at least seventeen percent of the facility's medical assistance recipient resident population receiving medically necessary ventilator care or tracheostomy care according to at

least one of the three most recently available medical assistance Picture Date CMI Reports.

(B) The department shall calculate a qualified nonpublic or county nursing facility's payment as follows:

(I) The determination of medically necessary ventilator care is based on whether there is a positive response to MDS 3.0 Section O0100F1 or O0100F2 on the MDS assessment identified on the Picture Date CMI Report. The determination of medically necessary tracheostomy care is based on whether there is a positive response to MDS 3.0 Section O0100E1 or O0100E2 on the MDS assessment identified on the Picture Date CMI Report.

(II) The quarterly payment shall equal the additional supplemental ventilator care and tracheostomy care per diem described in unit (a) multiplied by the number of eligible days described in unit (b) as follows:

(a) The additional supplemental ventilator care and tracheostomy care per diem shall equal the number of MA-recipient residents who receive necessary ventilator care or tracheostomy care/total MA-recipient residents x $130 as identified in the facility's most recently available Picture Date CMI Report.

(b) The facility's eligible days for the quarter are the facility's paid MA facility days and therapeutic leave days; if the facility does not meet the criteria of clause (A)(I) during the payment quarter, the facility's eligible days for the quarter are zero.

(C) The department shall publish on a quarterly basis the information contained in the Supplemental Ventilator Care and Tracheostomy Care Payments file currently published on the department's publicly accessible Internet website.

((vii) added June 30, 2021, P.L.256, No.56)

((7) amended June 30, 2011, P.L.89, No.22)

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

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

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

(iii) The department may publish amendments to the statement of policy if the department determines that changes to the process and guidelines for reviewing and responding to requests for approval of increases in medical assistance certified beds will facilitate access to medically necessary nursing facility services or are required to assure that long-term living care and services under the medical assistance program will be provided in a manner consistent with applicable Federal and

State law, including Title XIX of the Social Security Act. The department shall publish the proposed amendments in the Pennsylvania Bulletin and solicit public comments for thirty days. After consideration of the comments it receives, the department may proceed to adopt the amendments by publishing an amended statement of policy in the Pennsylvania Bulletin which shall include its responses to the public comments that it received concerning the proposed amendments.

(iv) ((iv) expired June 30, 2012. See Act 22 of 2011.)

((8) amended June 30, 2011, P.L.89, No.22)

(443.1 amended June 30, 2007, P.L.49, No.16)

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

Compiler's Note: Section 12 of Act 22 of 2011 provided that the addition of par. (1.5)(i) shall be retroactive to July 1, 2010.

Section 12 of Act 20 of 1995 provided that it is the intent of the General Assembly that the Department of Public Welfare promulgate final-form regulations which omit notice of proposed rulemaking for the purpose of revising regulations implementing section 443.1. These regulations shall be submitted before September 1, 1995. Section 12 shall expire September 1, 1995.

Section 443.2. Medical Assistance Payments for Home Health Care.--The following medical assistance payments shall be made in behalf of eligible persons whose care in the home has been prescribed by a physician, chiropractor or podiatrist:

(1) Rates established by the department for post-hospital home care, as specified by regulations of the department adopted under Title XIX of the Federal Social Security Act for not more than one hundred eighty days following a period of hospitalization, if such care is related to the reason the person was hospitalized and if given by a hospital as comprehensive, hospital type care in a patient's home;

(2) Rates established by the department for home health care services if such services are furnished by a voluntary or governmental health agency.

(443.2 amended Nov. 28, 1973, P.L.364, No.128)

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

(1) Rates established by the department for outpatient services as specified by regulations of the department adopted under Title XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396 et seq.) consisting of preventive, diagnostic, therapeutic, rehabilitative or palliative services; furnished by or under the direction of a physician, chiropractor or podiatrist, by a hospital or outpatient clinic which qualifies to participate under Title XIX of the Social Security Act, to a patient to whom such hospital or outpatient clinic does not furnish room, board and professional services on a continuous, twenty-four hour a day basis.

(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. ((1.1) added Dec. 28, 2015, P.L.500, No.92)

(2) Rates established by the department for (i) other laboratory and X-ray services prescribed by a physician, chiropractor or podiatrist and furnished by a facility other than a hospital which is qualified to participate under Title XIX of the Social Security Act, (ii) physician's services consisting of professional care by a physician, chiropractor or podiatrist in his office, the patient's home, a hospital, a nursing facility or elsewhere, (iii) the first three pints of whole blood, (iv) remedial eye care, as provided in Article VIII consisting of medical or surgical care and aids and services and other vision care provided by a physician skilled in diseases of the eye or by an optometrist which are not otherwise available under this Article, (v) special medical services for school children, as provided in the Public School Code of 1949, consisting of medical, dental, vision care provided by a physician skilled in diseases of the eye or by an optometrist or surgical care and aids and services which are not otherwise available under this article.

(3) Notwithstanding any other provision of law, for recipients aged twenty-one years or older receiving services under the fee for service delivery system who are eligible for medical assistance under Title XIX of the Social Security Act and for recipients aged twenty-one years or older receiving services under the fee-for-service delivery system who are eligible for general assistance-related categories of medical assistance, the following medically necessary services:

(i) Psychiatric outpatient clinic services not to exceed five hours or ten one-half-hour sessions per thirty consecutive day period.

(ii) Psychiatric partial hospitalization not to exceed five hundred forty hours per fiscal year.

(b) The department may grant exceptions to the limits specified in this section, section 443.1(4) or the department's regulations when any of the following circumstances applies:

(1) The department determines that the recipient has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of or result in the rapid, serious deterioration of the health of the recipient.

(2) The department determines that granting a specific exception to a limit is a cost-effective alternative for the medical assistance program.

(3) The department determines that granting an exception to a limit is necessary in order to comply with Federal law.

(c) The Secretary of Public Welfare shall promulgate regulations pursuant to section 204(1)(iv) of the act of July 31, 1968 (P.L.769, No.240), referred to as the Commonwealth Documents Law, to implement this section. Notwithstanding any other provision of law, the promulgation of regulations under this subsection shall, until December 31, 2005, be exempt from all of the following:

(1) Section 205 of the Commonwealth Documents Law.

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

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

(443.3 amended July 7, 2005, P.L.177, No.42)

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Compiler's Note: The Secretary of Public Welfare, referred to in this section, was redesignated as the Secretary of Human Services by Act 132 of 2014.

Compiler's Note: Section 12 of Act 20 of 1995 provided that it is the intent of the General Assembly that the Department of Public Welfare promulgate final-form regulations which omit notice of proposed rulemaking for the purpose of revising regulations implementing section 443.3. These regulations shall be submitted before September 1, 1995. Section 12 shall expire September 1, 1995.

Section 443.4. Additional Services for Eligible Persons Other Than the Medically Needy.--Except for the medically needy, persons eligible for medical assistance may, pursuant to regulations of the department, also receive dental services, vision care provided by a physician skilled in diseases of the eye or by an optometrist prescribed medications, prosthetics and appliances, ambulance transportation, skilled nursing home care for an unlimited period of time, and other remedial, palliative or therapeutic services prescribed by or provided under the direction of a physician or podiatrist.

(443.4 amended Nov. 28, 1973, P.L.364, No.128)

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Compiler's Note: Section 12 of Act 20 of 1995 provided that it is the intent of the General Assembly that the Department of Public Welfare promulgate final-form regulations which omit notice of proposed rulemaking for the purpose of revising regulations implementing section 443.4. These regulations shall be submitted before September 1, 1995. Section 12 shall expire September 1, 1995.

Section 443.5. Prepayment for Contracted Medical Services.--For categorically needy or medically needy persons eligible for medical assistance, prepaid capitation payments or insurance premiums for services under the medical assistance State plan may be made on behalf of eligible persons through competitive bidding with profit or non-profit contractors, insurers, or health maintenance organizations. Profit and non-profit insurers must be approved under applicable State laws. Prepaid capitation or premium payments made under such contracts shall not exceed payments made to other third party payers for comparable services and similar benefit conditions. Capitation payments charged for anticipated medical assistance eligible persons under a contract may be prepaid by the Commonwealth subject to monthly, quarterly, and annual adjustment by the department based on actual enrollment and fixed capitation rates.

(443.5 added July 15, 1976, P.L.993, No.202)

Section 443.6. Reimbursement for Certain Medical Assistance Items and Services.--(a) In order to receive reimbursement for items or services enumerated in subsection (b), the provider must secure authorization prior to actually providing the items

or services. The request for prior authorization must justify to the reasonable satisfaction of the department the need for an item or service.

(b) Payment for the following medical assistance items and services shall be made only after prior authorization has been secured:

(1) Prostheses and orthoses.

(2) Purchase of appliances or equipment if the appliance or equipment costs more than six hundred dollars ($600): Provided, however, That the department may require prior authorization for the purchase of specific appliances or equipment that costs less than six hundred dollars ($600).

(3) Rental of medical appliances or equipment for a period in excess of six months: Provided, however, That the department may require prior authorization for the rental of medical appliances or equipment for a period of less than six months.

(4) Oxygen and related equipment in the home unless a physician states that the physical surroundings in the home are suitable for the use of oxygen and that the recipient is adequately prepared and able to use the equipment.

(5) Dental services as the department may provide, including but not necessarily limited to, dental prostheses and appliances.

(6) Orthopedic shoes or other supportive devices for the feet when such shoes or devices are prescribed by a physician for the purpose of correcting or otherwise treating abnormalities of the feet or legs which cause serious detrimental medical effects.

(7) Other items or services as the department may authorize by publication of notice in the Pennsylvania Bulletin.

((b) amended July 7, 2005, P.L.177, No.42)

(c) The prior authorization requirements set forth in this section shall be applicable only to the extent that the items and services enumerated in subsection (b) are provided under the Pennsylvania Medical Assistance Plan. This section shall not be construed as mandating the provision of any item or service enumerated in this section.

(d) The requirements of this section shall not apply in an emergency situation.

(e) The department shall promulgate regulations to implement this section and shall establish a procedure for prior authorization. Such regulations may establish procedures for issuing prior authorization at whatever administrative level the department through the secretary deems appropriate. Appropriateness shall be determined by the secretary after hearings have been held and public input is received. Procedures adopted in accordance with this section shall provide authorization when appropriate, without undue delay. When no decision is made on a request to the department for covered services within twenty-one days of the date that the request is received by the department, the authorization shall be deemed approved. The department shall keep a record of those cases in which no decision is made within twenty-one days. The requirements of this section shall not apply in a medical emergency situation as defined by the department.

(f) Under no circumstances shall the department reimburse a provider for any medical services, procedures or drugs related to infertility therapy.

(g) The department shall establish benefit packages for dental and pharmacy services for medical assistance recipients twenty-one years of age or older, and any exceptions to such benefit packages as the department determines are appropriate.

Notwithstanding any other provision of law, including this section, during State fiscal year 2011-2012, the department shall establish such benefit packages, limits and exceptions thereto by publication of one or more notices in the Pennsylvania Bulletin. A notice shall describe the available benefit packages or limits and any exceptions thereto. The benefit packages, limits and exceptions thereto shall take effect as specified in the notice and remain in effect until changed by a subsequent notice issued on or before June 30, 2012, or thereafter by department regulation. ((g) added June 30, 2011, P.L.89, No.22)

(443.6 amended June 16, 1994, P.L.319, No.49)

Section 443.7. Health Care Provider Retention Account.--(443.7 repealed Dec. 22, 2005, P.L.458, No.88)

Section 443.8. Personal Needs Allowance Deduction for Medical Assistance-Eligible Persons in Nursing Facilities.--(a) A personal needs allowance of not less than forty dollars ($40) per month, for clothing and other personal needs, shall be deducted from a medical assistance-eligible person's gross income, as defined by departmental regulation, for purposes of determining the amount that person must pay toward the cost of skilled health care and intermediate services or intermediate care while residing in a nursing facility.

(b) The personal needs allowance under subsection (a) shall be increased to not less than forty-five dollars ($45) beginning July 1, 2007.

(443.8 added Nov. 29, 2004, P.L.1272, No.154)

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

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

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

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

(443.9 amended June 30, 2011, P.L.89, No.22)

Section 443.10. Maximum Payment to Practitioners for Inpatient Hospitalization.--The maximum payment made to a practitioner for all services provided to an eligible recipient during any one period of inpatient hospitalization shall be the lowest of the following:

(1) The practitioner's usual charge to the general public for the same service.

(2) The medical assistance maximum allowable fee for the service.

(3) A maximum payment limit, per recipient per the period of inpatient hospitalization, established by the medical assistance program and published as a notice in the Pennsylvania Bulletin. If the fee for the actual service exceeds the maximum payment limit, the fee for the actual procedure shall be the maximum payment for the period of inpatient hospitalization.

(443.10 added July 4, 2008, P.L.557, No.44)

Section 443.11. Mileage Reimbursement and Paratransit Services for Individuals Receiving Methadone Treatment.--(a) An individual receiving methadone treatment by a licensed provider, pursuant to a narcotic treatment program, shall be eligible for the following:

(1) mileage reimbursement equal to the distance from the individual's residence to the treatment program closest to the individual's residence; or

(2) paratransit services if the treatment is received at the treatment program closest to the individual's residence based on a one-way trip calculation.

(b) The department shall develop an exceptions process based on medical emergency, physical health, safety issues and availability of closest provider.

(c) County medical assistance transportation programs in consultation with the department shall develop procedures for the prevention, detection and reporting of suspected fraud and abuse relating to the reimbursement of mileage for methadone treatment.

(d) ((d) deleted by amendment Dec. 28, 2015, P.L.500, No.92)

(443.11 added Dec. 22, 2011, P.L.561, No.121)

Section 443.12. Nonemergency Medical Transportation Services.--(a) The department shall amend the Commonwealth's State Plan under Title XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396 et seq.) to provide nonemergency medical transportation services to eligible and enrolled medical assistance recipients utilizing a Statewide or regional full-risk brokerage model.

(b) Subject to Federal approval of the amendments to the Commonwealth's approved Title XIX State Plan, the department shall develop a proposal and solicit a broker to administer the program. A broker determined eligible by the department may submit a proposal. The department shall enter into a contract with each broker whose proposal has been selected to administer the program.

(c) The department shall issue the solicitation for a Statewide or regional full-risk brokerage model within one hundred eighty days after the effective date of this subsection.

(d) The department may not enter into a contract with a broker under subsection (b) prior to the completion of the analysis required under subsection (e). ((d) added June 28, 2019, P.L.168, No.19)

(e) Prior to the implementation of the full-risk brokerage model, the department, in coordination with the Department of Transportation and the Department of Aging, shall commission an analysis that provides at a minimum the following:

(1) An analysis of current Federal and State law, regulations and policies controlling the nonemergency medical transportation and other human services transportation programs administered in the Commonwealth, including the authorized methods of delivery and limitations or restrictions imposed on the methods of delivery.

(2) An analysis of the effectiveness and efficiency of the current nonemergency transportation service delivery as it relates to all human service programs in this Commonwealth.

(3) A review of other states' models of delivering nonemergency medical and other human services transportation, including the number of other states that utilize a full-risk brokerage model and the effect a brokerage model has had on public transit in those states.

(4) An analysis of the positive and negative impact of maintaining the current transportation delivery model versus implementing a full-risk brokerage model as it relates to the State and local government entities, including financial impact.

(5) An analysis of the impact on consumers, including an increase or decrease in quality and service availability.

((e) added June 28, 2019, P.L.168, No.19)

(f) The analysis under subsection (e) shall be completed no later than one hundred eighty days from the effective date of this subsection. A preliminary report of the analysis under subsection (e) shall be completed no later than ninety days from the effective date of this subsection. The analysis under subsection (e) and the preliminary report under this subsection shall be delivered to the following:

(1) The Secretary of Human Services.

(2) The Secretary of Aging.

(3) The Secretary of Transportation.

(4) The chairperson and minority chairperson of the Appropriations Committee of the Senate.

(5) The chairperson and minority chairperson of the Appropriations Committee of the House of Representatives.

(6) The chairperson and minority chairperson of the Health and Human Services Committee of the Senate.

(7) The chairperson and minority chairperson of the Health Committee of the House of Representatives.

((f) added June 28, 2019, P.L.168, No.19)

(443.12 added June 22, 2018, P.L.258, No.40)

Section 443.13. Emergency Transportation Services.--Subject to Federal approval as may be necessary and contingent on Federal financial participation, from money appropriated for the department under the act of August 3, 2023 (P.L.471, No.1A), known as the General Appropriation Act of 2023, sufficient funds shall be included to provide reimbursement for ground mileage for every loaded mile and to provide the greater of the highest Medicare rates published in the Ambulance Fee Schedule Public Use File for calendar year 2023 or the current Medicaid Ambulance Fees as updated by Medical Assistance Bulletin 26-22-07 effective date January 1, 2023, beginning January 1, 2024, for services provided under the Medical Assistance - Fee-for-Service, Medical Assistance - Capitation and Medical Assistance - Community HealthChoices appropriations in the General Appropriation Act of 2023.

(443.13 added Oct. 23, 2023, P.L.63, No.15)

Section 443.14. Medical Assistance Coverage for Pasteurized Donor Human Milk.--(a) Pasteurized donor human milk is compensable under the medical assistance program in accordance with the Commonwealth's approved State plan if:

(1) The pasteurized donor human milk is medically necessary for an inpatient infant or an outpatient infant.

(2) The infant's mother is medically or physically unable to produce maternal breast milk or produce maternal breast milk in sufficient quantities to meet the infant's needs or if the maternal breast milk is contraindicated.

(b) The department shall regularly review and update, as needed, written guidance regarding pasteurized donor human milk. Any updated pasteurized donor human milk guidance shall be posted on the department's publicly accessible Internet website.

(c) The Department of Health, in collaboration with the department, shall develop and conduct a public information campaign to inform families and health care providers of the availability of pasteurized donor human milk in this Commonwealth to treat inpatient infants and outpatient infants,

as provided in this section and as medically necessary, including the availability of coverage through medical assistance.

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

"Inpatient infant." An infant who is younger than twelve months of age based on the infant's corrected gestational age, who is receiving care in an inpatient setting, for whom pasteurized donor human milk is medically necessary. Pasteurized donor human milk is medically necessary for an infant with any of the following health conditions:

(1) An infant birth weight equal to or less than one thousand eight hundred grams.

(2) An infant gestational age equal to or less than thirty-four weeks.

(3) A high risk for development of necrotizing enterocolitis, bronchopulmonary dysplasia, sepsis or retinopathy of prematurity.

(4) A congenital or acquired gastrointestinal condition or other serious medical condition associated with long-term feeding or malabsorption complications.

(5) Congenital heart disease requiring surgery in the first year of life.

(6) Has had or will have an organ or bone marrow transplant, or has an immunologic deficiency.

(7) Renal disease requiring dialysis in the first year of life.

(8) Infant hypoglycemia or jaundice.

(9) Neonatal abstinence syndrome.

(10) Any other health condition for which the use of pasteurized donor human milk is medically necessary as determined by the department.

"Licensed milk bank." A milk bank licensed in this Commonwealth or through a hospital licensure process in accordance with the act of February 12, 2020 (P.L.13, No.7), known as the "Keystone Mother's Milk Bank Act."

"Necrotizing enterocolitis." A life-threatening condition that most often occurs in a premature infant, but also occurs in a term infant or near-term infant, and that causes intestinal inflammation characterized by variable injury or damage to the intestinal tract resulting in the potential death of intestinal tissue.

"Neonatal abstinence syndrome." A withdrawal syndrome of an infant that occurs when an infant is born after exposure to substance abuse in utero, and that is associated with multiple side effects, including tremors, vomiting, poor feeding, poor weight gain and high-pitched crying, which may lead to increased length of hospital stays and additional health care costs depending on severity.

"Outpatient infant." An infant who is younger than twelve months of age based on the infant's corrected gestational age, who is receiving care in an outpatient setting, for whom pasteurized donor human milk is medically necessary. Pasteurized donor human milk is medically necessary for an infant with any of the following health conditions:

(1) A congenital or acquired gastrointestinal condition or other serious medical condition associated with long-term feeding or malabsorption complications.

(2) Congenital heart disease requiring surgery in the first year of life.

(3) Has had or will have an organ or bone marrow transplant or has an immunologic deficiency.
(4) A history of sepsis.
(5) Renal disease requiring dialysis in the first year of life.
(6) Any other health condition for which the use of pasteurized donor human milk is medically necessary as determined by the department.
"Pasteurized donor human milk." Human milk derived from a donor as defined in section 3 of the "Keystone Mother's Milk Bank Act," which is donated to a licensed milk bank for processing and distribution.
(443.14 added Nov. 21, 2023, P.L.183, No.32)

Compiler's Note: The preamble of Act 32 of 2023 provided that Act 32 may be referred to as Owen's Law.

Section 444. Post Hospital Care; Benefits. (444 repealed July 31, 1968, P.L.904, No.273)

Section 444.1. Limitation on Charges.--As a condition of participation in the medical assistance program, vendors of services shall agree to accept the rates of payment authorized by this article and shall not seek nor accept additional payments. The department shall permit each person eligible for assistance under this act freedom to choose whichever practitioner and or vendor of the services, care or prescribed drugs he shall desire so long as such practitioner or vendor is entitled to participate in the assistance program provided for in this act.
(444.1 added July 31, 1968, P.L.904, No.273)

Section 444.2. Physicians' Liability Limited.--Any physician rendering service as a member of a hospital utilization review committee, a hospital tissue committee, a health insurance review committee, a physicians' advisory committee, or any other committee established for the purpose of this medical assistance program shall not be liable for any civil damages as a result of any acts or omissions in rendering the service as a member of any such committee except any acts or omissions intentionally designed to harm or any grossly negligent acts or omissions which result in harm to the person receiving such service.
(444.2 added July 31, 1968, P.L.904, No.273)

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Section 445. Purchased Hospital and Post Hospital care; Eligibility. (445 repealed July 31, 1968, P.L.904, No.273)

Section 446. Application; Special Provisions.--In addition to the provisions of section 431 which apply also to applications for medical assistance the following provisions are applicable:
(1) Whenever a person in need of medical assistance is unable to make application therefor by reason of his illness or infirmity, or by reason of his minority, application on his behalf may be made by a relative, friend or official of the agency providing medical or other care. Such application shall contain a statement as required in section 431 except that such applicant shall be permitted to make affidavit that the facts set forth in such statement are, to the best of his knowledge and belief, true and correct.
(2) The department may establish eligibility for medical assistance upon application regardless of the condition of health of the person at the time of making the application.

(446 amended July 31, 1968, P.L.904, No.273)

Section 447. Relatives' Responsibility; Repayment.--(a) Notwithstanding any other provision of law, no repayment shall be required of any medical assistance paid in behalf of any person for which he was eligible; and, with respect to the determination of eligibility for such assistance, no relative, other than spouses for each other and parents for unemancipated minor children, shall be required to contribute to the cost of the care for which such assistance is provided.

(b) Persons who apply for medical assistance shall be required to cooperate with the department in establishing paternity and pursuing a medical support order.

(c) The custodial parents of a dependent child under eighteen years of age who is disabled as defined by section 1611 of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1382) and who is not receiving benefits pursuant to Title XVI of the Social Security Act (42 U.S.C. § 1381 et seq.) shall be required to verify their income as a condition of eligibility of the child. ((c) added July 7, 2005, P.L.177, No.42)

(447 amended June 30, 1995, P.L.129, No.20)

Section 448. Medical Assistance Deductible.--Recipients of general assistance and general assistance-related medical assistance shall be responsible for a one hundred fifty dollar ($150) deductible each fiscal year for medical assistance-compensable ambulatory surgical center services, inpatient hospital services or outpatient hospital services, excluding laboratory and X-ray services.

(448 added May 16, 1996, P.L.175, No.35)

Section 449. Medical Assistance Pharmacy Services.--(a) Any managed care organization under contract to the department, or an entity with which the managed care organization contracts, must contract on an equal basis with any pharmacy qualified to participate in the Medical Assistance Program that is willing to comply with the managed care organization's or entity's pharmacy payment rates and terms and to adhere to quality standards established by the managed care organization or entity.

(b) The following shall apply:

(1) The department may conduct an audit or review of an entity for the purpose of determining compliance with this section.

(2) In the course of an audit or review under paragraph (1), an entity shall provide medical assistance-specific information from a pharmacy contract or agreement to the department.

(c) A contract or agreement between an entity and a pharmacy may not include any of the following:

(1) A confidentiality provision that prohibits the disclosure of information to the department.

(2) Any provision that restricts the disclosure of information to or communication with a managed care organization or the department.

(d) An entity shall maintain records regarding pharmacy services eligible for payment by the Medical Assistance Program and shall disclose the information to the department upon its request.

(e) Information disclosed or produced by an entity to the department under this section shall not be subject to public access under the act of February 14, 2008 (P.L.6, No.3), known as the "Right-to-Know Law."

(f) The following shall apply:

(1) If an entity approves a claim for payment under the Medical Assistance Program, the entity may not retroactively deny or modify the adjudicated claim unless any of the following apply:

(i) The claim was fraudulent.

(ii) The claim was duplicative of a previously paid claim.

(iii) The pharmacy did not dispense the pharmacy service on the claim.

(2) Nothing in this subsection shall be construed to prohibit the recovery of an adjudicated claim that was determined to be an overpayment or underpayment resulting from audit, review or investigation by a Federal or State agency or managed care organization.

(g) A managed care organization or pharmacy benefit manager may not mandate that a medical assistance recipient use a specific pharmacy unless it is consistent with subsection (a) and is preapproved by the department.

(h) A pharmacy benefit manager or pharmacy services administration organization may not do any of the following:

(1) Require that a pharmacist or pharmacy participate in a network managed by the pharmacy benefit manager or pharmacy services administration organization as a condition for the pharmacist or pharmacy to participate in another network managed by the same pharmacy benefit manager or pharmacy services administration organization.

(2) Automatically enroll or disenroll a pharmacist or pharmacy without cause.

(3) Charge or retain a differential between what is billed to a managed care organization as a reimbursement for a pharmacy service and what is paid to pharmacies by the pharmacy benefit manager or pharmacy services administration organization for the pharmacy service.

(4) Charge pharmacy transmission fees unless the amount of the fee is disclosed and applied at the time of claim adjudication.

(i) A managed care organization shall submit its policies and procedures, and any revisions, for development of network pharmacy payment methodology to the department. The department shall review all changes to pharmacy payment methodology prior to implementation.

(j) A managed care organization utilizing a pharmacy benefit manager shall report to the department information related to each outpatient drug encounter, including the following:

(1) The amount paid to the pharmacy benefit manager by the managed care organization.

(2) The amount paid by the pharmacy benefit manager to the pharmacy.

(3) Any differences between the amount paid in paragraph (1) and the amount paid in paragraph (2).

(4) Other information as requested by the department.

(k) A pharmacy shall, upon request by the department, submit the actual acquisition cost of prescriptions dispensed to medical assistance beneficiaries.

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

"Adjudicated claim" means a claim that has been processed to payment or denial.

"Entity" means a pharmacy, pharmacy benefit manager, pharmacy services administration organization or other entity that manages, processes or influences the payment for or dispenses pharmacy services to medical assistance recipients in the managed care delivery system.

"Pharmacy benefit management" means any of the following:

(1) The procurement of prescription drugs at a negotiated contracted rate for distribution within this Commonwealth.

(2) The administration or management of prescription drug benefits provided by a managed care organization.

(3) The administration of pharmacy benefits, including any of the following:

(i) Operating a mail-service pharmacy.

(ii) Processing claims.

(iii) Managing a retail pharmacy network.

(iv) Paying claims to pharmacies, including retail, specialty or mail-order pharmacies, for prescription drugs dispensed to medical assistance recipients receiving services in the managed care delivery system via a retail or mail-order pharmacy.

(v) Developing and managing a clinical formulary or preferred drug list, utilization management or quality assurance programs.

(vi) Rebate contracting and administration.

(vii) Managing a patient compliance, therapeutic intervention and generic substitution program.

(viii) Operating a disease management program.

(ix) Setting pharmacy payment pricing and methodologies, including maximum allowable cost and determining single or multiple source drugs.

"Pharmacy benefit manager" means a business that performs pharmacy benefit management. The term does not include a business that holds a valid license from the Insurance Department with accident and health authority to issue a health insurance policy and governed under any of the following:

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

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

(3) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

"Pharmacy services administration organization" means an organization comprised of pharmacy members that performs any of the following:

(1) Negotiates or contracts with a managed care organization or pharmacy benefit manager on behalf of its pharmacy members.

(2) Negotiates payment rates, payments or audit terms on behalf of its pharmacy members.

(3) Collects or reconciles payments on behalf of its pharmacy members.

(449 amended Nov. 25, 2020, P.L.1208, No.120)

Compiler's Note: Section 3 of Act 120 of 2020 provided that the amendment of section 449 shall apply to any agreement or contract relating to pharmacy services to medical assistance recipients in the managed care delivery system entered into or amended on or after the effective date of section 3.

Section 449.1. Prescription Drug Pricing Study.--(a) The Legislative Budget and Finance Committee shall conduct a study analyzing prescription drug pricing under the medical assistance managed care program. The committee shall do all of the following as it relates to the medical assistance managed care program only:

(1) Provide an overview of the distribution of and payment for pharmaceuticals in the medical assistance managed care program.

(2) Review the reimbursement practices of pharmacy benefit managers to pharmacies within this Commonwealth.

(3) Review the reimbursement practices of managed care organizations to pharmacy benefit managers.

(4) Investigate and compare the reimbursement rates paid by pharmacy benefit managers to independent pharmacies and to chain pharmacies.

(5) Study the best practices and laws adopted by other states to address concerns with pharmacy reimbursement practices of pharmacy benefit managers.

(b) The Legislative Budget and Finance Committee shall review and utilize data from the most recent twelve-month period.

(c) The department shall provide the following data for the medical assistance managed care program to the Legislative Budget and Finance Committee:

(1) The amount paid to a pharmacy provider per claim, including ingredient cost and the amount of any copayment deducted from the payment.

(2) The transmission fees charged by a pharmacy benefit manager to a pharmacy provider.

(3) The amount charged by the pharmacy benefit manager to the medical assistance managed care organization per claim, including all administrative fees and processing charges associated with the claim.

(4) Rebates paid by the pharmacy benefit manager to the managed care organization.

(5) Any other data the Legislative Budget and Finance Committee deems necessary.

(d) Pharmacy benefit managers and medical assistance managed care organizations shall provide the required data under subsection (c) to the department within forty-five days of the effective date of this section for distribution to the Legislative Budget and Finance Committee. The providing of data by the pharmacy benefit managers and medical assistance managed care organizations to the department or by the department to the Legislative Budget and Finance Committee shall not constitute a waiver of any applicable privilege or claim of confidentiality. All data shall be given confidential treatment, shall not be subject to subpoena by a third-party entity and may not be made public or otherwise shared by the department, the Legislative Budget and Finance Committee or any other person except to the extent allowed under this subsection.

(e) All data provided under subsection (b) for purposes of conducting the study shall be in a form that is de-identified of personal health information.

(f) The Legislative Budget and Finance Committee shall publish only aggregate data in the report. Any information disclosed or produced by a pharmacy benefit manager or a medical assistance managed care organization for the purposes of this study shall be confidential and not be subject to the act of February 14, 2008 (P.L.6, No.3), known as the "Right-to-Know Law."

(g) The Legislative Budget and Finance Committee shall submit a report of its findings and recommendations for legislative action to the General Assembly and the department within twelve months of the receipt of the data from the department under subsection (c).

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

"Adjudicated claim" shall have the same meaning as the term does in section 449.

"Entity" shall have the same meaning as the term does in section 449.

"Pharmacy benefit management" shall have the same meaning as the term does in section 449.

"Pharmacy benefit manager" shall have the same meaning as the term does in section 449.

"Pharmacy services administration organization" shall have the same meaning as the term does in section 449.

(449.1 added Nov. 25, 2020, P.L.1208, No.120)

Section 449.2. Pharmacy Benefits Manager Audit and Obligations.--(a) The Department of the Auditor General may conduct an audit and review of a pharmacy benefits manager that provides pharmacy benefits management to a medical assistance managed care organization under contract with the department. The Department of the Auditor General may review all previous audits completed by the department and shall have access to all documents it deems necessary to complete the review and audit.

(b) Any information disclosed or produced by a pharmacy benefits manager or a medical assistance managed care organization for the use of the department or the Department of the Auditor General under this section shall not be subject to the act of February 14, 2008 (P.L.6, No.3), known as the "Right-to-Know Law."

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

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

"Pharmacy benefits management" shall have the same meaning as in section 449.

"Pharmacy benefits manager" means a person, business or other entity that performs pharmacy benefits management. The term shall include any affiliated ownership of a medical assistance managed care organization that performs pharmacy benefits management.

(449.2 added Oct. 28, 2022, P.L.1632, No.98)

(g) Special Provisions Respecting Assistance

(Hdg. amended Apr. 8, 1982, P.L.231, No.75)

Section 451. Conformity with Federal Legislation.--Notwithstanding any other provision of law, the department, with the approval of the Governor, may by regulation grant assistance to any persons, modify or discontinue any type of assistance and establish new types of assistance in order to insure receipt of Federal contributions for such assistance. Any such regulation shall be void at the end of the regular session of the General Assembly held during the odd-numbered year next following the adoption of the regulation.

(451 amended July 15, 1976, P.L.993, No.202)

Section 452. Medical Assistance without Federal Participation. (452 repealed July 31, 1968, P.L.904, No.273)

Section 453. Expenditure of Public Funds for Abortions Limited.--Since it is the public policy of the Commonwealth to favor childbirth over abortion, no Commonwealth funds and no Federal funds which are appropriated by the Commonwealth shall

be expended by any State or local government agency for the performance of abortion: Provided, That nothing in this act shall be construed to deny the use of funds where a physician has certified in writing that the life of the mother would be endangered if the fetus were carried to full term or except for such medical procedures necessary for the victims of rape or incest when such rape or incest has been reported promptly to a law enforcement agency or public health service. Nothing contained in this section shall be interpreted to restrict or limit in any way, appropriations, made by the Commonwealth or a local governmental agency to hospitals for their maintenance and operation, or, for reimbursement to hospitals for services rendered which are not for the performance of abortions.

(453 added Dec. 19, 1980, P.L.1321, No.239)

Section 454. Medical Assistance Benefit Packages; Coverage, Copayments, Premiums and Rates.--(a) Notwithstanding any other provision of law to the contrary, the department shall promulgate regulations as provided in subsection (b) to establish provider payment rates; the benefit packages and any copayments for adults eligible for medical assistance under Title XIX of the Social Security Act (49 Stat 620, 42 U.S.C. § 1396 et seq.) and adults eligible for medical assistance in general assistance-related categories; and the premium or copayment requirements for disabled children whose family income is above two hundred percent of the Federal poverty income limit. Subject to such Federal approval as may be necessary, the regulations shall authorize and describe the available benefit packages and any copayments and premiums, except that the department shall set forth the copayment and premium schedule for disabled children whose family income is above two hundred percent of the Federal poverty income limit by publishing a notice in the Pennsylvania Bulletin. The department may adjust such copayments and premiums for disabled children by notice published in the Pennsylvania Bulletin. The regulations shall also specify the effective date for provider payment rates. ((a) amended July 9, 2013, P.L.369, No.55)

(b) For purposes of implementing this section, and notwithstanding any other provision of law, including section 814-A of this act, the secretary shall promulgate regulations pursuant to section 204(1)(iv) of the act of July 31, 1968 (P.L.769, No.240), referred to as the Commonwealth Documents Law, which shall, until December 31, 2005, be exempt from all of the following acts:

(1) Section 205 of the Commonwealth Documents Law.

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

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

(c) The department is authorized to grant exceptions to any limits specified in the benefit packages adopted under this section or when any of the following circumstances applies:

(1) The department determines the recipient has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of or result in the rapid, serious deterioration of the health of the recipient.

(2) The department determines that granting a specific exception to a limit is a cost-effective alternative for the medical assistance program.

(3) The department determines that granting an exception to a limit is necessary in order to comply with Federal law.

(d) As used in this section:

"Adult" means recipients twenty-one years of age or older, except when in relation to copayments, for which the term means recipients eighteen years of age or older.

"Benefit packages" means the list of items and services covered by medical assistance, including any limitations on covered items and services.

(454 added July 7, 2005, P.L.177, No.42)

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

Section 454.1. Case-Mix Rates for Nursing Facilities.--(a) From money appropriated for medical assistance long-term living under the act of August 3, 2023 (P.L.471, No.1A), known as the General Appropriation Act of 2023, for fiscal year 2023-2024, the department shall calculate each nursing facility's case-mix rate based on the cost database and peer group prices for each net operating cost center used in the calculation of each nursing facility's case-mix for fiscal year 2022-2023. Each nursing facility's case-mix rate shall be adjusted quarterly in accordance with 55 Pa. Code § 1187.96(a)(5) (relating to price- and rate-setting computations).

(b) From money appropriated for medical assistance Community HealthChoices under the General Appropriation Act of 2023, for fiscal year 2023-2024, the department shall calculate each nursing facility's case-mix rate based on the cost database and peer group prices for each net operating cost center used in the calculation of each nursing facility's case-mix for fiscal year 2022-2023. Each nursing facility's case-mix rate shall be adjusted quarterly in accordance with 55 Pa. Code § 1187.96(a)(5).

(454.1 added Oct. 23, 2023, P.L.63, No.15)

Section 455. Definitions of Limited Applicability.--The following words and phrases when used in sections 456 and 457 shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Commonwealth pharmacy program" means any of the following: the Medical Assistance Fee for Service Program, the General Assistance Fee for Service Program, PACE, PACENET, the Special Pharmaceutical Benefit Program in the Department of Public Welfare, the End Stage Renal Program in the Department of Health, the Public Employees Benefit Trust Fund, the Children's Health Insurance Program, the Workers' Compensation Program, the Department of Corrections and any other pharmacy program administered by the Commonwealth that is recognized by the Centers for Medicare and Medicaid as a State Pharmaceutical Assistance Program. The term shall not include managed care organizations under contract with the department.

"Least expensive" means the lowest cost to the Commonwealth within each Commonwealth pharmacy program. The net cost shall include the amount paid by the Commonwealth to a pharmacy for a drug under the current retail pharmacy reimbursement formula less any discounts or rebates, including those invoiced during the previous calendar quarter and inclusive of all dispensing fees.

"Manufacturer" means an entity which is engaged in any of the following:

(1) The production, preparation, propagation, compounding, conversion or processing of prescription drug products directly or indirectly by extraction from substances of natural origin, independently by means of chemical synthesis or by a combination of extraction and chemical synthesis.

(2) The packaging, repackaging, labeling or relabeling or distribution of prescription drug products. The term shall also include the entity holding legal title to or possession of the national drug code number for the covered prescription drug. The term does not include a wholesale distributor of drugs, drugstore chain organization or retail pharmacy licensed by the Commonwealth.

"National drug code number" means the identifying drug number maintained by the Food and Drug Administration. The complete 11-digit number must include the labeler code, product code and package size code.

(455 added July 7, 2005, P.L.177, No.42)

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Section 456. Rebates.--(a) Any Commonwealth pharmacy program that requires a manufacturer to remit a rebate to the program as a condition of participation shall have a clearly defined remittance procedure. The procedure shall include a process for the efficient collection of rebates that are not in dispute and a dispute resolution process.

(b) The development of the remittance procedure shall include consideration of the feasibility of a uniform procedure among Commonwealth pharmacy programs.

(c) A surcharge penalty may be levied by any Commonwealth pharmacy program against any manufacturer for the collection of past due rebates that are not in dispute, unless the surcharge is prohibited by Federal law. The penalty may be levied on any rebate more than one year past due. The surcharge shall be in addition to any interest and penalties authorized under existing law or contractual agreement and shall be equal to fifteen percent of the principal owed for each year that the rebate is past due. The calculation of the surcharge shall be prorated for any portion of the year that the rebate is past due. Notice shall be provided to the manufacturer prior to applying the surcharge to any past due manufacturer's rebates. The manufacturer shall be provided with thirty days from the date of the notice to satisfy any past due claims.

(456 added July 7, 2005, P.L.177, No.42)

Section 457. Pharmacy Management Systems.--(a) Each Commonwealth pharmacy program shall develop and implement:

(1) an online claims adjudication system; and

(2) a uniform, coordinated and standardized auditing procedure. Nothing shall preclude the implementation of successful systems and auditing procedures utilized in an existing Commonwealth pharmacy program.

(b) Each Commonwealth pharmacy program shall ensure that a therapeutic drug utilization review system is established to monitor and correct misutilization of drug therapies. The system shall provide prospective and retrospective analysis of potentially dangerous drug interactions, duplicative therapies, maximum allowable dosing, therapy duration and drug utilization. Nothing shall preclude the implementation of successful systems utilized in an existing Commonwealth pharmacy program.

(c) Each Commonwealth pharmacy program shall ensure that a surveillance utilization review system is established to monitor, identify and investigate potential drug misutilization. The system shall monitor potential fraud and abuse by enrollees, providers and prescribers for all appropriate Commonwealth pharmacy programs. Nothing shall preclude the implementation

of successful systems utilized in an existing Commonwealth pharmacy program.

(d) Each Commonwealth pharmacy program shall establish a procedure to ensure that, notwithstanding the provisions of the act of November 24, 1976 (P.L.1163, No.259), referred to as the Generic Equivalent Drug Law, a brand name product shall be dispensed and not substituted with an A-rated generic therapeutically equivalent drug if it is the least expensive alternative for the specific Commonwealth pharmacy program.

(457 added July 7, 2005, P.L.177, No.42)

Section 458. Enrollment Limitation.--Upon enrollment in a managed care plan, an eligible person who retains eligibility shall maintain enrollment in the managed care plan for not less than twelve months unless a waiver is granted by the department.

(458 added July 7, 2005, P.L.177, No.42)

Section 459. Established Drug Regimens.--When determining prior authorization criteria for a preferred drug class, the department shall consider the potential destabilizing effect on the recipient's health by any change in the recipient's established drug regimen, including, but not limited to, prescription drugs for human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), behavioral health, hemophilia, hepatitis C, biologic drugs, immunosuppressants and anticonvulsants.

(459 added July 7, 2005, P.L.177, No.42)

Section 459.1. Uniform Statewide preferred drug list.--(a) The department may not implement a uniform Statewide preferred drug list for the medical assistance managed care organizations until an analysis has been conducted, as commissioned by the department, to determine the projected cost to the medical assistance managed care organization and the projected supplemental rebates that could be obtained by the department through the use of a uniform Statewide preferred drug list.

(b) The analysis under subsection (a) shall be completed within sixty days of the effective date of this subsection. The analysis shall be delivered to the following:

(1) The chairperson and minority chairperson of the Appropriations Committee of the Senate.

(2) The chairperson and minority chairperson of the Appropriations Committee of the House of Representatives.

(3) The chairperson and minority chairperson of the Health and Human Services Committee of the Senate.

(4) The chairperson and minority chairperson of the Health Committee of the House of Representatives.

(459.1 added June 28, 2019, P.L.168, No.19)

Section 460. Pharmaceutical and Therapeutics Committee.--(a) Any Commonwealth pharmacy program that establishes or maintains a preferred drug list for the purpose of receiving supplemental rebates consistent with section 1927(d)(4) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396r-8(d)(4)) shall establish a pharmaceutical and therapeutics committee that shall serve in an advisory capacity to the department and to the secretary for the purpose of developing and maintaining a preferred drug list.

(b) The committee shall publicize its meetings pursuant to 65 Pa.C.S. Ch. 7 (relating to open meetings). The committee's deliberations, recommendations and decisions shall be open to the public except as limited by 65 Pa.C.S. §§ 707 (relating to exceptions to open meetings) and 708 (relating to executive sessions).

(c) The committee shall be comprised of the following members:

(1) Two individuals representing community pharmacists appointed by the secretary.

(2) Physicians, pharmacists and other members appointed by the secretary as needed to develop and maintain a preferred drug list.

((c) added Nov. 25, 2020, P.L.1213, No.121)

(460 amended July 4, 2008, P.L.557, No.44)

Section 460.1. Drug Utilization Review Board.--(a) The Drug Utilization Review Board shall be established by the department consistent with section 1927(g)(3) of the Social Security Act (42 U.S.C. § 1396r-8(g)(3)). The board shall have the following powers and duties:

(1) To advise the department and the secretary on the drug utilization review controls for prescription drugs as required by section 1927(g)(3) of the Social Security Act, including appropriate utilization protocols for individual medications and for therapeutic categories and prior authorization guidelines.

(2) To serve in an advisory capacity to the secretary for the purpose of developing and maintaining drug utilization review controls for prescription drugs and serve to promote patient safety by an increased review and awareness of outpatient prescribed drugs in the department's medical assistance program.

(b) The board shall publicize its meetings pursuant to 65 Pa.C.S. Ch. 7 (relating to open meetings). The committee's deliberations, recommendations and decisions shall be open to the public, except as limited by 65 Pa.C.S. §§ 707 (relating to exceptions to open meetings) and 708 (relating to executive sessions).

(460.1 added July 4, 2008, P.L.557, No.44)

(g.1) Minimum School Attendance Requirements

(Hdg. added June 16, 1994, P.L.319, No.49)

Section 461. Legislative Intent.--(a) The General Assembly finds and declares that:

(1) As a result of continuing changes in the economy and therefore the types of jobs available in today's economic climate, education and knowledge skills, including a high school diploma or its equivalent as a minimum educational attainment, are becoming more and more critical to both short-term and long-term prospects for economic independence through employment.

(2) A large percentage of AFDC recipients drop out of secondary school and fail to obtain a high school diploma or its equivalent prior to twenty-one years of age. These include many teenage parents who receive cash assistance through the AFDC program.

(3) Present welfare policy fails to provide any incentive to welfare families to keep their children in school until they receive a high school diploma. In fact, existing policy provides continuing financial support for high school dropouts with no responsibilities for educational attainment by AFDC recipients.

(b) The Commonwealth intends to review and evaluate whether requiring school attendance as a condition for the receipt of cash assistance under AFDC for members of AFDC families increases the future employability and economic independence of Pennsylvania children presently on the welfare rolls.

(461 added June 16, 1994, P.L.319, No.49)

Section 462. Definitions.--As used in this subarticle:

"AFDC" is an acronym for the program which provides aid to families with dependent children under this act.

"Attendance problem" means a situation which arises when a qualified individual has been reported as illegally absent under section 1354 of the act of March 10, 1949 (P.L.30, No.14), known as the "Public School Code of 1949."

"Demonstration program" means the School Attendance Improvement Program established in section 463.

"Full day" means the entire school day as defined by the school board.

"Qualified individual" means an individual from an area participating in the demonstration program who receives AFDC payments or a child whose parent or guardian receives AFDC payments, who is eight to eighteen years of age and who has not graduated from school or obtained a certificate of satisfactory completion of a general educational development test.

"School" means any public or private school operated pursuant to the act of March 10, 1949 (P.L.30, No.14), known as the "Public School Code of 1949"; any vocational, technical or college-affiliated program which satisfies requirements for completion of a high school education program; any program which leads to a certificate of satisfactory completion of a general educational development test; or any home educational program approved by the Department of Education.

(462 added June 16, 1994, P.L.319, No.49)

Section 463. Establishment of Program.--(a) Subject to Federal approval, there is established a demonstration program within the department to be known as the School Attendance Improvement Program. The demonstration program shall expire three years from the date of its implementation.

(b) The department shall select seven geographic areas in this Commonwealth representing rural, suburban and urban areas to participate in the demonstration program.

(463 added June 16, 1994, P.L.319, No.49)

Section 464. Required School Attendance.--(a) An individual who is an AFDC recipient or is a dependent child of an AFDC recipient from an area participating in the demonstration program shall be required to attend school without any attendance problems as a requirement for continuing eligibility for such AFDC assistance if all of the following apply:

(1) The individual is eight through eighteen years of age.

(2) The individual has not graduated from a public or private high school or obtained a certificate of satisfactory completion of a general educational development test.

(3) The individual is not enrolled in a home school program under section 1327.1 of the act of March 10, 1949 (P.L.30, No.14), known as the "Public School Code of 1949."

(4) The individual is not legally excused from attending school.

(5) The individual is not prohibited from attending school while an expulsion is pending.

(6) If the individual was expelled from a school, there is another school available which the individual can attend.

(7) The individual does not have good cause for failing to attend school, as set forth in section 465.

(b) An individual who fails to meet the requirements of subsection (a) shall be subject to the sanctions specified in section 466.

(c) The department may require consent to the release of school attendance records as a condition of eligibility.

(d) If an individual required to attend school under subsection (a) is enrolled in a public school, communications between the school district and the department or a county agency concerning the individual's school attendance may only

be made by the district's attendance officer as designated under section 1341 of the "Public School Code of 1949."

(464 added June 16, 1994, P.L.319, No.49)

Section 465. Qualified Reasons for Nonattendance.--An AFDC recipient from an area participating in the demonstration program shall not be subject to any sanctions for nonattendance for any one of the following reasons:

(1) The qualified individual is a caretaker for a child who is less than ninety days old.

(2) The qualified individual requires the use of child care services which are unavailable or unaffordable.

(3) Public or private transportation is necessary but is neither available nor affordable.

(4) The reasons defined in sections 1329, 1330 and 1417 of the "Public School Code of 1949" and 22 Pa. Code Ch. 11 (relating to pupil attendance).

(465 added June 16, 1994, P.L.319, No.49)

Section 466. Sanctions for Failure to Comply with Mandatory Attendance.--(a) The County Board of Assistance from an area participating in the demonstration program shall review the school attendance of, and maintain attendance records for, every qualified individual subject to its jurisdiction. When the total number of unexcused absences in any one school month exceeds three full days, the County Board of Assistance shall notify the qualified individual of the existence of an attendance problem for that school year and the possible imposition of sanctions under subsection (b). This notification shall be sent by certified mail to the last known address of the qualified individual or the individual's parent or legal guardian, whoever is the primary AFDC recipient, within ten days of the review.

(b) If, after notification under subsection (a), the County Board of Assistance determines in any subsequent month within the school year that the qualified individual continues to have an attendance problem, the County Board of Assistance shall reduce the monthly family size allowance by sixty-five dollars ($65) for each individual who fails to meet the attendance requirements set forth in this subarticle.

(c) The sanction provided by subsection (b) shall be effective for one payment month for each month that the qualified individual failed to meet the attendance requirement.

(d) In the case of a dropout, the sanction shall remain in effect until the qualified individual provides written proof from the school district that he or she has reenrolled and has met the attendance requirement for one month. Any month in which school is "in session" as defined by the school board may be used to meet the attendance requirement. The sanction shall be removed in the next possible payment month.

(466 added June 16, 1994, P.L.319, No.49)

Section 467. Powers and Duties of Department.--(a) Within ninety days of the effective date of this subarticle, the secretary shall submit to the appropriate Federal agency a request for any and all waivers of Federal law and regulations and for any other approvals by the Federal Government necessary for the implementation of this subarticle for an initial demonstration period of three years. It shall be the obligation of the secretary to enter into good faith negotiations with the appropriate Federal officials and to make every effort to obtain the necessary Federal waivers and approvals.

(b) The department and the County Board of Assistance from an area participating in the demonstration program shall be responsible for making the AFDC eligibility determinations and

budget computations necessary for the implementation of the provisions of section 464.

(c) The department shall obtain the necessary school attendance information at the initial eligibility determination and shall review the school attendance information at all subsequent eligibility determination reviews.

(d) The department shall disqualify for AFDC benefits any parent, guardian or otherwise qualified individual who fails to cooperate with or hinders the department in obtaining or reviewing school attendance enrollment information.

(e) The department shall provide to each participating school district, on a monthly basis, a list of all AFDC recipients under nineteen years of age who are residing in that school district.

(f) The department shall establish procedures to provide hearings for persons aggrieved by the provisions of this subarticle. These hearings shall be conducted under the provisions of 2 Pa.C.S. (relating to administrative law and procedure).

(g) On or before September 15 following the first school year of the implementation of this subarticle and on or before that date in each succeeding year of the demonstration program, the department shall provide a report covering the preceding school and fiscal year to the Secretary of the Senate and the Chief Clerk of the House of Representatives for distribution to members of the General Assembly. The report shall provide an evaluation of the effectiveness of the demonstration program in meeting its stated purposes. The annual report shall contain, but not be limited to, the following information, provided for each geographic area participating in the demonstration program, with the relevant school districts delineated:

(1) The number of AFDC recipients affected by the demonstration program who receive a high school diploma or a general equivalency diploma, beginning with the school year preceding the implementation of this subarticle and every year thereafter.

(2) The number of AFDC recipients who continue to receive public assistance as a result of their participation in the demonstration program under section 464, beginning with the first school year of the implementation of this subarticle and every year thereafter.

(3) The number of AFDC recipients who become ineligible for AFDC assistance as a result of section 464 during the first year of implementation of this subarticle and each year thereafter, together with the average length of time of their ineligibility and the amounts of Federal and State funds that would have been spent had these persons remained otherwise eligible for participation in AFDC, and the amount of State funds for general assistance spent to provide cash assistance to such persons during each fiscal year.

(4) An overall statement of the progress of the demonstration program during the preceding year, along with recommendations for improvement.

(h) Within sixty days after any necessary Federal waiver approval, the department shall promulgate regulations necessary to effectuate the provisions of this subarticle, except for the provisions of sections 468 and 469.

(i) The department shall conduct a three-year comprehensive review of the demonstration program.

(467 added June 16, 1994, P.L.319, No.49)

Section 468. Powers and Duties of Department of Education.--(a) The Department of Education, with the approval

of the State Board of Education, shall promulgate rules and regulations to define minimum standards of attendance required by section 464, to be implemented by all school districts from areas participating in the demonstration program to ensure meaningful participation in educational programming leading towards the attainment of a high school diploma or its equivalent by the AFDC recipients affected by the demonstration program.

(b) In cooperation with the department, the Department of Education shall provide guidance to local school districts from areas participating in the demonstration program relating to procedures for the efficient reporting of information to participating county assistance offices as required by section 469.

(c) The Secretary of Education shall be responsible for providing information and technical assistance to school districts from areas participating in the demonstration program concerning the implementation of model alternative educational programs with proven effectiveness in meeting the educational needs of AFDC recipients affected by the demonstration program.

(468 added June 16, 1994, P.L.319, No.49)

Section 469. Powers and Duties of School Districts.--School districts from areas participating in the demonstration program shall be responsible for reporting monthly to the appropriate county assistance office of the department the names and other appropriate identifying information of any AFDC recipient who fails to meet the school attendance requirement of section 464. In reporting attendance, the participating school district from an area participating in the demonstration program may not add partial days together to constitute a full day.

(469 added June 16, 1994, P.L.319, No.49)

(h) Fiscal Provisions

Section 471. Food Stamp Computations.--To compute for each quarter the amount of Commonwealth funds expended by the department for the administration of the food stamp program for every county, and for each city of the first class. For the fiscal year 1965-1966, thirty percent; for the fiscal year 1966-1967, forty percent; and, for the fiscal years 1967-1968, through 1974-1975 and the nine month period ending March 31, 1976, fifty percent of the amount so expended for every county, and for each city of the first class shall be certified to it, and shall become its obligation to be paid to the department.

(471 amended June 23, 1976, P.L.412, No.93)

Section 472. Other Computations Affecting Counties.--(472 expired January 1, 2019. See Act 76 of 2016.)

Section 473. Payments by Federal Government and Political Subdivisions.--All payments received by the department from the United States government or political subdivisions of the Commonwealth for assistance or for administrative costs shall be paid into the State Treasury, through the Department of Revenue, and credited to the current appropriation made to the department for the purpose of carrying out the purposes of this article.

Section 474. Apportionment of Restitution Payments.--So long as required as a condition of Federal participation, of the net amount collected or recovered by way of restitution from any person, or from his estate, by or for the department, for any assistance received to which the Federal government contributed, there shall be promptly paid to the United States an amount equal to its proportionate share of the amount

collected or recovered, and the remainder thereof shall be paid into the State Treasury, and shall be credited to the current appropriation to the department, as provided by law.

Section 475. Grant Increases.--(a) On July 1, 1982, the Department of Public Welfare shall raise general assistance and aid to families with dependent children allowances for assistance units of three or more persons by an average of at least five percent.

(b) If the department is prevented by court order from implementing the provisions of section 10 of this amendatory act, the provisions of this section shall be suspended and shall not take effect until the provisions of section 10 are implemented.

(475 added Apr. 8, 1982, P.L.231, No.75)

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Compiler's Note: Section 10 of Act 75 of 1982, referred to in this section, amended section 432(3) of Act 21.

(i) Prohibitions; Penalties

Section 481. False Statements; Investigations; Penalty.--(a) Any person who, either prior to, or at the time of, or subsequent to the application for assistance, by means of a wilfully false statement or misrepresentation, or by impersonation or by wilfully failing to disclose a material fact regarding eligibility or other fraudulent means, secures, or attempts to secure, or aids or abets or attempts to aid or abet any person in securing assistance, or Federal food stamps, commits a crime which shall be graded as provided in subsection (b).

(b) Any person violating subsection (a) commits the grade of crime determined from the following schedule:

Amount of Assistance or Food Stamps	Degree of Crime
$1,000 or more	Felony of the third degree
$999 and under, or an attempt to commit any act prohibited in subsection (a)	Misdemeanor of the first degree

((b) amended Oct. 24, 2018, P.L.777, No.125)

(c) Any person committing a crime enumerated in subsection (a) shall be ordered to pay restitution of any moneys received by reason of any false statement, misrepresentation, impersonation, failure to disclose required information or fraudulent means. Restitution ordered under this subsection may be paid in a lump sum, by monthly installments or according to such other schedule as is deemed just by the sentencing court. Notwithstanding the provisions of 18 Pa.C.S. § 1106(c)(2) (relating to restitution for injuries to person or property) to the contrary, the period of time during which the offender is ordered to make restitution may exceed the maximum term of imprisonment to which the offender could have been sentenced for the crime of which that person was convicted, if the sentencing court determines such period to be reasonable and in the interests of justice.

(d) There shall be a four-year statute of limitations on all crimes enumerated in subsection (a).

(e) The Treasury Department shall have the power to investigate and prosecute any case involving replacement of or

duplicate receipt of or altered assistance checks and shall have the power to collect any funds as a result of such investigations and prosecution. For purposes of this section those employes of the Treasury Department as are designated "investigators" are given the power and authority to subpoena any document for review or audit and may question and subpoena any person believed to have any knowledge in such cases. The Treasury Department shall make such rules and regulations as may be necessary to carry out the provisions of this section.

(f) An applicant for or recipient of aid to families with dependent children or general assistance convicted of any offense pursuant to subsection (a) shall be ineligible to receive cash assistance for a period of six months from the date of a first conviction, for a period of twelve months from the date of a second conviction and permanently from the date of a third conviction.

(481 amended May 16, 1996, P.L.175, No.35)

Compiler's Note: Section 28 of Act 207 of 2004 provided that any and all references in any other law to a "district justice" or "justice of the peace" shall be deemed to be references to a magisterial district judge.

Section 481.1. Penalty for Failure to Appear at Criminal Court Proceeding.--Any person receiving any form of assistance under this article who fails as a defendant to appear at a criminal court proceeding when issued a summons shall be disqualified from receiving assistance until such time as that person complies with the summons. The court shall cooperate with the department in the implementation of this section.

(481.1 added June 30, 1995, P.L.129, No.20)

Section 482. Influencing Vote of Recipient or Applicant; Penalty.--Any person employed in the administration of public assistance who, either directly or indirectly, influences or endeavors to influence the vote of any person receiving or applying for any form of assistance under the provisions of this article, shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay a fine not exceeding one hundred dollars ($100), or to undergo imprisonment not exceeding six months, or both.

Section 483. Violation; Penalty.--Any person knowingly violating any of the rules and regulations of the department made in accordance with this article shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay a fine, not exceeding one hundred dollars ($100), or to undergo imprisonment, not exceeding six months, or both.

Section 484. Prohibited Use of Public Assistance Funds.--(a) It shall be unlawful for any individual to:

(1) Purchase liquor or alcohol with an access device.

(2) Withdraw funds from an access device for any transaction in a licensed facility or any retail establishment that provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment.

(b) It shall be unlawful for a licensed gaming entity to allow for the withdrawal of funds from an access device or, through a point-of-sale transaction, to allow the use of public assistance benefits administered by the department.

(c) The Pennsylvania Gaming Control Board, in consultation with the department, shall take appropriate measures to prevent the use of public assistance funds for the purposes proscribed in this section.

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

"Licensed facility" means a "licensed facility" as defined in 4 Pa.C.S. § 1103 (relating to definitions).

"Licensed gaming entity" means a "licensed gaming entity" as defined in 4 Pa.C.S. § 1103.

(484 amended Oct. 24, 2018, P.L.777, No.125)

Section 485. Lost Access Devices.--(a) A recipient who requests the replacement of an access device shall pay a replacement fee of five dollars ($5) for the first replacement access device requested.

(b) A recipient who is sixty-four years of age or younger who requests the replacement of additional access devices shall pay a replacement fee of one hundred dollars ($100) for the second and each subsequent replacement access device requested.

(b.1) A recipient who is sixty-five years of age or older who requests the replacement of additional access devices shall pay a replacement fee of five dollars ($5) for the second and each subsequent replacement access device requested.

(c) Payments made pursuant to subsections (a), (b) and (b.1) shall be made to the department prior to the issuance of any replacement access device.

(d) The department shall notify the Office of Inspector General of the name of any recipient who has requested replacement of two or more access devices in a calendar year.

(e) The department shall not assess a replacement fee in accordance with subsection (a), (b) or (b.1), and no notification shall be made in accordance with subsection (c) if:

(1) A recipient is able to prove that the access device assigned to the recipient has been lost in postage or has otherwise been lost by the department.

(2) The access device assigned to a recipient by the department is damaged or does not function.

(3) A recipient's original access device was lost or damaged in a fire, flood or other natural disaster.

(f) This section shall apply to the extent permitted by Federal law.

(485 added Oct. 24, 2018, P.L.777, No.125)

(j) Banks and Employers to Supply Information

Section 487. Information to be Supplied.--(a) Every bank, industrial bank, credit union, trust company, bank and trust company, private banker, and building and loan association, or other financial institutions doing business in Pennsylvania, shall, when requested in writing so to do by the department, or any county board or by any official legislative investigating committee, or by any authorized agent thereof, disclose to such department, board, committee, or authorized agent, whether or not any person applying for or receiving public assistance, or former recipient within four years of closing their case, or any legally responsible relative of such applicant or recipient, or former recipient, has had, or has any money on deposit with, or invested in, such banking institution or building and loan association within one year prior to their application for assistance, or at any time thereafter, the amount and date of such deposit or investment, and the amounts and dates of withdrawals therefrom.

(b) Every employer shall, when requested in writing so to do by the department or any county board or by any official legislative investigating committee, or by any authorized agent thereof, disclose to such department, board, committee, or authorized agent within thirty days, whether or not any person

applying for or receiving public assistance or former recipient within four years of closing their case, or any legally responsible relative of such applicant or recipient or former recipient, has or had received, or will receive, any money in salary, wages, commission, or other compensation from such employer, and if so, the amount and date of such salary, wages, commission, or other compensation.

(487 amended Apr. 8, 1982, P.L.231, No.75)

Section 488. Violation; Penalty.--(a) Any bank, industrial bank, credit union, trust company, bank and trust company, private banker, building and loan association, or other financial institution doing business in Pennsylvania, or employer who or which wilfully violates the provisions of section 487 of this act, or who or which wilfully makes any false or misleading statement in connection with any disclosure required by said section, shall be guilty of a misdemeanor, and upon conviction thereof, shall be sentenced to pay a fine not exceeding one thousand dollars ($1000).

(b) (1) Any licensed gaming entity or retailer that wilfully violates the provisions of section 484 of this act commits a misdemeanor and shall, upon conviction, be sentenced to pay a fine not exceeding one thousand dollars ($1000).

(2) As used in this subsection, the term "licensed gaming entity" shall have the same meaning as provided in 4 Pa.C.S. § 1103 (relating to definitions).

(488 amended Oct. 24, 2018, P.L.777, No.125)

Section 489. Investigative Powers and Duties.--(a) In furtherance of the purposes set forth in this act to prevent, deter, investigate and prosecute persons who have committed or are committing fraud against assistance programs, the department may:

(1) Conduct investigations of all suspected criminal activities related to fraud, misuse or theft of moneys or benefits, or Federal food stamps, committed by persons who are or have been participating in, or administering programs of the department, or by persons who aid or abet others in criminal activity affecting welfare programs.

(2) Establish an investigations unit which shall have the power and duty to:

(i) investigate alleged violations of all criminal statutes related to fraud or other criminal activity connected with assistance programs administered by the department, except that suspected fraud or other criminal activity by medical providers or vendors will be investigated by State or Federal enforcement units having specific mandated authority; and

(ii) work in conjunction with the appropriate prosecuting authorities in the prosecution of cases where it is determined that evidence of criminal activity exists.

(b) The provisions of subsection (a) granting investigative authority to the department shall not prevent or interfere with the jurisdiction exercised by other law enforcement agencies in the investigation of welfare related violations.

(489 added Apr. 8, 1982, P.L.231, No.75)

(k) Employment Incentive Payments

(Hdg. added Apr. 8, 1982, P.L.231, No.75)

Section 491. Employment Incentive Payments.--(a) Any corporation, bank, savings institution, company, insurance company, or mutual thrift institution employing persons, who prior to their employment were cash assistance recipients, shall be entitled to employment incentive payments to be provided as

a credit against taxes imposed by Article IV, VII, VIII or IX of the act of March 4, 1971 (P.L.6, No.2), known as the "Tax Reform Code of 1971," or by the act of June 22, 1964 (P.L.16, No.2), known as "The Mutual Thrift Institutions Tax Act," and any person, partnership or proprietorship employing such persons shall be entitled to payments to be provided as a credit against taxes imposed by Article III of the "Tax Reform Code of 1971." For the purposes of computing any tax liabilities against which the credit may be applied, deductions from taxable income shall be reduced by employment incentive payments. Employment incentive payments unused as a tax credit in any taxable year may be carried over against tax liabilities of the employer in the three immediately subsequent taxable years.

(b) An employment incentive payment may be claimed by an employer who hires any person who is receiving aid to families with dependent children or who is receiving general assistance at the time of employment except that payments shall not be provided for:

(1) The employment of any person who displaces any other individual from employment, except persons discharged for cause as certified by the Office of Employment Security.

(2) The employment of any person closely related, as defined by paragraphs (1) through (8) of section 152(a) of the Internal Revenue Code, to the taxpayer, or, if the taxpayer is a corporation, to an individual who owns, directly or indirectly more than fifty percent of the outstanding stock of the corporation, bank, savings institution, company, insurance company, or mutual thrift institution.

(3) The employment of an individual for whom the employer is simultaneously receiving Federally or State funded job training payments.

((b) amended June 30, 1995, P.L.129, No.20)

(c) (1) The employment incentive payment shall be the sum of thirty percent of the first six thousand dollars ($6,000) of qualified first-year wages for such year, twenty percent of the first six thousand dollars ($6,000) of qualified second year wages for such year and ten percent of the first six thousand dollars ($6,000) of the qualified third year wages for such year.

(2) If the employer provides or pays for day care services for the children of the employe, the employer shall be eligible to receive an additional employment incentive payment of six hundred dollars ($600) during the first year of employment, five hundred dollars ($500) during the second year of employment, and four hundred dollars ($400) during the third year of employment.

(3) Total employment incentive payments shall not exceed ninety percent of total taxes paid by the employer against which the incentive payments may be claimed as a credit. Qualified wages must be cash remuneration to the employe, including any amounts deducted or withheld.

(d) To be eligible for employment incentive payments, the employment must continue for at least one year unless the employe voluntarily leaves the employment of the employer, becomes disabled or is terminated for cause. If the employe leaves his position voluntarily, becomes disabled, or is terminated for cause in less than one year, the employment incentive payment shall be reduced by the proportion of the year not worked. Employment initiated during the year may be claimed as an employment incentive payment in the subsequent year.

(e) The Department of Revenue, in cooperation with the department and the Department of Labor and Industry, shall administer the provisions of this section, promulgate appropriate rules, regulations and forms for that purpose and make such determinations as may be required. Determinations made with respect to the employment incentive payment provided in this section may be reviewed and appealed in the manner provided by law for other corporate or personal tax credits.

(f) The total amount of employment incentive payments authorized by this section shall not exceed twenty-five million dollars ($25,000,000) in any fiscal year. To insure that credits are not claimed in excess of this amount, an employer may claim the incentive payments only upon presentation of an authorizing certificate. Certificates will be issued to the employe by the department upon presentation to the department of evidence of a qualifying offer of employment. The Department of Revenue shall advise the department of the total number of certificates which may be issued in each calendar quarter consistent with the limitation on total incentive payments. If an employe does not accept the job for which the certificate is authorized, the certificate shall be returned by the employe to the department. If an employe terminates employment for any reason prior to the expiration of three years, the employer shall return the certificate, noting the date of the employe's hiring and termination, to the Department of Revenue. The department may issue certificates through the Office of Employment Security and may promulgate regulations to allocate certificates.

(g) Employment incentive payments shall not be available for employes hired after December 31, 1999, unless reenacted by the General Assembly. Not later than July 1, 1999, the department shall report to the General Assembly on the effectiveness of incentive payments to encourage the employment of cash assistance recipients and recommend whether the program should be continued. Credits may be claimed against taxes payable for tax years beginning January 1, 1994, and thereafter, and may be claimed for employes hired after the effective date of this section.

(491 reenacted and amended June 16, 1994, P.L.319, No.49)

Compiler's Note: Section 6 of Act 63 of 1999 provided that section 491 is repealed insofar as it is inconsistent with Act 63.

(l) Priority Employment Services Program
(Hdg. added Apr. 8, 1982, P.L.231, No.75)

Section 492. Priority Employment Services Program.--(a) The Department of Labor and Industry, through its Office of Employment Security, is hereby authorized to establish and provide special priority services to general assistance recipients above and beyond those currently available and permissible under Federal law, regulation and funding.

(b) The special priority services authorized by this section shall include, but are not limited to, the provision of job counseling, job testing and job readiness services beyond those currently available through Federal authority and an employer outreach program to encourage the employment of general assistance recipients in the private sector and to disseminate information regarding both Federal and State tax credit programs for which general assistance recipients are eligible.

(492 added Apr. 8, 1982, P.L.231, No.75)

(m) Employment Opportunities Incentive Grant Program
(Hdg. added Apr. 8, 1982, P.L.231, No.75)

Section 493. Employment Opportunities Incentive Grant Program.--(a) The Department of Labor and Industry is hereby authorized to make grants to vocational schools, institutions of higher learning, and commercial and nonprofit enterprises for the implementation of projects to provide for employment opportunities for welfare recipients. These grants shall:

(1) support training programs necessary for structurally unemployed persons to obtain and retain bona fide employment;

(2) develop and implement programs to reduce welfare dependency and chronic unemployment;

(3) improve and diversify the economic base of communities to increase the number of unsubsidized jobs for the chronically unemployed; and

(4) support and encourage employment opportunities programs for low-income community residents and provide them the opportunity to become self-sustaining.

(b) The Department of Labor and Industry may contract with grantees after:

(1) Establishing bid requirements and a specific request for proposal.

(2) Advertising the request for proposal in the Pennsylvania Bulletin and circulating the request for proposal through interested eligible groups.

(3) Bids shall be opened in a public meeting with all potential vendors notified.

(4) Bids shall be evaluated by the department.

(c) Prior to the awarding of a grant the Department of Labor and Industry shall submit a copy of the request for a proposal and the bid application of the prospective grantee or prospective grantees to the Chairman of the Health and Welfare Committee of the House of Representatives and the Chairman of the Public Health and Welfare Committee of the Senate.

(d) Projects receiving grants under this section shall demonstrate the following:

(1) Linkage with and participation of the county boards of assistance.

(2) Provisions for support services such as remedial and career education, academic education, counseling, in-service training and job-based curriculums.

(3) Demonstrate that funding would result in the creation of permanent private job opportunities.

(4) Demonstrate previous capability to administer programs of this nature.

(e) The Department of Labor and Industry, in order to effectuate and enforce the provisions of this section, shall promulgate necessary rules and regulations and prescribe conditions and procedures in order to assure compliance with this section.

(f) Grants under this section will be available through December 31, 1985, unless reenacted by the General Assembly. The Department of Labor and Industry shall report to the General Assembly on the effectiveness of the Employment Opportunities Incentive Grant Program annually. The annual report shall include, but not be limited to, the cost incurred by the department to administer the program, the number and the type of unsubsidized jobs made available as a result of the program, the number of welfare recipients removed from the welfare rolls as a result of the program and the projected savings to the Department of Public Welfare as a result of the program.

(493 added Apr. 8, 1982, P.L.231, No.75)

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

ARTICLE V
STATE BLIND PENSION

Section 501. Legislative Intent.--The legislative intent of this article is to provide pensions, paid entirely from Commonwealth funds, for certain blind persons, as authorized by section 17 of Article III of the Constitution of this Commonwealth, while assuring continued receipt by the Commonwealth of Federal funds now available for Federal-State blind pension grants for blind persons who are needy.

Section 502. Definitions.--As used in this article:

"Blind person" means a person twenty-one years of age or older who has three-sixtieths or ten two-hundredths, or less, normal vision.

"State blind pension" means a payment to any blind person who meets the eligibility conditions prescribed in section 506, or a payment in behalf of such blind person for medical or other health care, including nursing home care, but excluding inpatient hospital care and post hospital care in the home provided by a hospital.

Section 503. Administration.--This article shall be administered by the department without regard to any Federal laws or regulations respecting operation of a State plan for aid to the blind.

Section 504. Departmental Powers and Duties.--The department shall have the power, and its duty shall be:

(1) To establish rules and regulations, consistent with law, as to the determination of eligibility for State blind pensions and as to the procedures necessary for administration of this article.

(2) To provide State blind pension to or in behalf of all blind persons who meet the eligibility conditions prescribed in section 506. Such State blind pensions shall be paid from funds appropriated to the department.

(3) To hear and determine appeals from actions of its employes affecting the rights of those applying for or receiving State blind pension.

Section 505. Departmental Regulations for Protecting Information.--(a) The department shall have the power to make and enforce regulations:

(1) To protect the names of applicants for and recipients of State blind pension from improper publication and to restrict the use of information furnished to other agencies or persons to purposes connected with the administration of this article. Upon request by any adult resident of the Commonwealth, the department shall furnish the address and amount of State blind pension with respect to any persons about whom inquiry is made, but information so obtained shall not be used for commercial or political purposes.

(2) To protect the rights and interests of blind persons about whom personal or confidential information is in its possession.

(b) Such regulations shall not prevent or interfere with investigations by proper authorities as to the rights of persons to receive State blind pension or as to the amounts of State blind pension received.

Section 506. Eligibility.--The department shall provide a State blind pension to any blind person who:

(1) Resides in Pennsylvania;

(2) Is not an inmate of any penal institution or hospital for mental disease;

(3) Has actual annual income of his own of less than four thousand two hundred sixty dollars ($4,260); ((3) amended Apr. 6, 1980, P.L.99, No.37)

(4) Owns real or personal property of a combined value of not more than seven thousand five hundred dollars ($7500); and who

(5) Has not disposed of any property without fair consideration within the two years immediately preceding the date of application for State blind pension, or while receiving such pension, if ownership of such property, together with his other property, would render him ineligible for such pension;

(6) Is not receiving supplemental security income for the aged, blind and disabled pursuant to Title XVI of the Federal Social Security Act.

With respect to the determination of eligibility for State blind pension, the value of real property shall be deemed to be its assessed value minus encumbrances but in no case shall the assessed value be more than thirty percent of the official market value; the value of personal property shall be deemed to be its actual value; and interest in property owned by the entireties shall be deemed to be a one-half interest. Determination of the amount of an applicant's income and the value of his property shall be made by the department without regard to any Federal laws or regulations respecting income and resources of applicants for aid to the blind. The valuation of real property for the purposes of clause (4) shall not be increased by reason of reassessment, except to the extent that the real property has been actually enlarged or improved. Determination of the amount of an applicant's income shall exclude any increase in (i) social security payments to him provided under Federal law and taking effect subsequent to January 1, 1971; (ii) railroad retirement benefits provided to him under the Railroad Retirement Act of 1937, 45 U.S.C. § 228 et seq., and taking effect subsequent to January 1, 1976; and (iii) veterans' benefits provided to him and administered by the Veterans' Administration and taking effect subsequent to January 1, 1976. (Par. amended June 21, 1977, P.L.18, No.14)

(506 amended Dec. 26, 1974, P.L.991, No.324)

Compiler's Note: Section 9(c) of Act 173 of 1978 provided that section 506 is repealed insofar as it is inconsistent with 1 Pa.C.S. § 2301(c) (relating to equality of rights based on sex).

Section 507. Amount of Pension.--Except as provided for payment for nursing home care, the amount paid after the effective date of this act to an eligible blind person having actual annual income of his own of three thousand sixty dollars ($3,060) or less shall be one hundred dollars ($100) monthly, and the monthly amount paid to any other eligible blind person shall be fixed in such amount that the sum of his actual annual income and State blind pension equals four thousand two hundred sixty dollars ($4,260) a year.

(507 amended Apr. 6, 1980, P.L.99, No.37)

Section 508. Payment for Nursing Home Care.--The amount of State blind pension paid to or in behalf of an eligible blind person who is physically disabled and requires nursing home care, as prescribed by responsible physicians, shall be the

excess of (i) the maximum amount paid by the department for nursing home care of recipients of assistance under Article IV in like circumstances, over (ii) the amount of the blind person's actual income, but shall in no case be less than the appropriate amount specified in section 507.

Section 509. Medical Assistance and Burial.--Persons receiving State Blind Pensions shall be eligible for burial assistance and, under the medical assistance program of Article IV, for payment of home and office visits of physicians or chiropractors, prescribed drugs, dental care, vision care provided by a physician skilled in diseases of the eye or by an optometrist, ambulance service and visiting nurse service.

(509 amended July 31, 1968, P.L.904, No.273)

Section 510. Repayment; Support by Relatives.--Notwithstanding any other provisions of law, no repayment shall be required of any State blind pension for which a blind person was eligible; and, with respect to the determination of eligibility for State blind pension, no relative shall be required to make any monetary or any other payments or contributions for the support or maintenance of the blind person.

Section 511. Application.--(a) Every person applying for State blind pension shall be required to sign a statement setting forth the nature and amount of his income, the nature and value of his property, and such other facts as may be required by the department in order to determine whether he is eligible for State blind pension. Every such applicant shall make affidavit that the facts set forth in such statement are true and correct. Every person employed in the department who has power to administer oaths for any purpose shall have power to administer oaths for the purpose of carrying into effect the provisions of this section.

(b) Whenever a blind person is unable to make application for State blind pension by reason of his illness or infirmity, application on his behalf may be made by a relative or by an official of any institution in which he is receiving medical care. Such application shall contain the statements required in subsection (a) of this section except that such applicant shall be permitted to make affidavit that the facts set forth in such statement are, to the best of his knowledge and belief, true and correct.

(511 amended July 31, 1968, P.L.904, No.273)

Section 512. Trustees.--The department may appoint a trustee to receive the State blind pension payments for which a blind person is eligible, when, in its opinion, such trustee is necessary. A trustee shall serve without compensation from the department, and shall be subject to such rules, regulations and accounting as the department shall prescribe.

Section 513. False Statements; Penalty.--(a) Any person who, either prior to or at the time of, or subsequent to the application for State blind pension, by means of a wilfully false statement or misrepresentation, or by impersonation or other fraudulent means, secures, or attempts to secure, or aids or abets any person in securing, State blind pension shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay a fine not exceeding one thousand dollars ($1000), or to undergo imprisonment not exceeding one year, or both, and shall be sentenced to make restitution of any moneys he has received by reason of such false statement, misrepresentation, impersonation, or fraudulent means.

(b) Any person who, either prior to, or at the time of, or subsequent to the application for State blind pension, by means

of a wilfully false statement or misrepresentation, or by impersonation or other fraudulent means, secures or attempts to secure State blind pension not exceeding three hundred dollars ($300) shall, upon conviction thereof in a summary proceeding, be sentenced to pay restitution of such amount of State blind pension, and to pay a fine of not more than two hundred dollars ($200), and, in default of making restitution and payment of the fine imposed, to undergo imprisonment not exceeding sixty days.

Section 514. Influencing Vote of Recipient or Applicant; Penalty.--Any person employed in the administration of this article who, either directly or indirectly, influences or endeavors to influence the vote of any person applying for or receiving State blind pension shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay a fine not exceeding one hundred dollars ($100), or to undergo imprisonment not exceeding six months, or both.

Section 515. Violation; Penalty.--Any person knowingly violating any of the rules and regulations of the department made in accordance with this article shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay a fine not exceeding one hundred dollars ($100), or to undergo imprisonment, not exceeding six months or both.

ARTICLE V-A
HEALTH CARE OUTCOMES
(Art. added June 22, 2018, P.L.258, No.40)

SUBARTICLE A
PRELIMINARY PROVISIONS
(Subart. added June 22, 2018, P.L.258, No.40)

Section 501-A. Definitions.

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

"All Patient Refined Diagnosis Related Groups." A version of Diagnosis Related Groups that further subdivide the Diagnosis Related Groups into four severity-of-illness and four risk-of-mortality subclasses within each Diagnosis Related Groups.

"Diagnosis Related Groups." A classification system that uses patient discharge information to classify patients into clinically meaningful groups.

"Hospital." A public or private institution licensed as a hospital under the laws of this Commonwealth that participates in the Medicaid program.

"Managed care organization." A licensed managed care organization with whom the department has contracted to provide or arrange for services to a Medicaid recipient.

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

"Potentially avoidable admission." An admission of an individual to a hospital or long-term care facility that may have reasonably been prevented with adequate access to ambulatory care or health care coordination.

"Potentially avoidable complication." A harmful event or negative outcome with respect to an individual, including an infection or surgical complication, that:

(1) occurs after the person's admission to a hospital or long-term care facility; and

(2) may have resulted from the care, lack of care or treatment provided during the hospital or long-term care facility stay rather than from a natural progression of an underlying disease.

"Potentially avoidable emergency visit." Treatment of an individual in a hospital emergency room or freestanding emergency medical care facility for a condition that may not require emergency medical attention because the condition could be or could have been treated or prevented by a physician or other health care provider in a nonemergency setting.

"Potentially avoidable event." Any of the following:

(1) A potentially avoidable admission.

(2) A potentially avoidable complication.

(3) A potentially avoidable emergency visit.

(4) A potentially avoidable readmission.

(5) A combination of the events listed under this definition.

"Potentially avoidable readmission." A return hospitalization of an individual within a period specified by the department that may have resulted from a deficiency in the care or treatment provided to the individual during a previous hospital stay or from a deficiency in posthospital discharge follow-up. The term does not include a hospital readmission necessitated by the occurrence of unrelated events after the discharge. The term includes the readmission of an individual to a hospital for:

(1) The same condition or procedure for which the individual was previously admitted.

(2) An infection or other complication resulting from care previously provided.

(3) A condition or procedure that indicates that a surgical intervention performed during a previous admission was unsuccessful in achieving the anticipated outcome.

(501-A added June 22, 2018, P.L.258, No.40)

Section 502-A. Applicability.

This article shall apply to the extent permitted by Federal law.

(502-A added June 22, 2018, P.L.258, No.40)

SUBARTICLE B
MEDICAID OUTCOMES-BASED PROGRAMS
(Subart. added June 22, 2018, P.L.258, No.40)

Section 511-A. Establishment.

The department shall establish the following linked Medicaid outcomes-based programs:

(1) A Hospital Outcomes Program designed to provide a hospital with information to reduce potentially avoidable events and further increase efficiency in Medicaid hospital services.

(2) A Managed Care Organization Outcomes Program designed to provide a Medicaid managed care organization with information to reduce potentially avoidable events and further increase efficiency in Medicaid managed care programs.

(511-A added June 22, 2018, P.L.258, No.40)

Section 512-A. Selection of potentially avoidable event methodology.

The department shall select a methodology for identifying potentially avoidable events and the costs associated with the events and for measuring hospital and managed care organization

performance with respect to the events. The following shall apply:

(1) The department shall develop parameters for each of the potentially avoidable events in accordance with the selected methodology.

(2) To the extent possible, the methodology shall be one that has been used by a State program under Title XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 301 et seq.) or by a commercial payer in health care outcomes performance measurement and in outcome-based programs.

(3) The methodology shall utilize a clinical categorical model, enable the provision of performance information on both the aggregate and case level and risk adjust scoring to account for patient severity of illness and population chronic illness burden.

(512-A added June 22, 2018, P.L.258, No.40)

Section 513-A. Statewide analysis of Medicaid system.

The department shall conduct a comprehensive analysis of existing relevant State databases to increase efficiency in the Medicaid system. The following shall apply:

(1) The analysis shall identify instances of potentially avoidable events in the Medicaid system and the costs associated with these cases.

(2) The overall estimate of cost shall be broken down into actionable categories, including, but not limited to, regions, hospitals, managed care organizations, physicians, service lines, Diagnosis Related Groups, medical conditions and procedures, patient characteristics, provider characteristics and Medicaid program type.

(3) Information collected from the potentially avoidable event study shall be utilized in the Hospital Outcomes Program and Managed Care Organization Outcomes Program.

(513-A added June 22, 2018, P.L.258, No.40)

Section 514-A. Report on Statewide analysis of Medicaid system.

(a) Report.--The department shall provide a report on the comprehensive analysis conducted under section 513-A to the General Assembly no later than December 31, 2019.

(b) Recommendations.--The report shall include recommendations on how hospitals and managed care organizations can improve efficiency and outcomes by reducing unnecessary services. The department shall align the recommendations with the department's objectives to advance high-value care, improve population health, engage and support providers and establish a sustainable Medicaid program with predictable costs.

(514-A added June 22, 2018, P.L.258, No.40)

SUBARTICLE C
HOSPITAL OUTCOMES PROGRAM
(Subart. added June 22, 2018, P.L.258, No.40)

Section 521-A. Procedure.

The Hospital Outcomes Program shall:

(1) Target reduction of potentially avoidable readmissions and complications.

(2) Apply to each State acute care hospital participating in the Medicaid program, except that program adjustments may be made for certain types of hospitals.

(3) Establish a performance reporting system for potentially avoidable readmissions and complications for hospitals participating in Medicaid.

(521-A added June 22, 2018, P.L.258, No.40)

Section 522-A. Hospital performance reporting.

The department shall develop and maintain a reporting system to provide each hospital with regular confidential reports regarding the hospital's performance with respect to potentially avoidable readmissions and potentially avoidable complications. The department shall:

(1) Conduct ongoing analyses of existing and relevant State claims databases to identify instances of potentially avoidable complications and readmissions and the expenditures associated with the cases.

(2) Create or locate Statewide complications and readmissions norms.

(3) Measure actual-to-expected hospital performance compared to Statewide norms.

(4) Compare hospitals with the hospitals' peers using risk adjustment procedures that account for the severity of illness of each hospital's patients.

(5) Distribute reports to hospitals to provide them with actionable information to create policies, contracts and programs designed to improve target outcomes.

(6) Foster collaboration among hospitals in sharing best practices.

(522-A added June 22, 2018, P.L.258, No.40)

Section 523-A. Hospital outcomes information sharing.

A hospital may share the information contained in the outcome performance reports with physicians and other health care providers providing services at the hospital to foster coordination and cooperation in the hospital's outcome improvement and efficiency initiatives.

(523-A added June 22, 2018, P.L.258, No.40)

Section 524-A. Value-based models.

After the implementation of the reporting system under section 522-A, the department shall evaluate value-based models that will support hospitals in reducing rates of potentially avoidable complications and readmissions.

(524-A added June 22, 2018, P.L.258, No.40)

Section 525-A. Medicaid enrolled hospital contract.

The department shall amend contracts entered into or renewed on or after the effective date of this section with the department's Medicaid enrolled hospitals as necessary to incorporate the Hospital Outcomes Program.

(525-A added June 22, 2018, P.L.258, No.40)

Section 526-A. Progress report on Hospital Outcomes Program.

By March 1, 2020, and each March 1 thereafter, the department shall provide a report on the progress of the Hospital Outcomes Program to the General Assembly. The report shall chart the reductions in the rates of potentially avoidable complications and readmissions and the impact of such reductions on Medicaid costs.

(526-A added June 22, 2018, P.L.258, No.40)

SUBARTICLE D
MANAGED CARE ORGANIZATION OUTCOMES PROGRAM
(Subart. added June 22, 2018, P.L.258, No.40)

Section 531-A. Procedure.

The Managed Care Organization Outcomes Program shall:

(1) Target reduction of avoidable admissions, readmissions and emergency visits.

(2) Apply to each managed care organization participating in the Medicaid program.

(3) Establish a performance reporting system for potentially avoidable admissions, readmissions and emergency

visits for managed care organizations participating in Medicaid managed care.

(4) Account for the diverse medically complex populations.

(531-A added June 22, 2018, P.L.258, No.40)

Section 532-A. Managed care organization performance reporting.

The department shall develop and maintain a reporting system to provide each managed care organization with regular confidential reports regarding the managed care organization's performance with respect to potentially avoidable admissions, readmissions and emergency visits. The department shall:

(1) Conduct ongoing analyses of existing and relevant State claims databases to identify instances of potentially avoidable admissions, readmissions and emergency visits with potential excess expenditures associated with the cases.

(2) Create or locate Statewide norms for admissions, readmissions and emergency visits.

(3) Measure actual-to-expected managed care organization performance compared to Statewide norms.

(4) Compare managed care organizations with the managed care organizations' peers using risk adjustment procedures that account for the chronic illness burden of each plan's enrollees.

(5) Distribute reports to managed care organizations to provide the managed care organizations with actionable information to create policies, contracts and programs designed to improve target outcomes.

(532-A added June 22, 2018, P.L.258, No.40)

Section 533-A. Managed care organization outcomes information sharing.

A managed care organization may share the information contained in the outcome performance reports with the managed care organization's participating providers to foster coordination and cooperation in the managed care organization's outcome improvement and efficiency initiatives.

(533-A added June 22, 2018, P.L.258, No.40)

Section 534-A. Value-based models.

After the implementation of the reporting system under section 532-A, the department shall evaluate value-based models that will support managed care organizations in reducing rates of potentially avoidable admissions, readmissions and emergency visits.

(534-A added June 22, 2018, P.L.258, No.40)

Section 535-A. Managed care organization Medicaid contracts.

The department shall amend contracts entered into or renewed on or after the effective date of this section with the department's participating managed care organizations as necessary to incorporate the Managed Care Organization Outcomes Program.

(535-A added June 22, 2018, P.L.258, No.40)

Section 536-A. Progress report on Managed Care Organization Outcomes Program.

By March 1, 2020, and each March 1 thereafter, the department shall provide a report on the progress of the Managed Care Organization Outcomes Program to the General Assembly. The report shall chart the reductions in the rates of potentially avoidable complications, readmissions and emergency room visits and the impact of such reductions on Medicaid costs.

(536-A added June 22, 2018, P.L.258, No.40)

ARTICLE VI
THE AGED

Section 601. Annual Grants; Aid for Community Living. (601 repealed June 20, 1978, P.L.477, No.70)

Section 602. LIFE Program.--(a) Informational materials and department correspondence used by the department to educate or notify an eligible individual about long-term care services and supports, including an individual's rights, responsibilities and choice of managed care organization to cover long-term care services and supports, shall include the following:

(1) A description of the LIFE program.

(2) A statement that an eligible individual has the option to enroll in the LIFE program or a managed care organization under the Community Health Choices Program.

(3) Contact information for LIFE providers.

(b) The department shall continue to provide training to the Independent Enrollment Broker on the LIFE program through the Independent Enrollment Broker LIFE module to better educate the Independent Enrollment Broker.

(c) At the end of each quarter, the department shall issue a report that tracks by county the enrollment of eligible individuals in long-term care service programs, including managed care organizations and LIFE programs.

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

"Eligible individual." An individual, age 55 or older, who is a resident of this Commonwealth and who requires long-term services or supports in order to remain living in the community and not in a nursing facility.

"Independent Enrollment Broker." A contracted Statewide entity that facilitates the eligibility and enrollment process for individuals seeking home and community-based services and works with service coordination providers to respond to participants' needs.

"LIFE program." A program which is a managed care program that provides all-inclusive care for elderly individuals in this Commonwealth as established in accordance with 42 CFR Pt. 460 (relating to programs of all-inclusive care for the elderly (PACE)).

(602 added June 22, 2018, P.L.258, No.40)

ARTICLE VII
CHILDREN AND YOUTH

(a) Departmental Powers and Duties as to Public Child Welfare

Section 701. Availability of Services.--The department shall assure within the Commonwealth the availability and equitable provision of adequate public child welfare services for all children who need them regardless of religion, race, settlement, residence or economic or social status.

Section 702. Consultation.--The department shall consult with and assist each county institution district or its successor in carrying out child welfare duties and functions as authorized by law.

Section 703. Rules and Regulations.--The department shall make and enforce all rules and regulations necessary and appropriate to the proper accomplishment of the child welfare duties and functions vested by law in the county institution districts or their successors. All rules and regulations which the department is authorized by this section to make with respect to the duties and functions of the county institution districts or their successors shall be binding upon them.

Section 704. Annual Grants.--(704 repealed July 9, 1976, P.L.846, No.148)

Compiler's Note: Section 1 of Act 148 of 1976 repealed section 704 but contained an effective date of January 1, 1978. The section was also later amended by Act 165 of 1976, but this amendment does not appear to be inconsistent with the earlier repeal and accordingly the text of the section is omitted as having been effectively repealed.

Section 704.1. Payments to Counties for Services to Children.--(a) The department shall reimburse county institution districts or their successors for expenditures incurred by them in the performance of their obligation pursuant to this act and the act of December 6, 1972 (P.L.1464, No.333), known as the "Juvenile Act," in the following percentages:

(1) Eighty percent of the cost of an adoption subsidy paid pursuant to subdivision (e) of Article VII of this act.

(2) No less than seventy-five percent and no more than ninety percent of the reasonable cost including staff costs of child welfare services, informal adjustment services provided pursuant to section 8 of the act of December 6, 1972 (P.L.1464, No.333), known as the "Juvenile Act," and such services approved by the department, including but not limited to, foster home care, group home care, shelter care, community residential care, youth service bureaus, day treatment centers and service to children in their own home and any other alternative treatment programs approved by the department.

(3) Sixty percent of the reasonable administrative costs approved by the department except for those staff costs included in clause (2) of this section as necessary for the provision of child welfare services.

(4) Fifty percent of the actual cost of care and support of a child placed by a county child welfare agency or a child committed by a court pursuant to the act of December 6, 1972 (P.L.1464, No.333), known as the "Juvenile Act," to the legal custody of a public or private agency approved or operated by the department other than those services described in clause (2). The Auditor General shall ascertain the actual expense for fiscal year 1974-1975 and each year thereafter by the Department of Public Welfare for each of the several counties and each city of the first class whose children resident within the county or city of the first class directly received the benefit of the Commonwealth's expenditure. The Auditor General shall also ascertain for each Commonwealth institution or facility rendering services to delinquent or deprived children the actual average daily cost of providing said services. The Auditor General shall certify to each county and city of the first class the allocated Commonwealth expenditures incurred on behalf of its children and notify the Secretary of Public Welfare and each county and city of the first class of same.

(5) Fifty percent of the reasonable cost of medical and other examinations and treatment of a child ordered by the court pursuant to the act of December 6, 1972 (P.L.1464, No.333), known as the "Juvenile Act," and the expenses of the appointment of a guardian pendente lite, summons, warrants, notices, subpoenas, travel expenses of witnesses, transportation of the child, and other like expenses incurred in proceedings under the act of December 6, 1972 (P.L.1464, No.333), known as the "Juvenile Act."

(6) Effective July 1, 1991, the department shall reimburse county institution districts or their successors one hundred percent of the reasonable costs of providing adoption services.

(7) Effective July 1, 1993, the department shall reimburse county institution districts or their successors eighty percent of the reasonable costs of providing foster home care, community residential care, supervised independent living and community-based alternative treatment programs.

(8) The department shall reimburse county institution districts or their successors for the reasonable costs of institutional services for dependent and delinquent children other than detention services for delinquents in accordance with the following schedule:

(i) Effective July 1, 1992, fifty-five percent.

(ii) Effective July 1, 1993, sixty percent.

((a) amended Aug. 5, 1991, P.L.315, No.30)

(b) The department shall make additional grants to any county institution district or its successor to assist in establishing new services to children in accordance with a plan approved by the department for up to the first three years of operation of those services. In order to provide necessary information to the General Assembly relative to the grants provided under this subsection, a report will be developed by the Legislative Budget and Finance Committee and provided to the members of the General Assembly no later than July 1, 1980, concerning all grants made and expenditures accomplished under the provisions of this subsection for the period up to and including December 31, 1979. This report shall include information on the amount of moneys that went to individual counties and a description of activities and services financed with these moneys including the number and types of clients served under each of the grant programs and any other information necessary in order to fully inform the General Assembly on such programs. All officials of the Department of Public Welfare, grant recipient county organizations, and other agencies which receive State moneys under the provisions of this subsection shall cooperate with the committee and its staff in carrying out this reporting requirement, including making available all necessary fiscal and programmatic data.

(c) No payment pursuant to subsection (a)(2), (3) or (4) or of subsection (b) shall be made for any period in which the county institution district or its successor fails to substantially comply with the regulations of the department promulgated pursuant to section 703 including but not limited to those regulations relating to minimum child welfare services, minimum standards of child welfare services and minimum standards of child welfare administration on a merit basis.

(d) Amounts due from county institution districts or their successors for children committed to facilities operated by the department shall be paid by the counties to the Department of Revenue by orders to be drawn by the duly authorized agent of the Department of Revenue at each youth development center or forestry camp on the treasurers of such counties, who shall accept and pay the same to the Department of Revenue. Promptly after the last calendar day of each month the agent of the Department of Revenue shall mail accounts to the commissioners of such counties as may have become liable to the Commonwealth during the month under the provisions of this section. These accounts shall be duly sworn or affirmed to, and it shall be the duty of said commissioners, immediately upon receipt of such accounts, to notify the treasurers of their respective counties of the amounts of said accounts, with instructions to

pay promptly to the Department of Revenue the amounts of said orders when presented. It shall then be the duty of such county treasurers to make such payments as instructed by their respective county commissioners. In lieu of payments by the county to the Commonwealth, the department may deduct the amount due the Commonwealth from the reimbursement payments by the department to the county institution districts or their successors.

(e) If, after due notice to the parents or other persons legally obligated to care for and support the child, and after affording them an opportunity to be heard, the court finds that they are financially able to pay all or part of the costs and expenses stated in subsection (a), the court may order them to pay the same and prescribe the manner of payment. Unless otherwise ordered, payment shall be made to the clerk of the court for remittance to the person to whom compensation is due, or if the costs and expenses have been paid by the county, to the appropriate officer of the county.

(f) ((f) deleted by amendment Aug. 5, 1991, P.L.315, No.30)

(g) 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, 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) amended Dec. 28, 2015, P.L.500, NO.92)

(g.1) After the final cumulative report for expenditures has been approved, if a county has adjustments to revenues or expenditures for the time period covered by the expenditure report in addition to the payments under subsection (g), the county shall submit to the department a revised expenditure

report. After the report is approved, the department may adjust any payment under subsection (g) to account for any revision to a county's expenditure report. ((g.1) added July 9, 2013, P.L.369, No.55)

(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).

((g.2) amended Dec. 28, 2015, P.L.500, No.92)

(h) At the end of each of calendar years 1978 and 1979, every county shall compare the amount received in child welfare reimbursements for calendar year 1976 pursuant to section 704 of this act and section 36 of the act of December 6, 1972 (P.L.1464, No.333), known as the "Juvenile Act" with child welfare reimbursements received for each of calendar years 1978 and 1979 pursuant to this section. The resulting difference in reimbursements for child welfare services received between calendar year 1976 and each of calendar years 1978 and 1979 shall then be compared with the amount the county paid in each of calendar years 1978 and 1979 for youth development center or forestry camp commitments pursuant to subsection (a)(4). If there is an increase in reimbursements for child welfare services and that increase is less in either or both of calendar years 1978 and 1979 than the amount expended by the county for its share of the cost of youth development center and forestry camp commitments, then any such county shall be entitled to receive additional block grants as provided in subsection (b) equal to the amount of such difference.

(704.1 added July 9, 1976, P.L.846, No.148)

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Compiler's Note: The Secretary of Public Welfare, referred to in this section, was redesignated as the Secretary of Human Services by Act 132 of 2014.

Section 704.2. Contingent Liability of State and Local Government; Intention of Act.--(a) Neither the State nor a county institution district or its successor shall be required to expend public funds for services described in section 704.1 on behalf of a child until such child has exhausted his eligibility and receipt of benefits under all other existing or future private, public, local, State or Federal programs other than programs funded by the act of October 20, 1966 (3rd Sp.Sess., P.L.96, No.6), known as the "Mental Health and Mental Retardation Act of 1966."

(b) Upon exhaustion of such eligibility as aforesaid, the Commonwealth and the county institution districts or their successors shall share the financial obligation accruing under section 704.1 to the extent such obligations are not borne by the Federal Government or any private person or agency.

(c) It is the intention of this section that its provisions be construed so as to maintain and not decrease or destroy any eligibility of any person, any facility of the State or any political subdivision to receive any Federal assistance, grants or funds.

(704.2 added July 9, 1976, P.L.846, No.148)

Section 704.3. Provider Submissions.--(a) 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. The department may include components of the recommendations of the rate methodology task force established under this section as part of the provider documentation to ensure Federal reimbursement. ((a) amended June 22, 2018, P.L.258, No.40)

(b) The department shall convene a task force to include representatives from public and private children and youth social service agencies and other appropriate stakeholders as determined by the secretary or deputy secretary for the Office of Children, Youth and Families.

(c) The task force established under subsection (b) shall develop recommendations for a methodology to determine reimbursement for actual and projected costs, which are reasonable and allowable, for the purchase of services from providers and for other purchased services. The task force shall provide written recommendations for the purchase of services from providers to the General Assembly no later than April 30, 2014. The task force shall provide written recommendations for other purchased services no later than December 31, 2014. The task force shall be convened within sixty days after the effective date of this section.

(d) As used in this section, the term "provider" means an entity licensed or certified to provide twenty-four-hour out-of-home community-based or institutional care and supervision of a child, with the care and supervision being paid for or provided by a county using Federal or State funds disbursed under this article.

(704.3 added July 9, 2013, P.L.369, No.55)

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

Section 705. Annual Plans and Computation of Grants.--(705 repealed July 9, 1976, P.L.846, No.148)

Section 706. Payment of Annual Grants.--(706 repealed July 9, 1976, P.L.846, No.148)

Section 707. Adjustment of Annual Grants.--(707 repealed July 9, 1976, P.L.846, No.148)

Section 708. Departmental Administration of County Child Welfare Services.--On and after January 1, 1968, the department shall provide, maintain, administer, manage and operate a program of child welfare services in a county institution district or its successor when the department determines, after hearing, that such county institution district or its successor is not complying with the regulations prescribing minimum child welfare services or minimum standards of performance of child welfare services or minimum standards of child welfare personnel administration on a merit basis, and that, as a result, the needs of children and youth are not being adequately served.

When, in pursuance of this section, the department takes charge of, and directs the operation of the child welfare services of a county institution district or its successor, the county shall be charged and shall pay the cost of such services, including reasonable expenditures incident to the administration thereof incurred by the department. The amount so charged and to be paid by the county shall be reduced by the amount of the

payments that would have been made pursuant to section 704.1 if the county institution district or its successor had maintained a child welfare program in compliance with the regulations of the department.

The amount due the Commonwealth may be deducted from any Commonwealth funds otherwise payable to the county. All sums collected from the county under this section, in whatever manner such collections are made, shall be paid into the State treasury and shall be credited to the current appropriation to the department for child welfare.

The department shall relinquish the administration of the child welfare program of the county institution district or its successor when the department is assured that the regulations of the department will be complied with thereafter and that the needs of children and youth will be adequately served.

(708 amended July 9, 1976, P.L.846, No.148)

Section 709. Reimbursement to Counties.--(709 repealed Aug. 5, 1991, P.L.315, No.30)

Section 709.1. Needs-Based Budgeting Process.--(a) Prior to September 15, 1991, and August 15 each year thereafter, counties shall submit to the department a needs-based budget in a form prescribed by the department containing their annual client and budget estimates and a description of proposed changes in their annual plan for the fiscal year beginning the following July 1.

(b) Representatives of the department shall meet with representatives of each of the counties to discuss the needs-based budgets and proposed changes in annual plans and shall make a thorough review of county submissions. County submissions shall clearly distinguish funding supported by section 704.1(a) from grants authorized by section 704.1(b). On the basis of the discussions and review, the department shall make its determination of each of the counties total costs and reimbursable costs and the amount allowed each of the counties in accordance with section 704.1(a).

(c) The total of the amounts allowed for each county pursuant to section 704.1(a) as determined by the department shall be the aggregate child welfare needs-based budget. The determination of the aggregate child welfare needs-based budget and the child welfare needs of each county along with supporting documentation shall be submitted to the Governor by November 15, 1991, and November 1 each year thereafter.

(d) Contemporaneously with the submission of the General Fund budget, the Governor shall submit the aggregate child welfare needs-based budget and the child welfare needs of each county along with supporting documentation to the Majority Chairman and the Minority Chairman of the Appropriations Committee of the Senate and the Majority Chairman and the Minority Chairman of the Appropriations Committee of the House of Representatives. The department may modify the calculation of the aggregate child welfare needs-based budget any time prior to May 1 of each year, provided that such revision is based on receipt of actual data or adopted regulatory changes which, when compared to previously calculated projected data or regulation, requires the revision.

(709.1 added Aug. 5. 1991, P.L.315, No.30)

Section 709.2. Review of County Submissions.--(a) The department shall promulgate guidelines for reviewing and determining county submitted needs-based budgets. The guidelines for the 1992-1993 fiscal year shall be published as a bulletin. Guidelines for approving 1993-1994 fiscal year needs-based budgets shall be adopted by regulation no later than July 1,

1992, but shall not be adopted as emergency regulations pursuant to section 6(b) of the act of June 25, 1982 (P.L.633, No.181), known as the "Regulatory Review Act."

(b) The department determination shall consider whether the county's budget is reasonable in relation to past costs, projected cost increases, number of children in the county and the number of children served, service level trends and projections of other sources of revenue.

(c) To the extent that county staffing patterns are less than that required to meet department staffing regulations, the department determinations shall permit a requesting county to hire sufficient staff to meet the minimum staffing regulations. A determination may disallow expenditures for additional staff if the functions for which the staff is to be hired already meets the minimum required by department regulations.

(d) No determination by the department may be based on payment standards that have not been adopted as of the time of the review in accordance with the "Regulatory Review Act."

(709.2 added Aug. 5, 1991, P.L.315, No.30)

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

(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 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 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."

(709.3 amended Dec. 28, 2015, P.L.500, No.92)

Section 709.4. Children Services Advisory Committee.--(a) There is hereby created a temporary Children Services Advisory Committee consisting of thirteen persons as follows:

(1) The Secretary of Public Welfare.

(2) Three persons selected by the Secretary of Public Welfare to represent county children and youth programs, private community services and private institutional services.

(3) The Majority Chairman and the Minority Chairman of the Aging and Youth Committee and the Majority Chairman and the Minority Chairman of the Appropriations Committee of the Senate and the Majority Chairman and the Minority Chairman of the Aging and Youth Committee and the Majority Chairman and the Minority Chairman of the Appropriations Committee of the House of Representatives, each of whom may select a temporary or permanent designee who need not be a member of the General Assembly.

(4) The chairman of the Juvenile Court Judges' Commission.

(b) The purpose of the committee shall be to study and report to the Governor and the General Assembly by December 31, 1992, on subjects which shall include, but not be limited to:

(1) Uniform children and youth service definitions.

(2) A methodology or alternative methodologies for the calculation of standardized rates based on uniform service definitions.

(3) The impact of variable reimbursement rates for different types of services on the nature of the services provided to children and youth and the desirability of any change in those reimbursement rates from those enacted into law or implemented by the department.

(c) The Children Services Advisory Committee shall remain in existence until it has submitted its report or December 31, 1992, whichever shall first occur. The Children Services Advisory Committee shall be initially convened by the Secretary of Public Welfare on or before October 1, 1991.

(709.4 added Aug. 5, 1991, P.L.315, No.30)

Compiler's Note: The Secretary of Public Welfare, referred to in this section, was redesignated as the Secretary of Human Services by Act 132 of 2014.

(b) Departmental Powers and Duties as to Delinquency

Section 721. Consultation to Community Agencies; Grants to Political Subdivisions.--The Department of Public Welfare shall have the power, and its duty shall be:

(1) To offer consultation and advice to local and State-wide public or private agencies, including juvenile courts, to community groups concerned with the prevention of juvenile delinquency in the planning and developing of measures to reduce the incidence of delinquency and to make grants to political

subdivisions for delinquency prevention projects developed jointly with the department;

(2) To offer consultation, guidance and assistance to public and voluntary agencies and institutions, including the juvenile courts, in developing, strengthening and improving programs for predisposition study, probation supervision, institutional treatment and after-care of delinquent youth, including training courses for personnel of the agencies and institutions. In order to develop or strengthen police and probation services for juveniles, and upon assurance that such services will meet standards approved by the department, the department shall make annual grants to political subdivisions.

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Section 722. Statistics; Assistance for Research.--The department shall gather, collate, interpret and disseminate statistics and reports relating to the problem of juvenile delinquency and to the treatment of juveniles. It shall also assist counties and local public and private agencies to study the causes and methods of prevention of juvenile delinquency.

Section 723. Gifts and Donations.--Through the secretary or his designee, the department may accept or refuse grants, appropriations, contributions, or unencumbered property, real, personal or mixed, tangible or intangible, or any interest therein, for the purposes described in this section from the Federal government, the Commonwealth and any donor. All grants, appropriations and contributions of money accepted shall be held by the State Treasurer as custodian for the Department of Public Welfare and shall be paid out on its requisition to further the objectives of this article.

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Section 724. Institutional Programs; Recommendations; Additional Facilities; Charges.--(a) The department shall develop recommended measures for corrective treatment of juvenile delinquents requiring differing corrective techniques and to assure the availability of appropriate facilities for them, the department shall plan with and offer a recommended program of coordination among existing public and private institutions for the development of specialized programs of re-education, treatment and rehabilitation and shall establish and operate any additional facilities needed.

(b) Using actual costs of maintenance and service to juveniles as the basis of calculations, the department, in consultation with the training schools, shall establish rates of care to be charged by the training schools to the counties and to the departments of public welfare of cities of the first class.

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Section 725. Study of Delinquents; Recommendations to Courts.--The department shall have the power, and its duty shall be:

(1) To establish and administer a program designed to assist the juvenile courts and other public and private agencies, on their request, in the diagnosis and study of juvenile

delinquents and of children with mental or behavioral problems, and to recommend to them the most appropriate disposition for the rehabilitation and treatment of such children; this program shall be based on review of local studies of the children but when local studies indicate the need, or when it is requested, may include residential study of the children in centers which the department is hereby authorized to establish and operate.

(2) To accept custody of children committed by the juvenile courts for study, and on the basis of its review of local studies of each child and any additional residential studies as are deemed necessary, to recommend to the court that the child be placed in an appropriate public or voluntary institution, or to recommend any other placement or treatment which may be indicated. The department may recommend that the court transfer any child from one type of care to another or return him to his home for trial periods. Notice of any transfer shall be sent by the department promptly to the parents, guardian or nearest relative of the child. The department may also recommend the discharge of a child from its custody but any decision with respect thereto shall remain the sole responsibility of the committing court.

(c) Interstate Compact on Juveniles

Section 731. Authorization; Compact Provisions.--(731 repealed July 2, 2004, P.L.468, No.54)

Section 731.1. Out-of-State Confinement.--(731.1 repealed July 2, 2004, P.L.468, No.54)

Section 732. Compact Administrator.--(732 repealed July 2, 2004, P.L.468, No.54)

Section 733. Supplementary Agreements.-- (733 repealed July 2, 2004, P.L.468, No.54)

Section 734. Discharge of Financial Obligations.-- (734 repealed July 2, 2004, P.L.468, No.54)

Section 735. Enforcement of Compact.-- (735 repealed July 2, 2004, P.L.468, No.54)

(d) Interstate Placement of Children

(Hdg. amended July 25, 1973, P.L.205, No.50 and July 27, 1973, P.L.231, No.61)

Section 741. Department Consent Required. (741 repealed July 27, 1973, P.L.231, No.61)

Section 742. Exemption. (742 repealed July 27, 1973, P.L.231, No.61)

Section 743. Indemnity Bond. (743 repealed July 27, 1973, P.L.231, No.61)

Section 744. Regulations; Supervision. (744 repealed July 27, 1973, P.L.231, No.61)

Section 745. Violation; Penalty. (745 repealed July 27, 1973, P.L.231, No.61)

Section 746. Definitions.--As used in this act:

"Child" means any individual who has not yet passed his eighteenth birthday and includes one conceived but not yet born.

"Department" means the Department of Public Welfare of this Commonwealth.

"Person" means an individual, agency, association, corporation or institution.

"Placement" means either effecting admission of a child to an institution, except an educational institution, or effecting his reception in a family home, whether or not a charge is made for his care by the institution or family home.

(746 added July 27, 1973, P.L.231, No.61)

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Section 747. Consent Required for Bringing Child into State.--(a) Without first obtaining the consent of the department, no person shall bring or send any child or cause him to be brought or sent into this Commonwealth with the purpose of placement or of procuring the child's adoption.

(b) Subsection (a) of this section shall not apply if the child is received into this Commonwealth by an institution or agency supervised by the department and notice of the child's placement is furnished the department within seven days.

(747 added July 27, 1973, P.L.231, No.61)

Section 748. Department's Consent to Placement.--Before issuing its consent to a child's placement in this Commonwealth as required in section 747, the department shall:

(1) Satisfy itself that the proposed placement and all arrangements therefor, are suitable for the nature of the child and are in conformity with applicable regulations of the department;

(2) Receive from the person accepting the child for placement or adoption written agreement to conform to all applicable regulations of the department and, at least semi-annually, and at such other times as the department may require, to report as to the location and well-being of the child until he reaches his eighteenth birthday or is adopted.

(748 added July 27, 1973, P.L.231, No.61)

Section 749. Bond Required; Forfeiture and Assignment.--At its discretion, the department may require of the person bringing or sending a child into this Commonwealth for placement or adoption or of the person who receives such child, an indemnity bond in favor of the Commonwealth of Pennsylvania in the penal sum of one thousand dollars ($1,000) conditioned as follows: That the child is not of unsound mind or body and that, if prior to his eighteenth birthday or his adoption, he becomes a public charge or is adjudged a delinquent, he will be removed from the State on demand of the department.

Any person, subject to this act, having had thirty days' notice and demand by the department to remove from the State any child admitted under the provisions of this act shall, upon failure to remove the child, forfeit the sum of one thousand dollars ($1,000) as a penalty therefor to be recovered upon such bond by a suit in the name of the Commonwealth of Pennsylvania. This sum, or any part thereof, collected by the Commonwealth may be assigned by the department to a supervised child caring agency designated by the department to replace the child.

(749 added July 27, 1973, P.L.231, No.61)

Section 750. Notice of Movement of Child from this Commonwealth.--No person shall take any child, send or cause him to be taken or sent to another state for the purpose of placement or of procuring his adoption without providing information to the department about the child and his placement. The department shall immediately send such information to the appropriate department of government of the receiving state.

(750 added July 27, 1973, P.L.231, No.61)

Section 751. Regulations.--The department may make such regulations for the administration of this act as it deems necessary.

(751 added July 27, 1973, P.L.231, No.61)

Section 752. Application.--The provisions of this act shall not apply to a parent, stepparent, grandparent, aunt or uncle, nor to an adult brother, sister, half brother or half sister, when any such relative receives or brings a child into this Commonwealth for the purpose of giving him a home in the relative's own family.

If Pennsylvania becomes a party to the Interstate Compact on Children, this act shall not apply to public or voluntary agencies in other party states.

(752 added July 27, 1973, P.L.231, No.61)

Section 753. Penalty.--Any person who knowingly violates any provision of this act is guilty of a misdemeanor and, upon conviction thereof, shall be sentenced to pay a fine of not more than one hundred dollars ($100) or to undergo imprisonment for not more than thirty days or both.

(753 added July 27, 1973, P.L.231, No.61)

Section 761. Authorization; Compact Provisions.--The Governor is hereby authorized and directed to execute a compact on behalf of the Commonwealth of Pennsylvania with any other state or states legally joining therein in form substantially as follows:

Interstate Compact on the Placement of Children

ARTICLE I

Purpose and Policy

It is the purpose and policy of the party states to cooperate with each other in the interstate placement of children to the end that:

(a) Each child requiring placement shall receive the maximum opportunity to be placed in a suitable environment and with persons or institutions having appropriate qualifications and facilities to provide a necessary and desirable degree and type of care.

(b) The appropriate authorities in a state where a child is to be placed may have full opportunity to ascertain the circumstances of the proposed placement, thereby promoting full compliance with applicable requirements for the protection of the child.

(c) The proper authorities of the state from which the placement is made may obtain the most complete information on the basis of which to evaluate a projected placement before it is made.

(d) Appropriate jurisdictional arrangements for the care of children will be promoted.

ARTICLE II

Definitions

As used in this compact:

(a) "Child" means a person who, by reason of minority, is legally subject to parental guardianship or similar control.

(b) "Sending agency" means a party state, officer or employe thereof, a subdivision of a party state or officer or employe thereof, a court of a party state, a person, corporation, association, charitable agency or other entity which sends, brings or causes to be sent or brought, any child to another party state.

(c) "Receiving state" means the state to which a child is sent, brought or caused to be sent or brought, whether by public authorities or private persons or agencies and whether for placement with state or local public authorities or for placement with private agencies or persons.

(d) "Placement" means the arrangement for the care of a child in a family, free or boarding home, or in a child-caring agency or institution but does not include any institution

caring for the mentally ill, mentally defective or epileptic or any institution primarily educational in character and any hospital or other medical facility.

ARTICLE III

Conditions for Placement

(a) No sending agency shall send, bring or cause to be sent or brought into any other party state, any child for placement in foster care or as a preliminary to a possible adoption unless the sending agency shall comply with each and every requirement set forth in this article and with the applicable laws of the receiving state governing the placement of children therein.

(b) Prior to sending, bringing or causing any child to be sent or brought into a receiving state for placement in foster care or as a preliminary to a possible adoption, the sending agency shall furnish the appropriate public authorities in the receiving state written notice of the intention to send, bring or place the child in the receiving state. The notice shall contain:

(1) The name, date and place of birth of the child.

(2) The identity and address or addresses of the parents or legal guardian.

(3) The name and address of the person, agency or institution to, or with which, the sending agency proposes to send, bring or place the child.

(4) A full statement of the reasons for such proposed action and evidence of the authority pursuant to which the placement is proposed to be made.

(c) Any public officer or agency in a receiving state, which is in receipt of a notice pursuant to paragraph (b) of this article, may request of the sending agency or any other appropriate officer or agency of, or in the sending agency's state, and shall be entitled to receive therefrom such supporting or additional information as it may deem necessary under the circumstances to carry out the purpose and policy of this compact.

(d) The child shall not be sent, brought or caused to be sent or brought into the receiving state until the appropriate public authorities in the receiving state shall notify the sending agency, in writing, to the effect that the proposed placement does not appear to be contrary to the interests of the child.

ARTICLE IV

Penalty for Illegal Placement

The sending, bringing or causing to be sent or brought into any receiving state, of a child, in violation of the terms of this compact, shall constitute a violation of the laws respecting the placement of children of both the state in which the sending agency is located or from which it sends or brings the child and of the receiving state. Such violation may be punished or subjected to penalty in either jurisdiction in accordance with its laws. In addition to liability for any such punishment or penalty, any such violation shall constitute full and sufficient grounds for the suspension or revocation of any license, permit or other legal authorization held by the sending agency which empowers or allows it to place or care for children.

ARTICLE V

Retention of Jurisdiction

(a) The sending agency shall retain jurisdiction over the child sufficient to determine all matters in relation to the custody, supervision, care, treatment and disposition of the child which it would have had if the child had remained in the

sending agency's state until the child is adopted, reaches majority, becomes self-supporting, or is discharged with the concurrence of the appropriate authority in the receiving state. Such jurisdiction shall also include the power to effect or cause the return of the child or its transfer to another location and custody pursuant to law. The sending agency shall continue to have financial responsibility for support and maintenance of the child during the period of the placement. Nothing contained herein shall defeat a claim of jurisdiction by a receiving state sufficient to deal with an act of delinquency or crime committed therein.

(b) When the sending agency is a public agency, it may enter into an agreement with an authorized public or private agency in the receiving state providing for the performance of one or more services in respect of such case by the latter, as agent for the sending agency.

(c) Nothing in this compact shall be construed to prevent a private, charitable agency, authorized to place children in the receiving state, from performing services or acting as agent in that state for a private charitable agency of the sending state nor to prevent the agency in the receiving state from discharging financial responsibility for the support and maintenance of a child who has been placed, on behalf of the sending agency, without relieving the responsibility set forth in paragraph (a) hereof.

ARTICLE VI
Institutional Care of Delinquent Children

A child adjudicated delinquent may be placed in an institution in another party jurisdiction, pursuant to this compact, but no such placement shall be made unless the child is given a court hearing, on notice to the parent or guardian, with opportunity to be heard prior to his being sent to such other party jurisdiction for institutional care and the court finds that:

(1) Equivalent facilities for the child are not available in the sending agency's jurisdiction, and

(2) Institutional care in the other jurisdiction is in the best interest of the child and will not produce undue hardship.

ARTICLE VII
Compact Administrator

The executive head of each jurisdiction party to this compact shall designate an officer who shall be general coordinator of activities under this compact in his jurisdiction and who, acting jointly with like officers of other party jurisdictions, shall have power to promulgate rules and regulations to carry out more effectively the terms and provisions of this compact.

ARTICLE VIII
Limitations

This compact shall not apply to:

(a) The sending or bringing of a child into a receiving state by his parent, stepparent, grandparent, adult brother or sister, adult uncle or aunt, or his guardian and leaving the child with any such relative or nonagency guardian in the receiving state.

(b) Any placement, sending or bringing of a child into a receiving state, pursuant to any other interstate compact to which both the state from which the child is sent or brought and the receiving state, are party or to any other agreement between said states which has the force of law.

ARTICLE IX
Enactment and Withdrawal

This compact shall be open to joinder by any state, territory or possession of the United States, the District of Columbia, the Commonwealth of Puerto Rico and, with the consent of Congress, the Government of Canada or any province thereof. It shall become effective with respect to any such jurisdiction when such jurisdiction has enacted the same into law. Withdrawal from this compact shall be by the enactment of a statute repealing the same but shall not take effect until two years after the effective date of such statute and until written notice of the withdrawal has been given by the withdrawing state to the Governor of each other party jurisdiction. Withdrawal of a party state shall not affect the rights, duties and obligations under this compact of any sending agency therein with respect to a placement made prior to the effective date of withdrawal.

ARTICLE X

Construction and Severability

The provisions of this compact shall be liberally construed to effectuate the purposes thereof. The provisions of this compact shall be severable and if any phrase, clause, sentence or provision of this compact is declared to be contrary to the constitution of any party state or of the United States or the applicability thereof to any government agency, person or circumstance is held invalid, the validity of the remainder of this compact and the applicability thereof to any government agency, person or circumstance shall not be affected thereby. If this compact shall be held contrary to the constitution of any state party thereto, the compact shall remain in full force and effect as to the remaining states and in full force and effect as to the state affected as to all severable matters.

(761 added July 25, 1973, P.L.205, No.50)

Section 762. Financial Responsibility.--Financial responsibility for any child placed, pursuant to the provisions of the Interstate Compact on the Placement of Children, shall be determined in accordance with the provisions of Article V thereof in the first instance. However, in the event of partial or complete default of performance thereunder, the provisions of any laws of the Commonwealth fixing responsibility for the support of children also may be invoked.

(762 added July 25, 1973, P.L.205, No.50)

Section 763. Definitions.--(1) As used in paragraph (a) of Article V of the Interstate Compact on the Placement of Children, the phrase "appropriate authority in the receiving state," with reference to this State, shall mean the Department of Public Welfare;

(2) As used in Article III of the Interstate Compact on the Placement of Children, the "appropriate public authorities" shall, with reference to this State, mean the Department of Public Welfare and said department shall receive and act with reference to notices required by said Article III;

(3) As used in Article VII of the Interstate Compact on the Placement of Children, the term "executive head" means the Governor of the Commonwealth of Pennsylvania. The Governor is hereby authorized to designate an officer who shall be the compact administrator in accordance with the terms of said Article VII.

(763 added July 25, 1973, P.L.205, No.50)

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Section 764. Agreements.--The officers and agencies of this State and its subdivisions, having authority to place children, are hereby empowered to enter into agreements with appropriate officers or agencies of, or in, other party states pursuant to paragraph (b) of Article V of the Interstate Compact on the Placement of Children. Any such agreement which contains a financial commitment or imposes a financial obligation on this State, or subdivision, or agency thereof, shall not be binding unless it has the approval in writing, of the Secretary of Public Welfare in the case of the State or any agency thereof and of the local public welfare administrative authority in the case of a subdivision of the State.
(764 added July 25, 1973, P.L.205, No.50)

Compiler's Note: The Secretary of Public Welfare, referred to in this section, was redesignated as the Secretary of Human Services by Act 132 of 2014.

Section 765. Courts; Jurisdiction.--Any court having jurisdiction to place delinquent children may place such a child in an institution of or in another state pursuant to Article VI of the Interstate Compact on the Placement of Children and shall retain jurisdiction as provided in Article V thereof.
(765 added July 25, 1973, P.L.205, No.50)

(e) Adoption Opportunities Act
(Subart. repealed June 28, 2019, P.L.93, No.14)

Section 771. Declaration of Purpose. (771 repealed June 28, 2019, P.L.93, No.14)

Section 772. Definitions. (772 repealed June 28, 2019, P.L.93, No.14)

Section 773. Rules and Regulations. (773 repealed June 28, 2019, P.L.93, No.14)

Section 774. Adoption Opportunity Payments and Reimbursement. (774 repealed June 28, 2019, P.L.93, No.14)

ARTICLE VIII
THE BLIND AND VISUALLY HANDICAPPED
(Art. VIII repealed June 22, 1999, P.L.99, No.15)

Section 801. Departmental Powers and Duties.--(801 repealed June 22, 1999, P.L.99, No.15)

Section 802. Business Enterprises; Revolving Fund.--(802 repealed June 22, 1999, P.L.99, No.15)

Section 803. Business Enterprises; Equipment; Leases; Repayment.--(803 repealed June 22, 1999, P.L.99, No.15)

Section 804. Business Enterprises; Regulations; Grants and Contributions.--(804 repealed June 22, 1999, P.L.99, No.15)

ARTICLE VIII-A
NURSING FACILITY ASSESSMENTS
(Art. added Sept. 30, 2003, P.L.169, No.25)

Section 801-A. Definitions.--As used in this article--

"Assessment" means the fee implemented pursuant to this article on every nursing facility.

"County nursing facility" means a long-term care nursing facility that is licensed by the Department of Health under the act of July 19, 1979 (P.L.130, No.48), known as the "Health Care Facilities Act," and controlled by the county institution district or county government if no county institution district exists. The term does not include intermediate care facilities for individuals with an intellectual disability controlled by

the county institution district or county government. (Def. amended June 28, 2019, P.L.168, No.19)

"Medical assistance managed care organization" means a Medicaid managed care organization as defined in section 1903(m)(1)(A) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396b(m)(1)(A)) that is a party to a Medicaid managed care contract with the department. The term shall not include a behavioral health managed care organization that is a party to a Medicaid managed care contract with the department. (Def. added June 28, 2019, P.L.168, No.19)

"Medical assistance provider" means a person or entity enrolled by the department as a provider of services in the medical assistance program. (Def. amended June 28, 2019, P.L.168, No.19)

"Nursing facility" means a non-Federal, nonpublic long-term care nursing facility licensed by the Department of Health pursuant to the act of July 19, 1979 (P.L.130, No.48), known as the "Health Care Facilities Act." The term does not include intermediate care facilities for individuals with an intellectual disability. (Def. amended June 28, 2019, P.L.168, No.19)

"Program" means the medical assistance program.

(801-A amended July 8, 2016, P.L.480, No.76)

Section 802-A. Authorization.--In order to generate additional revenues for medical assistance recipients to have access to medically necessary nursing facility services, the department shall implement a monetary assessment on each nursing facility and, beginning July 1, 2007, may implement a monetary assessment on each county nursing facility subject to the conditions and requirements specified in this article and any approved Federal waiver obtained under section 812-A. In each year in which the department implements an assessment on county nursing facilities, any requirement or obligation imposed on or relating to nursing facilities in sections 803-A, 804-A, 805-A, 806-A, 807-A, 808-A, 809-A, 810-A, 811-A, 812-A, 813-A and 814-A shall be deemed to apply equally to county nursing facilities.

(802-A amended June 30, 2007, P.L.49, No.16)

Section 803-A. Implementations.--The assessment shall be implemented on an annual basis as a health care-related fee as defined in section 1903(w)(3)(B) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396b(w)(3)(B)) or any amendments thereto and may be imposed only to the extent that the revenues generated therefrom will qualify as the State share of program expenditures eligible for Federal financial participation.

(803-A added Sept. 30, 2003, P.L.169, No.25)

Section 804-A. Amount.--The aggregate amount of the assessment and the assessment rate shall be determined in accordance with this article and implemented on an annual basis by the secretary, in consultation with the Secretary of the Budget, and shall be approved by the Governor. In each year in which the assessment is implemented, the assessment rate shall be fixed so as to generate at least fifty million dollars ($50,000,000) in additional revenue subject to the maximum aggregate amount that may be assessed under 42 CFR 433.68(f)(3)(i) (relating to permissible health care-related taxes after the transition period) or any other maximum established under Federal law.

(804-A amended June 30, 2007, P.L.49, No.16)

Section 805-A. Administration.--(a) The secretary, before implementing an assessment in each fiscal year, shall publish a notice in the Pennsylvania Bulletin that specifies the amount

of the assessment being proposed and an explanation of the assessment methodology and amount determination that identifies the aggregate impact on nursing facilities subject to the assessment. Interested parties shall have thirty (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 rate of the assessment.

(b) Except as permitted under section 809-A, the secretary's determination of the aggregate amount and rate of the assessment pursuant to subsection (a) 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; nor shall any assessments implemented under this article or forms or reports required to be completed by nursing facilities pursuant to this article 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."

(805-A added Sept. 30, 2003, P.L.169, No.25)

Section 806-A. Restricted account.--There is hereby created a restricted account in the General Fund for the receipt and deposit of moneys from the assessment, any Federal financial participation received by the Commonwealth as a direct result of the assessment and any penalties and interest received under section 810-A. Moneys in the account are hereby appropriated to the department to fund nursing facility services provided by medical assistance nursing facility providers to the extent permitted by section 1903(w) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396b(w)).

(806-A added Sept. 30, 2003, P.L.169, No.25)

Section 807-A. Assessment Amount and Timing.--Each nursing facility shall remit the assessment amounts due as determined by the department pursuant to section 805-A(a) in periodic submissions, not to exceed five times per year, as specified by the department. A nursing facility shall report and remit the total assessment amount owed electronically on forms and in accordance with instructions and by the due dates prescribed by the department. The prescribed due dates shall be at least thirty (30) days after the date of publication of the second notice under section 805-A(a).

(807-A amended June 28, 2019, P.L.168, No.19)

Section 808-A. Records.--Upon request by the department, a nursing facility shall furnish to the department such records as the department may specify in order to determine the assessment for a fiscal year or the amount of the assessment due from the nursing facility or to verify that the nursing facility has paid the correct amount due. In the event that the department determines that a nursing facility has failed to pay an assessment or that it has underpaid an assessment, the department shall notify the nursing facility in writing of the amount due, including interest, and the date on which the amount due must be paid, which shall not be less than thirty (30) days from the date of the notice. In the event that the department determines that a nursing facility has overpaid an assessment, the department shall notify the nursing facility in writing of the overpayment and, within thirty (30) days of the date of the notice of the overpayment, shall either refund the amount of

the overpayment or offset the amount of the overpayment against any amount that may be owed to the department from the facility.

(808-A added Sept. 30, 2003, P.L.169, No.25)

Section 809-A. Request for Review.--A nursing facility that is aggrieved by a determination of the department as to the amount of the assessment due from the nursing facility or a remedy imposed pursuant to section 810-A 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. 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 nursing facility may not challenge the assessment rate determined by the secretary but only whether the department correctly determined the assessment amount due from the nursing facility using the assessment rate in effect for the fiscal year.

(809-A added Sept. 30, 2003, P.L.169, No.25)

Section 810-A. 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) When a nursing facility 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) When a nursing facility 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 nursing facility in the amount of one thousand dollars ($1,000), plus an additional amount of two hundred dollars ($200) per day for each additional day that the failure to file the report or furnish the records continues.

(3) When a nursing facility that is a medical assistance provider or 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 fails to pay all or part of an assessment or penalty within sixty (60) days of the date that payment is due, the department may deduct or instruct a medical assistance managed care organization to deduct the unpaid assessment or penalty and any interest owed thereon from any medical assistance payments due to the nursing facility or to any related medical assistance provider until the full amount is recovered. Any such deduction shall be made only after written notice to the medical assistance provider and may be taken in amounts over a period of time taking into account the financial condition of the medical assistance provider. ((3) amended June 28, 2019, P.L.168, No.19)

(4) Within sixty (60) days after the end of each calendar quarter, the department shall notify the Department of Health of any nursing facility that has assessment, penalty or interest amounts that have remained unpaid for ninety (90) days or more. The Department of Health shall not renew the license of any such nursing facility until the department notifies the Department of Health that the nursing facility has paid the outstanding amount in its entirety or that the department has agreed to permit the nursing facility to repay the outstanding amount in installments and that, to date, the nursing facility has paid the installments in the amount and by the date required by the department.

(5) The secretary may waive all or part of the interest or penalties assessed against a nursing facility pursuant to this article for good cause as shown by the nursing facility.

(810-A added Sept. 30, 2003, P.L.169, No.25)

Section 811-A. Liens.--Any assessments implemented and interest and penalties assessed against a nursing facility pursuant to this article shall be a lien on the real and personal property of the nursing facility 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."

(811-A added Sept. 30, 2003, P.L.169, No.25)

Section 812-A. Federal Waiver.--To the extent necessary in order to implement this article, the department shall seek a waiver pursuant to 42 CFR 433.68(e) (relating to permissible health care-related taxes after the transition period) from the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.

(812-A added Sept. 30, 2003, P.L.169, No.25)

Section 813-A. Repayment.--No nursing facility shall be directly guaranteed a repayment of its assessment in derogation of 42 CFR 433.68(f) (relating to permissible health care-related taxes): Provided, however, That in each fiscal year in which an assessment is implemented, the department shall use the State revenue collected from the assessment and any Federal funds received by the Commonwealth as a direct result of the assessments to make program payments through fee-for-service or managed care to medical assistance nursing facility providers 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 in 42 CFR 433.68(f). If the department implements an assessment on county nursing facilities, the department shall allocate assessment revenues available to make program payments through fee-for-service or managed care to both county and non county nursing facilities in a manner that is consistent with Federal law and without creating a direct or an indirect guarantee to hold any nursing facility harmless. The secretary shall submit any Title XIX State Plan amendments to the United States Department of Health and Human Services that are necessary to make the payments.

(813-A amended June 28, 2019, P.L.168, No.19)

Section 814-A. Regulations.--(a) The department may issue such regulations and orders as may be necessary to implement the nursing facility assessment program in accordance with the requirements of this article.

(b) During each fiscal year in which an assessment is implemented pursuant to this article, the department shall not adopt new regulations or revise existing regulations that limit, restrict or reduce eligibility for medical assistance nursing facility services or program participation or reimbursement for medical assistance nursing facility providers without publishing a notice of proposed rulemaking and adopting a final-form regulation after public notice and comment in accordance with 45 Pa.C.S. (relating to legal notices) and the act of July 31, 1968 (P.L.769, No.240), known as the "Commonwealth Documents Law," and subject to review pursuant to the act of June 25, 1982 (P.L.633, No.181), known as the "Regulatory Review Act." Notice of proposed rule making shall not be omitted pursuant to section 204 of the "Commonwealth Documents Law," and no final-form regulation subject to this section may take effect

pursuant to emergency certification by the Governor under section 6(d) of the "Regulatory Review Act."

(c) Notwithstanding subsection (b) and subject to compliance with the requirements of section 6(d) of the "Regulatory Review Act" relating to emergency certification by the Attorney General or by the Governor, the department may adopt emergency-certified regulations if all of the following apply:

(1) The regulations are necessary for the department to comply with changes in applicable Federal statutes or regulations relating to:

(i) eligibility for medical assistance nursing facility services; or

(ii) program participation or reimbursement for medical assistance nursing facility providers.

(2) A delay in adoption of regulations will result in either the loss of Federal funds or replacement of Federal funds with State funds in an amount in excess of one million dollars ($1,000,000).

(3) Before publishing the regulations under section 6(d) of the "Regulatory Review Act," the department publishes advance notice in the Pennsylvania Bulletin announcing its intent to adopt regulations pursuant to section 6(d) and solicits public comments for at least fourteen days.

(4) The department publishes responses to the comments it received during the fourteen-day public comment period upon adoption of the regulations under section 6(d) of the "Regulatory Review Act."

(814-A amended June 30, 2007, P.L.49, No.16)

Section 815-A. Time periods.--The assessment authorized in this article shall be imposed July 1, 2003, through June 30, 2022.

(815-A reenacted and amended June 28, 2019, P.L.168, No.19)

2018 Unconstitutionality: The amendment of section 815-A by Act 80 of 2012 was declared unconstitutional on July 18, 2018, by the Supreme Court of Pennsylvania in Washington v. Commonwealth, Department of Public Welfare, 188 A.3d 1135 (Pa. 2018). In footnote 25 of its decision, the Supreme Court indicated that section 8 of Act 80 of 2012 expired on June 30, 2016. Section 8 of Act 80 of 2012 provided for the amendment of section 815-A. Section 815-A provided the time period for imposition of assessments under Article VIII-A of the Human Services Code. Section 8 of Act 80 of 2012 changed the final date for imposition of assessments from June 30, 2012, to June 30, 2016. The Supreme Court noted that Act 76 of 2016 changed the final date for imposition of assessments from June 30, 2016, to June 30, 2019. The Legislative Reference Bureau effectuated the 2018 unconstitutionality.

ARTICLE VIII-B
MEDICAID MANAGED CARE ORGANIZATION ASSESSMENTS
(Art. repealed July 4, 2008, P.L.557, No.44)

Section 801-B. Definitions. (801-B repealed July 4, 2008, P.L.557, No.44)

Section 802-B. Authorization. (802-B repealed July 4, 2008, P.L.557, No.44)

Section 803-B. Implementation. (803-B repealed July 4, 2008, P.L.557, No.44)

Section 804-B. Assessment percentage. (804-B repealed July 4, 2008, P.L.557, No.44)

Section 805-B. Calculation and payment. (805-B repealed July 4, 2008, P.L.557, No.44)
Section 806-B. Use of assessment proceeds. (806-B repealed July 4, 2008, P.L.557, No.44)
Section 807-B. Records. (807-B repealed July 4, 2008, P.L.557, No.44)
Section 808-B. Payment of assessment. (808-B repealed July 4, 2008, P.L.557, No.44)
Section 809-B. Appeal rights. (809-B repealed July 4, 2008, P.L.557, No.44)
Section 810-B. Enforcement. (810-B repealed July 4, 2008, P.L.557, No.44)
Section 811-B. Time periods. (811-B repealed July 4, 2008, P.L.557, No.44)

ARTICLE VIII-C
INTERMEDIATE CARE FACILITIES FOR PERSONS WITH AN INTELLECTUAL DISABILITY ASSESSMENTS
(Art. added July 4, 2004, P.L.528, No.69)
(Hdg. amended July 9, 2013, P.L.369, No.55)

Section 801-C. 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." The fee implemented pursuant to this article on every intermediate care facility for persons with an intellectual disability.

"Department." (Def. deleted by amendment June 28, 2019, P.L.168, No.19)

"Intermediate care facility for persons with an intellectual disability" or "ICF/ID." A public or private facility defined in section 1905 of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1905).

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

"Medical assistance program" or "program." The medical assistance program as administered by the Department of Human Services.

"Secretary." (Def. deleted by amendment June 28, 2019, P.L.168, No.19)

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

(801-C amended July 8, 2016, P.L.480, No.76)

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

Section 802-C. Authorization.

In order to generate additional revenues for medical assistance program recipients to have access to medically necessary intellectual disability services, the department shall implement a monetary assessment on each ICF/ID subject to the conditions and requirements specified in this article.

(802-C amended July 9, 2013, P.L.369, No.55)

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

Section 803-C. Implementation.

The ICF/ID assessments shall be implemented on an annual basis as a health care-related tax 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 will qualify as the State share of program expenditures eligible for Federal financial participation.

(803-C amended July 9, 2013, P.L.369, No.55)

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

Section 804-C. Amount.

The assessment rate shall be determined in accordance with this article and implemented on an annual basis by the department, as approved by the Governor, upon notification to and in consultation with the ICFs/ID. In each year in which the assessment is implemented, the assessment rate shall equal the amount established by the department subject to the maximum aggregate amount that may be assessed pursuant to the 6% indirect guarantee threshold set forth in 42 CFR 433.68(f)(3)(i) (relating to permissible health care-related taxes) or any other maximum aggregate amount established by law.

(804-C amended July 9, 2013, P.L.369, No.55)

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

Section 805-C. Administration.

(a) Notice of assessment.--The secretary, before implementing an assessment in any fiscal year, shall publish a notice in the Pennsylvania Bulletin that specifies the amount of the assessment being proposed and an explanation of the assessment methodology and amount determination that identifies the aggregate impact on ICFs/ID 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 rate of the assessment.

(b) Review of assessment.--Except as permitted under section 809-C, the secretary's determination of the aggregate amount and the rate of the assessment pursuant to subsection (a) 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. No assessment implemented under this article nor forms or reports required to be completed by ICFs/ID pursuant to this article shall 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, or the act of June 25, 1982 (P.L.633, No.181), known as the Regulatory Review Act.

(805-C amended July 9, 2013, P.L.369, No.55)

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

Section 806-C. Calculation.

Using the assessment rate implemented by the secretary pursuant to section 804-C, each ICF/ID shall calculate the assessment amounts it owes for a calendar quarter on a form specified by the department and shall submit the form and the

amount owed to the department no later than the last day of that calendar quarter or 30 days from the date of the department's second notice published pursuant to section 805-C(a), whichever is later.

(806-C amended July 9, 2013, P.L.369, No.55)

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

Section 807-C. Purposes and uses.

No ICF/ID shall be directly guaranteed a repayment of its assessment in derogation of 42 CFR 433.68 (relating to permissible health care-related taxes), provided, however, in each fiscal year in which an assessment is implemented, the department shall use the State revenue collected from the assessment and any Federal funds received by the Commonwealth as a direct result of the assessment to fund services for persons with an intellectual disability.

(807-C amended July 9, 2013, P.L.369, No.55)

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

Section 808-C. Records.

Upon request by the department, an ICF/ID shall furnish to the department such records as the department may specify in order to determine the assessment rate for a fiscal year or the amount of the assessment due from the ICF/ID or to verify that the ICF/ID has paid the correct amount due. In the event that the department determines that an ICF/ID has failed to pay an assessment or that it has underpaid an assessment, the department shall notify the ICF/ID in writing of the amount due, including interest, and the date on which the amount due must be paid, which shall not be less than 30 days from the date of the notice. In the event that the department determines that an ICF/ID has overpaid an assessment, the department shall notify the ICF/ID in writing of the overpayment and, within 30 days of the date of the notice of the overpayment, shall 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 ICF/ID.

(808-C amended July 9, 2013, P.L.369, No.55)

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

Section 809-C. Appeal rights.

An ICF/ID that is aggrieved by a determination of the department as to the amount of the assessment due from the ICF/ID or a remedy imposed pursuant to section 810-C 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 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, an ICF/ID may not challenge the assessment rate determined by the secretary, but only whether the department correctly determined the assessment amount due from the ICF/ID using the assessment rate in effect for the fiscal year.

(809-C amended July 9, 2013, P.L.369, No.55)

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

Section 810-C. 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 an ICF/ID 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 an ICF/ID fails to file a report or to furnish records to the department as required by this article, the department may impose a penalty against the ICF/ID in the amount of $1,000 per day for each day the report or required records are not filed or furnished to the department.

(3) When an ICF/ID fails to pay all or part of an assessment or penalty within 60 days of the date that payment is due, the department may terminate the ICF/ID from participation in the medical assistance program and/or deduct the unpaid assessment or penalty and any interest owed thereon from any payments due to the ICF/ID until the full amount is recovered. Any such termination or payment deduction shall be made only after written notice to the ICF/ID.

(4) The secretary may waive all or part of the interest or penalties assessed against an ICF/ID pursuant to this article for good cause as shown by the ICF/ID.

(810-C amended July 9, 2013, P.L.369, No.55)

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

Section 811-C. Time periods.

(a) Imposition.--The assessment authorized under this article shall not be imposed as follows:

(1) Prior to July 1, 2003, for private ICFs/ID.

(2) Prior to July 1, 2004, for public ICFs/ID.

(3) In the absence of Federal financial participation as described under section 803-C.

(b) Cessation.--The assessment authorized under this article shall cease June 30, 2024, or earlier, if required by law. ((b) amended June 28, 2019, P.L.168, No.19)

(811-C amended July 8, 2016, P.L.480, No.76)

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

ARTICLE VIII-D
SENIOR CARE AND SERVICES STUDY COMMISSION
(Art. VIII-D added June 30, 2007, P.L.49, No.16)

Section 801-D. 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:

"Commission." The Senior Care and Services Study Commission.

(801-D added June 30, 2007, P.L.49, No.16)

Section 802-D. Senior Care and Services Study Commission.

(a) Declaration of policy.--The General Assembly recognizes that the health care needs of Pennsylvania's current and future senior population should be assessed.

(b) Establishment.--There is established a Senior Care and Services Study Commission.

(c) Purpose.--The purpose of the commission shall be all of the following:

(1) Reviewing the current care and service offerings and resources available for Commonwealth residents over the age of 65 years.

(2) Projecting future need for the various levels of senior care and services through 2025.

(3) Evaluating the ability of the current assessment and delivery systems to meet the projected service needs.

(4) Projecting the resources necessary to meet the projected need and making policy recommendations as to how the projected need can best be met considering the resource limitations that may exist at the time the commission completes its work under this article.

(d) Composition.--

(1) The commission shall consist of all of the following members:

(i) The Secretary of the Budget or a designee.

(ii) The Secretary of Health or a designee.

(iii) The Secretary or a designee.

(iv) The Secretary of Aging or a designee.

(v) One member appointed by the President pro tempore of the Senate.

(vi) One member appointed by the Minority Leader of the Senate.

(vii) One member appointed by the Speaker of the House of Representatives.

(viii) One member appointed by the Minority Leader of the House of Representatives.

(ix) The following members appointed by the Governor:

(A) Two Commonwealth residents aged 65 or older who use long-term living services.

(B) One individual representing nonprofit nursing facilities.

(C) One individual representing for-profit nursing facilities.

(D) One individual representing county nursing facilities.

(E) One individual representing hospital-based nursing facilities.

(F) One individual representing home and community-based service providers.

(G) One individual representing area agencies on aging.

(H) One representative of an organized labor group representing employees providing long-term living services.

(I) One physician whose practice is focused in long-term care settings.

(J) One individual representing other long-term living stakeholders as may be determined by the Governor.

(2) Appointments under paragraphs (1)(v), (vi), (vii), (viii) and (ix) shall be made within 60 days of the effective date of this section.

(3) Upon appointment of the last member under paragraph (2), the commission shall transmit notice to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin of the date of the last appointment. The date of the last appointment shall be considered the date of the establishment of the commission.

(e) Election of chairperson.--The members of the commission shall elect a chairperson of the commission from among themselves.

(f) Terms of members.--

(1) The terms of those members who serve by virtue of the public office they hold shall be concurrent with their service in the office from which they derive their membership.

(2) Except as provided in paragraph (1), members shall serve until their successors are appointed if they represent the interest of the membership class for which they were appointed.

(g) Meetings.--The first meeting of the commission shall be held within 30 days of establishment of the commission. Subsequent meetings shall be held at least quarterly, but more frequent meetings may be convened either at the call of the chairperson or by request of a simple majority of the commission members.

(h) Initial review.--The commission shall complete the initial review required under subsection (c)(1) within three months of its establishment.

(i) Public input sessions.--Within three months of issuing the findings under subsection (h), the commission shall hold no fewer than three public input sessions across this Commonwealth for the purpose of receiving public comment on current or proposed programs serving seniors.

(j) Projections.--The commission shall obtain the projections under subsection (c)(2) and (4) no later than one year from its establishment. Nothing in this subsection shall prohibit the commission, if a majority of the members agree, from using a Commonwealth-procured study initiated prior to the establishment of the commission to obtain this information.

(k) Final report.--The commission shall publish a final report as required under subsection (c)(1), (2), (3) and (4) no later than 18 months following its establishment and shall submit the report to the Governor and the General Assembly. The final report of the commission and any information and data compiled by the commission in accordance with this article shall be made available on the publicly accessible Internet website operated by the Department of Aging when the commission submits its final report to the Governor and the General Assembly.

(l) Expenses.--The commission is authorized to incur expenses deemed necessary to implement this article.

(802-D added June 30, 2007, P.L.49, No.16)

Section 803-D. Expiration.

The commission shall expire following issuance of its report under section 802-D(k) or three years after the establishment of the commission, whichever occurs first.

(803-D added June 30, 2007, P.L.49, No.16)

ARTICLE VIII-E
HOSPITAL ASSESSMENTS
(Art. added July 4, 2008, P.L.557, No.44)

Section 801-E. 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." The fee authorized to be implemented under this article. (Def. amended June 28, 2019, P.L.43, No.12)

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

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

"Contractual allowance." The difference between what a hospital charges for services and the amounts that certain payers have agreed to pay for the services as further described in the Medicare Provider Reimbursement Manual published by the United States Department of Health and Human Services.

"Exempt hospital." (Def. deleted by amendment Dec. 17, 2009, P.L.598, No.54)

"General acute care hospital." A hospital other than a hospital that the secretary has determined meets one of the following:

(1) Is excluded under 42 CFR 412.23(a), (b), (d), (e) and (f) (relating to Excluded hospitals: Classifications) as of March 20, 2008, from reimbursement of certain Federal funds under the prospective payment system described by 42 CFR 412 (relating to prospective payment systems for inpatient hospital services).

(2) Is a Federal veterans' affairs hospital.

(3) Is a high volume Medicaid hospital.

(4) Provides care, including inpatient hospital services, to all patients free of charge.

(5) Is a free-standing acute care hospital organized primarily for the treatment of and research on cancer and which is an exempt hospital under section 801-G.

(Def. amended June 28, 2019, P.L.43, No.12)

"High volume Medicaid hospital." A hospital that the secretary has determined meets all of the following:

(1) is a nonprofit hospital subsidiary of a State-related institution as that term is defined in 62 Pa.C.S. § 103 (relating to definitions); and

(2) has provided more than 60,000 inpatient acute care days of care to Pennsylvania medical assistance patients as reported by the hospital's State fiscal year 2014-2015 medical assistance hospital cost report on file with the department as of June 6, 2018.

(Def. amended June 28, 2019, P.L.43, No.12)

"Hospital." A facility or the site of a facility that is licensed as a hospital under 28 Pa. Code Pt. IV Subpt. B (relating to general and special hospitals) and located within a municipality. (Def. amended June 28, 2019, P.L.43, No.12)

"Municipality." A city of the first class.

"Net patient revenue." Gross revenues received or earned by a hospital for inpatient and outpatient hospital services, including medical assistance supplemental revenues received by the hospital for inpatient and outpatient hospital services, less any deducted amounts for bad debt expense, charity care expense and contractual allowances as identified in the hospital's records or on forms as specified by the department. (Def. amended June 28, 2019, P.L.43, No.12)

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

(801-E added July 4, 2008, P.L.557, No.44)

Section 802-E. Authorization.

(a) General rule.--In order to generate additional revenues for the purpose of assuring that medical assistance recipients have access to hospital and other health care services, and subject to the conditions and requirements specified under this article, a municipality may, by ordinance, impose an assessment on the following:

(1) Each general acute care hospital.

(2) Each high volume Medicaid hospital.

((a) amended June 28, 2019, P.L.43, No.12)

(a.1) Assessment imposed by ordinance.--A municipality shall, by ordinance, establish the assessment imposed under subsection (a)(1) and (2) as a percentage of each hospital's net patient revenue reduced by all revenues received from Medicare for the year as the municipality shall specify, and may establish different assessment percentages under subsection (a)(1) or (2). ((a.1) amended June 28, 2019, P.L.43, No.12)

(a.2) Adjustments to assessment percentage.--

(1) For State fiscal years beginning after June 30, 2013, and subject to the advance written approval of the secretary as prescribed by the department, the municipality may make a uniform adjustment to an assessment percentage established by ordinance under subsection (a).

(2) After receiving written approval under paragraph (1) and before implementing an adjustment, the municipality shall provide advance public notice. The notice shall specify the proposed adjusted assessment percentage and identify the aggregate impact on hospitals subject to an assessment. An interested party shall have 30 days in which to submit comments to the municipality. Upon expiration of the 30-day comment period, the municipality, after consideration of the comments, shall publish a subsequent notice announcing the adjusted assessment percentage.

((a.2) added June 28, 2019, P.L.43, No.12)

(b) Administrative provisions.--The ordinances adopted pursuant to subsections (a), (a.1) and (a.2) may include appropriate administrative provisions including, without limitation, provisions for the collection of interest and penalties and provisions for the calculation and imposition of the assessment on a hospital subject to an assessment which, during a fiscal year in which an assessment is imposed under this article, changes ownership or control, begins operations, closes or experiences any other change that affects its status as a general acute care hospital or high volume Medicaid hospital. ((b) amended June 28, 2019, P.L.43, No.12)

(c) Maximum assessment.--In each year in which the assessment is implemented, the assessment shall be subject to 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.

(802-E reenacted Oct. 22, 2010, P.L.829, No.84)

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

Section 803-E. Implementation.

The assessment authorized under this article, once imposed, shall be implemented as a health-care related fee as defined under section 1903(w)(3)(B) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396b(w)(3)(B)) or any amendments thereto and may be collected only to the extent and for the periods that the secretary determines that revenues generated by the assessment will qualify as the State share of program expenditures eligible for Federal financial participation.

(803-E added July 4, 2008, P.L.557, No.44)

Section 804-E. Administration.

(a) Remittance.--Upon collection of the funds generated by the assessment authorized under this article, the municipality shall remit a portion of the funds to the Commonwealth for the purposes set forth under section 802-E, except that the municipality may retain funds in an amount necessary to reimburse it for its reasonable costs in the administration and collection of the assessment and to fund a portion of its costs of operating public health clinics and public health programs as set forth in an agreement to be entered into between the municipality and the Commonwealth acting through the secretary.

(b) Establishment.--There is established a restricted account in the General Fund for the receipt and deposit of funds under subsection (a). Funds in the account shall be used by the department for either or both of the following purposes:

(1) Making supplemental or increased medical assistance payments for hospital services to hospitals and to maintain or increase other medical assistance payments to hospitals, as 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 health care services within the municipality.

(804-E amended June 28, 2019, P.L.43, No.12)

Section 805-E. No hold harmless.

No hospital subject to the assessment shall be directly 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 a portion of the funds received under section 804-E(a) for the purposes outlined under section 804-E(b) 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)(i). The secretary shall submit any Title XIX State Plan amendments to the United States Department of Health and Human Services that are necessary to make the payments authorized under section 804-E(b).

(805-E amended June 28, 2019, P.L.43, No.12)

Section 806-E. Federal waiver.

To the extent necessary in order to implement this article, the department shall seek a waiver under 42 CFR 433.68(e) (relating to permissible health care-related taxes) from the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.

(806-E added July 4, 2008, P.L.557, No.44)

Section 807-E. Tax exemption.

Notwithstanding any exemptions granted by any other Federal, State or local tax or other law, including section 204(a)(3)

of the act of May 22, 1933 (P.L.853, No.155), known as The General County Assessment Law, no hospital subject to the assessment shall be exempt from the assessment.

(807-E amended June 28, 2019, P.L.43, No.12)

Section 808-E. Time period.

(a) Cessation.--The assessment authorized under this article shall cease June 30, 2024.

(b) Assessment.--

(1) A municipality shall have the power to enact the assessment authorized in section 802-E(a)(2) either prior to or during its fiscal year ending June 30, 2010.

(2) A municipality may adjust an assessment percentage as specified under section 802-E(a.2) either prior to or during the fiscal year in which the adjusted assessment percentage takes effect.

(808-E amended June 28, 2019, P.L.43, No.12)

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

ARTICLE VIII-F
MEDICAID MANAGED CARE ORGANIZATION ASSESSMENTS
(Art. repealed Dec. 28, 2015, P.L.500, No.92)

Section 801-F. Definitions. (801-F repealed Dec. 28, 2015, P.L.500, No.92)

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

The Secretary of Public Welfare, referred to in this section, was redesignated as the Secretary of Human Services by Act 132 of 2014.

Section 802-F. Authorization. (802-F repealed Dec. 28, 2015, P.L.500, No.92)

Section 803-F. Implementation. (803-F repealed Dec. 28, 2015, P.L.500, No.92)

Section 804-F. Assessment percentage. (804-F repealed Dec. 28, 2015, P.L.500, No.92)

Section 805-F. Calculation and payment. (805-F repealed Dec. 28, P.L.500, No.92)

Section 806-F. Use of assessment proceeds. (806-F repealed Dec. 28, 2015, P.L.500, No.92)

Section 807-F. Records. (807-F repealed Dec. 28, 2015, P.L.500, No.92)

Section 808-F. Payment of assessment. (808-F repealed Dec. 28, 2015, P.L.500, No.92)

Section 809-F. Appeal rights. (809-F repealed Dec. 28, 2015, P.L.500, No.92)

Section 810-F. Enforcement. (810-F repealed Dec. 28, 2015, P.L.500, No.92)

Section 811-F. Time periods. (811-F repealed Dec. 28, 2015, P.L.500, No.92)

ARTICLE VIII-G
STATEWIDE QUALITY CARE ASSESSMENT
(Art. added July 9, 2010, P.L.336, No.49)
(Hdg. reenacted July 9, 2013, P.L.369, No.55)

Compiler's Note: See section 6 of Act 84 of 2010 in the appendix to this act for special provisions relating to continuation of prior law.

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:

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

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

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

"Contractual allowance." The difference between what a hospital charges for services and the amounts that certain payers have agreed to pay for the services as further described in the Medicare Provider Reimbursement Manual published by the United States Department of Health and Human Services.

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

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

"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.

(Def. amended Dec. 28, 2015, P.L.500, No.92)

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

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

"Medical assistance 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. The term shall not include a behavioral health managed care organization that is a party to a Medicaid managed care contract with the department.

"Net inpatient revenue." Gross revenues received or earned by a hospital for inpatient services, including medical assistance supplemental revenues received by the hospital for inpatient hospital services, less any deducted amounts for bad debt expense, charity care expense and contractual allowances as identified in the hospital's records and reported on forms specified by the department.

(1) (Deleted by amendment).

(2) (Deleted by amendment).

(Def. amended Oct. 23, 2023, P.L.63, No.15)

"Net outpatient revenue." Gross revenues received or earned by a hospital for outpatient services, including medical assistance supplemental revenues received by the hospital for outpatient hospital services, less any deducted amounts for bad debt expense, charity care expense and contractual allowances as identified in the hospital's records and reported on forms specified by the department.

(1) (Deleted by amendment).

(2) (Deleted by amendment).

(Def. amended Oct. 23, 2023, P.L.63, No.15)

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

(801-G reenacted and amended July 9, 2013, P.L.369, No.55)

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

Section 802-G. Authorization.

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

(802-G reenacted July 9, 2013, P.L.369, No.55)

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

Section 803-G. Implementation.

(a) Health care-related fee.--The assessment authorized under this article, once imposed, shall be implemented as a health care-related fee as defined under section 1903(w)(3)(B) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396b(w)(3)(B)) or any amendments thereto and may be collected only to the extent and for the periods that the secretary determines that revenues generated by the assessment will qualify as the State share of program expenditures eligible for Federal financial participation.

(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;

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

(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;

(4) for fiscal year 2018-2019, an amount equal to 2.98% of the net inpatient revenue of the covered hospital and 1.55% of the net outpatient revenue of the covered hospital; ((4) amended Oct. 23, 2023, P.L.63, No.15)

(5) for fiscal years 2019-2020, 2020-2021, 2021-2022 and 2022-2023, an amount equal to 3.32% of the net inpatient revenue of the covered hospital and 1.73% of the net outpatient revenue of the covered hospital; ((5) amended Oct. 23, 2023, P.L.63, No.15)

(6) for fiscal year 2023-2024, an amount equal to 3.54% of the net inpatient revenue of the covered hospital and 1.78% of the net outpatient revenue of the covered hospital; and ((6) added Oct. 23, 2023, P.L.63, No.15)

(7) for fiscal years 2024-2025, 2025-2026, 2026-2027 and 2027-2028, an amount equal to 4.36% of the net inpatient revenue of the covered hospital and 2.20% of the net outpatient revenue of the covered hospital. ((7) added Oct. 23, 2023, P.L.63, No.15)

((b) amended June 22, 2018, P.L.258, No.40)

(c) Adjustments to assessment percentage.--The secretary may adjust the assessment percentage specified in subsection (b) for all or part of the fiscal year for inpatient services, outpatient services or both, provided that, before 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) amended June 22, 2018, P.L.258, No.40)

(c.1) Rebasing net inpatient revenue amounts.--For purposes of calculating the annual assessment amount owed for fiscal years 2016-2017 and 2017-2018, 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. ((c.1) amended June 22, 2018, P.L.258, No.40)

(c.2) Rebasing net inpatient revenue and net outpatient revenue amounts on amounts owed for fiscal years prior to 2023-2024.--For purposes of calculating the annual assessment amount owed for fiscal years 2018-2019, 2019-2020, 2020-2021, 2021-2022 and 2022-2023, the secretary may require the use of net inpatient revenue and net outpatient revenue amounts as identified in the records of covered hospitals for a State fiscal year commencing on or after July 1, 2015. If the secretary decides that the net inpatient and net outpatient revenue amounts should be based on a State fiscal year commencing on or after July 1, 2015, the secretary shall transmit a notice to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin specifying the State fiscal year for which the net inpatient and net outpatient

revenue amounts will be used at least 30 days prior to the date on which an assessment amount calculated with the rebased amounts is due to be paid to the department. ((c.2) amended Oct. 23, 2023, P.L.63, No.15)

(c.3) Rebasing net inpatient revenue and net outpatient revenue amounts on amounts owed for fiscal year 2023-2024 and thereafter.--For purposes of calculating the annual assessment amount owed on or after July 1, 2023, the secretary may require the use of net inpatient revenue and net outpatient revenue amounts as identified in the records of covered hospitals for a State fiscal year commencing on or after July 1, 2018. If the secretary decides that the net inpatient and net outpatient revenue amounts should be based on a State fiscal year commencing on or after July 1, 2019, the secretary shall transmit a notice to the Legislative Reference Bureau for publication in the next available issue of the Pennsylvania Bulletin specifying the State fiscal year for which the net inpatient revenue and net outpatient revenue amounts will be used at least 30 days prior to the date on which an assessment amount calculated with the rebased amounts is due to be paid to the department. ((c.3) added Oct. 23, 2023, P.L.63, No.15)

(d) Maximum amount.--In each year in which the assessment is implemented, the assessment shall be subject to 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.--Except as permitted under section 810-G, the secretary's determination of the assessment percentage pursuant to subsection (b) 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; nor shall any assessments implemented under this article or forms or reports required to be completed by covered hospitals pursuant to this article 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.

(803-G reenacted and amended July 9, 2013, P.L.369, No.55)

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

Section 804-G. Administration.

(a) Calculation and notice of assessment amount.--Using the assessment percentage established under section 803-G and covered hospitals' net inpatient revenue and net outpatient revenue, the department shall calculate and notify each covered hospital of the assessment amount owed for the fiscal year. Notification pursuant to this subsection may be made in writing or electronically at the discretion of the department. ((a) amended Oct. 23, 2023, P.L.63, No.15)

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

(1) If a single covered hospital changes ownership or control, the department will calculate the assessment as follows:

(i) if the change of ownership occurs before July 1, 2018, the department shall calculate the assessment using the hospital's net inpatient revenue and net outpatient revenue amounts for State fiscal year

2018-2019, or a later fiscal year that has been specified by the secretary in accordance with section 803-G(c.3);

(ii) if the change of ownership occurs on or after July 1, 2018, the department shall calculate the assessment using the hospital's net inpatient revenue and net outpatient revenue amounts for State fiscal year 2018-2019, or a later fiscal year that has been specified by the secretary in accordance with section 803-G(c.3); or

(iii) if the net inpatient revenue and net outpatient revenue amounts for the State fiscal year 2018-2019, or a later fiscal year that has been specified by the secretary in accordance with section 803-G(c.3), are unavailable due to a covered hospital's establishment as a new hospital under subsection (a.3), the department will calculate the assessment using the hospital's net inpatient revenue and net outpatient revenue amounts under subsection (a.3).

(1.1) 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 assessment amount owed by the single covered hospital resulting from the merger or consolidation as follows:

(i) if the merger or consolidation occurs before July 1, 2018, the department shall calculate the assessment using the merged or consolidated hospitals' combined net inpatient revenue and net outpatient revenue amounts for State fiscal year 2018-2019 or a later fiscal year that has been specified by the secretary in accordance with section 803-G(c.3);

(ii) if the merger or consolidation occurs on or after July 1, 2018, the department shall calculate the assessment using the merged or consolidated hospitals' combined net inpatient revenue and net outpatient revenue amounts for State fiscal year 2018-2019 or a later fiscal year that has been specified by the secretary in accordance with section 803-G(c.3); or

(iii) if one or more hospitals' net inpatient revenue and net outpatient revenue amounts for the State fiscal year 2018-2019, or a later fiscal year that has been specified by the secretary in accordance with section 803-G(c.3), is unavailable due to the hospital's establishment as a new hospital under subsection (a.3), the following apply:

(A) The department shall calculate the assessment using the new hospital's net inpatient revenue and net outpatient revenue amounts under subsection (a.3).

(B) For a hospital that is not a new hospital, the department shall calculate the hospital's net inpatient revenue and net outpatient revenue amounts for State fiscal year 2018-2019 or a later fiscal year that has been specified by the secretary in accordance with section 803-G(c.3).

(C) The department shall combine the amount calculated under clause (A) with the amount calculated under clause (B) to determine the combined net inpatient revenue and net outpatient revenue amounts for the merged or consolidated hospitals.

(3) The single covered hospital is liable for any outstanding assessment amounts, including outstanding amounts related to periods prior to the change of ownership or control, of any covered hospital that was merged or consolidated.

((a.1) amended Oct. 23, 2023, P.L.63, No.15)

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

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

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

(a.3) Calculation of assessment for new hospitals.--A hospital that begins operation as a covered hospital after July 1, 2018, shall be assessed as follows:

(1) During the State fiscal year in which a covered hospital begins operation or in which a hospital becomes a covered hospital, the covered hospital is not subject to the assessment.

(2) For the State fiscal year following the State fiscal year under paragraph (1), the department shall calculate the hospital's assessment amount using the net inpatient revenue and net outpatient revenue from the State fiscal year in which the covered hospital began operation or became a covered hospital through the end of the State fiscal year.

(i) (Deleted by amendment).

(ii) (Deleted by amendment).

(3) For the State fiscal year following the first full State fiscal year under paragraph (2), the department shall calculate the hospital's assessment amount using the net inpatient and net outpatient revenue from the prior State fiscal year. For subsequent State fiscal years, the department shall use the net inpatient revenue and net outpatient revenue calculated under this paragraph or a later fiscal year that has been specified by the secretary in accordance with section 803-G(c.3).

(4) If estimated net inpatient revenue and net outpatient revenue is used in calculating a covered hospital's assessment under this subsection, the department shall reconcile any amounts received based on reported actual net inpatient revenues and net outpatient revenues.

((a.3) amended Oct. 23, 2023, P.L.63, No.15)

(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. ((b) amended Dec. 28, 2015, P.L.500, No.92)

(c) Records.--Upon request by the department, a covered hospital shall furnish to the department such records as the department may specify in order for the department to validate the net inpatient and net outpatient revenues reported by the hospital or to determine the assessment for a fiscal year or the amount of the assessment due from the covered hospital or to verify that the covered hospital has paid the correct amount due. ((c) amended June 22, 2018, P.L.258, No.40)

(d) Underpayments and overpayments.--In the event that the department determines that a covered hospital has failed to pay an assessment or that it has underpaid an assessment, the department shall notify the covered hospital in writing of the amount due, including interest, and the date on which the amount due must be paid, which shall not be less than 30 days from the date of the notice. In the event that the department determines that a covered hospital has overpaid an assessment, the department shall notify the covered hospital in writing of the overpayment and, within 30 days of the date of the notice of the overpayment, shall offset the amount of the overpayment against any amount that may be owed to the department from the covered hospital. ((d) amended June 22, 2018, P.L.258, No.40)

(804-G reenacted and amended July 9, 2013, P.L.369, No.55)

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

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 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. ((2) amended Oct. 23, 2023, P.L.63, No.15)

(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.

(3) (Deleted by amendment June 30, 2011, P.L.89, No.111).

(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 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 $220,000,000.

(4.3) For State fiscal years 2018-2019, 2019-2020 and 2020-2021, 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 $295,000,000.

(4.4) For State fiscal years 2021-2022 and 2022-2023, 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 $300,000,000.

(4.5) For State fiscal year 2023-2024, 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 $368,000,000. ((4.5) added Oct. 23, 2023, P.L.63, No.15)

(4.6) For State fiscal years 2024-2025, 2025-2026, 2026-2027 and 2027-2028, 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 $452,000,000. ((4.6) added Oct. 23, 2023, P.L.63, No.15)

(5) The amounts retained by the department pursuant to paragraphs (1), (2), (4), (4.1), (4.2), (4.3), (4.4), (4.5) and (4.6) 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), subject to paragraph (7). ((5) amended Oct. 23, 2023, P.L.63, No.15)

(6) Not later than 180 days following the end of the State fiscal year, the department shall prepare a revenue reconciliation schedule for the prior State fiscal year that includes information supporting the amounts received or deposited into and paid out of the restricted account to support actual payments to hospitals and managed care organizations pursuant to subsection (a)(1) and (2).

(7) Any positive balance remaining in the restricted account in excess of $10,000,000 annually, which is not used by the Commonwealth to obtain Federal matching funds and paid out for hospital payments, shall be factored into the calculation of a new assessment rate by reducing the amount of hospital assessment funds that must be generated during the next fiscal year in which the department is able to calculate a new rate. If a new assessment rate is not calculated, the funds remaining in the restricted account shall be refunded to the covered hospital that paid the assessment in proportion to the covered hospital's assessment amount paid in the fiscal year.

((b) amended June 22, 2018, P.L.258, No.40)

(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.

(805-G amended Dec. 28, 2015, P.L.500, No.92)

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

Section 806-G. No hold harmless.

No covered hospital shall be directly 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 funds received under this article for the purposes outlined under section 805-G 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)(i). The secretary shall submit to the United States Department of Health and Human Services any State Medicaid plan amendments that are necessary to make the payments authorized under section 805-G.

(806-G reenacted July 9, 2013, P.L.369, No.55)

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

Section 807-G. Federal waiver.

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

(807-G reenacted July 9, 2013, P.L.369, No.55)

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

Section 808-G. Tax exemption.

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

(b) Interpretation.--The assessment imposed under this article shall be recognized by the Commonwealth as uncompensated goods and services under the act of November 26, 1997 (P.L.508, No.55), known as the Institutions of Purely Public Charity Act, and shall be considered a community benefit for purposes of any required or voluntary community benefit report filed or prepared by a covered hospital.

(808-G reenacted July 9, 2013, P.L.369, No.55)

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

Section 809-G. 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) When a covered hospital 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) When a covered hospital 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 covered hospital in the amount of $1,000, plus an additional amount of $200 per day for each additional day that the failure to file the report or furnish the records continues.

(3) When a covered hospital that is a medical assistance provider, or 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, fails to pay all or part of an assessment or penalty within 60 days of the date that payment is due, the department may deduct the unpaid assessment or penalty and any interest owed thereon from any medical assistance payments due to the covered hospital or to any related medical assistance provider until the full amount is recovered. Any such deduction shall be made only after written notice to the covered hospital and medical assistance provider and may be taken in installments over a period of time, taking into account the financial condition of the medical assistance provider.

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

(5) The secretary may waive all or part of the interest or penalties assessed against a covered hospital pursuant to this article for good cause as shown by the covered hospital.

(809-G reenacted July 9, 2013, P.L.369, No.55)

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

Section 810-G. Request for review.

A covered hospital that is aggrieved by a determination of the department as to the amount of the assessment due from the covered hospital or a remedy imposed pursuant to section 809-G 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. 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 covered hospital may not challenge an assessment percentage determined by the secretary pursuant to section 803-G(b) but only whether the department correctly determined the assessment amount due from the covered hospital using the assessment percentage in effect for the fiscal year. A notice of review filed pursuant to this section shall not operate as a stay of the covered hospital's obligation to pay

the assessment amount due for a fiscal year as specified in section 804-G(b).

(810-G reenacted July 9, 2013, P.L.369, No.55)

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

Section 811-G. Liens.

Any assessments implemented and interest and penalties assessed against a covered hospital under this article shall be a lien on the real and personal property of the covered hospital 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.

(811-G reenacted July 9, 2013, P.L.369, No.55)

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

Section 812-G. Regulations.

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

(812-G reenacted July 9, 2013, P.L.369, No.55)

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

Section 813-G. Conditions for payments.

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

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

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

(3) The department receives Federal approval of amendments to its medical assistance managed care organization contracts authorizing adjustments to its capitation payments funded in accordance with section 805-G.

(813-G reenacted and amended July 9, 2013, P.L.369, No.55)

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

Section 814-G. Report.

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

(1) The name, address and amount of assessment for each covered hospital subject to the Quality Care Assessment.
(2) The total amount of assessment revenue collected for each year.
(3) The amount of assessment paid by each covered hospital, including any interest and penalties paid.
(4) The name and address of each hospital receiving supplemental payments instituted as a result of the Quality Care Assessment.
(5) The payment amount and type of supplemental payment received by each hospital.
(6) The total amount of fee-for-service inpatient acute care payment made to each hospital.
(7) The number of medical assistance patient days and discharges by hospital.
(8) Any proposed changes to the payment methodologies and standards.
(814-G reenacted July 9, 2013, P.L.369, No.55)

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

Section 815-G. Expiration.
The assessment under this article shall expire June 30, 2028.
(815-G amended Oct. 23, 2023, P.L.63, No.15)

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

Section 816-G. Retroactive applicability.
This article shall apply retroactively to July 1, 2010.
(816-G reenacted July 9, 2013, P.L.369, No.55)

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

ARTICLE VIII-H
PENNSYLVANIA TRAUMA SYSTEMS STABILIZATION
(Repealed July 2, 2019, P.L.359, No.54)

Section 801-H. Scope of article. (801-H repealed July 2, 2019, P.L.359, No.54)
Section 802-H. Definitions. (802-H repealed July 2, 2019, P.L.359, No.54)
Section 803-H. Accreditation of Level III trauma centers. (803-H repealed July 2, 2019, P.L.359, No.54)
Section 804-H. Submission of list. (804-H repealed July 2, 2019, P.L.359, No.54)
Section 805-H. Funding. (805-H repealed July 2, 2019, P.L.359, No.54)

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

Section 806-H. Notification of trauma center closure. (806-H repealed July 2, 2019, P.L.359, No.54)
Section 807-H. Reporting. (807-H repealed July 2, 2019, P.L.359, No.54)
Section 808-H. Certification and financial report. (808-H repealed July 2, 2019, P.L.359, No.54)

ARTICLE VIII-I
MANAGED CARE ORGANIZATION ASSESSMENTS
(Art. added Dec. 28, 2015, P.L.500, No.92)

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 (relating to definitions).

(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.).

(801-I added Dec. 28, 2015, P.L.500, No.92)

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.

(802-I added Dec. 28, 2015, P.L.500, No.92)

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.

(803-I added Dec. 28, 2015, P.L.500, No.92)

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).

(804-I added Dec. 28, 2015, P.L.500, No.92)

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).

(805-I added Dec. 28, 2015, P.L.500, No.92)

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.

(806-I added Dec. 28, 2015, P.L.500, No.92)

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.

(807-I added Dec. 28, 2015, P.L.500, No.92)

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.

(808-I added Dec. 28, 2015, P.L.500, No.92)

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.

(809-I added Dec. 28, 2015, P.L.500, No.92)

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 exemptions 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).

(810-I added Dec. 28, 2015, P.L.500, No.92)

Section 811-I. Expiration (811-I repealed May 29, 2020, P.L.158, No.23).

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.

(812-I added Dec. 28, 2015, P.L.500, No.92)

ARTICLE IX
DEPARTMENTAL POWERS AND DUTIES AS TO SUPERVISION

Compiler's Note: Section 26 of Act 179 of 1992 provided that Article IX is repealed insofar as it relates to health care facilities as defined in Chapter 8 of Act 179.

Compiler's Note: Section 21 of Act 118 of 1990 provided that Article IX is repealed insofar as it is inconsistent with Act 118.

Compiler's Note: Section 10 of Act 136 of 1980 provided that Article IX is repealed insofar as it relates to health care facilities as defined in Chapter 8 of Act 48 of 1979.

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

"Child 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 care furnished in a place of worship during religious services. (Def. amended June 22, 2018, P.L.258, No.40)

"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 child care home or child care center operated for profit and subject to the provisions of Article X. (Def. amended June 22, 2018, P.L.258, No.40)

"Institution for adults" means any incorporated or unincorporated public or private organization, society or association including any agency of a county, county institution district or municipality which provides for food, shelter and some service to adults, or which provides rehabilitation, training, guidance or counselling to the blind or visually handicapped, or to the physically or mentally handicapped, including but limited to the following: homes for the aged and infirm, nursing homes, convalescent homes, placement agencies for adults, general and special hospitals and institutions for mentally ill and defective adults, rehabilitation centers having living-in arrangements, workshops and facilities for the rehabilitation of the visually, mentally or physically handicapped, and all organizations for the prevention of blindness.

"Maternity home and hospital" means any house, home or place in which, within a period of six months, any person receives for care or treatment during pregnancy, or during or immediately after parturition, more than one woman, except women related to such person by blood or marriage within the second degree.

"State institutions" mean and include all hospitals for the mentally ill, or any other institutions for mentally retarded or epileptic persons, or for juvenile delinquents and dependents, and charitable institutions, within this Commonwealth, maintained in whole by the Commonwealth, and whose boards of trustees are departmental administrative boards within the department.

"Supervised institution" means any charitable institution within the Commonwealth which receives financial assistance from the Commonwealth, either directly or indirectly, and to which the Governor does not appoint any member of the board of inspectors, managers, trustees or directors; all houses or

places within the Commonwealth in which any person of unsound mind is detained, whenever the occupant or owner of the house, or person having charge of such person of unsound mind, receives any compensation for custody, control or attendance, other than as an attendant or nurse; and also all institutions, houses, or places, in which more than one such person is detained, with or without compensation paid for custody or attendance; all children's institutions and maternity homes and hospitals within the Commonwealth; all homes or hospitals for crippled children within the Commonwealth, except the State Hospital for Crippled Children; all hospitals, almshouses, or poorhouses, maintained by any county, city, borough, township or poor district of this Commonwealth; and all institutions, associations and societies within this Commonwealth into whose care the custody of delinquent, dependent or neglected children may be committed, and all houses and places maintained by such institutions, associations or societies in which such children may be kept or detained.

Section 902. Supervisory Powers.--The department shall have supervision over:

(1) All State institutions;

(2) All supervised institutions;

(3) All children's institutions within this Commonwealth;

(4) All maternity homes and hospitals within this Commonwealth;

(5) Any labor or system of labor carried on in the penal, correctional or reformatory institutions of the State;

(6) Any system of reparation provided by the Commonwealth for relief from conditions caused by mine-caves, fire, flood, or other casualty, and constituting a menace to public safety and welfare;

(7) All boarding homes for children which have been licensed by the State;

(8) All institutions for adults within this Commonwealth.

Section 911. Visitation and Inspection.--(a) The department shall have the power, and its duty shall be:

(1) To make and enforce rules and regulations for a visitation, examination and inspection of all supervised institutions and said visitation, examination or inspection may occur both before and after the beginning of operation of the supervised facility.

(2) To visit and inspect, at least once in each year, all State and supervised institutions; to inquire and examine into their methods of instruction, discipline, detention, care or treatment, the care, treatment, government or management of their inmates or those committed thereto, or being detained, treated or residing therein, the official conduct of their inspectors, trustees, managers, directors or other officer or officers charged with their management by law or otherwise, or having the management, care, custody or control thereof, the buildings, grounds, premises, and equipment thereof, or connected therewith, and all and every matter and thing relating to their usefulness, administration, and management, and to the welfare of the inmates thereof, or those committed thereto or being detained, treated or residing therein.

((a) amended July 15, 1976, P.L.993, No.202)

(b) For these purposes and for the purpose of determining whether or not a facility should be subject to the supervision of the department in accordance with section 902, the secretary, or other officer, inspector or agent of the department, shall have free and full access to the grounds, premises, and buildings of and to all the records, books or papers of or

relating to any such State or supervised institution, and full opportunity to interrogate or interview any inmate thereof, or any person or persons committed to or being detained, treated or residing therein, and all persons connected with any such State or supervised institution as officers, or charged with the management, thereof, by law or otherwise, or in any way having the care, custody, control, or management thereof, or connected therewith as employes, are hereby directed and required to give to the secretary, or to such officer, inspector or agent of the department, such means, facilities and opportunity for such visitation, examination, inquiry and interrogation, as is hereby provided and required, or as the department, by its duly ordained rules or regulations, may require. ((b) amended July 15, 1976, P.L.993, No.202)

(c) Whenever upon the visitation, examination, and inspection of any State or supervised institution, any condition is found to exist therein which, in the opinion of the department, is unlawful, unhygienic, or detrimental to the proper maintenance and discipline of such State or supervised institution, or to the proper maintenance, custody, safety, and welfare of the inmates thereof, or of the persons committed thereto, or being treated, detained or residing therein, to direct the officer or officers charged by law with or in any way having or exercising the control, government, or management of such State or supervised institution, to correct the said objectionable condition in the manner and within the time specified by the department, whereupon it shall be the duty of such officer or officers to comply with the direction of the department. If such officer or officers shall fail to comply with such direction, the department may request the Department of Justice to institute appropriate legal proceeding to enforce compliance therewith, or the department may withhold any State money available for such institution until such officer or officers comply with such direction.

(d) To cause to be visited and examined any person found by an inquisition to be insane, and to authorize such visiting and examining by an officer or agent of the department, or any board of visitors, or by a physician, and to apply to the court having jurisdiction over the committee or guardian of such insane person, or to a judge of a court of common pleas of the county in which the insane person is a resident or detained, to make such orders for the maintenance, custody, or care of the insane person, and for the care and disposition of the property of the insane person as the case may require.

Section 916. Recommendations.--The department shall have the power, and its duty shall be, from time to time, to recommend and bring to the attention of the officers or other persons having the management of the State and supervised institutions such standards and methods as may be helpful in the government and administration of such institutions and for the betterment of the inmates therein, whereupon it shall be the duty of such officers or other persons to adopt and put into practice such standards and methods.

Section 921. Additional Provisions Respecting Certain Institutions; Purpose; Definitions; Standards; Inspection.--(a) The purpose of this section is to comply with Federal law and regulations, particularly the Social Security amendments of 1950, and to promote the public health, safety and welfare, by providing for the establishment, enforcement and application of standards for the safe and adequate care of individuals in institutions herein defined.

It is not the purpose of this section to authorize the duplication of the work of any State department heretofore, now or hereafter charged with responsibilities and authority with reference to standards herein authorized. To prevent such duplication, the department may call upon any other department, board or commission of the Commonwealth of Pennsylvania to cooperate with it in the performance of its duties and responsibilities hereunder.

(b) As used in this section, "institution" means an establishment which furnishes (in single or multiple facilities) food and shelter to three or more persons unrelated to the proprietor, and which provides some care or service which meet some need beyond the basic provisions of food, shelter and laundry. The term "institution" shall include, but not be limited to, homes for the aged and infirm, nursing homes, convalescent homes, rehabilitation centers providing living-in facilities, boarding homes for adults which provide personal care and services, hospitals, and infirmaries providing living-in arrangements.

(c) The department shall establish standards for the safe and adequate care of individuals, not inconsistent with the laws of this Commonwealth and the rules and regulations of the various departments of the Commonwealth, for all such institutions within this Commonwealth, which standards shall make adequate and proper provisions for (i) fire protection, (ii) water supply and sewage disposal, (iii) sanitation, (iv) lighting and heating, (v) ventilation, (vi) safety, (vii) equipment, (viii) bed space, (ix) keeping of records of identification of residents in the institution and their next of kin, of medical care provided and all pertinent admission and discharge data, and (x) humane care.

In the establishment, amendment or revocation of standards, the department shall confer with an advisory committee of not less than seven or more than eleven persons, to be appointed by the secretary with the consent of the Governor, from representatives of recognized agencies and religious organizations conducting institutions and from the public at large. The secretary or someone designated by him shall be the chairman of the advisory committee.

(d) The department shall be responsible for the maintenance of the standards herein provided; and for that purpose the department or its duly authorized representative shall have free and full access to the premises and records mentioned in subsection (c) of this section of any such institution and full opportunity to interrogate or interview any officer, employe or resident thereof.

The department shall also be responsible for the coordination and cooperation in the application of these standards where any other department, board or commission of the Commonwealth of Pennsylvania may be charged either by law or by regulation with the enforcement of any standards herein authorized; and where any department, board or commission of the Commonwealth of Pennsylvania is charged with responsibilities relative to the enforcement of standards. The department may ask for, and such other department, board or commission shall furnish it with, the proper reports and information in order that the department may be satisfied that the standards are being observed.

When the department calls to the attention of any other department, board or commission of the State government any failure to comply with the standards herein set forth, such other department, board or commission of the Commonwealth of

Pennsylvania shall undertake the enforcement of the standards within their responsibility.

The department shall visit and inspect such institutions at least annually.

(e) Whenever the department shall upon inspection, investigation or complaint find any violation in any institution of rules or regulations adopted by the department, or any failure to establish, provide or maintain standards and facilities required by this act or by the department, it shall give immediate written notice thereof, to the officer or officers charged by law with or in any way having or exercising the control, government or management of such institution, to correct the said objectionable condition in the manner and within the time specified by the department; whereupon, it shall be the duty of such officer or officers to comply with the direction of the department. If such officer or officers fail to comply with such direction, the department may request the Department of Justice to institute appropriate legal proceedings to enforce compliance therewith, and the department may withhold any State money available for such institution until such officer or officers comply with such direction.

Section 922. Reorganization Plan No. 5 of 1955.--Nothing in this act shall be construed to repeal or affect Reorganization Plan No. 5 of 1955.

ARTICLE X
DEPARTMENTAL POWERS AND DUTIES AS TO LICENSING

Compiler's Note: Section 26 of Act 179 of 1992 provided that Article X is repealed insofar as it relates to health care facilities as defined in Chapter 8 of Act 179.

Compiler's Note: Section 21 of Act 118 of 1990 provided that Article X is repealed insofar as it is inconsistent with Act 118.

Compiler's Note: Section 10 of Act 136 of 1980 provided that Article X is repealed insofar as it relates to health care facilities as defined in Chapter 8 of Act 48 of 1979.

(a) Licensing Provisions

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

"Adult day care" means care given for part of the twenty-four hour day to adults requiring assistance to meet personal needs and who, because of physical or mental infirmity, cannot themselves meet these needs, but who do not require nursing care.

"Adult day care center" means any premises operated for profit, in which adult day care is simultaneously provided for four or more adults who are not relatives of the operator.

"Age in place" and "aging in place" means receiving care and services at a licensed assisted living residence to accommodate changing needs and preferences in order to remain in the assisted living residence. (Def. added July 25, 2007, P.L.402, No.56)

"Assisted living residence" means any premises in which food, shelter, personal care, assistance or supervision and supplemental health care services are provided for a period exceeding twenty-four hours for four or more adults who are not relatives of the operator and who require assistance or supervision in such matters as dressing, bathing, diet,

financial management, evacuation from the residence in the event of an emergency or medication prescribed for self-administration. (Def. added July 25, 2007, P.L.402, No.56)

"Assisted living residence administrator" means an individual who is charged with the general administration of an assisted living residence, whether or not such individual has an ownership interest in the residence or his function and duties are shared with other individuals. (Def. added July 25, 2007, P.L.402, No.56)

"Boarding home for children" means any premises operated for profit in which care is provided for a period exceeding twenty-four hours for any child or children under sixteen years of age, who are not relatives of the operator and who are not accompanied by parent, individual standing in loco parentis or legal guardian. The term shall not be construed to include any such premises selected for care of such child or children by a parent, individual standing in loco parentis or legal guardian for a period of thirty days or less, nor any such premises conducted under social service auspices.

"Child care" means care in lieu of parental care given for part of the twenty-four hour day to children under sixteen years of age, away from their own homes, but does not include child care furnished in places of worship during religious services. (Def. amended June 22, 2018, P.L.258, No.40)

"Child care center" means any premises operated for profit in which child care is provided simultaneously for seven or more children who are not relatives of the operator, except such centers operated under social service auspices. (Def. amended June 22, 2018, P.L.258, No.40)

"Cognitive support services" means services provided to an individual who has memory impairments and other cognitive problems which significantly interfere with their ability to carry out activities of daily living without assistance and who require that supervision, monitoring and programming be available to them 24 hours per day, seven days per week, in order for them to reside safely in the setting of their choice. The term includes assessment, health support services and a full range of dementia-capable activity programming and crisis management. (Def. added July 25, 2007, P.L.402, No.56)

"Direct care staff" means a person who directly assists residents with activities of daily living; provides services; or is otherwise responsible for the health, safety and welfare of the residents.

"Facility" means an adult day care center, child care center, family 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." (Def. amended June 22, 2018, P.L.258, No.40)

"Family child care home" means a home where child 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. (Def. amended June 22, 2018, P.L.258, No.40)

"Hospital" means any premises, other than a mental health establishment as defined herein, operated for profit, having an organized medical staff and providing equipment and services primarily for inpatient care for two or more individuals who require definitive diagnosis and/or treatment for illness, injury or other disability or during or after pregnancy, and

which also regularly makes available at least clinical laboratory services, diagnostic X-ray services and definitive clinical treatment services. The term shall include such premises providing either diagnosis or treatment, or both, for specific illnesses or conditions.

"Immobile person" means an individual who is unable to move from one location to another or has difficulty in understanding and carrying out instructions without the continued full assistance of other persons, or is incapable of independently operating a device such as a wheelchair, prosthesis, walker or cane to exit a building.

"Informed consent agreement" means a formal, mutually agreed upon, written understanding which:

(1) results after thorough discussion among the assisted living residence staff, the resident and any individuals the resident wants to be involved; and

(2) identifies how to balance the assisted living residence's responsibilities to the individuals they serve with a resident's choices and capabilities with the possibility that those choices will place the resident or other residents at risk of harm.

(Def. added July 25, 2007, P.L.402, No.56)

"Maternity home" means any premises operated for profit in which, within a period of six months, any person receives more than one woman or girl, not a relative of the operator, for care during pregnancy or immediately after delivery.

"Mental health establishment" means any premises or part thereof, private or public, for the care of individuals who require care because of mental illness, mental retardation or inebriety but shall not be deemed to include the private home of a person who is rendering such care to a relative.

"Nursing home" means any premises operated for profit in which nursing care and related medical or other health services are provided, for a period exceeding twenty-four hours, for two or more individuals, who are not relatives of the operator, who are not acutely ill and not in need of hospitalization, but who, because of age, illness, disease, injury, convalescence or physical or mental infirmity need such care.

"Person" means any individual, partnership, association or corporation operating a facility.

"Personal care home" means any premises in which food, shelter and personal assistance or supervision are provided for a period exceeding twenty-four hours for four or more adults who are not relatives of the operator, who do not require the services in or of a licensed long-term care facility but who do require assistance or supervision in such matters as dressing, bathing, diet, financial management, evacuation of a residence in the event of an emergency or medication prescribed for self administration.

"Personal care home administrator" means an individual who is charged with the general administration of a personal care home, whether or not such individual has an ownership interest in the home or his functions and duties are shared with other individuals.

"Relative" means parent, child, stepparent, stepchild, grandparent, grandchild, brother, sister, half brother, half sister, aunt, uncle, niece, nephew.

"Social service auspices" means any nonprofit agency regularly engaged in the affording of child or adult care.

"Special care designation" means a licensed assisted living residence or a distinct part of the residence which is specifically designated by the department as capable of

providing cognitive support services to residents with severe cognitive impairments, including, but not limited to, dementia or Alzheimer's disease, in the least restrictive manner to ensure the safety of the resident and others in the residence while maintaining the resident's ability to age in place. (Def. added July 25, 2007, P.L.402, No.56)

"Supplemental health care services" means the provision by an assisted living residence of any type of health care service, either directly or through contractors, subcontractors, agents or designated providers, except for any service that is required by law to be provided by a health care facility pursuant to the act of July 19, 1979 (P.L.130, No.48), known as the "Health Care Facilities Act." (Def. added July 25, 2007, P.L.402, No.56)

(1001 amended Dec. 21, 1988, P.L.1883, No.185)

Compiler's Note: See the preamble and sections 8, 9, 10 and 11 of Act 56 of 2007 for special provisions relating to legislative findings, construction of law, Legislative Budget and Finance Committee report and assisted living residence licenses.

Section 1002. Operation and Maintenance Without License Prohibited.--No person shall maintain, operate or conduct any facility, as defined herein, without having a license therefor issued by the department.

Section 1003. Application for License.--Any person desiring to secure a license for maintaining, operating and conducting a facility shall submit an application therefor to the department upon forms prepared and furnished by the department, together with such other information as the department shall require. Application for annual renewal of license shall be made in the same manner as application for original licensure.

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 child care homes, boarding homes for children or for public or nonprofit mental institutions.

(1006 amended Dec. 28, 2015, P.L.500, No.92)

Compiler's Note: Section 20 of Act 92 of 2015, which amended section 1006, provided that the requirement that a family child care home be licensed as a facility as defined in section 1001 shall apply upon expiration of the family child care home's current certificate of registration.

Section 1007. Issuance of License.--When, after investigation, the department is satisfied that the applicant or applicants for a license are responsible persons, that the place to be used as a facility is suitable for the purpose, is appropriately equipped and that the applicant or applicants and the place to be used as a facility meet all the requirements of this act and of the applicable statutes, ordinances and regulations, it shall issue a license and shall keep a record thereof and of the application.

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.

(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.

(1008 amended Dec. 28, 2015, P.L.500, No.92)

Section 1009. Term and content of License.--All licenses issued by the department under this act shall expire one year next following the day on which issued, shall be on a form prescribed by the department, shall not be transferable, shall be issued only to the person for the premises and for the facility named in the application and shall specify the maximum number of individuals who may be cared for in the facility at any one time. The license shall at all times be posted in a conspicuous place on the applicant's premises.

Section 1016. Right to Enter and Inspect.--(a) For the purpose of determining the suitability of the applicants and of the premises or whether or not any premises in fact qualifies as a facility as defined in section 1001 of this act or the continuing conformity of the licensees to this act and to the applicable regulations of the department, any authorized agent of the department shall have the right to enter, visit and inspect any facility licensed or requiring a license under this act and shall have full and free access to the records of the facility and to the individuals therein and full opportunity to interview, inspect or examine such individuals.

(b) An authorized agent of the department shall also confer with the operators of facilities regarding the minimum standards of the department, encourage the adoption of higher standards and recommend methods of improving care and services.

(c) All child care centers and family child care homes shall have a fire detection device or system that is operable and properly maintained at all times in compliance with the act of April 27, 1927 (P.L.465, No.299), referred to as the "Fire and Panic Act," the act of November 10, 1999 (P.L.491, No.45), known as the "Pennsylvania Construction Code Act," and applicable regulations. The following shall apply:

(1) To verify operability, a child care center or a family child care home shall manually test all fire detection devices or systems at least once every thirty days and shall maintain a written record of the testing with the facility's fire drill logs. Operability shall also be demonstrated during the department's annual inspection.

(2) If a fire detection device or system cannot be tested every thirty days, the child care center or family child care home shall have the device or system tested at least annually by a fire safety professional and shall maintain written documentation of the test results with the facility's fire drill logs. The documentation shall be on the fire safety professional's letterhead.

(3) A child care center or family child care home shall keep the proof and date of purchase of an interconnected fire detection device or system with the facility's fire drill logs.

(4) The department's certification staff shall conduct a visual inspection of the child care center or family child care home to identify whether the child care center or family child care home may not be in compliance with fire safety requirements with respect to smoke detectors under the "Fire and Panic Act" and the "Pennsylvania Construction Code Act." Upon inspection under this section, notice of any suspected failure to satisfy the safety requirements of this subsection in a child care center or family child care home shall be provided to the building code official charged by law or ordinance with the enforcement of safety requirements. Upon request by the department, the building code official shall furnish to the department the inspection reports and any other pertinent information with respect to the requirements of this subsection for a child care center or family child care home to ensure compliance with this section.

(5) For the purposes of this subsection, the term "child care center" shall include for-profit and nonprofit child care centers in this Commonwealth.

(1016 amended July 14, 2020, P.L.639, No.62)

Section 1018. Records.--Every person licensed under this act to maintain, operate and conduct a facility shall keep such records and make such reports as are required by the department.

Section 1021. Regulations.--(a) (1) The department shall adopt regulations establishing minimum standards for building, equipment, operation, care, program and services, training and staffing and for the issuance of licenses.

(2) Regulations for assisted living residences shall:

(i) Meet or exceed standards established in 55 Pa. Code § 2600 (relating to personal care homes). Residents' rights in those or subsequent regulations shall not be subject to waiver.

(ii) Require an assisted living residence to provide a resident with the resident's own living unit. Two residents may voluntarily agree to share one unit, provided that the agreement is in writing and contained in each of the residency agreements of those residents. A licensee shall not require residents to share a unit.

(iii) Provide that supplemental health care services shall be packaged, contracted and priced separately from the resident agreement.

(iv) Require that each living unit contain a private bathroom, living and bedroom space, kitchen capacity, which may mean electrical outlets to have small appliances such as a microwave and refrigerator, closets and adequate space for storage and a door with a lock, except where a lock or appliances in a unit under special care designation would pose a risk or be unsafe.

(v) Establish minimum square footage requirements for individual living units which excludes bathrooms and closet space. Exceptions to the size of the living unit may be made at the discretion of the department.

(vi) Establish a special care designation for assisted living residences and units that require specialized staff training, service planning, activity programming and security measures for residents receiving cognitive support services.

(vii) Create standards for informed consent agreements that promote aging in place which include written acknowledgment of the risks that residents assume while directing their own care and which release the facility from liability for adverse outcomes resulting from actions consistent with the terms of the informed consent agreement. Such informed consent agreements

shall only be entered into upon the mutual agreement of the resident and the assisted living residence.

(viii) Create standards for transfer and discharge that require the assisted living residence to make a reasonable accommodation for aging in place and that may include services from outside providers.

(b) The department shall, by regulation, set fees for application for assisted living residence licensure and licensure renewal. Fees received by the department shall augment the department's funding for quality assurance and shall be used for the purposes of this article.

(c) ((c) deleted by amendment July 8, 2016, P.L.480, No.76)

(d) The department shall develop regulations under this article in consultation with industry stakeholders, consumers and other interested parties.

(1021 amended July 25, 2007, P.L.402, No.56)

Compiler's Note: See the preamble and sections 8, 9, 10 and 11 of Act 56 of 2007 for special provisions relating to legislative findings, construction of law, Legislative Budget and Finance Committee report and assisted living residence licenses.

Section 1026. Refusal to Issue License; Revocation; Notice.--(a) Whenever the department, upon inspection or investigation, shall learn of violation of this act or of regulations adopted by the department pursuant to this act, it shall give written notice thereof to the offending person. Such notice shall require the offending person to take action to bring the facility into compliance with this act or with the relevant regulations within a specified time.

(b) The department shall refuse to issue a license or shall revoke a license for any of the following reasons:

(1) Violation of or non-compliance with the provisions of this act or of regulations pursuant thereto;

(2) Fraud or deceit in obtaining or attempting to obtain a license;

(3) Lending, borrowing or using the license of another, or in any way knowingly aiding or abetting the improper granting of a license;

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

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

(c) Whenever the department revokes or refuses to issue a license, it shall give written notice thereof by certified mail. Such notice shall specify the reason for the refusal or revocation.

Section 1031. Violation; Penalty.--(a) Any person operating a facility within this Commonwealth without a license required by this act shall upon conviction 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 nonresidential 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 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.

(1031 amended Dec. 28, 2015, P.L.500, No.92)

(b) Injunctions Against Unlicensed Activities; Procedures

Section 1051. Definition.--As used in this subarticle--

"Private institution" means any of the following facilities by whatever term known and irrespective of the age group served: Mental hospital, institution for the mentally defective, day care center, nursing home, hospital, personal care home, assisted living residence and other similar institution which is operated for profit and which requires a license issued by the department.

(1051 amended July 25, 2007, P.L.402, No.56)

Compiler's Note: See the preamble and sections 8, 9, 10 and 11 of Act 56 of 2007 for special provisions relating to legislative findings, construction of law, Legislative Budget and Finance Committee report and assisted living residence licenses.

Section 1052. Actions Against Unlicensed Institutions.--Whenever a license is required by law for the establishment, operation or conduct of a private institution, the department responsible for issuing such license, upon advice of the Attorney General, may maintain an action in the name of the Commonwealth for an injunction or other process restraining or prohibiting any person from establishing, conducting or operating any private institution during any period after a license to engage in such activity has been refused, has not been renewed or has been revoked by the department.

Compiler's Note: Section 504 of Act 164 of 1980 provided that section 1052 is repealed insofar as it is inconsistent with Act 164.

Section 1053. Actions Against Violations of Law and Rules and Regulations.--Whenever any person, regardless of whether such person is a licensee, has violated the laws of this Commonwealth pertaining to the licensing of a private institution or the rules and regulations adopted pursuant to such laws by the department, the department, upon the advice of the Attorney General, may maintain an action in the name of the Commonwealth for an injunction or other process restraining or prohibiting such person from engaging in such activity.

Compiler's Note: Section 504 of Act 164 of 1980 provided that section 1053 is repealed insofar as it is inconsistent with Act 164.

Section 1054. Venue.--An action authorized under the provisions of this subarticle shall be instituted in the court of common pleas in the county where the alleged unauthorized activity is committed.

Section 1055. Injunction or Restraining Order When Appeal is Pending.--Whenever the department shall have refused to grant or renew a license, or shall have revoked a license required by law to operate or conduct a private institution, or shall have ordered the person to refrain from conduct violating the rules and regulations of the department and the person deeming himself aggrieved by such refusal or revocation or order shall have appealed the action of the department, the court may,

during pendency of such appeal, issue a restraining order or injunction upon proof that the operation of the private institution or its failure to comply with the order of the department adversely affects the well-being and safety of the patients or inmates in the private institution.

Section 1056. Injunction or Restraining Order When No Appeal is Pending.--Should a person, who is refused a license or the renewal of a license to operate or conduct a private institution, or whose license to operate or conduct a private institution is revoked, or who has been ordered to refrain from conduct or activity which violates the rules and regulations of the department, fail to appeal or should such appeal be decided finally favorably to the department, then the court shall issue a permanent injunction upon proof that the person is operating or conducting a private institution without a license as required by law, or has continued to violate the rules and regulations of the department.

Section 1057. Appeals. (1057 repealed June 3, 1971, P.L.118, No.6)

Section 1057.1. Appeals.--(a) (1) An appeal from the decision of the department relating to the licensure or revocation of a personal care home shall not act as a supersedeas but, upon cause shown and where circumstances require it, the reviewing authority shall have the power to grant a supersedeas.

(2) An appeal from the decision of the department relating to revocation of an assisted living residence license shall not act as a supersedeas but, upon cause shown and where circumstances require it, the reviewing authority shall have the power to grant a supersedeas.

(b) If, without good cause, one or more Class I or Class II violations remain uncorrected or when the home or residence has demonstrated a pattern of episodes of noncompliance alternating with compliance over a period of at least two years such as would convince a reasonable person that any correction of violations would be unlikely to be maintained, the department may petition the court to appoint a master designated as qualified by the department to assume operation of the home or residence at the operator's expense for a specified period of time or until all violations are corrected and all applicable laws and regulations are complied with.

(1057.1 amended July 25, 2007, P.L.402, No.56)

Compiler's Note: See the preamble and sections 8, 9, 10 and 11 of Act 56 of 2007 for special provisions relating to legislative findings, construction of law, Legislative Budget and Finance Committee report and assisted living residence licenses.

Section 1057.2. Relocation.--(a) The department, in conjunction with appropriate local authorities, shall relocate residents from a personal care home or assisted living residence if any of the following conditions exist:

(1) The home or residence is operating without a license.

(2) The licensee is voluntarily closing a home or residence and relocation is necessary for the health and welfare of the resident or residents.

((a) amended July 25, 2007, P.L.402, No.56)

(b) The department shall offer relocation assistance to residents relocated under this section. Except in an emergency, the resident shall be involved in planning his transfer to another placement and shall have the right to choose among the available alternative placements. The department may make

temporary placement until final placement can be arranged. Residents shall be provided with an opportunity to visit alternative placement before relocation or following temporary emergency relocation. Residents shall choose their final placement and shall be given assistance in transferring to such place.

(c) Residents shall not be relocated pursuant to this section if the secretary determines, in writing, that such relocation is not in the best interest of the resident.

(1057.2 added Dec. 21, 1988, P.L.1883, No.185)

Compiler's Note: See the preamble and sections 8, 9, 10 and 11 of Act 56 of 2007 for special provisions relating to legislative findings, construction of law, Legislative Budget and Finance Committee report and assisted living residence licenses.

Section 1057.3. Rules and Regulations for Personal Care Home and Assisted Living Residences.--(a) The rules and regulations for the licensing of personal care homes and assisted living residences promulgated by the department shall require that:

(1) (i) Prior to a resident's admission to a personal care home or assisted living residence, an initial standardized screening instrument be completed for that resident by the provider or a human service agency. Such standardized screening instrument shall be developed by the department.

(ii) For a personal care home, the screening will be done to determine that the potential resident does not require the services in or of a long-term care facility and whether the potential resident requires the services of a personal care home and, if so, the nature of the services and supervision necessary.

(iii) For an assisted living residence, the screening will be done to determine whether the potential resident requires the services provided by an assisted living residence. A resident who currently does not require assistance in obtaining supplemental health care services, but who may require such services in the future or who wishes to obtain assistance in obtaining such services or reside in a facility in which such services are available, may be admitted to the assisted living residence, provided the resident is only provided service required or requested by the resident. Where services are required, the assisted living residence shall develop a support plan as defined in 55 Pa. Code § 2600 (relating to personal care homes) and any other regulations applicable to assisted living residences.

(iv) An initial screening shall not be required to commence supplemental health care services to a resident of an assisted living residence who was not receiving such services at the time of the resident's admission, to transfer a resident from a portion of an assisted living residence that does not provide supplemental health care services to a portion of the residence that provides such service or to transfer a resident from a personal care home to an assisted living residence licensed by the same operator.

(2) In addition to the screening, each resident receive a complete medical examination by a physician prior to, or within thirty days of, admission and that once admitted, each resident receive a screening and medical evaluation at least annually.

(3) A personal care home or assisted living residence administrator refer an applicant whose needs cannot be met by the home or residence to an appropriate assessment agency.

(3.1) Prospective or current residents for whom placement in a skilled nursing facility is imminent shall be given priority for assisted living residence services funded through a home- and community-based waiver.

(3.2) All individuals receiving services under the home- and community-based waivers shall have a comprehensive assessment of their needs using an instrument that provides comparable data elements and at comparable time intervals as specified by the State for Medicaid for nursing facilities.

(4) Each resident be provided by the administrator with notice of any Class I or Class II violations uncorrected after five days.

(5) All residents sign a standard written admission agreement which shall include the disclosure to each resident of the actual rent and other charges for services provided by the personal care home or assisted living residence.

(6) For residents eligible for Supplemental Security Income (SSI) benefits, actual rent and other charges not exceed the resident's actual current monthly income reduced by a personal needs allowance for the resident in an amount to be determined by the department, but not less than twenty-five dollars ($25).

(7) A personal care home or assisted living residence not seek or accept any payments from a resident who is a Supplemental Security Income (SSI) recipient in excess of one-half of any funds received by the resident under the act of March 11, 1971 (P.L.104, No.3), known as the "Senior Citizens Rebate and Assistance Act."

(8) A personal care home or assisted living residence not seek or accept from a resident who is eligible for Supplemental Security Income (SSI) benefits any payment from any funds received as lump sum awards, gifts or inheritances, gains from the sale of property, or retroactive government benefits: Provided, however, That an owner or operator may seek and accept payments from funds received as retroactive awards of Social Security or Supplemental Security Income (SSI) benefits, but only to the extent that the retroactive awards cover periods of time during which the resident actually resided in the personal care home or assisted living residence.

(9) Each resident who is a recipient of, or an eligible applicant for, Supplemental Security Income (SSI) benefits be provided, at no additional charge to the resident, necessary personal hygiene items and personal laundry services. This requirement does not include cosmetic items.

(10) All residents may leave and return to a personal care home or assisted living residence, receive visitors, have access to a telephone and mail and participate in religious activities.

(11) Personal care home and assisted living residence owners, administrators or employees be prohibited from being assigned power of attorney or guardianship for any resident.

(12) Each assisted living residence demonstrate the ability to provide supplemental health care services in a manner duly protective of the health, safety and well-being of its residents utilizing employes, independent contractors or contractual arrangements with other health care facilities or practitioners licensed, registered or certified to the extent required by law to provide such service. To the extent prominently disclosed in a written admission agreement, an assisted living residence may require residents to use providers of supplemental health care services designated by the assisted living residence.

(13) A personal care home not provide supplemental health care services to residents, provided, however, that a personal care home may assist residents in obtaining health care services

in the manner provided by 55 Pa. Code §§ 2600.29 (relating to hospice care and services), 2600.142 (relating to assistance with health care) and 2600.181 (relating to self-administration) through 2600.191 (relating to medications) or as otherwise provided by regulations adopted by the department not inconsistent with the requirements of this section.

(b) Subject to subsection (a)(13), the department shall not prohibit immobile persons who do not require the services of a licensed long-term care facility from residing in a personal care home, provided that appropriate personal care services and health care services are available to the resident and the design, construction, staffing or operation of the personal care home allows for safe emergency evacuation. Persons requiring the services of a licensed long-term care facility, including immobile persons, may reside in an assisted living residence, provided that appropriate supplemental health care services are provided such residents and the design, construction, staffing and operation of the assisted living residence allows for their safe emergency evacuation.

(c) For consumers with Alzheimer's disease or dementia, or where the assisted living residence holds itself out to the public as providing services or housing for consumers with cognitive impairments, assisted living residences shall disclose to consumers and provide:

(1) The residence's written statement of its philosophy and mission which reflects the needs of consumers with cognitive impairments.

(2) A description of the residence's physical environment and design features to support the functioning of consumers with cognitive impairments.

(3) A description of the frequency and types of individual and group activities designed specifically to meet the needs of consumers with cognitive impairments.

(4) A description of security measures provided by the residence.

(5) A description of training provided to staff regarding provision of care to consumers with cognitive impairments.

(6) A description of availability of family support programs and family involvement.

(7) The process used for assessment and establishment of a plan of services for the consumer, including methods by which the plan of services will remain responsive to changes in the consumer's condition.

(d) Cognitive support services.--

(1) An assisted living residence shall provide to consumers with cognitive impairments cognitive support services, including dementia-specific activity programming.

(2) Assisted living residences shall identify measures to address consumers with cognitive impairments who have tendencies to wander.

(3) If national accreditation of secured assisted living residences for persons in need of cognitive support services becomes available, the department may deem all assisted living residences accredited by accrediting bodies that have standards that equal or exceed those in this act and regulations as meeting the special care designation under this act.

(e) An assisted living residence may not admit, retain or serve a consumer with any of the following conditions or health care needs unless an exception, upon the written request of the assisted living residence, is granted by the department:

(1) Ventilator dependency.

(2) Stage III and IV decubiti and vascular ulcers that are not in a healing stage.

(3) Continuous intravenous fluids.

(4) Reportable infectious diseases, such as tuberculosis, in a communicable state that require isolation of the consumer or require special precautions by a caretaker to prevent transmission of the disease unless the Department of Health directs that isolation be established within the assisted living residence.

(5) Nasogastric tubes.

(6) Physical restraints.

(7) Continuous skilled nursing care twenty-four hours a day.

(f) Any of the following individuals may certify that a consumer may not be admitted or retained in an assisted living residence and the department shall by regulation establish the standards required for the certification:

(1) The assisted living residence administrator acting in consultation with supplemental health care providers.

(2) A consumer's physician or certified registered nurse practitioner.

(3) The medical director of the assisted living residence.

(g) An assisted living residence may admit, retain or serve a consumer for whom a determination is made by the department, upon the written request of the assisted living residence, that the consumer's specific health care needs can be met by a provider of assisted living services or within an assisted living residence, in conformity with standards set by the department through regulation, including a consumer requiring:

(1) gastric tubes, except that a determination shall not be required if the consumer is capable of self-care of the gastric tube or a licensed health care professional or other qualified individual cares for the gastric tube;

(2) tracheostomy, except that a determination shall not be required if the consumer is independently capable of self-care of the tracheostomy;

(3) skilled nursing care twenty-four hours a day, except that a determination shall not be required if the skilled nursing care is provided on a temporary or intermittent basis;

(4) a sliding scale insulin administration, except that a determination shall not be required if the consumer is capable of self-administration or a licensed health care professional or other qualified individual administers the insulin;

(5) intermittent intravenous therapy, except that a determination shall not be required if a licensed health care professional manages the therapy;

(6) insertions, sterile irrigation and replacement of a catheter, except that a determination shall not be required for routine maintenance of a urinary catheter if the consumer is capable of self-administration or a licensed health care professional administers the catheter;

(7) oxygen, except a determination shall not be required if the consumer is capable of self-administration or a licensed health care professional or other qualified individual administers the oxygen;

(8) inhalation therapy, except that a determination shall not be required if the consumer is capable of self-administration or a licensed health care professional or other qualified individual administers the therapy;

(9) other types of supplemental health care services that an assisted living residence administrator, acting in consultation with supplemental health care providers, determines

can be provided in a safe and effective manner by the assisted living residence; or

(10) other types of care that can be provided in a safe and effective manner in an assisted living residence as determined by regulations adopted by the department.

(h) (i) Subject to subsection (a)(12), an assisted living residence may admit or retain a resident who does not require supplemental health care services or who, subject to any restrictions provided in the written resident agreement, makes alternative arrangements for such services.

(ii) Portions or sections of an assisted living residence may be designated for use by residents not requiring supplemental health care services, or an assisted living residence may provide services both to residents receiving supplemental health care services and to residents not receiving such service within the same portions or sections of the assisted living residence.

(i) No person, organization or program shall use the term "assisted living" in any name or written material, except as a licensee in accordance with this article.

(1057.3 amended July 25, 2007, P.L.402, No.56)

Compiler's Note: See the preamble and sections 8, 9, 10 and 11 of Act 56 of 2007 for special provisions relating to legislative findings, construction of law, Legislative Budget and Finance Committee report and assisted living residence licenses.

Section 1058. Bonds and Costs.--No bond shall be required of and no costs shall be taxed against the department on account of any such action.

Section 1059. Law Supplementary.--The provisions of this subarticle shall be construed as supplementary to all other provisions dealing with the same subject matter. No action brought under the provisions of this subarticle shall prevent the prosecution or institution of any civil or criminal action otherwise provided by law for violation of any law providing for licensing or departmental rules or regulations promulgated thereunder.

(c) Registration Provisions
(Subart. repealed Dec. 28, 2015, P.L.500, No.92)

Section 1070. Definitions.--(1070 repealed Dec. 28, 2015, P.L.500, No.92)

Section 1071. Operation Without Registration Certificate Prohibited.--(1071 repealed Dec. 28, 2015, P.L.500, No.92)

Section 1072. Application for Registration Certificate.--(1072 repealed Dec. 28, 2015, P.L.500, No.92)

Section 1073. Issuance of Registration Certificate.--(1073 repealed Dec. 28, 2015, P.L.500, No.92)

Section 1074. Visitation and Inspection.--(1074 repealed Dec. 28, 2015, P.L.500, No.92)

Section 1075. Records.--(1075 repealed Dec. 28, 2015, P.L.500, No.92)

Section 1076. Regulations.--(1076 repealed Dec. 28, 2015, P.L.500, No.92)

Section 1077. Technical Assistance.--(1077 repealed Dec. 28, 2015, P.L.500, No.92)

Section 1078. Operation Without Registration Certificate.--(1078 repealed Dec. 28, 2015, P.L.500, No.92)

Section 1079. Denial, Nonrenewal, or Revocation.--(1079 repealed Dec. 28, 2015, P.L.500, No.92)

Section 1080. Emergency Closure.--(1080 repealed Dec. 28, 2015, P.L.500, No.92)

(d) Personal Care Home
(Hdg. added Dec. 21, 1988, P.L.1883, No.185)

Section 1085. Classification of Violations.--The department shall classify each violation of its regulations by personal care homes or assisted living residences into one of the following categories: (Intro. par. amended July 25, 2007, P.L.402, No.56)

(1) Class I. A violation which indicates a substantial probability that death or serious mental or physical harm to any resident may result.

(2) Class II. A violation which has a substantial adverse effect upon the health, safety or well-being of any resident.

(3) Class III. A minor violation which has an adverse effect upon the health, safety or well-being of any resident.

(1085 added Dec. 21, 1988, P.L.1883, No.185)

Compiler's Note: See the preamble and sections 8, 9, 10 and 11 of Act 56 of 2007 for special provisions relating to legislative findings, construction of law, Legislative Budget and Finance Committee report and assisted living residence licenses.

Section 1086. Penalties.--(a) The department shall assess a penalty for each violation of this subarticle or regulations of the department. Penalties shall be assessed on a daily basis from the date on which the citation was issued until the date such violation is corrected except in the case of Class II violations. In the case of Class II violations, assessment of a penalty shall be suspended for a period of five days from the date of citation provided that, except for good cause, the provider has corrected the violation. If the violation has not been corrected within the five-day period, the fine shall be retroactive to the date of citation.

(b) The department shall assess a penalty of twenty dollars ($20) per resident per day for each Class I violation.

(c) The department shall assess a minimum penalty of five dollars ($5) per resident per day, up to a maximum of fifteen dollars ($15) per resident per day, for each Class II violation.

(d) There shall be no monetary penalty for Class III violations unless the provider fails to correct the Class III violation within fifteen days. Failure to correct the violation within fifteen days may result in an assessment of up to three dollars ($3) per resident per day for each Class III violation, retroactive to the date of the citation.

(e) A personal care home or assisted living residence found to be operating without a license shall be assessed a penalty of five hundred dollars ($500). 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 home or residence fails to make such application. ((e) amended July 25, 2007, P.L.402, No.56)

(f) Any provider charged with violation of this act 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, not to exceed five hundred dollars ($500), to the Secretary of Public Welfare 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.

(g) 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 subarticle. Fines collected pursuant to this act shall not be subject to the provisions of 42 Pa.C.S. § 3733 (relating to deposits into account).

(h) The department shall promulgate regulations necessary for the implementation of this section in order to ensure uniformity and consistency in the application of penalties.

(1086 added Dec. 21, 1988, P.L.1883, No.185)

Compiler's Note: The Secretary of Public Welfare, referred to in this section, was redesignated as the Secretary of Human Services by Act 132 of 2014.

Compiler's Note: See the preamble and sections 8, 9, 10 and 11 of Act 56 of 2007 for special provisions relating to legislative findings, construction of law, Legislative Budget and Finance Committee report and assisted living residence licenses.

Section 1087. Revocation or Nonrenewal of License.--(a) (1) The department shall temporarily revoke the license of a personal care home or assisted living residence if, without good cause, one or more Class I violations remain uncorrected twenty-four hours after the operator has been cited for such violation or if, without good cause, one or more Class II violations remain uncorrected fifteen days after being cited for such violation.

(2) Upon the revocation of a license pursuant to this subsection, all residents shall be relocated.

(3) The revocation may terminate upon the department's determination that its violation is corrected.

(4) If, after three months, the department does not issue a new license for a personal care home or assisted living residence license revoked pursuant to this section:

(i) Such revocation or nonrenewal pursuant to this section shall be for a minimum period of five years.

(ii) No provider of a personal care home or assisted living residence who has had a license revoked or not renewed pursuant to this section shall be allowed to operate or staff or hold an interest in a home or residence that applies for a license for a period of five years after such revocation or nonrenewal.

(b) The department shall revoke or refuse to renew the license of a personal care home or assisted living residence if, during any two-year period, the home or residence, without

good cause, on two or more separate occasions, has been found to have violated a regulation of the department which has been categorized as Class I.

(c) The power of the department to revoke or refuse to renew or issue a license pursuant to this section is in addition to the powers and duties of the department pursuant to section 1026.

(1087 amended July 25, 2007, P.L.402, No.56)

Compiler's Note: See the preamble and sections 8, 9, 10 and 11 of Act 56 of 2007 for special provisions relating to legislative findings, construction of law, Legislative Budget and Finance Committee report and assisted living residence licenses.

Section 1088. Personal Care Home Information.--The department shall post information on its Internet website relating to the licensure and inspection of personal care homes. The information shall be updated at least annually. The information shall include the following:

(1) Number of licensed personal care homes.

(2) Number of residents in licensed personal care homes.

(3) Number of personal care homes which have received an annual inspection.

(4) Number of personal care home inspectors, Statewide and by region.

(5) Ratio of department staff responsible for the licensure and inspection of personal care homes divided by the total number of licensed personal care homes.

(6) Number of personal care homes operating with a provisional license, Statewide and by county.

(7) Number of personal care homes operating with a full license, Statewide and by county.

(8) Number of personal care homes which the department has closed or taken legal action to close.

(9) For each personal care home, a licensing inspection summary which lists any violation under this article.

(10) Summary of types of violations which are listed in licensing inspection summaries, in accordance with the classification of violations set forth under this article.

(11) Upon implementation of a financial penalty program, the Internet website shall include information relating to assessed financial penalties against licensed personal care homes as provided for in this article.

(12) A summary of the specific plans of the department to ensure compliance with this article regarding inspection of licensed personal care homes and enforcement of regulations.

(13) Other information the department deems pertinent.

(1088 added July 4, 2008, P.L.557, No.44)

ARTICLE XI
MENTAL HEALTH: DEPARTMENTAL POWERS AND DUTIES; COMMISSIONER OF MENTAL HEALTH; INTERSTATE COMPACT; RECIPROCAL AGREEMENTS; RESEARCH FOUNDATION

(a) Departmental Powers and Duties; Commissioner of Mental Health

Section 1101. Mental Health: Departmental Powers and Duties.--The department shall have the power, and its duty shall be:

(1) To administer and enforce the laws of this Commonwealth relative to mental health, the care, prevention, early recognition and treatment of mental illness, mental defects, epilepsy and inebriety, the licensing and regulation of institutions for the mentally ill, mentally defective and epileptic, the admission and commitment of patients to such institutions and the transfer, discharge, escape, interstate rendition and deportation of such patients.

(2) Subject to any inconsistent provisions in this act contained, approve or disapprove the advice and recommendations of the several boards of trustees of State mental institutions. (2 amended Oct. 19, 1967, P.L.459, No.216)

(3) To establish and administer a program designed to assist the juvenile courts and other public and private agencies, on their request, in the diagnosis and study of children with mental or behavioral problems, and to recommend to them the most appropriate disposition for the rehabilitation and treatment of such children; this program shall be based on review of local studies of the children but when local studies indicate the need, or when it is requested, may include residential study of the children in centers which the department is hereby authorized to establish and operate.

Compiler's Note: The Secretary of Public Welfare, referred to in this section, was redesignated as the Secretary of Human Services by Act 132 of 2014.

Section 1111. Commissioner of Mental Health.--(1111 repealed July 9, 1987, P.L.207, No.32)

(b) Interstate Compact on Mental Health

Section 1121. Authorization; Compact Provisions.--The Governor is hereby authorized and directed to execute a compact on behalf of the Commonwealth of Pennsylvania with any other state or states legally joining therein in form substantially as follows:

INTERSTATE COMPACT ON MENTAL HEALTH

The contracting states solemnly agree that:

ARTICLE I

The party states find that the proper and expeditious treatment of the mentally ill and mentally deficient can be facilitated by cooperative action to the benefit of the patients, their families and society as a whole. Further the party states find that the necessity of and desirability for furnishing such care and treatment bears no primary relation to the residence or citizenship of the patient but that on the contrary the controlling factors of community safety and humanitarianism require that facilities and services be made available for all who are in need of them. Consequently, it is the purpose of this compact and of the party states to provide the necessary legal basis for the institutionalization or other appropriate care and treatment of the mentally ill and mentally deficient under a system that recognizes the paramount importance of patient welfare and to establish the responsibilities of the party states in terms of such welfare.

ARTICLE II

As used in this compact:

(1) "Sending states" shall mean a party state from which a patient is transported pursuant to the provisions of the compact or from which it is contemplated that a patient may be so sent.

(2) "Receiving state" shall mean a party state to which a patient is transported pursuant to the provisions of the compact or to which it is contemplated that a patient may be so sent.

(3) "Institution" shall mean any hospital or other facility maintained by a party state or political subdivision thereof for the care and treatment of mental illness or mental deficiency.

(4) "Patient" shall mean any person subject to or eligible as determined by the laws of the sending state for institutionalization or other care, treatment or supervision pursuant to the provisions of this compact.

(5) "After-care" shall mean care, treatment and services provided a patient as defined herein on convalescent status or conditional release.

(6) "Mental illness" shall mean mental disease to such extent that a person so afflicted requires care and treatment for his own welfare or the welfare of others or of the community.

(7) "Mental deficiency" shall mean mental deficiency as defined by appropriate clinical authorities to such extent that a person so afflicted is incapable of managing himself and his affairs but shall not include mental illness as defined herein.

(8) "State" shall mean any state, territory or possession of the United States, the District of Columbia and the Commonwealth of Puerto Rico.

(9) "Court" shall mean the court of common pleas or other court of record having jurisdiction or law judge thereof of the county in which the patient is or resides.

ARTICLE III

(a) Whenever a person physically present in any party state shall be in need of institutionalization by reason of mental illness or mental deficiency, he shall be eligible for care and treatment in an institution in that state, irrespective of his residence, settlement or citizenship qualifications.

(b) The provisions of paragraph (a) of this article to the contrary notwithstanding, any patient may be transferred to an institution in another state whenever there are factors based upon clinical determinations indicating that the care and treatment of said patient would be facilitated or improved thereby. Any such institutionalization may be for the entire period of care and treatment or for any portion or portions thereof. The factors referred to in this paragraph shall include the patient's full record with due regard for the location of the patient's family, character of the illness and probable duration thereof and such other factors as shall be considered appropriate.

(c) No state shall be obliged to receive any patient pursuant to the provisions of paragraph (b) of this article unless the sending state has given advance notice of its intention to send the patient, furnished all available medical and other pertinent records concerning the patient, giving the qualified medical or other appropriate clinical authorities of the receiving state an opportunity to examine the patient, if said authorities so wish and unless the receiving state shall agree to accept the patient.

(d) In the event that the laws of the receiving state establish a system of priorities for the admission of patients, an interstate patient under this compact shall receive the same priority as a local patient and shall be taken in the same order and at the same time that he would be taken if he were a local patient.

(e) Pursuant to this compact, the determination as to the suitable place of institutionalization for a patient may be reviewed at any time and such further transfer of the patient may be made as seems likely to be in the best interest of the patient.

ARTICLE IV

(a) Whenever pursuant to the laws of the state in which a patient is physically present, it shall be determined that the patient should receive after-care or supervision, such care or supervision may be provided in a receiving state. If the medical or other appropriate clinical authorities having responsibility for the care and treatment of the patient in the sending state shall have reason to believe that after-care in another state would be in the best interest of the patient and would not jeopardize the public safety, they shall request the appropriate authorities in the receiving state to investigate the desirability of affording the patient such after-care in said receiving state and such investigation shall be made with all reasonable speed. The request for investigation shall be accompanied by complete information concerning the patient's intended place of residence and the identity of the person in whose charge it is proposed to place the patient, the complete medical history of the patient and such other documents as may be pertinent.

(b) If the medical or other appropriate clinical authorities having responsibility for the care and treatment of the patient in the sending state and the appropriate authorities in the receiving state find that the best interest of the patient would be served thereby and if the public safety would not be jeopardized thereby, the patient may receive after-care or supervision in the receiving state.

(c) In supervising, treating or caring for a patient on after-care pursuant to the terms of this article, a receiving state shall employ the same standards of visitation, examination, care and treatment that it employs for similar local patients.

ARTICLE V

Whenever a dangerous or potentially dangerous patient escapes from an institution in any party state, that state shall promptly notify all appropriate authorities within and without the jurisdiction of the escape in a manner reasonably calculated to facilitate the speedy apprehension of the escapee. Immediately upon the apprehension and identification of any such dangerous or potentially dangerous patient, he shall be detained in the state where found, pending disposition in accordance with law.

ARTICLE VI

The duly accredited officers of any state party to this compact, upon the establishment of their authority and the identity of the patient, shall be permitted to transport any patient being moved pursuant to this compact through any and all states party to this compact without interference.

ARTICLE VII

(a) No person shall be deemed a patient of more than one institution at any given time. Completion of transfer of any patient to an institution in a receiving state shall have the effect of making the person a patient of the institution in the receiving state.

(b) The sending state shall pay all costs of and incidental to the transportation of any patient pursuant to this compact but any two or more party states may, by making a specific

agreement for that purpose, arrange for a different allocation of costs as among themselves.

(c) No provision of this compact shall be construed to alter or affect any internal relationships among the departments, agencies and officers of and in the government of a party state or between a party state and its subdivisions as to the payment of costs or responsibilities therefor.

(d) Nothing in this compact shall be construed to prevent any party state or subdivision thereof from asserting any right against any person, agency or other entity in regard to costs for which such party state or subdivision thereto may be responsible pursuant to any provision of this compact.

(e) Nothing in this compact shall be construed to invalidate any reciprocal agreement between a party state and a nonparty state relating to institutionalization, care or treatment of the mentally ill or mentally deficient or any statutory authority pursuant to which such agreements may be made.

ARTICLE VIII

(a) Nothing in this compact shall be construed to abridge, diminish or in any way impair the rights, duties and responsibilities of any patient's guardian on his own behalf or in respect of any patient for whom he may serve, except that where the transfer of any patient to another jurisdiction makes advisable the appointment of a supplemental or substitute guardian, any court of competent jurisdiction in the receiving state may make such supplemental or substitute appointment and the court which appointed the previous guardian shall, upon being duly advised of the new appointment and upon the satisfactory completion of such accounting and other acts as such court may by law require, relieve the previous guardian of power and responsibility to whatever extent shall be appropriate in the circumstances: Provided, however, That in the case of any patient having settlement in the sending state, the court of competent jurisdiction in the sending state shall have the sole discretion to relieve a guardian appointed by it or continue his power and responsibility, whichever it shall deem advisable. The court in the receiving state may, in its discretion, confirm or reappoint the person or persons previously serving as guardian in the sending state in lieu of making a supplemental or substitute appointment. No mentally ill or mentally deficient patient shall be transferred between party states until consent has been obtained from the person legally responsible for the patient's maintenance.

(b) The term "guardian" as used in paragraph (a) of this article shall include any guardian, trustee, legal committee, conservator or other person or agency however denominated who is charged by law with power to act for or responsibility for the person or property of a patient.

ARTICLE IX

(a) No provision of this compact, except Article V, shall apply to any person institutionalized while under sentence in a penal or correctional institution or while subject to trial on a criminal charge or whose institutionalization is due to the commission of an offense for which, in the absence of mental illness or mental deficiency, said person would be subject to incarceration in a penal or correctional institution.

(b) To every extent possible, it shall be the policy of states party to this compact that no patient shall be placed or detained in any prison, jail or lockup but such patient shall, with all expedition, be taken to a suitable institutional facility for mental illness or mental deficiency.

ARTICLE X

(a) Each party state shall appoint a "compact administrator" who on behalf of his state shall act as general coordinator of activities under the compact in his state and who shall receive copies of all reports, correspondence and other documents relating to any patient processed under the compact by his state, either in the capacity of sending or receiving state. The compact administrator or his duly designated representative shall be the official with whom other party states shall deal in any matter relating to the compact or any patient processed thereunder.

(b) The compact administrators of the respective party states shall have power to promulgate reasonable rules and regulations to carry out more effectively the terms and provisions of this compact.

ARTICLE XI

The duly constituted administrative authorities of any two or more party states may enter into supplementary agreements for the provision of any service or facility or for the maintenance of any institution on a joint or cooperative basis whenever the states concerned shall find that such agreements will improve services, facilities or institutional care and treatment in the fields of mental illness or mental deficiency. No such supplementary agreement shall be construed so as to relieve any party state of any obligation which it otherwise would have under other provisions of this compact.

ARTICLE XII

This compact shall enter into full force and effect as to any state when enacted by it into law and such state shall thereafter be a party thereto with any and all states legally joining therein.

ARTICLE XIII

(a) A state party to this compact may withdraw therefrom by enacting a statute repealing the same. Such withdrawal shall take effect one year after notice thereof has been communicated officially and in writing to the governors and compact administrators of all other party states. However, the withdrawal of any state shall not change the status of any patient who has been sent to said state or sent out of said state pursuant to the provisions of the compact.

(b) Withdrawal from any agreement permitted by Article VII (b) as to costs, or from any supplementary agreement made pursuant to Article XI, shall be in accordance with the terms of such agreement.

ARTICLE XIV

This compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this compact shall be severable and if any phrase, clause, sentence or provision of this compact is declared to be contrary to the constitution of any party state or of the United States or the applicability thereof to any government agency, person or circumstance is held invalid, the validity of the remainder of this compact and the applicability thereof to any government agency, person or circumstance shall not be affected thereby. If this compact shall be held contrary to the constitution of any state party thereto, the compact shall remain in full force and effect as to the remaining states and in full force and effect as to the state affected as to all severable matters.

Section 1122. Compact Administrator.--Pursuant to said compact, the Governor is hereby authorized and empowered to designate an officer who shall be the compact administrator and who, acting jointly with like officers of other party states, shall have power to promulgate rules and regulations to carry

out more effectively the terms of the compact. Said compact administrator shall serve subject to the pleasure of the Governor. The compact administrator is hereby authorized, empowered and directed to cooperate with all departments, agencies and officers of and in the government of this State and its subdivisions in facilitating the proper administration of the compact or of any supplementary agreement or agreements entered into by this State thereunder.

Section 1123. Supplementary Agreements.--The compact administrator is hereby authorized and empowered to enter into supplementary agreements with appropriate officials of other states pursuant to Articles VII and XI of the compact. In the event that such supplementary agreement shall require or contemplate the use of any institution or facility of this State or require or contemplate provision of any service by this State, no such agreement shall have force or effect until approved by the head of the department or agency under whose jurisdiction said institution or facility is operated or whose department or agency will be charged with the rendering of such service.

Section 1124. Financial Obligations.--The compact administrator, subject to the approval of the Auditor General, may make or arrange for any payments necessary to discharge any financial obligations imposed upon this State by the compact or by any supplementary agreement entered into thereunder.

Section 1125. Consultation with Families of Transferees.--The compact administrator is hereby directed to consult with the immediate family of any proposed transferee.

Section 1126. Limitation of Compact Applicability.--This compact shall apply only to patients who either are in institutions maintained by the Commonwealth of Pennsylvania, having been duly and properly committed or admitted pursuant to laws of the Commonwealth of Pennsylvania or whose admission to an institution maintained by the Commonwealth is being sought by a sending state pursuant to this compact, and shall not in any case apply to any patient of a private licensed institution.

(c) Reciprocal Agreements with Other States

Section 1131. Agreements Authorized.--The department, subject to the approval of the Attorney General, is hereby authorized to enter into reciprocal agreements with corresponding state agencies of other states regarding the interstate transportation or transfer of persons with mental illness or defect and to arrange with the proper officials in this State for the acceptance, transfer, and support of persons who are residents of this State but who are temporarily detained or who are receiving psychiatric or mental care in public institutions of other states in accordance with the terms of such agreements.

(d) Commonwealth Mental Health Research Foundation

Section 1141. Creation.--There is hereby created a body corporate and politic constituting a public corporation and governmental instrumentality known as the "Commonwealth Mental Health Research Foundation," referred to in this subarticle as the foundation. The foundation shall be administered exclusively in accordance with the provisions of this subarticle. The foundation is hereby constituted an instrumentality of the Commonwealth and the exercise by the foundation of powers and

duties conferred upon it by this act shall be deemed and held to be an essential governmental function of the Commonwealth.

Section 1142. Purpose.--It shall be the purpose of the foundation to support, encourage and finance research of every nature and description in the field of mental health including all aspects thereof or related thereto and to train men in the field of mental health including all aspects thereof or related thereto.

Section 1143. Powers and Duties.--The foundation shall have the following powers and duties:

(1) It shall maintain a principal office at such place as shall be designated by the secretary.

(2) It may contract and be contracted within its own name.

(3) It may sue and be sued in its own name, and plead and be impleaded. Any and all actions at law or in equity against it shall be brought only in Dauphin County.

(4) It shall have an official seal.

(5) It shall make necessary bylaws, rules and regulations for the management and regulation of its affairs.

(6) It shall have the power and authority to acquire, own, use, hire, lease, operate and dispose of personal property, real property and interests in real property.

(7) It may make and enter into all contracts and agreements necessary or incidental to the performance of its duties and the execution of its powers under this act.

(8) It may employ such employes as may, in the judgment of the board of trustees, be necessary and to fix their compensation.

(9) It shall not be required to pay any taxes or assessments on any property acquired or used by it.

Section 1144. Board of Trustees.--(a) The foundation shall be administered by a board of fifteen trustees consisting of the Governor, the secretary, the Commissioner of Mental Health and twelve trustees appointed by the Governor for terms of three years each and until their respective successors shall be duly appointed and qualified. Of the original appointed trustees the terms of three shall expire on December 31, 1957, the terms of three shall expire on December 31, 1958, and the terms of three shall expire on December 31, 1959. Of the three additional appointed trustees, the term of one shall expire December 31, 1964, the term of one shall expire December 31, 1965, and the term of one shall expire December 31, 1966. Any trustee may be reappointed. Any person appointed to fill a vacancy shall serve for the unexpired term.

(b) The members of the board shall not be entitled to any compensation for their services as members.

(c) Eight members of the board shall constitute a quorum and any action taken by a majority of a quorum present at a duly convened meeting of the board shall be the legal action of the board.

(d) The secretary shall be the chairman of the board and the foundation shall have such other officers as the board deems necessary.

(e) The board shall meet regularly at least three times each year and specially upon the call of the chairman.

Section 1145. Research Advisory Committee.--The secretary shall appoint a Research Advisory Committee of nine members, one of whom shall be the Commissioner of Mental Health, who shall be its chairman. In appointing such committee, the secretary shall select one representative from each of the following six medical schools, colleges or mental institutions having an active research department: The School of Medicine

of Temple University, the School of Medicine of the University of Pennsylvania, the Pennsylvania State University, the School of Medicine of the University of Pittsburgh, the Eastern Pennsylvania Psychiatric Institute and Carnegie Institute of Technology. The Research Advisory Committee, subject to approval of the board, shall choose and supervise the projects to be undertaken by the foundation. The members of the Research Advisory Committee shall not be entitled to any compensation for their services as members but shall be entitled to reimbursement for all necessary expenses incurred in connection with the performance of their duties as members. The programs of research and of training men in the field of mental health shall be carried out only in Commonwealth institutions under the jurisdiction of the department. This section shall not be construed to prevent ancillary research or training outside of these institutions so long as the primary program in connection with which the ancillary research or training is undertaken is conducted within a Commonwealth institution.

Section 1146. Administration.--(a) The board of trustees shall have sole and exclusive jurisdiction to administer the foundation and no other department, board or officer of the Commonwealth shall have any jurisdiction whatsoever in connection therewith except as set forth in this subarticle. No appropriation made to the foundation shall be available unless and until it shall have complied with section 604 of The Administrative Code of 1929 in the same manner as if it were an administrative department, board or commission.

(b) All moneys belonging to the foundation shall be invested in securities or deposited with depositories subject to the same restrictions as are imposed by law upon the investment or deposit of Commonwealth funds, except that any donor of money or other property may specify that such donation shall be held in the form in which acquired by the board or that such donation shall be invested in or converted into some other specific property or class of investment. So long as the board complies with the instructions of the donor in this regard, it shall be relieved of all liability which may result from the imprudent investment of such moneys.

(c) The board of trustees shall have general supervisory powers and responsibility for the propriety of all expenditures by the foundation. All payments for the general cost of administration of the foundation in excess of three hundred dollars ($300) shall be made only with the prior approval of the board. All payments for research and training made by the foundation in excess of three hundred dollars ($300) shall be made only with the prior approval of the board which shall not approve any such expenditure until it has first been approved by the Research Advisory Committee. The board shall have the right to approve a future series of payments at one time so long as the specific purpose therefor is known at the time of approval.

(d) The board shall set up a system for the payment of all sums less than three hundred dollars ($300) upon the approval of a responsible executive officer of the foundation. Such system shall contain adequate checks so as to insure that no moneys are improperly diverted from the foundation.

(e) There shall be maintained by the foundation an adequate set of financial books and records in accordance with generally accepted accounting theory and practice.

(f) The financial books and records of the foundation shall be audited at least once each year by a certified public accountant or firm of certified public accountants who shall

report to the board. Such report shall be a public record and a copy thereof shall be furnished to each trustee, the Governor, the secretary, the Attorney General and to such other persons who request copies from the foundation, for which other copies a charge adequate to cover printing and other related costs may be made.

(g) The fiscal year of the foundation shall commence on July 1, and end on the following June 30.

(h) The Attorney General and the secretary shall each have the right to examine all phases of the operations of the foundation, including all of its books and records, at such time and in such manner as they or either of them shall deem necessary.

Section 1147. Gifts and Grants.--The foundation is hereby authorized to accept gifts or grants of money or property of any nature from any source whatsoever. Such gifts and grants may be accepted for the general purposes of the foundation, for specific purposes within the general purposes of the foundation or to be held in trust for the benefit of the foundation with the income to be used for a specific purpose within the general purposes of the foundation or for the general purposes of the foundation.

Section 1148. Patents.--All discoveries and patentable inventions resulting from the work of the foundation, or of any employe or person granted financial aid by the foundation, shall become the property of the foundation by assignment or other transfer from the discoverer or inventor. Each employe of the foundation or other person granted financial aid by the foundation shall be required to sign an agreement agreeing to assign and transfer to the foundation all of his right, title and interest in any development or patent acquired as a result of such employment or receipt of financial aid before being employed or granted such aid. All royalties or other income received from the use of any such patents or discoveries shall be paid to the foundation to be used for its general purposes.

ARTICLE XII
DOMESTIC VIOLENCE AND RAPE VICTIMS SERVICES
(Art. expired June 18, 1987. See Act 157 of 1982.)

Compiler's Note: Section 4 of Act 44 of 1988 provided that it is the intent of the General Assembly that section 2333 of the Administrative Code of 1929, which was added by Act 44, is a reenactment of Article XII.

Section 1201. Legislative Findings and Intent.--(1201 expired June 18, 1987. See Act 157 of 1982.)

Section 1202. Definitions.--(1202 expired June 18, 1987. See Act 157 of 1982.)

Section 1203. Additional Costs.--(1203 expired June 18, 1987. See Act 157 of 1982.)

Section 1204. Program Grants Authorized.--(1204 expired June 18, 1987. See Act 157 of 1982.)

Section 1205. Public Review and Accountability.--(1205 expired June 18, 1987. See Act 157 of 1982.)

Section 1206. Termination of Article.--(1206 expired June 18, 1987. See Act 157 of 1982.)

ARTICLE XIII
FAMILY FINDING AND KINSHIP CARE
(Art. repealed June 28, 2019, P.L.93, No.14)

ARTICLE XIV
FRAUD AND ABUSE CONTROL
(Hdg. added July 10, 1980, P.L.493, No.105)

Section 1401. Definitions.--The following words and phrases when used in this article shall have, unless the context clearly indicates otherwise, the meanings given to them in this section:

"Eligible person" means anyone who lawfully receives or holds a medical assistance eligibility identification card from the department.

"Health services corporation" means a nonprofit hospital plan corporation or a nonprofit professional health service plan corporation approved under Pennsylvania law.

"Medical assistance" means medical services rendered to eligible persons under Articles IV and V of this act.

"Medical assistance program" means the services funded and operations administered by the department under Articles IV and V of this act.

"Medical facility" means a licensed or approved hospital, skilled nursing facility, intermediate care facility, clinic,

shared health facility, pharmacy, laboratory or other medical institution.

"Practitioner" means any medical doctor, doctor of osteopathy, dentist, optometrist, podiatrist, chiropractor or other medical professional personnel licensed by the Commonwealth or by any other state who is authorized to participate in the medical assistance program.

"Provider" means any individual or medical facility which signs an agreement with the department to participate in the medical assistance program, including, but not limited to, licensed practitioners, pharmacies, hospitals, nursing homes, clinics, home health agencies and medical purveyors.

"Purveyor" means any person other than a practitioner, who, directly or indirectly, engages in the business of supplying to patients any medical supplies, equipment or services for which reimbursement under the program is received, including, but not limited to, clinical laboratory services or supplies, x-ray laboratory services or supplies, inhalation therapy services or equipment, ambulance services, sick room supplies, physical therapy services or equipment and orthopedic or surgical appliances or supplies.

"Recipient" means an eligible person who receives medical assistance from a participating provider.

"Shared health facility" means an entity which provides the services of three or more health care practitioners, two or more of whom are practicing within different professions, in one physical location. To meet this definition, the practitioners must share any of the following: common waiting areas, examining rooms, treatment rooms, equipment, supporting staff or common records. In addition, to meet this definition, at least one practitioner must receive payment on a fee-for-services basis, and payments under the medical assistance program to any person or entity providing services or merchandise at the location must exceed thirty thousand dollars ($30,000) per year. "Shared health facility" does not mean or include any licensed or approved hospital facility, a skilled nursing facility, intermediate care facility, public health clinics, or any entity organized or operating as a facility wherein ambulatory medical services are provided by an organized group of practitioners all of whom practice the same profession pursuant to an arrangement between such group and a health services corporation or a Federally approved health maintenance organization operating under Pennsylvania law, and where a health services corporation or a health maintenance organization is reimbursed on a prepaid capitation basis for the provision of health care services under the medical assistance program.

(1401 added July 10, 1980, P.L.493, No.105)

Section 1402. Special Provider Participation Requirements.--(a) As a condition of participation in the medical assistance program, a medical facility shall be required to disclose to the department upon execution of a new provider agreement or renewal thereof the name and social security number of any person who has a direct or indirect ownership or control interest of five percent or more in such medical facility; such disclosure shall include the identity of any such person who has been convicted of a criminal offense under section 1407 and the specific nature of the offense involved. In addition to the disclosure required upon execution of a provider agreement, any change in such ownership or control interest of five percent or more shall be reported to the department within thirty days of the date such change occurs. Failure to submit a complete

and accurate report shall constitute a deceptive practice under section 1407(a)(1) and will justify a termination of the provider agreement by the department.

(b) As a second condition of participation in the medical assistance program, a provider must maintain for a minimum of four years appropriate medical and financial records to fully support his claims and charges for payment under the medical assistance program. Such records shall at reasonable times be made available for inspection, review and copying by the department or by other authorized State officers.

(c) Payments under the medical assistance program will be made directly to providers who have signed a provider agreement with the department. Providers shall not factor, assign, reassign or execute a power of attorney for the rights to any claims or payments for services rendered under the medical assistance program. Notwithstanding the above stated language a provider may use accounts receivables as collateral at a certified lending institution.

(d) Each nursing facility shall maintain a complete and accurate record of all receipts and disbursements for medical assistance recipients' personal funds and shall furnish each such patient a quarterly report of all transactions recorded for that recipient. ((d) amended July 7, 2005, P.L.177, No.42)

(e) Each nursing facility shall be inspected at least twice annually for compliance with this act and regulations of the department. ((e) added July 7, 2005, P.L.177, No.42)

(1402 added July 10, 1980, P.L.493, No.105)

Section 1403. Special Participation Requirements for Shared Health Facilities.--(a) The registration requirements are as follows:

(1) Each shared health facility shall register with the department and specify the kind or kinds of services the facility is authorized to provide and shall establish a uniform system of reports and internal audits which meet the requirements of the department. In addition, the owner of the premises upon which the facility is located, or the lessor of the structure in which the facility is located, if either has a role in operating the facility, shall file a statement specifying the kind or kinds of services the facility is authorized to provide, and shall establish a uniform system of reports and audits meeting the requirements of the department.

(2) Application for registration of a shared health facility shall be made upon forms prescribed by the department. The application shall contain:

(i) the name of the facility;

(ii) the kind or kinds of services to be provided;

(iii) the location and physical description of the facility;

(iv) the name, social security number and residence address of every person, partnership or corporation having any financial interest in the ownership (including leasehold ownership) of the facility and the structure in which the facility is located;

(v) the name, social security number and residence address of every person, partnership or corporation holding any mortgage, lien, leasehold or any other security interest in the shared health facility or in any equipment located in and used in connection with shared health facility and a brief description of such lien or security interest;

(vi) the name, residence address and professional license number of every practitioner participating in the shared health facility;

(vii) the name and residence address of the individual designated as operator to assume responsibility for the central

coordination and management of the activities of the shared health facility; and

(viii) such other information as the department may require to carry out the provisions of this act.

(3) Each operator shall apply for an initial registration upon notification by the department and shall apply for renewal of such registration annually thereafter.

(b) The notification requirements are as follows:

(1) Each operator shall notify the department within fifteen days of any change in:

(i) the persons, partnerships or corporations having any financial interest in the ownership (including leasehold ownership) of the shared health facility; or

(ii) the persons, partnerships or corporations holding any mortgage, lien, leasehold or any other security interests in the shared health facility or in any equipment located in and used in connection with a shared health facility. A statement of the monetary and repayment provisions of that lien or security interest shall accompany such notification.

(2) Each operator shall notify the department within fifteen days of the termination of the services of the individual designated to assume responsibility for coordination and management of the activities of the shared health facility and of the name, residence address and professional qualifications of any new individual appointed to assume such central administrative responsibility.

(3) Each operator shall notify the department within fifteen days of any termination of the services of any practitioner in the shared health facility and of the name, residence address and license number of each practitioner newly participating in the facility.

(c) The minimum care requirements are as follows:

(1) To ensure quality, continuity and proper coordination of medical care, each shared health facility shall:

(i) designate an individual who shall coordinate and manage the facility's activities. The person so designated shall be responsible for compliance with the provisions of this act;

(ii) devise an appropriate means of assuring that a recipient will be treated by a practitioner familiar with the recipient's medical history;

(iii) post conspicuously the names and scheduled office hours of all practitioners practicing in the facility;

(iv) maintain proper recipient records which shall contain at least the following information:

(A) the full name, address and medical assistance record number of each recipient;

(B) the dates of all visits to all providers in the shared health facility;

(C) the chief complaint for each visit to each provider in the shared health facility;

(D) pertinent history and all physical examinations rendered by each provider in the shared health facility;

(E) diagnostic impressions for each visit to any provider in the shared health facility;

(F) all medications prescribed by any provider in the shared health facility;

(G) the precise dosage and prescription regimens for each medication prescribed by a provider in the shared health facility;

(H) all x-ray, laboratory work and electrocardiograms ordered at each visit by any provider in the shared health facility and their results;

(I) all referrals by providers in the shared health facility to other medical practitioners and the reason for such referrals; and

(J) a statement as to whether or not the recipient is expected to return for further treatment and the dates of all return appointments;

(v) assign a clearly identified general practitioner to each recipient. This assignment may be changed at any time at the recipient's request;

(vi) make available to registered recipients either:

(A) the central answering services telephone number of each recipient's designated practitioner service or such practitioner's personally designated colleagues; or

(B) a centralized twenty-four-hour-a-day, seven-day-weekly telephone line for off-hour recipient emergency questions;

(vii) maintain a central day-book registry which shall record:

(A) the name and medical assistance record number of all recipients entering the facility; and

(B) the chief complaint and the names of all providers whose services were requested by the recipient and/or to whom such recipient was referred;

(viii) insure that the physical facilities of each shared health facility shall provide for privacy for all recipients during examination, interview and treatment; and

(ix) post conspicuously the telephone number of the office within the department which is responsible for providing information concerning shared health facilities and/or for receiving complaints concerning the provision of health care services at shared health facilities.

(2) It shall be the responsibility of each facility's administrator to ensure that recipient records and summaries of all recipient visits include diagnosis and pharmaceuticals prescribed and are at all times available at either the facility or at a place immediately accessible to all health providers at the facility.

(3) Nothing in this act shall in any way be interpreted as infringing upon the recipient's rights to free selection of a personal practitioner.

(4) The department shall have the right to inspect the business records, recipient records, leases and other contracts executed by any provider in a shared health facility. Such inspections may be by site visits to the facility.

(d) Prohibited acts of shared health facilities are as follows:

(1) the rental fee for letting space to providers in a shared health facility shall not be calculated wholly or partially, directly or indirectly, as a percentage of earnings or billings of the provider for services rendered on the premises in which the shared health facility is located. The operator of each facility shall file a copy of each lease and any renewal thereof with the department;

(2) no purveyor, whether or not located in a building which houses a shared health facility, shall directly or indirectly offer, pay or give to any provider, and no provider shall directly or indirectly solicit, request, receive or accept from any purveyor any sum of money, credit or other valuable consideration for:

(i) recommending or procuring goods, services or equipment of such purveyor;

(ii) directing patronage or clientele to such purveyor; or

(iii) influencing any person to refrain from using or utilizing goods, services or equipment of any purveyor;

(3) no provider or purveyor shall demand or collect any reimbursement contrary to the fee schedule of the medical assistance program;

(4) no purveyor shall provide to a recipient eligible to receive benefits under the provisions of the medical assistance program any services, equipment, pharmaceutical or other medical supplies differing in quantity or in any other respect from that described in the payment invoice submitted by such purveyor to the department. No purveyor shall provide to any recipient eligible to receive benefits under the provisions of the program any services, equipment, pharmaceutical or medical supplies differing in quality, quantity or in any other respect from that prescribed by the provider;

(5) (i) no provider in a shared health facility or person employed in such facility shall refer a recipient to another provider located in such facility unless there is a medical justification for such referral and unless the records of the referring provider pertaining to such recipient clearly set forth the justification for such referral;

(ii) no provider practicing in a shared health facility who treats a recipient referred to him by another provider shall fail to communicate in writing to the referring provider the diagnostic evaluation and the therapy rendered. The referring provider shall incorporate such information into the recipient's permanent record;

(iii) the invoice submitted to the department by the provider to whom such recipient has been referred shall contain the name and provider number of the referring provider and identify the medical problem which necessitated the referral;

(6) if a pharmacy is located in or adjacent to the building in which a shared health facility is located, such shared health facility shall prominently post a notice in the common waiting room or area informing recipients that all pharmaceuticals prescribed by practitioners in the facility may be obtained at any participating pharmacy of the recipient's choice;

(7) all provider invoices submitted for services rendered at a shared health facility shall contain the provider number of the facility at which the service was performed, clearly identify the practitioner who provided the service and be signed by the provider after the service has been performed;

(8) all orders issued by providers for ancillary clinical services, including but not limited to, x-rays, electrocardiograms, clinical laboratory services, electroencephalograms, as well as orders for medical supplies and equipment, shall contain the prescriber's medical assistance number and the provider number assigned to the facility at which the order was written; and

(9) each provider and purveyor shall submit a true bill or invoice for services rendered in the program.

(1403 added July 10, 1980, P.L.493, No.105)

Section 1404. Special Recipient Participation Requirements.--(a) Any person applying for medical assistance benefits shall certify to the department that he or she has not transferred title to or ownership interests in any real or personal property to any third person or party within the two years immediately preceding such application; if such a transfer has occurred, the recipient must disclose the nature of the transfer and must demonstrate that it involves a bona fide arm's length transaction resulting in compensation paid to the

transferor in an amount equal to or greater than the fair market value of the property as determined by the department.

(b) The acceptance of medical assistance benefits shall operate as an assignment to the department, by operation of law, of the assistance recipient's rights to recover support, specified by a court as support for the payment of medical care, and to payment for medical care from any third party. ((b) amended June 16, 1994, P.L.319, No.49)

(c) Any person applying for medical assistance benefits shall authorize the department to inspect, review and copy any and all medical records relating to services received by the applicant or by any person for which the applicant is legally responsible. The department shall maintain the confidentiality of such records.

(1404 added July 10, 1980, P.L.493, No.105)

Section 1405. Freedom of Choice and Nondiscrimination.--(a) A recipient of medical assistance benefits shall, in all cases, have the freedom to obtain medical services from whichever participating provider or providers he so chooses; however, the participating provider so chosen is free to accept or reject the recipient as a patient.

(b) Once a provider has elected to participate in the medical assistance program and has signed an agreement with the department, such providers shall not refuse to render services to any recipient on the basis of sex, race, creed, color, national origin or handicap.

(1405 added July 10, 1980, P.L.493, No.105)

Section 1406. Restrictions on Provider Charges and Payments.--(a) All payments made to providers under the medical assistance program shall constitute full reimbursement to the provider for covered services rendered. Providers may not seek or request supplemental or additional payments from recipients for covered services unless authorized by law or regulation; nor may a provider charge a recipient for other services to supplement a covered service paid for by the department. However, nothing in this act shall preclude charges for uncovered services rendered to a recipient.

(b) Charges made to the department by a provider for covered services or items furnished shall not exceed, in any case, the usual and customary charges made to the general public by such provider for the same services or items.

(1406 added July 10, 1980, P.L.493, No.105)

Section 1407. Provider Prohibited Acts, Criminal Penalties and Civil Remedies.--(a) It shall be unlawful for any person to:

(1) Knowingly or intentionally present for allowance or payment any false or fraudulent claim or cost report for furnishing services or merchandise under medical assistance, or to knowingly present for allowance or payment any claim or cost report for medically unnecessary services or merchandise under medical assistance, or to knowingly submit false information, for the purpose of obtaining greater compensation than that to which he is legally entitled for furnishing services or merchandise under medical assistance, or to knowingly submit false information for the purpose of obtaining authorization for furnishing services or merchandise under medical assistance.

(2) Solicit or receive or to offer or pay any remuneration, including any kickback, bribe or rebate, directly or indirectly, in cash or in kind from or to any person in connection with the furnishing of services or merchandise for which payment may be in whole or in part under the medical assistance program or in

connection with referring an individual to a person for the furnishing or arranging for the furnishing of any services or merchandise for which payment may be made in whole or in part under the medical assistance program.

(3) Submit a duplicate claim for services, supplies or equipment for which the provider has already received or claimed reimbursement from any source.

(4) Submit a claim for services, supplies or equipment which were not rendered to a recipient.

(5) Submit a claim for services, supplies or equipment which includes costs or charges not related to such services, supplies or equipment rendered to the recipient.

(6) Submit a claim or refer a recipient to another provider by referral, order or prescription, for services, supplies or equipment which are not documented in the record in the prescribed manner and are of little or no benefit to the recipient, are below the accepted medical treatment standards, or are unneeded by the recipient.

(7) Submit a claim which misrepresents the description of services, supplies or equipment dispensed or provided; the dates of services; the identity of the recipient; the identity of the attending, prescribing or referring practitioner; or the identity of the actual provider.

(8) Submit a claim for reimbursement for a service, charge or item at a fee or charge which is higher than the provider's usual and customary charge to the general public for the same service or item.

(9) Submit a claim for a service or item which was not rendered by the provider.

(10) Dispense, render or provide a service or item without a practitioner's written order and the consent of the recipient, except in emergency situations, or submit a claim for a service or item which was dispensed, or provided without the consent of the recipient, except in emergency situations.

(11) Except in emergency situations, dispense, render or provide a service or item to a patient claiming to be a recipient without making a reasonable effort to ascertain by verification through a current medical assistance identification card, that the person or patient is, in fact, a recipient who is eligible on the date of service and without another available medical resource.

(12) Enter into an agreement, combination or conspiracy to obtain or aid another to obtain reimbursement or payments for which there is not entitlement.

(13) Make a false statement in the application for enrollment as a provider.

(14) Commit any of the prohibited acts described in section 1403(d)(1), (2), (4) and (5).

(b) (1) A person who violates any provision of subsection (a), excepting subsection (a)(11), is guilty of a felony of the third degree for each such violation with a maximum penalty of fifteen thousand dollars ($15,000) and seven years imprisonment. A violation of subsection (a) shall be deemed to continue so long as the course of conduct or the defendant's complicity therein continues; the offense is committed when the course of conduct or complicity of the defendant therein is terminated in accordance with the provisions of 42 Pa.C.S. § 5552(d) (relating to other offenses). Whenever any person has been previously convicted in any state or Federal court of conduct that would constitute a violation of subsection (a), a subsequent allegation, indictment or information under subsection (a) shall be classified as a felony of the second

degree with a maximum penalty of twenty-five thousand dollars ($25,000) and ten years imprisonment.

(2) In addition to the penalties provided under subsection (b), the trial court shall order any person convicted under subsection (a):

(i) to repay the amount of the excess benefits or payments plus interest on that amount at the maximum legal rate from the date payment was made by the Commonwealth to the date repayment is made to the Commonwealth;

(ii) to pay an amount not to exceed threefold the amount of excess benefits or payments.

(3) Any person convicted under subsection (a) shall be ineligible to participate in the medical assistance program for a period of five years from the date of conviction. The department shall notify any provider so convicted that the provider agreement is terminated for five years, and the provider is entitled to a hearing on the sole issue of identity. If the conviction is set aside on appeal, the termination shall be lifted.

(4) The Attorney General and the district attorneys of the several counties shall have concurrent authority to institute criminal proceedings under the provisions of this section.

(5) As used in this section the following words and phrases shall have the following meanings:

"Conviction" means a verdict of guilty, a guilty plea, or a plea of nolo contendere in the trial court.

"Medically unnecessary or inadequate services or merchandise" means services or merchandise which are unnecessary or inadequate as determined by medical professionals engaged by the department who are competent in the same or similar field within the practice of medicine.

(c) (1) If the department determines that a provider has committed any prohibited act or has failed to satisfy any requirement under section 1407(a), it shall have the authority to immediately terminate, upon notice to the provider, the provider agreement and to institute a civil suit against such provider in the court of common pleas for twice the amount of excess benefits or payments plus legal interest from the date the violation or violations occurred. The department shall have the authority to use statistical sampling methods to determine the appropriate amount of restitution due from the provider.

(2) Providers who are terminated from participation in the medical assistance program for any reason shall be prohibited from owning, arranging for, rendering or ordering any service for medical assistance recipients during the period of termination. In addition, such provider may not receive, during the period of termination, reimbursement in the form of direct payments from the department or indirect payments of medical assistance funds in the form of salary, shared fees, contracts, kickbacks or rebates from or through any participating provider.

(3) Notice of any action taken by the department against a provider pursuant to clauses (1) and (2) will be forwarded by the department to the Medicaid Fraud Control Unit of the Department of Justice and to the appropriate licensing board of the Department of State for appropriate action, if any. In addition, the department will forward to the Medicaid Fraud Control Unit of the Department of Justice and the appropriate Pennsylvania licensing board of the Department of State any cases of suspected provider fraud.

(1407 added July 10, 1980, P.L.493, No.105)

Section 1408. Other Prohibited Acts, Criminal Penalties and Civil Remedies.--(a) It shall be unlawful for any person to:

(1) knowingly or intentionally make or cause to be made a false statement or misrepresentation or to wilfully fail to disclose a material fact regarding eligibility, including, but not limited to, facts regarding income, resources or potential third-party liability, for either themselves or any other individual, either prior to or at the time of or subsequent to the application for any medical assistance benefits or payments;

(2) having knowledge of the occurrence of any event affecting his initial or continued right to any such benefit or payment or the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceal or fail to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized;

(3) having made application to receive any such benefit or payment for the use and benefit of himself or another and having received it, knowingly or intentionally converts such benefit or any part thereof to a use other than for the use and benefit of himself or such other person; or

(4) knowingly or intentionally visit more than three practitioners or providers, who specialize in the same field, in the course of one month for the purpose of obtaining excessive services or benefits beyond what is reasonably needed (as determined by medical professionals engaged by the department) for the treatment of a diagnosed condition of the recipient.

(5) borrow or use a medical assistance identification card for which he is not entitled or otherwise gain or attempt to gain medical services covered under the medical assistance program if he has not been determined eligible for the program.

(b) (1) Any person violating subsection (a)(1), (2) or (3) commits the grade of crime determined from the following schedule:

Amount of Benefit	Degree of Crime
$3,000 or more	Felony of the third degree
$1,500 to $2,999	Misdemeanor of the first degree
$1,000 to $1,499	Misdemeanor of the second degree
$999 and under or an attempt to commit any act prohibited in subsection (a)(1), (2) or (3)	Misdemeanor of the third degree

(1.1) Pursuant to 42 Pa.C.S. § 1515(a)(7) (relating to jurisdiction and venue), jurisdiction over cases graded a misdemeanor of the third degree under this section shall be vested in district justices.

(1.2) Any person committing a crime enumerated in subsection (a)(1), (2), (3), (4) or (5) shall be ordered to pay restitution of any medical assistance benefits or payments made on behalf of either themselves or another individual. A restitution order under this subsection may be paid in a lump sum or by monthly installments or according to such other schedule as is deemed just by the sentencing court. Notwithstanding the provisions of 18 Pa.C.S. § 1106(c)(2) (relating to restitution for injuries to person or property) to the contrary, the period of time during which the offender is ordered to make restitution may exceed the maximum term of imprisonment to which the offender

could have been sentenced for the crime of which he was convicted if the sentencing court determines such period to be reasonable and in the interest of justice.

(1.3) There shall be a five-year statute of limitations on all crimes enumerated in subsection (a).

(2) A person who commits a violation of subsection (a)(4) or (5) is guilty of a misdemeanor of the first degree for each violation thereof with a maximum penalty thereof of ten thousand dollars ($10,000) and five years imprisonment.

(c) (1) Anyone who is convicted of a violation of subsection (a)(1), (2), (3), (4) or (5) shall, upon notification by the department, forfeit any and all rights to medical assistance benefits for any period of incarceration.

(2) If the department determines that a recipient misuses or overutilizes medical assistance benefits, the department is authorized to restrict a recipient to a provider of his choice for each medical specialty or type of provider covered under the medical assistance program.

(3) If the department determines that a general assistance eligible person who is also a medical assistance recipient has violated the provisions of subsection (a)(3), (4) or (5), the department shall have the authority to terminate such recipient's rights to any and all medical assistance benefits for a period up to one year.

(4) If the department determines that a person has violated the provisions of subsection (a)(1), (3), (4) or (5), the department shall have the authority to institute a civil suit against such person for the amount of the benefits obtained by the person in violation of subsection (a)(1), (3), (4) or (5), plus legal interest from the date the violation or violations occurred.

(5) The department shall also have the authority to administratively impose a one thousand dollar ($1,000) penalty against a person for each violation of subsection (a).

(6) (i) If it is found that a recipient or a member of his family or household, who would have been ineligible for medical assistance, possessed unreported real or personal property in excess of the amount permitted by law, the amount collectible shall be limited to an amount equal to the market value of such unreported property or the amount of medical assistance granted during the period it was held up to the date the unreported excess real or personal property is identified, whichever is less. Repayment of the overpayment shall be sought from the recipient, the person receiving or holding such property, the recipient's estate and/or survivors benefiting from receiving such property. Proof of date of acquisition of such property must be provided by the recipient or person acting on his behalf.

(ii) Where a person receiving medical assistance for which he would have been ineligible due to possession of such unreported property and proof of date of acquisition of such property is not provided, it shall be deemed that such real or personal property was held by the recipient the entire time he was on medical assistance and repayment shall be for all medical assistance paid for the recipient or the value of such excess property, whichever is less. Repayment shall be sought from the recipient, the person acting on the recipient's behalf, the person receiving or holding such property, the recipient's estate and/or survivors benefiting from receiving such property.

(d) The department is authorized to institute a civil suit to enforce any of the rights established by this section.

(1408 amended June 16, 1994, P.L.319, No.49)

Compiler's Note: Section 28 of Act 207 of 2004 provided that any and all references in any other law to a "district justice" or "justice of the peace" shall be deemed to be references to a magisterial district judge.

Section 1409. Third Party Liability.--(a) (1) No person having private health care coverage shall be entitled to receive the same health care furnished or paid for by a publicly funded health care program. For the purposes of this section, "publicly funded health care program" shall mean care for services rendered by a State or local government or any facility thereof, health care services for which payment is made under the medical assistance program established by the department or by its fiscal intermediary, or by an insurer or organization with which the department has contracted to furnish such services or to pay providers who furnish such services. For the purposes of this section, "privately funded health care" means medical care coverage contained in accident and health insurance policies or subscriber contracts issued by health plan corporations and nonprofit health service plans, certificates issued by fraternal benefit societies, and also any medical care benefits provided by self insurance plan including self insurance trust, as outlined in Pennsylvania insurance laws and related statutes.

(2) If such a person receives health care furnished or paid for by a publicly funded health care program, the insurer of his private health care coverage shall reimburse the publicly funded health care program, the cost incurred in rendering such care to the extent of the benefits provided under the terms of the policy for the services rendered.

(3) Each publicly funded health care program that furnishes or pays for health care services to a recipient having private health care coverage shall be entitled to be subrogated to the rights that such person has against the insurer of such coverage to the extent of the health care services rendered. Such action may be brought within five years from the date that service was rendered such person.

(4) When health care services are provided to a person under this section who at the time the service is provided has any other contractual or legal entitlement to such services, the secretary of the department shall have the right to recover from the person, corporation, or partnership who owes such entitlement, the amount which would have been paid to the person entitled thereto, or to a third party in his behalf, or the value of the service actually provided, if the person entitled thereto was entitled to services. The Attorney General may, to recover under this section, institute and prosecute legal proceedings against the person, corporation, health service plan or fraternal society owing such entitlement in the appropriate court in the name of the secretary of the department.

(5) The Commonwealth of Pennsylvania shall not reimburse any local government or any facility thereof, under medical assistance or under any other health program where the Commonwealth pays part or all of the costs, for care provided to a person covered under any disability insurance, health insurance or prepaid health plan.

(6) In local programs fully or partially funded by the Commonwealth, Commonwealth participation shall be reduced in the amount proportionate to the cost of services provided to a person.

(7) When health care services are provided to a dependent of a legally responsible relative, including but not limited

to a spouse or a parent of an unemancipated child, such legally responsible relative shall be liable for the cost of health care services furnished to the individual on whose behalf the duty of support is owed. The department shall have the right to recover from such legally responsible relative the charges for such services furnished under the medical assistance program.

(b) (1) When benefits are provided or will be provided to a beneficiary under this section because of an injury for which another person is liable, or for which an insurer is liable in accordance with the provisions of any policy of insurance issued pursuant to Pennsylvania insurance laws and related statutes the department shall have the right to recover from such person or insurer the reasonable value of benefits so provided. The Attorney General or his designee may, at the request of the department, to enforce such right, institute and prosecute legal proceedings against the third person or insurer who may be liable for the injury in an appropriate court, either in the name of the department or in the name of the injured person, his guardian, personal representative, estate or survivors.

(2) The department may:

(i) compromise, or settle and release any such claims; or

(ii) waive any such claim, in whole or in part, or if the department determines that collection would result in undue hardship upon the person who suffered the injury, or in a wrongful death action upon the heirs of the deceased.

(3) No action taken in behalf of the department pursuant to this section or any judgment rendered in such action shall be a bar to any action upon the claim or cause of action of the beneficiary, his guardian, personal representative, estate, dependents or survivors against the third person who may be liable for the injury, or shall operate to deny to the beneficiary the recovery for that portion of any damages not covered hereunder.

(4) (i) Where an action is brought by the department pursuant to this section, it shall be commenced within seven years of the date the cause of action arises:

(ii) Notwithstanding subclause (i), if a beneficiary has commenced an action to recover damages for an injury for which benefits are provided or will be provided and if the department was not provided with adequate notice under this section or section 1409.1, the department may commence an action under this section within the later of seven years of the date the cause of action arises or two years from the date the department discovers the settlement or judgment. Notice shall be adequate if all of the following notices have been provided to the department, if required:

(A) Notice of suit under clause (5)(i) from either the beneficiary or any third party or insurer.

(B) Notice of any election from the beneficiary under clause (5)(iii).

(C) Notice of settlement under clause (5)(iv) from either the beneficiary or any third party or insurer.

(D) Notice of any allocation proceeding under section 1409.1(b)(3).

(iii) The following shall apply:

(A) The death of the beneficiary does not abate any right of action established by this section.

(B) When an action or claim is brought by persons entitled to bring such actions or assert such claims against a third party who may be liable for causing the death of a beneficiary, any settlement, judgment or award obtained is subject to the

department's claims for reimbursement of the benefits provided to the beneficiary under the medical assistance program.

(C) Where the action or claim is brought by the beneficiary alone and the beneficiary incurs a personal liability to pay attorney's fees and costs of litigation, the department's claim for reimbursement of the benefits provided to the beneficiary shall be limited to the amount of the medical expenditures for the services to the beneficiary.

(D) Where benefits are provided or will be provided for a minor's care, any statute of limitation or repose applicable to an action or claim in which the minor's medical expenses may be sought shall be tolled until the minor reaches the age of majority. The period of minority shall not be deemed a portion of the time period within which the action must be commenced. As used in this clause, the term "minor" shall mean any individual who has not yet attained the age of 18.

(5) If either the beneficiary or the department brings an action or claim against such third party or insurer, the beneficiary or the department shall within thirty days of filing the action give to the other written notice by personal service or by certified or registered mail of the action or claim. Any third party or insurer that has received information indicating that the beneficiary received benefits under the medical assistance program shall give written notice to the department by personal service or by certified or registered mail of the action or claim. Proof of the notices shall be filed in the action or claim.

(i) If a beneficiary files an action or claim that does not seek recovery of expenses for which benefits under the medical assistance program are provided, the beneficiary shall include in the notice to the department a statement that the action or claim does not seek recovery of the expenses.

(ii) If a parent files an action or claim that does not seek recovery of a minor's medical expenses paid by the medical assistance program, the parent shall include in the notice to the department a statement that the action or claim does not seek the recovery of the expenses.

(iii) If a beneficiary files an action or claim that seeks the recovery of expenses for which benefits under the medical assistance program are provided and later elects not to seek recovery of the expenses, the beneficiary shall provide reasonable notice to the department by personal service or by certified or registered mail. Notice shall be reasonable if it allows the department sufficient time to petition to intervene in the action and prosecute its claim.

(iv) Notice of any settlement shall be provided to the department by the beneficiary and any third party or insurer within thirty days of the settlement. Where judicial approval of the settlement is required, reasonable notice of the settlement shall be provided to the department before a judicial hearing for approval of the settlement. Notice is reasonable if it allows the department sufficient time to intervene in the action and prosecute its claim.

(v) If an action or claim is brought by either the department or beneficiary, the other may, at any time before trial on the facts, become a party to or shall consolidate his action or claim with the other if brought independently.

(vi) The beneficiary may include as part of his claim the amount of benefits that have been or will be provided by the medical assistance program.

(6) If an action or claim is brought by the department pursuant to subsection (b)(1), written notice to the beneficiary

given pursuant to this section shall advise him of his right to intervene in the proceeding and his right to recover the reasonable value of the benefits provided.

(7) Except as provided under section 1409.1, in the event of judgment, award or settlement in a suit or claim against such third party or insurer:

(i) If the action or claim is prosecuted by the beneficiary alone, the court or agency shall first order paid from any judgment or award the reasonable litigation expenses, as determined by the court, incurred in preparation and prosecution of such action or claim, together with reasonable attorney's fees, when an attorney has been retained. After payment of such expenses and attorney's fees the court or agency shall, on the application of the department, allow as a first lien against the amount of such judgment or award, the amount of the expenditures for the benefit of the beneficiary under the medical assistance program.

(ii) If the action or claim is prosecuted both by the beneficiary and the department, the court or agency shall first order paid from any judgment or award, the reasonable litigation expenses incurred in preparation and prosecution of such action or claim, together with reasonable attorney's fees based solely on the services rendered for the benefit of the beneficiary. After payment of such expenses and attorney's fees, the court or agency shall apply out of the balance of such judgment or award an amount of benefits paid on behalf of the beneficiary under the medical assistance program.

(iii) With respect to claims against third parties for the cost of medical assistance services delivered through a managed care organization contract, the department shall recover the actual payment to the hospital or other medical provider for the service. If no specific payment is identified by the managed care organization for the service, the department shall recover its fee schedule amount for the service.

(8) Except as provided under section 1409.1, upon application of the department, the court or agency shall allow a lien against any third party payment or trust fund resulting from a judgment, award or settlement in the amount of any expenditures in payment of additional benefits arising out of the same cause of action or claim provided on behalf of the beneficiary under the medical assistance program, when such benefits were provided or became payable subsequent to the date of the judgment, award or settlement.

(9) Unless otherwise directed by the department, no payment or distribution shall be made to a claimant or a claimant's designee of the proceeds of any action, claim or settlement where the department has an interest without first satisfying or assuring satisfaction of the interest of the Commonwealth. Any person who, after receiving notice of the department's interest, knowingly fails to comply with the obligations established under this clause shall be liable to the department, and the department may sue to recover from the person.

(10) When the department has perfected a lien upon a judgment or award in favor of a beneficiary against any third party for an injury for which the beneficiary has received benefits under the medical assistance program, the department shall be entitled to a writ of execution as lien claimant to enforce payment of said lien against such third party with interest and other accruing costs as in the case of other executions. In the event the amount of such judgment or award so recovered has been paid to the beneficiary, the department shall be entitled to a writ of execution against such

beneficiary to the extent of the department's lien, with interest and other accruing costs as in the cost of other executions.

(11) Except as otherwise provided in this act, notwithstanding any other provision of law, the entire amount of any settlement of the injured beneficiary's action or claim, with or without suit, is subject to the department's claim for reimbursement of the benefits provided any lien filed pursuant thereto, but in no event shall the department's claim exceed one-half of the beneficiary's recovery after deducting for attorney's fees, litigation costs, and medical expenses relating to the injury paid for by the beneficiary.

(12) In the event that the beneficiary, his guardian, personal representative, estate or survivors or any of them brings an action against the third person who may be liable for the injury, notice of institution of legal proceedings, notice of settlement and all other notices required by this act shall be given to the secretary (or his designee) in Harrisburg except in cases where the secretary specifies that notice shall be given to the Attorney General. The beneficiary's obligations under this subsection shall be met by the attorney retained to assert the beneficiary's claim, or by the injured party beneficiary, his guardian, personal representative, estate or survivors, if no attorney is retained.

(13) The following special definitions apply to this subsection:

"Beneficiary" means any person who has received benefits or will be provided benefits under this act because of an injury for which another person may be liable. It includes such beneficiary's guardian, conservator, or other personal representative, his estate or survivors.

"Insurer" includes any insurer as defined in the act of May 17, 1921 (P.L.789, No.285), known as "The Insurance Department Act of one thousand nine hundred and twenty-one," including any insurer authorized under the Laws of this Commonwealth to insure persons against liability or injuries caused to another, and also any insurer providing benefits under a policy of bodily injury liability insurance covering liability arising out of ownership, maintenance or use of a motor vehicle which provides uninsured motorist endorsement of coverage pursuant to the act of July 19, 1974 (P.L.489, No.176), known as the "Pennsylvania No-fault Motor Vehicle Insurance Act."

(c) Following notice and hearing, the department may administratively impose a penalty of up to five thousand dollars ($5,000) per violation upon any person who wilfully fails to comply with the obligations imposed under this section.

(1409 amended July 4, 2008, P.L.557, No.44)

Compiler's Note: Section 12 of Act 44 of 2008, which amended section 1409, provided that the amendment shall apply retroactively to actions filed on or after the effective date of section 12.

Section 1409.1. Federal Law Recovery of Medical Assistance Reimbursement.--(a) To the extent that Federal law limits the department's recovery of medical assistance reimbursement to the medical portion of a beneficiary's judgment, award or settlement in a claim against a third party, the provisions of this section shall apply.

(b) In the event of judgment, award or settlement in a suit or claim against a third party or insurer:

(1) If the action or claim is prosecuted by the beneficiary alone, the court or agency shall first order paid from any

judgment or award the reasonable litigation expenses, as determined by the court, incurred in preparation and prosecution of the action or claim, together with reasonable attorney fees. After payment of the expenses and attorney fees, the court or agency shall allocate the judgment or award between the medical portion and other damages and shall allow the department a first lien against the medical portion of the judgment or award, the amount of the expenditures for the benefit of the beneficiary under the medical assistance program.

(2) If the action or claim is prosecuted both by the beneficiary and the department, the court or agency shall first order paid from any judgment or award the reasonable litigation expenses incurred in preparation and prosecution of the action or claim, together with reasonable attorney fees based solely on the services rendered for the benefit of the beneficiary. After payment of the expenses and attorney fees, the court or agency shall allocate the judgment or award between the medical portion and other damages and shall make an award to the department out of the medical portion of the judgment or award the amount of benefits paid on behalf of the beneficiary under the medical assistance program.

(3) The department shall be given reasonable advance notice before the court makes any allocation of a judgment or award under this section.

(4) The provisions of section 1409(b)(7)(iii) shall apply to this section.

(1409.1 added July 4, 2008, P.L.557, No.44)

Compiler's Note: Section 12 of Act 44 of 2008, which added section 1409.1, provided that section 1409.1 shall apply retroactively to actions filed on or after the effective date of section 12.

Section 1410. Rules and Regulations.--The department shall have the power and its duty shall be to adopt rules and regulations to carry out the provisions of this article.

(1410 added July 10, 1980, P.L.493, No.105 and repealed in part June 25, 1982, P.L.633, No.181)

Section 1411. Venue and Limitations on Actions.--Any civil actions or criminal prosecutions brought pursuant to this act for violations hereof shall be commenced within five years of the date the violation or violations occur. In addition, any such actions or prosecutions may be brought in any county where the offender has an office or place of business or where claims and payments are processed by the Commonwealth or where authorized by the Rules of the Pennsylvania Supreme Court.

(1411 added July 10, 1980, P.L.493, No.105, and repealed in part Dec. 20, 1982, P.L.1409, No.326)

Section 1412. Repayment from Probate Estates.--(a) Notwithstanding any other provision of this act or any other law, the department shall establish and implement an estate recovery program to recover medical assistance paid with respect to individuals who were fifty-five years of age or older at the time that assistance was received. Under this program, the department shall recover from the probate estate of an individual the amount of medical assistance paid for all nursing facility services, home- and community-based services and related hospital and prescription drug services. With the approval of the Governor, the department may expand the estate recovery program by regulation to include medical assistance for services other than those listed in this section and to recover against other real and personal property in which an individual had any legal title or interest at the time of death.

The department's claim shall have the priority of a debt due the Commonwealth.

(a.1) Liability for debt shall be as follows:

(1) If property subject to the department's claim is transferred without the department's claim being satisfied, then the executor or administrator transferring such property, if there is one, shall become liable to pay the department's claim.

(2) If property subject to the department's claim is transferred to the extent that the transfer is made without valuable and adequate consideration in money or something worth money at the time of the transfer and without the department's claim being satisfied, then the executor or administrator transferring such property, if there is one, and the person receiving such property shall become liable to pay the department's claim.

(b) The executor or administrator of the estate of a decedent who attained fifty-five years of age shall ascertain whether the decedent received medical assistance during the five years preceding death and, if so, shall give notice to the department to secure from the department a statement of the department's claim for medical assistance consistent with 20 Pa.C.S. § 3392(3) and (6) (relating to classification and order of payment). The department must submit its claim to the executor or administrator within forty-five days of receipt of notice or the claim shall be forfeited.

(c) This section shall apply notwithstanding the provisions of section 447.

(1412 amended June 30, 1995, P.L.129, No.20)

Section 1413. Data Matching.--(a) All entities providing health insurance or health care coverage to individuals residing within this Commonwealth shall provide such information on coverage and benefits, as the department may specify, for any recipient of medical assistance or child support services identified by the department by name and either policy number or Social Security number. The information the department may specify in its request may include information needed to determine during what period individuals or their spouses or their dependents may be or may have been covered by the entity and the nature of the coverage that is or was provided by the entity, including the name, address and identifying number of the plan.

(b) All entities providing health insurance or health care coverage to individuals residing within this Commonwealth shall accept the department's right of recovery and the assignment to the department of any right of an individual or any other entity to payment for an item or service for which payment has been made by the medical assistance program and shall receive, process and pay claims for reimbursement submitted by the department or its authorized contractor with respect to medical assistance recipients who have coverage for such claims.

(c) To the maximum extent permitted by Federal law and notwithstanding any policy or plan provision to the contrary, a claim by the department for reimbursement of medical assistance shall be deemed timely filed with the entity providing health insurance or health care coverage and shall not be denied solely on the basis of the date of submission of the claim, the type or format of the claim or a failure to present proper documentation at the point of sale that is the basis of the claim, if it is filed as follows:

(1) within five years of the date of service for all dates of service occurring on or before June 30, 2007; or

(2) within three years of the date of service for all dates of service occurring on or after July 1, 2007.

(c.1) Any action by the department to enforce its rights with respect to a claim submitted by the department under this section must be commenced within six years of the department's submission of the claim. All entities providing health care coverage within this Commonwealth shall respond within forty-five days to any inquiry by the department regarding a claim for payment for any health care item or service that is submitted not later than three years after the date of provision of the health care item or service.

(d) The department is authorized to enter into agreements with entities providing health insurance and health care coverage for the purpose of carrying out the provisions of this section. The agreement shall provide for the electronic exchange of data between the parties at a mutually agreed-upon frequency, but no less frequently than monthly, and may also allow for payment of a fee by the department to the entity providing health insurance or health care coverage.

(e) Following notice and hearing, the department may impose a penalty of up to one thousand dollars ($1,000) per violation upon any entity that wilfully fails to comply with the obligations imposed by this section.

(e.1) It is a condition of doing business in this Commonwealth that every entity subject to this section comply with the provisions of this section and agree not to deny a claim submitted by the department on the basis of a plan or contract provision that is inconsistent with subsection (c).

(f) This section shall apply to every entity providing health insurance or health care coverage within this Commonwealth, including, but not limited to, plans, policies, contracts or certificates issued by:

(1) A stock insurance company incorporated for any of the purposes set forth in section 202(c) of the act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921."

(2) A mutual insurance company incorporated for any of the purposes set forth in section 202(d) of "The Insurance Company Law of 1921."

(3) A professional health services plan corporation as defined in 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

(4) A health maintenance organization as defined in the act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act."

(5) A fraternal benefit society as defined in section 2403 of "The Insurance Company Law of 1921."

(6) A person who sells or issues contracts or certificates of insurance which meet the requirements of this act.

(7) A hospital plan corporation as defined in 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations).

(8) Health care plans subject to the Employee Retirement Income Security Act of 1974 (Public Law 93-406, 88 Stat. 829), self-insured plans, service benefit plans, managed care organizations, pharmacy benefit managers and every other organization that is, by statute, contract or agreement, legally responsible for the payment of a claim for a health care service or item to the maximum extent permitted by Federal law.

(1413 amended July 4, 2008, P.L.557, No.44)

Section 1414. Special Needs Trusts.--(a) A special needs trust must be approved by a court of competent jurisdiction if required by rules of court.

(b) A special needs trust shall comply with all of the following:

(1) The beneficiary shall be an individual under the age of sixty-five who is disabled, as that term is defined in Title XVI of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1381 et seq.).

(2) The beneficiary shall have special needs that will not be met without the trust.

(3) The trust shall provide:

(i) That all distributions from the trust must be for the sole benefit of the beneficiary.

(ii) That any expenditure from the trust must have a reasonable relationship to the needs of the beneficiary.

(iii) That, upon the death of the beneficiary or upon the earlier termination of the trust, the department and any other state that provided medical assistance to the beneficiary must be reimbursed from the funds remaining in the trust up to an amount equal to the total medical assistance paid on behalf of the beneficiary before any other claimant is paid: Provided, however, That in the case of an account in a pooled trust, the trust shall provide that no more than fifty percent of the amount remaining in the beneficiary's pooled trust account may be retained by the trust without any obligation to reimburse the department.

(4) The department, upon review of the trust, must determine that the trust conforms to the requirements of Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.), this section, any other State law and any regulations or statements of policy adopted by the department to implement this section.

(c) If at any time it appears that any of the requirements of subsection (b) are not satisfied or the trustee refuses without good cause to make payments from the trust for the special needs of the beneficiary and, provided that the department or any other public agency in this Commonwealth has a claim against trust property, the department or other public agency may petition the court for an order terminating the trust.

(d) Before the funding of a special needs trust, all liens and claims in favor of the department for repayment of cash and medical assistance shall first be satisfied.

(e) At the death of the beneficiary or upon earlier termination of the trust, the trustee shall notify and request a statement of claim from the department, addressed to the secretary.

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

"Pooled trust" means a trust subject to the act of December 9, 2002 (P.L.1379, No.168), known as the "Pooled Trust Act."

"Special needs" means those items, products or services not covered by the medical assistance program, insurance or other third-party liability source for which a beneficiary of a special needs trust or his parents are personally liable and that can be provided to the beneficiary to increase the beneficiary's quality of life and to assist in and are related to the treatment of the beneficiary's disability. The term may include medical expenses, dental expenses, nursing and custodial care, psychiatric/psychological services, recreational therapy, occupational therapy, physical therapy, vocational therapy, durable medical needs, prosthetic devices, special rehabilitative services or equipment, disability-related training, education, transportation and travel expenses, dietary

needs and supplements, related insurance and other goods and services specified by the department.

"Special needs trust" means a trust or an account in a pooled trust that is established in compliance with this section for a beneficiary who is an individual who is disabled, as such term is defined in Title XVI of the Social Security Act (42 U.S.C. § 1382c(a)(3)), as amended, consists of assets of the individual and is established for the purpose or with the effect of establishing or maintaining the beneficiary's resource eligibility for medical assistance.

(1414 added July 7, 2005, P.L.177, No.42)

Compiler's Note: See section 11 of Act 20 of 1995 in the appendix to this act for special provisions relating to waiver of Federal law and regulations and other approvals by Federal Government necessary for implementation of programs added by Act 20.

Section 1415. Health Insurance Premium Payment Program.--(a) The department is authorized to purchase employe group health care coverage on behalf of any medical assistance recipient whenever it is cost effective to do so.

(b) Upon request of the department, every insurer shall provide the department with benefit information needed to determine the eligibility of a medical assistance recipient for employe group health care coverage.

(c) Every insurer shall honor a request for enrollment and purchase of employe group health insurance submitted by the department with respect to a medical assistance recipient with consideration for enrollment season restrictions, but no enrollment restrictions shall delay enrollment more than ninety days from the date of the department's request. Once enrolled, the insurer shall honor a request for disenrollment submitted by the department, without imposing personal liability upon the medical assistance recipient, whenever it is no longer cost effective for the department to pay the premiums or when the recipient is no longer eligible for medical assistance.

(d) The department may administratively impose a civil penalty of up to one thousand dollars ($1,000) per violation against any insurer who fails to comply with the requirements of this section.

(e) This section shall apply to all such policies, contracts, certificates or programs issued, renewed, modified, altered, amended or reissued on or after the effective date of this section.

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

(1) The term "insurer" includes:

(i) A stock insurance company incorporated for any of the purposes set forth in section 202(c) of the act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921."

(ii) A mutual insurance company incorporated for any of the purposes set forth in section 202(d) of "The Insurance Company Law of 1921."

(iii) A professional health services plan corporation as defined in 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

(iv) A hospital plan corporation as defined in 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations).

(v) A fraternal benefit society as defined in 40 Pa.C.S. Ch. 63.

(vi) A health maintenance organization as defined in the "Health Maintenance Organization Act."

(vii) Any other person who sells or issues contracts or certificates of insurance.

(viii) A person, including an employer or third-party administrator, providing or administering employee group health care coverage, to the maximum extent permitted by Federal law.

(2) The phrase "employe group health care coverage" means health care coverage that the department is authorized to purchase for medical assistance recipients in section 1906 of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396e).

(1415 added July 7, 2005, P.L.177, No.42)

Section 1416. Parity in Insurance Coverage for State-Owned Psychiatric Hospitals.--(a) No insurer providing inpatient psychiatric care coverage to individuals covered by that insurer's plan shall deny payment to a State-owned psychiatric hospital for medically necessary services provided to that individual solely on the basis that the hospital is a government-owned facility, has no signed provider agreement with the insurer or does not participate in the insurer's network.

(b) The provision of psychiatric services at a State-owned psychiatric hospital shall be an assignment by operation of law to the hospital of the individual's right to recover for such services from that individual's insurer. The department may sue for and recover any amounts due from that individual's insurer.

(c) In determining the medical necessity of any inpatient psychiatric stay at a State-owned psychiatric hospital, it shall be rebuttably presumed that the patient could not be treated in an alternative setting if either of the following applies:

(1) The stay was required by court order.

(2) The patient was transferred to the State-owned psychiatric hospital from an acute psychiatric care facility or from an acute psychiatric care unit of a general hospital, because the patient was determined medically inappropriate for discharge.

(d) State-owned psychiatric hospitals may enter into provider agreements with insurers and may accept payments under such provider agreements as payment in full, excluding the patient's liability for unpaid deductible and coinsurance amounts. In the absence of a provider agreement, the insurer shall make payment for a hospital stay at its usual rate of payment to contracted psychiatric hospital providers or, in the absence of such a rate, the rate that the medical assistance program would pay for such care.

(e) The department may administratively impose a penalty of up to one thousand dollars ($1,000) per violation against any insurer that fails to comply with the requirements of this section.

(f) For the purposes of this section, the term "insurer" includes:

(1) A stock insurance company incorporated for any of the purposes set forth in section 202(c) of the act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921."

(2) A mutual insurance company incorporated for any of the purposes set forth in section 202(d) of "The Insurance Company Law of 1921."

(3) A professional health services plan corporation as defined in 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

(4) A hospital plan corporation as defined in 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations).

(5) A fraternal benefit society as defined in 40 Pa.C.S. Ch. 63.

(6) A health maintenance organization as defined in the act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act."

(7) Any other person who sells or issues contracts or certificates of insurance.

(8) Any person, including an employer or third-party administrator, providing or administering employe group health care coverage, to the maximum extent permitted by Federal law.

(1416 added July 7, 2005, P.L.177, No.42)

Section 1417. Fraud Reporting to Inspector General.--(a) If an employe of a county assistance office who has reason to believe a recipient or applicant of public assistance is committing fraud or providing false information in order to receive public assistance benefits, including, but not limited to, medical assistance, cash assistance and food stamps, the county assistance office employe shall make a fraud report directly to the Office of Inspector General.

(b) The county assistance employe shall not be subject to any sanctions for making a fraud report.

(1417 added Dec. 17, 2009, P.L.598, No.54)

Section 1418. Toll-Free DHS Fraud Tip Line.--(a) The department shall:

(1) Establish a toll-free telephone number and e-mail address for persons to report suspected fraud or abuse of public assistance programs, including, but not limited to, medical assistance, cash assistance and food stamps.

(2) Obtain the telephone number 1-866-DHS-TIPS for such purposes. If the phone number 1-866-DHS-TIPS is not available, the department shall obtain a substantially similar telephone number acronym for such purposes.

(3) Permit persons to provide information anonymously, should they choose to do so.

(4) Conduct a thorough investigation of all credible complaints or provide a referral to the Office of Inspector General for investigation, whether pertaining to a benefit recipient or provider.

(b) The department shall submit an annual report on its fraud prevention activities to the Governor and General Assembly. The report shall:

(1) Include, but not be limited to, information pertaining to the following:

(i) The number of complaints received through the Toll-Free DHS Fraud Tip Line, regular mail or via the Internet.

(ii) The number of investigations conducted by the department and the Office of Inspector General as a result of such complaints.

(iii) The number of criminal prosecutions and civil actions resulting from such investigations.

(iv) The estimated total cost avoided and funds reclaimed by the department as a result of such complaints.

(2) Be made available to the public through the department's publicly accessible Internet website.

(c) The following provisions apply to posting information relating to the Toll-Free DHS Fraud Tip Line:

(1) An owner, manager or provider who operates a business or medical facility in a public place who accepts food stamps or medical assistance as a form of payment for goods or services shall post a sign containing information regarding the Toll-Free DHS Fraud Tip Line.

(2) Any other owner, manager or provider may post the sign.

(3) An owner, manager or provider under paragraph (1) shall post at least one sign, no smaller than eight and one-half by

eleven inches and no larger than one by two feet, in a conspicuous manner clearly visible to the public and employes inside the business or medical facility.

(4) The department shall design the sign to include the following information:

(i) The Toll-Free DHS Fraud Tip Line telephone number, including the acronym.

(ii) Notice that callers may provide information anonymously if they choose to do so.

(5) The department shall design the sign to draw attention to the telephone number of the Toll-Free DHS Fraud Tip Line by displaying the number and acronym in bold type and large font.

(6) The department shall provide the sign on its publicly accessible Internet website for owners, managers and providers to print as needed.

(d) The following provisions relate to enforcement:

(1) A complaint regarding a possible violation of this section shall be made to the appropriate law enforcement agency or to the department.

(2) Except as otherwise provided under paragraph (3), upon receipt of a complaint by the department, the following apply:

(i) the department shall investigate the complaint and enforce this act; or

(ii) if the business or medical facility is subject to licensure by the Commonwealth, the department shall refer the complaint to the appropriate licensing agency for investigation and enforcement of this act.

(3) If the complaint is made to a law enforcement agency regarding a business, the agency shall investigate the complaint and enforce this act.

(e) It is a violation of this act to fail to post a sign as required under subsection (c).

(f) Any of the following shall be an affirmative defense to a prosecution or imposition of an administrative penalty under this act:

(1) When the violation occurred, the actual control of the business or medical facility was not exercised by the owner, manager or provider, but by a lessee.

(2) The owner, manager or provider made a good faith effort to post the sign.

(3) The owner, manager or provider asserting the affirmative defense must do so in the form of a sworn affidavit setting forth the relevant information mentioned under paragraphs (1) and (2).

(g) If the department or a State licensing agency determines that:

(1) A person has violated subsection (e), the person shall be issued a warning by the department or State licensing agency.

(2) A person has violated subsection (e) within one year of receiving a warning under paragraph (1), the person shall be subject to a penalty not to exceed two hundred fifty dollars ($250).

(3) A person has violated subsection (e) within one year of receiving a penalty under paragraph (2), the person shall be subject to a penalty not to exceed five hundred dollars ($500).

(h) The provisions of subsection (g) shall be subject to 2 Pa.C.S. (relating to administrative law and procedure).

(i) The penalties collected under subsection (g) shall be retained by the department or the State licensing agency initiating the enforcement action.

(1418 added September 24, 2014, P.L.2458, No.132)

ARTICLE XIV-A
INMATE MEDICAL COSTS
(Art. added June 30, 2011, P.L.89, No.22)

Section 1401-A. Definitions.

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

"Correctional institution." (Def. repealed July 5, 2012, P.L.1050, No.122)

"Drug." The term shall mean:

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

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

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

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

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

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

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

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

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

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

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

(1401-A added June 30, 2011, P.L.89, No.22)

Section 1402-A. Inmate medical cost containment.

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

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

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

(1402-A added June 30, 2011, P.L.89, No.22)

ARTICLE XIV-B
HUMAN SERVICES BLOCK GRANT PROGRAM

(Art. hdg. amended Nov. 4, 2016, P.L.1172, No.153)

Compiler's Note: Article XIV-B was added by Act 80 of 2012. Act 80 of 2012 was declared unconstitutional on July 18, 2018, by the Supreme Court of Pennsylvania in Washington v. Commonwealth, Department of Public Welfare, 188 A.3d 1135 (Pa. 2018). In footnote 20 of its decision, the Supreme Court determined that Article XIV-B had been reenacted by Act of 153 of 2016 and that its decision did not affect the validity of that reenactment.

Section 1401-B. 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:

"Block grant." The Human Services Block Grant Program established in section 1402-B. (Def. amended Nov. 4, 2016, P.L.1172, No.153)

"County-based human services." Programs approved by the Department of Human Services and provided by county governments through direct or contracted services, supportive services and service coordination. The term includes services designed to meet service needs of the following:

(1) Individuals in need of behavioral health services.

(2) Individuals with intellectual disabilities.

(3) Individuals in need of drug and alcohol treatment services.

(4) Individuals who are homeless or at immediate risk of becoming homeless.

(5) ((5) deleted by amendment).

(6) Low-income adults eligible to receive services under the act of October 5, 1994 (P.L.531, No.78), known as the Human Services Development Fund Act.

(7) Older individuals as provided for under section 2206-A of the act of April 9, 1929 (P.L.177, No.175), known as The Administrative Code of 1929, and eligible to receive services under the Human Services Development Fund Act.

(Def. amended Nov. 4, 2016, P.L.1172, No.153)

"Local collaborative arrangements." Two or more counties acting in concert to provide county-based human services through a single public or private entity.

(1401-B added June 30, 2012, P.L.668, No.80)

Compiler's Note: Section 1401-B was added by Act 80 of 2012. Act 80 of 2012 was declared unconstitutional on July 18, 2018, by the Supreme Court of Pennsylvania in Washington

v. Commonwealth, Department of Public Welfare, 188 A.3d 1135 (Pa. 2018). In footnote 20 of its decision, the Supreme Court determined that Article XIV-B had been reenacted by Act 153 of 2016 and that its decision did not affect the validity of that reenactment.

Section 1402-B. Establishment of Human Services Block Grant Program.

The following shall apply to the Human Services Block Grant Program:

(1) The Human Services Block Grant Program is established for the purpose of allocating block grant funds to county governments to provide locally identified county-based human services that will meet the service needs of county residents. A county's request to participate in the block grant shall be on a form and contain such information as the department may prescribe. The application to the department shall be adopted by a majority vote of the governing body and transmitted to the department accompanied by the signature of the chair of the board of commissioners and attested by the chief clerk of the county or, in the case of a home rule county, by the equivalent consistent with the provisions of the county charter.

(2) The department may approve a county's request based on the county's plan to provide human services and integrate its human service programs. The department shall consider such factors as:

(i) ((i) deleted by amendment).

(ii) ((ii) deleted by amendment).

(iii) ((iii) deleted by amendment).

(iv) ((iv) deleted by amendment).

(v) ((v) deleted by amendment).

(vi) ((vi) deleted by amendment).

(vii) Whether the county is part of a local collaborative arrangement.

(viii) The county's human services administrative structure.

(ix) The county's history of human services fiscal management.

(x) The county's history of compliance with statutory and regulatory requirements regarding the operation of its human services programs.

(3) A county's participation in the block grant is voluntary.

(1402-B amended Nov. 4, 2016, P.L.1172, No.153)

Compiler's Note: Section 1402-B was added by Act 80 of 2012. Act 80 of 2012 was declared unconstitutional on July 18, 2018, by the Supreme Court of Pennsylvania in Washington v. Commonwealth, Department of Public Welfare, 188 A.3d 1135 (Pa. 2018). In footnote 20 of its decision, the Supreme Court determined that Article XIV-B had been reenacted by Act 153 of 2016 and that its decision did not affect the validity of that reenactment.

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

Section 1403-B. Powers and duties of the department.

(a) Distribution of funds.--Notwithstanding any other law, the department may distribute those funds that have been appropriated to the department for the programs set forth in section 1405-B(a)(1) as a block grant for county-based human services.

(b) Administration of program.--The department shall have the power and duty to:

(1) Monitor county governments' administration of the block grant to ensure compliance with applicable Federal and State requirements.

(2) Allocate and disburse block grant funds to counties on a quarterly basis in accordance with section 1405-B.

(3) Provide technical support and assistance to counties.

(4) Require counties to submit reports containing such information pursuant to the implementation of this article and in the form and by the deadline prescribed by the department. The department shall issue instructions for the completion of county reports. The instructions shall be issued no later than August 31 of each year following the fiscal year for the report.

(5) Monitor, inspect or audit the financial, operating and accounting records of any county agency or contracted entity that receives any block grant funds if deemed necessary by the department.

(6) Withhold, recover or reduce any block grant funds of a county agency or contracted entity determined to have been spent or disbursed in violation of Federal or State requirements.

(6.1) Withhold, recover or reduce by no more than 5% the allocation of funds under this article to any county that does not timely file a complete plan or report under section 1404-B(4) and (5). The department may withhold, recover or reduce the allocation of funds until a complete plan or report is submitted.

(6.2) Require submission and implementation of an acceptable corrective action plan or terminate a county's participation in the Human Services Block Grant Program for a violation of this article.

(7) Establish procedures for the annual submission, review and approval process of county block grant plans for the expenditure of block grant funds and the delivery of county-based human services submitted under section 1404-B(5). The department shall issue instructions for county block grant plans for the next fiscal year no later than March 1 of each year. The department shall allow counties to submit revised block grant plans following the enactment of the General Appropriation Act for the current fiscal year. The department shall not approve a county plan which proposes the elimination of any of the following county-based human services:

(i) Community-based mental health services.

(ii) Intellectual disability services.

(iii) ((iii) deleted by amendment)

(iv) Drug and alcohol treatment and prevention services.

(v) Homeless assistance services.

(vi) Behavioral health services.

(7.1) Review and approve or disapprove a county's request to revise its plan during the fiscal year pursuant to section 1404-B(5.2).

(7.2) Consult with a Statewide association representing counties to select the data elements and outcome measures to be included in county plans under section 1404-B(5) beginning with the report for fiscal year 2018-2019. The department and the Statewide association shall review and

update the data elements and outcome measures at least every four years.

(8) Prepare and submit by January 1, 2014, and by December 15 each year thereafter, a report to the chairman and minority chairman of the Public Health and Welfare Committee of the Senate, the chairman and minority chairman of the Appropriations Committee of the Senate, the chairman and minority chairman of the Health Committee of the House of Representatives, the chairman and minority chairman of the Human Services Committee of the House of Representatives and the chairman and minority chairman of the Appropriations Committee of the House of Representatives of the expenditures of block grant funds by county governments to include:

(i) The allocation levels.

(ii) The expenditure levels.

(iii) The number of individuals served by the human services provided.

(iii.1) The efforts between counties, stakeholders, associations and the department to determine the data elements and outcome measures required for plans under section 1404-B(5).

(iv) Any other information deemed necessary by the department, including any information which would determine the effectiveness of the block grant.

(9) The annual report under paragraph (8) shall be made available for public inspection and posted on the department's publicly accessible Internet website.

(10) Promulgate regulations as may be necessary to carry out this article.

(11) Consult with a Statewide association representing counties to develop a method to informally resolve disputes under paragraphs (6), (6.1) and (6.2) or a disapproval of a plan under paragraph (7).

((b) amended Nov. 4, 2016, P.L.1172, No.153)

(1403-B added June 30, 2012, P.L.668, No.80)

Compiler's Note: Section 1403-B was added by Act 80 of 2012. Act 80 of 2012 was declared unconstitutional on July 18, 2018, by the Supreme Court of Pennsylvania in Washington v. Commonwealth, Department of Public Welfare, 188 A.3d 1135 (Pa. 2018). In footnote 20 of its decision, the Supreme Court determined that Article XIV-B had been reenacted by Act 153 of 2016 and that its decision did not affect the validity of that reenactment.

Section 1404-B. Powers and duties of counties.

The local county officials of each county government participating in the block grant shall have the power and duty to:

(1) Administer and disburse block grant funds for the provision of county-based human services in accordance with this article and regulations promulgated under section 1403-B(10) and Federal requirements.

(2) Establish or maintain, in agreement with another county or counties, local collaborative arrangements for the delivery of any county-based human service. Counties may establish new local collaborative arrangements under this paragraph for the provision of a specific county-based human service or county-based human services, subject to approval by the secretary.

(3) Determine and redetermine, when necessary, whether a person is eligible to participate in a county-based human

service, subject to appeal under 2 Pa.C.S. Ch. 5 Subch. B (relating to practice and procedures of local agencies).

(4) Submit required reports under section 1403-B(b)(4) no later than September 30 of each year following the fiscal year of the report. ((4) amended Nov. 4, 2016, P.L.1172, No.153)

(5) Submit to the department an annual Human Services Block Grant Plan for the next fiscal year no later than May 1 each year. The plan shall include the intended delivery of county-based human services by client population to be served, including a detailed description of how the county intends to serve its residents in the least restrictive setting appropriate to their needs and the distribution and the projected expenditure level of block grant funds by county-based human services allocated under this article in such form and containing such information as the department may require. Prior to submitting the annual Human Services Block Grant Plan to the department, the county shall hold at least two public hearings on the plan under 65 Pa.C.S. Ch. 7 (relating to open meetings), which shall include an opportunity for individuals and families who receive services to testify about the plan. Prior to submitting its plan to the department, a county shall provide the plan to its human services advisory boards for their review and comment. ((5) amended Nov. 4, 2016, P.L.1172, No.153)

(5.1) Follow and implement the plan submitted pursuant to paragraph (5). ((5.1) added Nov. 4, 2016, P.L.1172, No.153)

(5.2) During the fiscal year, submit to the department for prior approval any change in expenditure level of a county-based human service listed under section 1403-B(7) of 10% or more from the plan submitted pursuant to paragraph (5). ((5.2) added Nov. 4, 2016, P.L.1172, No.153)

(6) Submit to the department a written notice if a county intends to opt out of the block grant. Such opt out shall be submitted at least 30 days prior to the end of the State fiscal year and take effect at the beginning of the next State fiscal year. ((6) amended Nov. 4, 2016, P.L.1172, No.153)

(1404-B amended July 9, 2013, P.L.369, No.55)

Compiler's Note: Section 1404-B was added by Act 80 of 2012. Act 80 of 2012 was declared unconstitutional on July 18, 2018, by the Supreme Court of Pennsylvania in Washington v. Commonwealth, Department of Public Welfare, 188 A.3d 1135 (Pa. 2018). In footnote 20 of its decision, the Supreme Court determined that Article XIV-B had been reenacted by Act 153 of 2016 and that its decision did not affect the validity of that reenactment.

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

Section 1405-B. Allocation.

(a) Allocation.--The department shall allocate State block grant funds to counties as follows:

(1) The department shall allocate State block grant funds according to each county's proportional share of the aggregate amount of the following State funds allocated for the previous fiscal year:

(i) Funds allocated to counties under the act of October 5, 1994 (P.L.531, No.78), known as the Human Services Development Fund Act.

(ii) Funds allocated to counties for mental health and intellectual disability services under the act of October 20, 1966 (3rd Sp.Sess., P.L.96, No.6), known as the Mental Health and Intellectual Disability Act of 1966.

(iii) Funds allocated to counties for behavioral health services.

(iv) Funds allocated to counties for drug and alcohol services under section 2334 of the act of April 9, 1929 (P.L.177, No.175), known as The Administrative Code of 1929.

(v) Funds allocated to counties for the provision of services to the homeless.

(vi) ((vi) deleted by amendment)

(2) The department shall allocate Federal block grant funds to counties according to each county's previous fiscal year proportional share of each Federal appropriation associated with the funds identified in paragraph (1).

(3) Funds identified in paragraphs (1) and (2) that were allocated to county local collaborative arrangements shall be allocated to individual counties based on the individual county population.

(4) The department may revise the allocation of Federal funds identified in paragraph (2) as necessary to comply with applicable Federal requirements.

((a) amended Nov. 4, 2016, P.L.1172, No.153)

(a.1) Adjustment of allocation.--The department may adjust grants under this article to a county participating in the block grant based on the county's demonstrated need for funds to meet the specific human services needs of its residents for a fiscal year. Such adjustment shall not be considered in the county's allocation under subsection (a) for any subsequent fiscal year.

(b) Expenditure.--Each county participating in the block grant shall expend its allocated block grant funds as follows:

(1) For State fiscal year 2012-2013, each county shall expend on each of the following county-based human services at least 80% of the amount the county is allocated under the funds identified in subsection (a)(1) for that county-based human service:

(i) Community-based mental health services.

(ii) Intellectual disability services.

(iii) Child welfare services.

(iv) Drug and alcohol treatment and prevention services.

(v) Homeless assistance services.

(vi) Behavioral health services.

(2) For State fiscal year 2013-2014, each county shall expend on each of the following county-based human services at least 75% of the amount the county was allocated under the funds identified in subsection (a)(1) for that county-based human service:

(i) Community-based mental health services.

(ii) Intellectual disability services.

(iii) Child welfare services.

(iv) Drug and alcohol treatment and prevention services.

(v) Homeless assistance services.

(vi) Behavioral health services.

(3) For State fiscal year 2014-2015, each county shall expend on each of the following county-based human services at least 50% of the amount the county is allocated under the

funds identified in subsection (a)(1) for that county-based human service:

(i) Community-based mental health services.

(ii) Intellectual disability services.

(iii) Child welfare services.

(iv) Drug and alcohol treatment and prevention services.

(v) Homeless assistance services.

(vi) Behavioral health services.

(4) For State fiscal year 2015-2016, each county shall expend on each of the following county-based human services at least 25% of the amount the county is allocated under the funds identified in subsection (a)(1), for that county-based human service:

(i) Community-based mental health services.

(ii) Intellectual disability services.

(iii) Child welfare services.

(iv) Drug and alcohol treatment and prevention services.

(v) Homeless assistance services.

(vi) Behavioral health services.

(5) For State fiscal year 2016-2017 and thereafter, counties may expend block grant funds on county-based human services as determined by local need.

(c) Waiver.--A county may request in writing that the department waive the requirements of subsection (b). The department may grant the request upon a showing by the county that specific circumstances create a local need for funds to provide a human service that cannot be met without a waiver and that adequate and appropriate access to other human services will remain available in the county. A request for a waiver under this subsection shall specify the amount of funds and the human services on which those funds will be transferred and expended.

(d) Use of remaining funds.--Except as provided in subsection (b), counties may expend the remaining block grant funds on county-based human services needs as determined by county officials.

(e) Contribution to local collaborative arrangement.--Each county that is part of a local collaborative arrangement in accordance with section 1404-B(2) shall contribute at a minimum the percentage of funds specified in subsection (b) to the local collaborative arrangement for the provision of the county-based human services delivered by the local collaborative arrangement.

(1405-B amended July 9, 2013, P.L.369, No.55)

Compiler's Note: Section 1405-B was added by Act 80 of 2012. Act 80 of 2012 was declared unconstitutional on July 18, 2018, by the Supreme Court of Pennsylvania in Washington v. Commonwealth, Department of Public Welfare, 188 A.3d 1135 (Pa. 2018). In footnote 20 of its decision, the Supreme Court determined that Article XIV-B had been reenacted by Act 153 of 2016 and that its decision did not affect the validity of that reenactment.

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

Section 1406-B. Use of block grant funds.

(a) General rule.--Block grant funds received by counties under this article shall be used solely for the provision of county-based human services.

(b) Reinvestment.--A county participating in the block grant may submit to the department a written plan to reinvest up to 5% of its block grant allocation for any State fiscal year to be expended on county-based human services in the next State fiscal year.

(1) ((1) deleted by amendment)

(2) ((2) deleted by amendment)

(3) ((3) deleted by amendment)

(4) ((4) deleted by amendment)

((b) amended Nov. 4, 2016, P.L.1172, No.153)

(c) Eligibility.--No county shall be required to expend block grant funds under this article on behalf of an individual until the individual has exhausted eligibility and receipt of benefits under all other existing Federal, State, local or private programs.

(d) Allocation.--For State fiscal year 2012-2013, each county in expending block grant funds shall provide local matching funds for block grant funds allocated to it in the same percentage as that county's aggregate local match percentage for the State funds identified in section 1405-B(a)(1) in State fiscal year 2010-2011. For each State fiscal year thereafter, each county in expending block grant funds shall provide local matching funds for State block grant funds allocated to it in the same percentage as that county's aggregate local match percentage for the State funds identified in section 1405-B(a)(1) in State fiscal year 2011-2012.

(e) County obligation.--Except as provided in subsection (d), counties shall have no financial obligation to provide human services under this article in excess of their allocation of block grant funds for any fiscal year.

(1406-B amended July 9, 2013, P.L.369, No.55)

Compiler's Note: Section 1406-B was added by Act 80 of 2012. Act 80 of 2012 was declared unconstitutional on July 18, 2018, by the Supreme Court of Pennsylvania in Washington v. Commonwealth, Department of Public Welfare, 188 A.3d 1135 (Pa. 2018). In footnote 20 of its decision, the Supreme Court determined that Article XIV-B had been reenacted by Act 153 of 2016 and that its decision did not affect the validity of that reenactment.

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

Section 1407-B. Applicability of other statutes.

(a) Department.--The department's allocation of block grant funds to counties participating in the block grant under this article shall fully discharge its responsibilities and liabilities with respect to those counties under sections 201(1) and (7), 503, 509, 510 and 511 of the act of October 20, 1966 (3rd Sp.Sess., P.L.96, No.6), known as the Mental Health and Intellectual Disability Act of 1966.

(1) ((1) deleted by amendment)

(2) ((2) deleted by amendment)

(b) County.--

(1) Except as specified in paragraph (2), each county's provision of county-based human services through the expenditure of block grant funds, in combination with required local matching funds, shall fully discharge the county's responsibilities and liabilities to provide or fund county-based human services under:

(i) ((i) deleted by amendment)

(ii) Sections 301(d), 503, 509, 510 and 511 of the Mental Health and Intellectual Disability Act of 1966.

(iii) Section 401 of the act of June 24, 1937 (P.L.2017, No.396), known as the County Institution District Law.

(2) This article shall not be construed to affect the obligation of any county to provide funds for care in any county nursing home under section 443.1 or 472, care in any State institution as defined by section 901, medical assistance for inmates pursuant to section 441.1 or Article XIV-A or mental health or intellectual disability services provided by the department under section 505(b) or 508(c) of the Mental Health and Intellectual Disability Act of 1966.

(c) Allocations.--This article shall not be construed to prohibit the department from making specific grants or allocations of funds identified in section 1405-B(a)(1) to counties for specific human services in addition to their allocations of block grant funds under this article.

(1407-B amended Nov. 4, 2016, P.L.1172, No.153)

Compiler's Note: Section 1407-B was added by Act 80 of 2012. Act 80 of 2012 was declared unconstitutional on July 18, 2018, by the Supreme Court of Pennsylvania in Washington v. Commonwealth, Department of Public Welfare, 188 A.3d 1135 (Pa. 2018). In footnote 20 of its decision, the Supreme Court determined that Article XIV-B had been reenacted by Act 153 of 2016 and that its decision did not affect the validity of that reenactment.

Section 1408-B. Appeals.

A county agency or contracted entity aggrieved by a department determination made under section 1403-B(b)(6), (6.1) or (6.2) or a disapproval of a plan under section 1403-B(b)(7) may file a request for a review with the department's Bureau of Hearings and Appeals, which shall have exclusive jurisdiction in such matters. The procedures and requirements of 2 Pa.C.S. Ch. 5 Subch. A (relating to practice and procedure of Commonwealth agencies) and 1 Pa. Code Pt. II (relating to general rules of administrative practice and procedure) shall apply to requests for review filed under this section, except that in a request for a review, the county agency or contracted entity may not challenge the block grant funds allocation under section 1405-B.

(1408-B amended Nov. 4, 2016, P.L.1172, No.153)

Compiler's Note: Section 1408-B was added by Act 80 of 2012. Act 80 of 2012 was declared unconstitutional on July 18, 2018, by the Supreme Court of Pennsylvania in Washington v. Commonwealth, Department of Public Welfare, 188 A.3d 1135 (Pa. 2018). In footnote 20 of its decision, the Supreme Court determined that Article XIV-B had been reenacted by Act 153 of 2016 and that its decision did not affect the validity of that reenactment.

Section 1409-B. Limitations.

(a) Calculation of State appropriation.--No funds allocated for the block grant may be considered as part of the base for the calculation of any State appropriation for any fiscal year, including the county child welfare needs-based budget.

(b) Non-State match.--No funds allocated for the block grant may be used as the non-State match for other State funds, programs or grants.

(c) Other reimbursement.--((c) deleted by amendment)

(d) Certain residential service.--((d) deleted by amendment)

(1409-B amended Nov. 4, 2016, P.L.1172, No.153)

Compiler's Note: Section 1409-B was added by Act 80 of 2012. Act 80 of 2012 was declared unconstitutional on July 18, 2018, by the Supreme Court of Pennsylvania in Washington v. Commonwealth, Department of Public Welfare, 188 A.3d 1135 (Pa. 2018). In footnote 20 of its decision, the Supreme Court determined that Article XIV-B had been reenacted by Act 153 of 2016 and that its decision did not affect the validity of that reenactment.

Section 1410-B. Construction.

(a) Federal moneys.--This article shall be construed so as to maintain and not decrease or limit the eligibility of any person or facility or the Commonwealth or any political subdivision of the Commonwealth to receive any Federal assistance, grant or funds.

(b) Availability of services.--Nothing in this article creates or provides an individual with an entitlement to services or benefits. Services under this article shall only be available from county governments to the extent that funds are appropriated.

(c) County child welfare services.--((c) deleted by amendment)

(1410-B amended Nov. 4, 2016, P.L.1172, No.153)

Compiler's Note: Section 1410-B was added by Act 80 of 2012. Act 80 of 2012 was declared unconstitutional on July 18, 2018, by the Supreme Court of Pennsylvania in Washington v. Commonwealth, Department of Public Welfare, 188 A.3d 1135 (Pa. 2018). In footnote 20 of its decision, the Supreme Court determined that Article XIV-B had been reenacted by Act 153 of 2016 and that its decision did not affect the validity of that reenactment.

ARTICLE XIV-C
PENNSYLVANIA eHEALTH PARTNERSHIP PROGRAM
(Art. added July 8, 2016, P.L.480, No.76)

Compiler's Note: See section 12 of Act 76 of 2016 in the appendix to this act for special provisions relating to continuation of prior law.

Section 1401-C. 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:

"Board." The Pennsylvania eHealth Partnership Advisory Board.

"Department." The Department of Human Services of the Commonwealth.

"Electronic health record." An electronic record of health-related information relating to an individual that is created, gathered, managed and consulted by health care providers or payers.

"Fund." The Pennsylvania eHealth Partnership Fund.

"Health care provider." A person licensed by the Commonwealth to provide health care or professional clinical services. The term includes:

(1) A "health care practitioner" as defined in section 103 of the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

(2) A "health care provider" as defined in section 103 of the Health Care Facilities Act.

(3) A public health authority.

(4) A pharmacy.

(5) A laboratory.

(6) A person that provides items or services described in section 1861(s) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1395x(s)).

(7) A "provider of services" as defined in section 1861(u) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1395x(u)).

"Health information." Oral or recorded information in any form or medium that is created or received by a health care provider relating to the following:

(1) The past, present or future physical or mental health or medical condition of an individual.

(2) The past, present or future payment, treatment or operations for the provision of health care to an individual.

"Health information exchange." A Statewide interoperable system established under this article that electronically moves and exchanges health information between approved participating health care providers or health information organizations in a manner that ensures the secure exchange of health information to provide care to patients.

"Health information organization." An information technology infrastructure with an interoperable system that is established by a health care provider or payer or that connects participating health care providers or payers to ensure the secure digital exchange of health information among participants engaged in the care of the patient.

"Health information technology." Hardware, software, integrated technologies or related licenses, intellectual property, upgrades or packaged solutions sold as services that are designed for or support the use by health care entities or patients for the electronic creation, maintenance, access or exchange of health information.

"Interoperability." The ability of different operating and software systems to employ federally recognized standards to exchange data securely, accurately, effectively and in a manner that maintains and preserves the clinical purpose of the data.

"Participant." A person or entity which has been approved by the department to send and receive health information using the health information exchange.

"Payer." An entity that contracts or offers to contract to provide, deliver, pay or reimburse any of the costs of health care services, including an employer, a health care plan, the Federal government, the Commonwealth, a municipality, a labor union or an entity licensed under any of the following:

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

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

(3) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations).

(4) 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

"Secretary." The Secretary of Human Services of the Commonwealth.

(1401-C added July 8, 2016, P.L.480, No.76)

Section 1402-C. Pennsylvania eHealth Partnership Program.

The Pennsylvania eHealth Partnership Program is established within the department.

(1402-C added July 8, 2016, P.L.480, No.76)

Section 1403-C. Powers and duties.

The department's powers and duties shall include the following:

(1) Develop, establish and maintain a health information exchange that complies with Federal and State law and that:

(i) Promotes efficient and effective communication among multiple health care providers, payers and participants.

(ii) Creates efficiencies and promotes accuracy in the delivery of health care.

(iii) Supports the ability to improve community health status.

(2) Determine criteria for organizations and individuals to become and remain participants in the health information exchange, including criteria for organizations and individuals to be suspended and disengaged as participants in the health information exchange.

(3) Develop and maintain a directory of health care providers' contact information to enable participants to share health information electronically.

(4) Develop and maintain standards to ensure interoperability.

(5) Establish and collect fees. Fees may include transaction fees, subscription fees or other fees or donations to cover costs of the implementation and operation of the health information exchange or for other services provided under this article. Receipt of services provided by or through the department may be conditioned on payment of fees. Participation in the health information exchange by any health care provider, payer, consumer or any other person shall be voluntary.

(6) Establish an advisory board under section 1404-C with a diverse membership representing interested and affected groups and individuals.

(7) Develop and conduct public information programs to educate and inform consumers and patients about health information.

(8) Submit an annual report to the Governor, the President pro tempore of the Senate and the Speaker of the House of Representatives for distribution to appropriate legislative committees on the activities of the program for the year, including a summary of the receipts and expenditures, a list of contracts and a summary of any reportable security breaches that occurred and corrective actions that were taken.

(9) Develop and maintain:

(i) a registry of patients choosing to opt out of the health information exchange; and

(ii) procedures to reenroll into the health information exchange.

(10) Promulgate regulations, as necessary, to implement and administer this article.

(11) Perform all other activities in furtherance of the purposes of this article.

(1403-C added July 8, 2016, P.L.480, No.76)

Section 1404-C. Pennsylvania eHealth Partnership Advisory Board.

(a) Establishment.--The Pennsylvania eHealth Partnership Advisory Board is established within the department as an advisory board.

(b) Composition.--The board shall consist of the following members who must be residents of this Commonwealth:

(1) The secretary or a designee, who shall be an employee of the department, designated in writing prior to service.

(2) The Secretary of Health of the Commonwealth or a designee, who shall be an employee of the Department of Health, designated in writing prior to service.

(3) The Insurance Commissioner or a designee, who shall be an employee of the Insurance Department, designated in writing prior to service.

(4) One representative of the health care community focused on an unserved or underserved rural or urban patient population, who shall be appointed by the secretary from a list of individuals submitted for consideration by both the Pennsylvania Area Health Education Center and the Association of Community Health Centers.

(5) One physician or nurse appointed by the secretary from lists of individuals submitted by the Pennsylvania Medical Society, the Pennsylvania Osteopathic Medical Association, the Pennsylvania Academy of Family Physicians and the Pennsylvania State Nurses Association. At least one name on each list must include an individual residing in an unserved or underserved rural patient population area and an individual in an unserved or underserved urban patient population area.

(6) One hospital representative appointed by the secretary from a list of individuals submitted by the Hospital and Healthsystem Association of Pennsylvania. At least one name on the list must include an individual residing in an unserved or underserved rural or urban patient population area.

(7) One insurance representative appointed by the secretary from lists of individuals submitted by the Blue Cross and Blue Shield plans and the Insurance Federation of Pennsylvania.

(8) One representative of an assisted living residence, personal care home, long-term care nursing facility, continuing care facility or behavioral or mental health facility who shall be appointed by the secretary.

(9) Two consumer representatives appointed by the secretary who are not primarily involved in providing health care or health care insurance. At least one of the individuals must have expertise in health care or health care information technology or the laboratory industry.

(10) Three representatives from established health information organizations appointed by the President pro tempore of the Senate, in consultation with the Majority Leader and the Minority Leader of the Senate, each of whom shall recommend one person. At least one of the representatives must be from the private information technology sector with knowledge about security issues.

(11) Three representatives from established health information organizations appointed by the Speaker of the House of Representatives, in consultation with the Majority Leader and the Minority Leader of the House of Representatives, each of whom shall recommend one person. At least one of the representatives must be from the private information technology sector with knowledge about security issues.

(12) One home care or hospice representative appointed by the secretary from a list of individuals submitted by a Statewide home care association.

(c) Terms.--Except for a member under subsection (b)(1), (2) or (3), a member of the board shall serve for a term of three years after completion of the initial terms designated under subsection (g) and may not be eligible to serve more than two full consecutive three-year terms. A member shall remain on the board until the member's replacement is appointed.

(d) Quorum.--A majority of the appointed members of the board shall constitute a quorum for the transaction of any business. An act by a majority of the members present at a meeting at which there is a quorum shall be deemed to be that of the board.

(e) Meetings.--The board shall hold meetings at least quarterly and may provide for special meetings as the board deems necessary. The meetings shall be subject to the requirements of 65 Pa.C.S. Ch. 7 (relating to open meetings). Meetings of the board may be held anywhere within this Commonwealth.

(f) Chairperson.--The secretary shall appoint a chairperson of the board. The members of the board shall annually elect, by a majority vote of the members, a vice chairperson from among the members of the board.

(g) Initial appointment and vacancy.--

(1) A member appointed under subsection (b)(4), (5) or (6) shall be appointed to an initial term of two years with the option for reappointment to two additional three-year terms.

(2) A member appointed under subsection (b)(7) or (8) shall be appointed to an initial term of one year with the option for reappointment to two additional three-year terms.

(3) A member appointed under subsection (b)(9) or (12) shall be appointed to an initial term of three years with the option for reappointment to one additional three-year term.

(4) A member appointed under subsection (b)(10) or (11) shall be appointed to an initial term that coincides with the appointing members' terms with the option for reappointment to two additional three-year terms.

(h) Formation.--The board must be formed within 90 days of the effective date of this section.

(i) Reimbursement.--The members of the board may not receive a salary or per diem allowance for serving as members of the board but shall be reimbursed for actual and necessary expenses incurred in the performance of the members' duties.

(1404-C added July 8, 2016, P.L.480, No.76)

Section 1405-C. Establishment of fund.

The Pennsylvania eHealth Partnership Fund, established under section 501 of the act of July 5, 2012 (P.L.1042, No.121), known as the Pennsylvania eHealth Information Technology Act, is continued. The fund shall be administered by the department upon the effective date of this section.

(1405-C added July 8, 2016, P.L.480, No.76)

Compiler's Note: The act of July 5, 2012 (P.L.1042, No.121), known as the Pennsylvania eHealth Information Technology Act, referred to in this section, was repealed by the act of July 8, 2016 (P.L.480, No.76).

Section 1406-C. Funds.

All money deposited into the fund shall be held for the purposes under this article, may not be considered a part of

the General Fund and shall be used only to effectuate the purposes of this article as determined by the department. All interest earned from the investment or deposit of money accumulated in the fund shall be deposited in the fund for the same use.

(1406-C added July 8, 2016, P.L.480, No.76)

Section 1407-C. Consent and confidentiality of health information.

(a) Construction.--

(1) Nothing under this article shall be construed to prohibit a health care provider or payer from obtaining and storing a patient's health records in electronic form or exchanging health information with another health care provider or payer in accordance with Federal or State law other than this article.

(2) Nothing under this article shall supersede or limit any other law which requires additional consent to the release of health information or otherwise establishes greater restrictions or limitations on the release of health information.

(b) Consent.--The department shall publish a consent form including notice of a patient's ability to decline to allow exchange of the patient's electronic health information in the health information exchange. The notice shall include, at a minimum and in plain language, the following information:

(1) Definition of a health information exchange.

(2) Explanation of the benefits of participation in the health information exchange.

(3) Explanation of the limits of the patient's ability to decline the release or exchange of the patient's health information with the health information exchange.

(4) Explanation of the manner in which the health information exchange will address privacy issues.

(5) Explanation of the manner in which an individual may decline to participate in the health information exchange.

(c) Opt-out registry.--

(1) In order to decline participation in the health information exchange, a patient must sign and date a form declining participation. If appropriate, the signature must be witnessed by the patient's representative. Copies of the completed form shall be sent by the provider within five business days to the department to be included in an opt-out registry.

(2) After receipt of the form, the department shall within five business days notify health information organizations that the patient has not authorized the release of the health information through the health information exchange.

(3) Once the patient is included in the opt-out registry, the department shall notify the patient. The notification shall include a copy of the completed form signed by the patient or electronic notification to the patient.

(4) The patient alone shall decide to opt out of the health information exchange.

(d) Disclosure.--

(1) The department may not disclose, without prior written consent of the patient, any health information that the department or the department's employees, agents or contractors retain under this article, or to which the department or the department's agents or contractors have

access or any other health records maintained or accessible by the department under this article, to any person who is not an authorized employee, agent or contractor of the department, except as required or permitted by law.

(2) Sharing health information among participants in the health information exchange shall not be considered a disclosure under paragraph (1).

(3) Violations of this subsection:

(i) shall subject employees, agents and contractors to administrative discipline, including discharge and suspension; and

(ii) shall subject contractors to monetary penalties or contract revocation or suspension.

(e) Construction.--Nothing under this article may be construed to alter a proprietary interest held by a participant in a record, data or information released, accepted or included in the health information exchange, except that the paperwork approved by the department may require participants to license the interests by contract in order to allow for the free flow of information.

(1407-C added July 8, 2016, P.L.480, No.76)

Section 1408-C. Nonapplicability.

(a) Sovereign immunity.--This article shall be subject to 1 Pa.C.S. § 2310 (relating to sovereign immunity reaffirmed; specific waiver).

(b) Public record.--Health information or personally identifying information shall not be considered a public record for purposes of the act of February 14, 2008 (P.L.6, No.3), known as the Right-to-Know Law.

(c) Rights.--Nothing under this article is intended to affect common law or statutory rights or obligations with respect to patient accessibility to the patient's electronic or nonelectronic medical records.

(d) Construction.--Nothing under this article shall be construed to alter, limit or supersede any other provision of law regarding the department's duties, powers, responsibilities and authority that exist separate from this article.

(1408-C added July 8, 2016, P.L.480, No.76)

ARTICLE XIV-D
PENNSYLVANIA RURAL HEALTH REDESIGN CENTER AUTHORITY
(Art. added October 23, 2023, P.L.63, No.15)

SUBARTICLE A
PRELIMINARY PROVISIONS
(Subart. added October 23, 2023, P.L.63, No.15)

Compiler's Note: See section 10 of Act 15 of 2023 in the appendix to this act for special provisions relating to continuation of prior law.

Section 1401-D. Scope of article.

This article relates to the Pennsylvania Rural Health Redesign Center Authority.

(1401-D added Oct. 23, 2023, P.L.63, No.15)

Section 1402-D. Purpose.

It is the purpose of this article to protect and promote access by the residents of this Commonwealth to high-quality

health care in rural communities by encouraging innovation in health care delivery.

(1402-D added Oct. 23, 2023, P.L.63, No.15)

Section 1403-D. 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:

"Acute care hospital." A facility that provides inpatient and outpatient services, which may include an emergency department or intensive care unit.

"Authority." The Pennsylvania Rural Health Redesign Center Authority continued in section 1411-D.

"Board." The governing body of the authority.

"Conflict of interest." A situation in which a board member:

(1) Has an interest in one or more parties involved in an action under section 1412-D.

(2) May gain access to competitively sensitive or strategically relevant information about a participating payer or participant rural hospital.

"Critical access hospital." As defined in 42 U.S.C. § 1395x(mm)(1) (relating to definitions).

"Eligible hospital services." All inpatient and hospital-based outpatient items and services. The term shall exclude all other items and services, including the following:

(1) Postacute care.

(2) Professional services.

(3) Durable medical equipment.

(4) Dental services.

(5) Noninpatient or non-hospital-based outpatient behavioral health services.

(6) Long-term care services, except for swing bed services for critical access hospitals.

"Fund." The Pennsylvania Rural Health Redesign Center Fund continued in section 1441-D.

"Global budget." The prospectively set annual budget that is the basis for payment for each participant rural hospital for eligible hospital services by participating payers.

"Global budget model." An innovative payment and service delivery model that is intended to reduce health care costs while maintaining access to care, improving the quality of care in rural counties and meeting the health needs of participant rural hospitals' local communities, and under which participating payers pay participant rural hospitals using a global budget methodology established by the authority.

"Government program." A health benefit plan offered or administered by or on behalf of the United States or the Commonwealth or an agency or instrumentality of either, including:

(1) The medical assistance program.

(2) The children's health insurance program established under Article XXIII-A of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

(3) A health benefit plan offered or administered by or on behalf of the Commonwealth or an agency or instrumentality of the Commonwealth.

(4) Health care benefits administered under 10 U.S.C. (relating to armed forces) or 38 U.S.C. (relating to veterans' benefits).

(5) The Medicare program established under 42 U.S.C. Ch. 7 Subch. XVIII (relating to health insurance for aged and disabled).

"Insurer." A person, corporation or other entity licensed by the Commonwealth with authority to offer, issue or renew an insurance policy, subscriber contract or certificate providing health care coverage, including:

(1) An insurance company, association or exchange governed by The Insurance Company Law of 1921, including section 630 and Article XXIV of The Insurance Company Law of 1921.

(2) A health maintenance organization governed by the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

(3) A hospital plan corporation as defined in 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations).

(4) A professional health service corporation as defined in 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

"Medicaid managed care organization." An entity as defined in 42 U.S.C. § 1396b(m)(1)(A) (relating to payment to states) that is a party to an agreement with the department, including a county Medicaid managed care organization and a permitted assignee of an agreement. The term does not include an assignor of an agreement.

"Participant rural hospital." A rural hospital that has been selected and signs an agreement to participate in the global budget model.

"Participating payer." A payer that operates in rural counties and, with respect to one or more specified products, programs or payment arrangements, signs an agreement with the authority to participate in the global budget model.

"Payer." An insurer, government program or Medicaid managed care organization that pays or administers payment for health care services under an insurance policy, subscriber contract, certificate, administrative services arrangement or other payment arrangement.

"Rural county." A county within this Commonwealth where the population density is less than 284 persons per square mile as defined by the Center for Rural Pennsylvania, established under section 301 of the act of June 30, 1987 (P.L.163, No.16), known as the Rural Pennsylvania Revitalization Act.

"Rural hospital." An acute care hospital or critical access hospital located in a rural county.

"Rural hospital transformation plan." A description of the health care delivery system transformation that a participant rural hospital will undergo under the global budget model, as approved by the board and the Federal Government.

"Swing bed." A hospital bed that has been approved by the Medicare program established under under 42 U.S.C. Ch. 7 Subch. XVIII to provide posthospital skilled nursing facility care when the rural hospital participates in the Medicare program.

(1403-D added Oct. 23, 2023, P.L.63, No.15)

SUBARTICLE B
PENNSYLVANIA RURAL HEALTH REDESIGN CENTER AUTHORITY
(Subart. added October 23, 2023, P.L.63, No.15)

Section 1411-D. Pennsylvania Rural Health Redesign Center Authority.

(a) Continuation.--The Pennsylvania Rural Health Redesign Center Authority is continued as a body corporate and politic constituting a public corporation and government instrumentality. The powers and duties of the authority shall

be vested in and exercised by the board, which shall have the sole power to employ staff, including an executive director, legal counsel, consultants or any other staff deemed necessary by the board to effectuate the purposes of this article. Individuals employed by the board shall not be employees of the Commonwealth for any purpose, including for purposes of compensation, pension benefits or retirement.

(b) Composition.--The board shall consist of the following members:

(1) The Secretary of Health or a designee, who shall be an employee of the Department of Health designated in writing prior to service.

(2) The secretary or a designee, who shall be an employee of the department designated in writing prior to service.

(3) The Insurance Commissioner or a designee, who shall be an employee of the Insurance Department designated in writing prior to service.

(4) One member selected by each participating payer that is an insurer on behalf of the participating payer and the participating payer's parents, affiliates, subsidiaries, other associated entities and successors. The selection under this paragraph shall exclude any affiliated, subsidiary or otherwise associated Medicaid managed care organization.

(5) One member selected by each participating payer that is a Medicaid managed care organization.

(6) One member selected by the organization representing hospitals and health systems in this Commonwealth. This member shall be considered a participant rural hospital member on the board.

(7) Participant rural hospital members, the number of which shall not exceed the number of participating payer members. The participant rural hospital members shall represent the participant rural hospitals and shall be selected from different, geographically diverse participant rural hospitals and appointed as follows:

(i) The President pro tempore of the Senate, the Minority Leader of the Senate, the Speaker of the House of Representatives and the Minority Leader of the House of Representatives shall each appoint one member.

(ii) The Governor shall appoint the remaining members.

(8) Two members appointed by the Governor who are nationally recognized experts in rural health care delivery or in developing and administering global budgets.

(c) Terms.--The following shall apply to terms of the members of the board:

(1) The terms of the members specified under subsection (b)(1), (2) and (3) shall be concurrent with their holding of public office.

(2) The board members specified in subsection (b)(4), (5) and (6) shall serve for a term of three years and shall not be eligible to serve more than two full consecutive three-year terms.

(3) A board member specified in subsection (b)(7) shall serve for a term of two years and shall not be eligible to serve more than two full consecutive two-year terms.

(4) A board member specified in subsection (b)(8) shall serve for a term of four years and shall not be eligible to serve more than two full consecutive four-year terms.

(5) If a member of the board leaves prior to completing a term due to change in professional status, including, but

not limited to, retirement, changing jobs, failure to qualify or other reason, a new member shall be appointed or selected within 60 days of the seat becoming vacant.

(d) Quorum.--A majority of the members of the board shall constitute a quorum. Action may be taken by the board at a meeting upon a vote of a majority of its members present in person or through electronic means. If a tie vote occurs at any meeting, it shall be the duty of the chairperson to cast the deciding vote.

(e) Meetings.--The board shall meet at the call of the chairperson or as may be provided in the bylaws of the board. The board shall hold meetings at least quarterly, which shall be subject to the requirements of 65 Pa.C.S. Ch. 7 (relating to open meetings).

(f) Chairperson.--The Governor shall appoint a chairperson from among the board members.

(g) Formation.--The board shall be formed within 90 days of the effective date of this section.

(h) Conflict of interest.--Board members shall recuse themselves from discussions and actions where a conflict of interest may exist. Board members may not receive confidential information, data or material related to an entity where a conflict of interest may exist.

(i) Compensation and expenses.--Members of the board shall not receive a salary or per diem allowance for serving as members of the board but shall be reimbursed for actual and necessary expenses incurred in the performance of their duties. Reasonable expenses may include reimbursement of travel and living expenses while engaged in board business. The expenses shall be paid for by the fund.

(1411-D added Oct. 23, 2023, P.L.63, No.15)

Section 1412-D. Powers and duties.

(a) General rule.--The board shall exercise all powers necessary and appropriate to carry out its duties under this article, including the following:

(1) Adopt bylaws necessary to carry out the provisions of this article. The bylaws shall include a provision addressing conflicts of interest as well as a provision that restricts board discussions and decisions to the administration of the global budget model as provided under subsection (b).

(2) Make, execute and deliver contracts, grants and other instruments necessary or convenient to exercise the powers and duties of the board.

(3) Apply for, solicit, receive, establish priorities for, allocate, disburse, contract or grant for, administer and expend money in the fund and other money made available to the authority from any other source consistent with the purposes of this article. The authority shall be exempt from the provisions of 62 Pa.C.S. Pts. I (relating to Commonwealth Procurement Code) and II (relating to general procurement provisions).

(4) Apply for, accept and administer grants and loans to carry out the purposes of the authority.

(5) Accept money from both public and private sources, consistent with Federal and State law.

(6) Take, hold, administer, assign, lend, encumber, mortgage, invest or otherwise dispose of, at public or private sale, on behalf of the authority and for any of the authority's purposes, real property, personal property and money or any interest therein, including any mortgage or loan interest owned by the authority or under its control

or in its possession and the income therefrom either absolutely or in trust. The following apply:

(i) The board may acquire property or money for this purpose by purchase or lease and by the acceptance of gifts, grants, bequests, devises or loans, but no obligation of the authority shall be a debt of the Commonwealth, and the authority shall have no power to pledge the credit or taxing power of the Commonwealth nor to make its debts payable out of any money except those of the corporation. This subparagraph is not intended to mean that the board may acquire rural hospitals or participant rural hospitals.

(ii) All accrued and future earnings from money invested by the board and other accrued and future nonappropriated funds, including, but not limited to, funds obtained from the Federal Government and contributions, shall be available to the authority and shall be deposited in the State Treasury and may be utilized at the discretion of the board for carrying out any of the corporate purposes of the authority. Any placement of the funds by the State Treasurer in depositories or investments shall be consistent with guidelines approved by the board. For the purpose of administration, the authority shall be subject to sections 610, 613 and 614 of the act of April 9, 1929 (P.L.177, No.175), known as The Administrative Code of 1929.

(7) Seek waivers from State agency requirements as necessary to carry out the purposes of this article.

(8) Coordinate with the appropriate State agency to seek waivers from Federal requirements as necessary to carry out the purposes of this article.

(9) Establish advisory groups with a diverse membership representing interested and affected groups and individuals as the board finds necessary to carry out the purposes of this article.

(10) Collaborate with all applicable State agencies for purposes of implementing this article.

(11) Perform all other activities necessary to further the purposes of this article.

(b) Global budget model.--The board is responsible for administering the global budget model and shall:

(1) Evaluate and select rural hospitals for participation in the global budget model as a participant rural health hospital on the basis of diversity, vision and commitment to health care delivery transformation.

(2) Provide technical assistance, training and education to rural hospitals and participant rural hospitals.

(3) Collect and maintain data from rural hospitals and participant rural hospitals, participating payers and others as necessary to carry out the responsibilities of this article.

(4) Perform data analysis and quality assurance.

(5) Calculate, approve and administer global budgets. The global budgets may include payments for eligible hospital services provided under a participant rural hospital's employee health plan.

(6) Consistent with Federal and State law, review and approve rural hospital transformation plans, advise and approve changes to operational and payment mechanisms and approve exceptions to agreed-upon payment rules through an approved procedure provided in the board's bylaws.

(7) Assist rural hospitals and participant rural hospitals in working with community-based organizations to determine the targeted population health improvement goals.

(8) Evaluate the progress of the implementation of each participant rural hospital's global budget toward population health improvement goals and the cost of achieving health care goals.

(9) Monitor global budgets and quality metrics for participant rural hospitals.

(10) Provide an annual assessment of each participant rural hospital's compliance with its rural hospital transformation plan and global budget targets.

(11) Require a participant rural hospital to submit a corrective action plan for failure to submit a rural hospital transformation plan, comply with its rural hospital transformation plan or meet its global budget targets.

(12) Terminate a participant rural hospital from the global budget model in accordance with the participant rural hospital's participation agreement.

(13) Contract with an independent evaluation group to provide the board and executive director with an evaluation of the global budget model's progress in the areas of population health, quality of care and cost targets.

(14) Review and update the definition of "eligible hospital services" by transmitting a notice to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin, subject to obtaining all necessary Federal approvals. The board shall use data collected under paragraph (3) in its review.

(c) Audit.--

(1) The accounts and books of the authority shall be examined and audited annually by an independent certified public accounting firm. The audit shall be public information.

(2) The authority shall, by December 31 of each year, file a copy of the audit of the preceding Commonwealth fiscal year required under paragraph (1) with the Secretary of the Senate and the Chief Clerk of the House of Representatives and provide a copy to the Department of Health.

(d) Reports.--The authority shall:

(1) Electronically submit an annual report on the performance and compliance of each participant rural hospital to the Department of Health and to other appropriate parties, including associations, foundations, academic institutions and community-based organizations, as determined by the board.

(2) Electronically submit an annual report to the Governor, the President pro tempore of the Senate and the Speaker of the House of Representatives for distribution to the Health and Human Services Committee of the Senate and the Health Committee of the House of Representatives on the activities of the authority for the year.

(3) Comply with applicable Federal reporting requirements.

(e) Publication.--The authority shall annually transmit a financial statement and the authority's audit as a notice to the Legislative Reference Bureau for publication in the next available issue of the Pennsylvania Bulletin.

(1412-D added Oct. 23, 2023, P.L.63, No.15)

SUBARTICLE C
PARTICIPATION IN GLOBAL BUDGET MODEL

(Subart. added October 23, 2023, P.L.63, No.15)

Section 1421-D. Roles of participating payers.

(a) Letter of interest.--A payer may submit a letter of interest to the authority to participate in the global budget model.

(b) Agreement to participate.--As a condition of participation, a participating payer shall sign an agreement with the authority. The agreement shall detail the terms and conditions of participation in the global budget model.

(c) Termination.--A participating payer may terminate its participation with a participant rural hospital according to the terms and conditions of the agreement under subsection (b).

(1421-D added Oct. 23, 2023, P.L.63, No.15)

Section 1422-D. Roles of participant rural hospitals.

(a) Letter of interest.--A rural hospital may submit a letter of interest to the authority to participate in the global budget model.

(b) Condition of participation.--As a condition of participation, the following shall occur:

(1) A rural hospital shall submit an initial rural hospital transformation plan in the manner and form prescribed by the authority for review and approval.

(2) A participant rural hospital shall sign an agreement with the authority. The agreement shall detail the terms and conditions of participation in the global budget model.

(3) A participant rural hospital shall submit annual updates to its rural hospital transformation plan in the manner and form prescribed by the authority for review and approval.

(1422-D added Oct. 23, 2023, P.L.63, No.15)

SUBARTICLE D
DATA COLLECTION AND CONFIDENTIALITY
(Subart. added October 23, 2023, P.L.63, No.15)

Section 1431-D. Data collection and retention.

(a) Authority.--The authority may collect and analyze data from participating payers, rural hospitals, participant rural hospitals and the department necessary to carry out the authority's responsibilities under this article. Data collected by the authority shall only be used for administering the global budget model. The authority shall obtain the written approval of a participating payer, rural hospital, participant rural hospital or the department before the authority can use the entity's data for any other purpose. The authority shall retain the data for no more than seven years.

(b) Participant rural hospital.--A participant rural hospital may authorize its insurer or administrator to provide data to the authority regarding payments for eligible hospital services provided under the hospital's employee health plan.

(c) Release of data.--Unless specifically provided for in this article, the authority may not release and no data source, person, member of the public or other user of any data of the authority may gain access to:

(1) Raw data which could reasonably be expected to reveal the identity of an individual patient.

(2) Raw data disclosing discounts or allowances between participating payers and participant rural hospitals which is prejudicial to an individual participating payer or participant rural hospital.

(3) Data which the department provides to the authority, unless the secretary or the designee of the secretary specifically authorizes the release or access.

(4) Any data where a conflict of interest occurs.

(1431-D added Oct. 23, 2023, P.L.63, No.15)

Section 1432-D. Confidentiality of data, contracts and agreements.

(a) Right-to-Know Law inapplicable.--Any contract or agreement between participating payers and participant rural hospitals or any data, including patient data, provided by a participating payer, a participant rural hospital, including a participant rural hospital's insurer or administrator, a rural hospital or the department to the authority and maintained by the authority for the purposes of carrying out the requirements of this article shall be confidential and shall not be subject to the act of February 14, 2008 (P.L.6, No.3), known as the Right-to-Know Law, or discoverable or admissible as evidence in any civil, criminal or administrative action or proceeding.

(b) Authority access to data.--Nothing in this section shall prohibit the authority from accessing the data to carry out its responsibilities in accordance with law.

(c) Release of data.--Data provided to the Centers for Medicare and Medicaid Services, or any other entity, by the authority shall be provided consistent with applicable laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936), the Health Information Technology for Economic and Clinical Health Act (Public Law 111-5, 123 Stat. 226-279 and 467-496) and implementing regulations, to the extent allowed by law and written agreements between the authority and each participating payer and participant rural hospital.

(1432-D added Oct. 23, 2023, P.L.63, No.15)

SUBARTICLE E
PENNSYLVANIA RURAL HEALTH REDESIGN CENTER FUND
(Subart. added October 23, 2023, P.L.63, No.15)

Section 1441-D. Continuation of fund.

The Pennsylvania Rural Health Redesign Center Fund is continued as a separate fund in the State Treasury.

(1441-D added Oct. 23, 2023, P.L.63, No.15)

Section 1442-D. Money in fund.

The General Assembly may appropriate money to carry out the provisions of this article. All money deposited into the fund shall be held for the purposes of the authority and may not be considered a part of the General Fund but shall be used only to effectuate the purposes of this article as determined by the authority. All interest earned from the investment or deposit of money accumulated in the fund shall be deposited in the fund for the same use. Any money returned to the authority by any party shall be deposited into the fund.

(1442-D added Oct. 23, 2023, P.L.63, No.15)

ARTICLE XV
REPEALS; EFFECTIVE DATE

Section 1501. Specific Repeals.--The following acts and parts of acts and all amendments thereof are repealed to the extent specified:

(1) The act of April 8, 1862 (P.L.318), entitled "Supplement to the act incorporating the House of Refuge of Western

Pennsylvania, approved twenty-second April, one thousand eight hundred and fifty," absolutely.

(2) The act of April 11, 1862 (P.L.425), entitled, "A further supplement to an act to incorporate an Association for the establishment of a House of Refuge for Western Pennsylvania, approved the twenty-second day of April, Anno Domini one thousand eight hundred and fifty," absolutely.

(3) Section 3 of the act of June 9, 1911 (P.L.855), entitled, "An act authorizing the establishment and maintenance of psychopathic wards in certain hospitals; providing for the regulation thereof, the commitment of persons suffering with mental disorders to such wards, and for the payment of the expenses of maintaining and treating persons committed thereto," absolutely.

(4) The act of July 11, 1917 (P.L.769), entitled, "An act to regulate the importation into the State of Pennsylvania of dependent, delinquent, or defective children; and providing a penalty for the violation thereof," absolutely.

(5) Sections 2302, 2303, 2304, 2305.1, 2306, 2307, 2310, 2310.1, 2310.2, 2310.3, 2310.4, 2313.3, 2314, 2315, 2315.1, 2315.2, 2315.3, 2315.4, 2316, 2318, 2320.1, 2322, 2323, 2324, 2325, 2329, 2330, 2331, and 2332 of the act of April 9, 1929 (P.L.177), known as "The Administrative Code of 1929," absolutely.

(6) The act of April 18, 1935 (P.L.48), entitled, "An act requiring banks, trust companies, bank and trust companies, private bankers, and building and loan associations to disclose the amount of deposits and investments of persons applying for or receiving unemployment relief under certain circumstances," absolutely.

(7) The act of June 24, 1937 (P.L.2051), known as the "Public Assistance Law," absolutely.

(8) Sections 2 and 3 of the act of June 19, 1939 (P.L.434), entitled, "An act to regulate the acquiring of a legal settlement in this Commonwealth by any person now or hereafter confined in any public institution outside of the Commonwealth," absolutely.

(9) The act of June 19, 1939 (P.L.438), entitled, "An act declaring certain restricted State hospitals to be general hospitals, and, within the limitations of their individual facilities, open for the treatment of patients and cases which other general hospitals may treat," absolutely.

(10) The act of April 23, 1941 (P.L.20), entitled "An act concerning reciprocal agreements for the interstate transportation and the support of poor and indigent persons and to make uniform the law with reference thereto," absolutely.

(11) The act of June 3, 1943 (P.L.847), entitled, as amended, "An act creating a revolving fund in the State Treasury to be used by the Department of Public Welfare, to purchase, own, install, maintain and lease equipment and accessories for suitable business enterprises for the blind and for making advancements to blind persons for the purchase of merchandise, stock, equipment and accessories necessary to operate vending or refreshment stands or other suitable business enterprises in locations leased or arranged for by the Department of Public Welfare; providing for the payment for the lease of such equipment and accessories and for repayment of such advancements; authorizing the Department of Public Welfare to adopt rules and regulations and accept Federal funds," absolutely.

(12) The act of May 2, 1949 (P.L.889), entitled, "An act regulating the use of gifts and donations to State hospitals;

prohibiting the withholding of allocations of money to such hospitals for certain purposes and imposing duties on the Department of Welfare," absolutely.

(13) The act of September 26, 1951 (P.L.1532), entitled, "An act providing for the commitment and transfer of certain female juvenile delinquents to the Pennsylvania Training School for Girls or to certain other institutions, and imposing duties on the courts of this Commonwealth and the Department of Welfare relative thereto," absolutely.

(14) The act of June 29, 1953 (P.L.300), entitled, "An act providing for compliance with Federal law and the approval of certain institutions; providing for inspections of such institutions; conferring powers and imposing duties on the Department of Welfare; and imposing penalties," absolutely.

(15) The act of October 22, 1955 (P.L.725), entitled, "An act relating to reciprocal agreements for the interstate transportation and support of the mentally ill," absolutely.

(16) The act of January 26, 1956 (P.L.955), entitled, "An act authorizing and directing the Governor on behalf of the Commonwealth of Pennsylvania to execute an interstate compact concerning juveniles and for related purposes," absolutely.

(17) The act of May 21, 1956 (P.L.1642), known as the "Commonwealth Mental Health Research Foundation Act," absolutely.

(18) The act of May 29, 1956 (P.L.1803), entitled, as amended, "An act providing for the establishment of forestry conservation camps by the Department of Forests and Waters for the development and conservation of the forests of this Commonwealth and for the rehabilitation and training of male youth; giving additional powers to the Department of Public Welfare; and making an appropriation," absolutely.

(19) The act of July 15, 1957 (P.L.946), entitled, "An act providing for the selection of suitable lands throughout the Commonwealth for the erection thereon of new mental outpatient clinics," absolutely.

(20) Sections 1, 3, 4, 5, 5.1, 5.2, 5.3 and 6 of the act of November 21, 1959 (P.L.1579), entitled, "An act authorizing the Department of Property and Supplies, with the approval of the Governor, to acquire, purchase or lease certain institutions for use by the Department of Public Welfare as youth development centers; giving additional powers to the Department of Public Welfare in connection with youth development centers; providing for reimbursement by counties for expenses of minors committed to youth development centers; and making appropriations," absolutely.

(21) The act of July 25, 1961 (P.L.860), entitled, "An act authorizing and directing the Governor on behalf of the Commonwealth of Pennsylvania to execute an interstate compact concerning mental health and for related purposes," absolutely.

(22) The act of August 8, 1963 (P.L.595), entitled, "An act relating to private institutions licensed by the Department of Public Welfare or Department of Health; providing remedies against persons operating without a license or violating the laws or rules or regulations made thereunder; and prescribing procedures to be followed," in so far as it applies to the Department of Public Welfare.

(23) The act of August 26, 1965 (P.L.400), entitled "An act relating to pensions, nursing home care and medical and other health care for the blind; prescribing powers and duties of the Department of Public Welfare in connection therewith, and prescribing penalties," absolutely.

(24) The act of February 2, 1966 (P.L.1881), entitled "An act providing for the licensure and regulation of certain homes, hospitals and day care centers; prescribing powers and duties of the Department of Public Welfare, imposing license fees and providing penalties," absolutely.

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Section 1502. General Repeal.--All other acts and parts of acts, general, local and special, are repealed in so far as they are inconsistent herewith.

Section 1503. This act shall take effect immediately.

Compiler's Note: See the preamble to Act 55 of 2013 in the appendix to this act for special provisions relating to legislative findings and declarations.

APPENDIX

Supplementary Provisions of Amendatory Statutes

1995, JUNE 30, P.L.129, NO.20

Section 11. Within 90 days of the effective date of this section, the Department of Public Welfare shall submit to the appropriate Federal agency a request for any and all waivers of Federal law and regulations and for any other approvals by the Federal Government necessary for the implementation of the programs added by this act. It shall be the obligation of the Department of Public Welfare to enter into good faith negotiations with the appropriate Federal authorities and to make every effort to obtain the necessary Federal waivers and approvals.

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Compiler's Note: Act 20 amended or added sections 201.1, 403, 405.2, 414, 432, 434.2, 442.1, 447, 481.1, 491 and 1412 of Act 21.

1996, MAY 16, P.L.175, NO.35

Section 19. Within 90 days of the effective date of this section, the Department of Public Welfare shall submit to the appropriate Federal agency a request for necessary waivers of Federal law and regulations and for any other approvals by the Federal Government necessary for the implementation of the changes and additions made by this act. It is the obligation of the department to enter into good faith negotiations with the appropriate Federal authorities and to make every effort to obtain the necessary Federal waivers and approvals.

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Compiler's Note: Act 35 amended or added sections 401, 402, 403, 405, 405.1, 405.3, 405.5, 408, 432, 432.3, 432.4, 432.5, 432.6, 432.7, 432.7A, 432.12, 432.19, 432.22, 434, 442.1, 448, 449 and 481.

Section 20. Upon receipt of approval by the Federal Government of the changes and additions made by this act, the Department of Public Welfare shall transmit to the Legislative Reference Bureau notice of the approval for publication in the Pennsylvania Bulletin. Notice shall include the announcement of implementation of the provisions to be in effect for 180 days, pending adoption of rulemaking by the department pursuant to the Joint Committee on Documents Resolution 1994-1, 24 Pa.B. 2347 (April 30, 1994).

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

2007, JULY 25, P.L.402, NO.56

The General Assembly finds and declares as follows:

(1) Assisted living residences are a significant long-term care alternative nationwide.

(2) Assisted living residences are a combination of housing and supportive services, as needed. They are widely accepted by the general public because they allow people to age in place, maintain their independence and exercise decision making and personal choice.

(3) It is in the best interest of all Pennsylvanians that a system of licensure and regulation be established for assisted living residences in order to ensure accountability and a balance of availability between institutional and home-based and community-based long-term care for adults who need such care.

Compiler's Note: Act 56 amended or added sections 211, 212, 213, 1001, 1021, 1051, 1057.1, 1057.2, 1057.3, 1085, 1086 and 1087 of Act 21.

Section 8. Except to the extent inconsistent with this act, a reference in another statute to a personal care home, a personal care boarding home, personal care housing or a personal care home administrator shall be construed to also include an assisted living residence or an assisted living residence administrator, including, but not limited to, the use of such terms in:

(1) the definition of "caretaker" in 18 Pa.C.S. § 2713;

(2) the definition of "health care provider" in 42 Pa.C.S. § 5101.1;

(3) the definition of "health center" in 53 Pa.C.S. § 5602;

(4) the authorization to conduct studies and evaluations and to develop community housing options by the Department of Aging as provided by section 2203-A of the act of April 9, 1929 (P.L.177, No.175), known as The Administrative Code of 1929;

(5) the authorization to develop community-based service and housing options for impaired and chronically ill older

persons provided to area agencies on aging by section 2207-A of The Administrative Code of 1929;

(6) the term "residence" in section 2201-A of the act of July 28, 1953 (P.L.723, No.230), known as the Second Class County Code,

(7) the authorization to provide tax-exempt bond allocations pursuant to Chapter 27 of the act of June 29, 1996 (P.L.434, No.67), known as the Job Enhancement Act;

(8) the definition of "exempt facility" in section 2702 of the Job Enhancement Act;

(9) the definition of "facility" in section 103 of the act of November 6, 1987 (P.L.381, No.79), known as the Older Adults Protective Services Act;

(10) establishing the qualifications for a pediatric extended care center administrator pursuant to section 15(b)(2) of the act of November 24, 1999 (P.L.884, No.54), known as the Prescribed Pediatric Extended Care Centers Act;

(11) the definition of "health care provider" in section 503 of the act of March 20, 2002 (P.L.154, No.13), known as the Medical Care Availability and Reduction of Error (Mcare) Act;

(12) the definition of "facility" in section 2 of the act of December 9, 2002 (P.L.1388, No.171), known as the Elder Care Payment Restitution Act;

(13) the list of facilities required to make refunds pursuant to section 3 of the Elder Care Payment Restitution Act; or

(14) the definition of "family" as excluding persons residing in a personal care boarding home in section 3 of the act of November 30, 2004 (P.L.1561, No.198), known as the Family Support for Persons with Disabilities Act.

Section 9. Within nine months after the effective date of this section, the Legislative Budget and Finance Committee shall report to the General Assembly on existing Federal and other states' initiatives and programs that provide financial assistance for assisted living. This study shall include information on other Federal or state assisted living programs that are effectively administered and may be considered a model. Within six months after receipt of the report, a joint legislative task force consisting of selected members of the Aging and Youth Committee of the Senate and the Aging and Older Adult Services Committee of the House of Representatives shall review the report and any recommendations contained therein and shall report back to the full committees with a proposal for a funding mechanism for assisted living in this Commonwealth. The chairman of the Aging and Youth Committee of the Senate and the chairman of the Aging and Older Adult Services Committee of the House of Representatives shall select three members from the majority party and three members from the minority party and the Secretary of Aging shall serve as chairperson of the task force.

Section 10. Nothing in this act shall be construed to alter existing statutory or regulatory requirements pertaining to personal care homes until the regulations required by this act are published by the Department of Public Welfare in the Pennsylvania Bulletin.

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Section 11. The Department of Public Welfare shall not issue any assisted living residence licenses until final regulations

are published by the Department of Public Welfare in the Pennsylvania Bulletin.

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

2010, OCTOBER 22, P.L.829, NO.84

Section 6. The addition of Article VIII-H of the act is a continuation of the act of March 24, 2004 (P.L.148, No.15), known as the Pennsylvania Trauma Systems Stabilization Act. The following apply:

(1) Except as otherwise provided in Article VIII-H of the act, all activities initiated under the Pennsylvania Trauma Systems Stabilization Act shall continue and remain in full force and effect and may be completed under Article VIII-H of the act. Resolutions, orders, regulations, rules and decisions which were made under the Pennsylvania Trauma Systems Stabilization Act and which are in effect on the effective date of this section shall remain in full force and effect until revoked, vacated or modified under Article VIII-H of the act. Contracts, obligations and agreements entered into under the Pennsylvania Trauma Systems Stabilization Act are not affected nor impaired by the repeal of the Pennsylvania Trauma Systems Stabilization Act.

(2) Except as set forth in paragraph (3), any difference in language between Article VIII-H of the act and the Pennsylvania Trauma Systems Stabilization Act is intended only to conform to the style of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, and is not intended to change or affect the legislative intent, judicial construction or administrative interpretation and implementation of the Pennsylvania Trauma Systems Stabilization Act.

(3) Paragraph (2) does not apply to the following:

(i) The addition of the definitions of "comprehensive emergency services," "hospital," "trauma center" and "travel distance" in section 802-H of the act.

(ii) The addition of sections 803-H(b), (c) and (d), 804-H(a), 805-H(a), (c) and (d) and 808-H of the act.

Compiler's Note: The short title of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, referred to in this section, was amended by the act of December 28, 2015 (P.L.500, No.92). The amended short title is now the Human Services Code.

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Compiler's Note: Act 84 amended, added or reenacted sections 441.4, 802-E, 804-E, 805-E, 807-E, 808-E and 803-G and Article VIII-H of Act 21.

2013, JULY 9, P.L.369, NO.55

Preamble

The General Assembly finds and declares as follows:

(1) It is the purpose of this act to provide fiscal and administrative support that promotes the health, safety and welfare of the citizens of this Commonwealth.

(2) Pennsylvania, through the Department of Public Welfare and the counties, provides a broad array of health care and other human services to low-income families, children and youth, those with intellectual and physical disabilities and the elderly.

(3) Section 24 of Article III of the Constitution of Pennsylvania requires the General Assembly to adopt all appropriations for the operation of government in this Commonwealth. The Supreme Court has repeatedly affirmed that, "It is fundamental within Pennsylvania's tripartite system that the General Assembly enacts the legislation establishing those programs which the State provides for its citizens and appropriates the funds necessary for their operation."

(4) Section 11 of Article III of the Constitution of Pennsylvania requires the adoption of a general appropriation bill that embraces "nothing but appropriations." While actual appropriation can be contained in a general appropriations act, the achievement and implementation of a comprehensive budget involves much more than appropriations. Ultimately, the budget has to be balanced under Section 13 of Article VIII of the Constitution of Pennsylvania. This may necessitate changes to sources of funding and enactment of statutes to achieve full compliance with these constitutional provisions.

(5) Therefore, it is the intent of the General Assembly through this act to provide further implementation of the General Appropriation Act of 2013, as it affects the operations and funding for the delivery of health care and human services that protect our most vulnerable and needy citizens.

(6) This act shall accomplish all of the following:

(i) Provide for the expansion of the Human Services Block Grant Pilot Program.

(ii) Extend the authority for State and local assessments that support hospitals and intermediate care facilities for persons with an intellectual disability that serve persons in the medical assistance program.

(iii) Provide for separate medical assistance fee-for-service payments for normal newborn care and for mothers' obstetrical delivery.

(iv) Reauthorize the nursing facility revenue adjustment neutrality factor to provide continued payments for nursing facilities that serve persons in the medical assistance program.

(v) Provide for quarterly medical assistance day-one incentive payments to qualified nonpublic nursing facilities.

(vi) Provide for publication of a premium schedule for families with children with special needs, who receive benefits under the medical assistance program.

(vii) Establish a process to assure that the revenue of the Commonwealth is timely disbursed and expended properly for the delivery of public child welfare services.

(viii) Reauthorize the reallocation of excess funds for payment to qualifying hospitals accredited or seeking accreditation as Level III trauma centers.

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Compiler's Note: Act 55 amended, added or reenacted sections 443.1, 454, 704.1 and 704.3, Article VIII-C heading, sections 801-C, 802-C, 803-C, 804-C, 805-C, 806-C, 807-C, 808-C, 809-C, 810-C, 811-C, 802-E and 808-E, Article VIII-G heading, sections 801-G, 802-G, 803-G, 804-G, 805-G, 806-G, 807-G, 808-G, 809-G, 810-G, 811-G, 812-G, 813-G, 814-G, 815-G and 805-H, Article XIII heading and sections 1301, 1302, 1302.1, 1302.2, 1402-B, 1404-B, 1405-B and 1406-B of Act 21.

2016, JULY 8, P.L.480, NO.76

Section 12. Except as otherwise provided under Article XIV-C of the act, all activities initiated under the act of July 5, 2012 (P.L.1042, No.121), known as the Pennsylvania eHealth Information Technology Act, shall continue and remain in full force and effect and may be completed under Article XIV-C of the act. Orders, regulations, rules and decisions which were made under the Pennsylvania eHealth Information Technology Act and which are in effect on the effective date of this section shall remain in full force and effect until revoked, vacated or modified under Article XIV-C of the act. Contracts and obligations entered into under the Pennsylvania eHealth Information Technology Act are not affected nor impaired by the repeal of the Pennsylvania eHealth Information Technology Act. All contracts, grants, procurement documents and partnership agreements under the Pennsylvania eHealth Information Technology Act in effect on the effective date of this section are assigned to the Department of Human Services.

Compiler's Note: Act 76 amended, deleted or added sections 441.1, 443.1, 472, 704.3, 801-A, 815-A, 801-C, 811-C, 801-E, 808-E and 1021 and Article XIV-C of Act 21.

2018, JUNE 22, P.L.258, NO.40

Section 10. Within one year of the effective date of this section, the Department of Human Services shall amend any regulation at 55 Pa. Code Pt. V that uses the term "day care" as it relates to children and replace the term with the term "child care."

Compiler's Note: Act 40 amended or added sections 216, 408, 443.1, 443.12, Article V-A and sections 602, 704.3, 801-G, 803-G, 804-G, 805-G, 815-G, 901 and 1001 of Act 21.

2020, JULY 14, P.L.639, NO.62

Section 2. All regulations and parts of regulations are abrogated insofar as they are inconsistent with this act.

Compiler's Note: Act 62 amended section 1016 of Act 21.

2023, OCTOBER 23, P.L.63, NO.15

Section 10. The addition of Article XIV-D of the act is a continuation of the act of November 27, 2019 (P.L.742, No.108), known as the Pennsylvania Rural Health Redesign Center Authority Act. The following apply:

(1) Except as otherwise provided in the addition of Article XIV-D of the act, all activities initiated under the Pennsylvania Rural Health Redesign Center Authority Act shall continue and remain in full force and effect and may be completed under the addition of Article XIV-D of the act. Orders, regulations, rules and decisions which were made under the Pennsylvania Rural Health Redesign Center Authority Act and which are in effect on the effective date of section 9 of this act shall remain in full force and effect until revoked, vacated or modified under the addition of Article XIV-D of the act. Contracts, obligations and collective bargaining agreements entered into under the Pennsylvania Rural Health Redesign Center Authority Act are not affected nor impaired by the repeal of the Pennsylvania Rural Health Redesign Center Authority Act.

(2) Except as set forth in paragraph (3), any difference in language between the addition of Article XIV-D of the act and the Pennsylvania Rural Health Redesign Center Authority Act is not intended to change or affect the legislative intent, judicial construction or administration and implementation of the Pennsylvania Rural Health Redesign Center Authority.

(3) Paragraph (2) does not apply to the addition of the following provisions:

(i) Section 1411-D(c) of the act.

(ii) Section 1442-D of the act.

Compiler's Note: Act 15 amended or added sections 443.1, 443.13, 454.1, 801-G, 803-G, 804-G, 805-G, 815-G and Art. XIV-D of Act 21.

2023, November 21, P.L.183, NO.32

The General Assembly finds and declares as follows:

(1) In the United States, one in nine infants are born prematurely, one of the highest rates among developed countries.

(2) Up to 70% of mothers with infants in neonatal intensive care units cannot provide enough breast milk to meet all of their infants' needs, despite adequate lactation support and effort.

(3) Pasteurized donor human milk provides a lifesaving health benefit for high-risk infants as a supplement or bridge when determined to be medically necessary.

(4) Pasteurized donor human milk is evidence-based nutritional medicine that is essential to the health of medically fragile infants in both inpatient and outpatient settings due to its anti-inflammatory and immunological components.

(5) A human milk diet for medically compromised infants provides unparalleled protection against serious health complications that can lead to longer hospital stays, multiple medical and surgical procedures, readmissions, lifelong disability or even death.

(6) Along with avoiding serious medical complications, the use of pasteurized donor human milk in a hospital

increases exclusive maternal breastfeeding rates. A mother's own milk provides the ultimate nutrition for the infant but is not always adequate to meet the infant's needs.

(7) Pasteurized donor human milk dramatically reduces the risk of necrotizing enterocolitis, the most prevalent gastrointestinal emergency among preterm infants.

(8) Necrotizing enterocolitis has a 24% mortality rate overall and surgical necrotizing enterocolitis has a 40% mortality rate and may result in the partial or complete destruction of the intestinal lining and may lead to short-term and lifelong health consequences, including premature death.

(9) The use of pasteurized donor human milk has been shown to decrease the overall incidence of necrotizing enterocolitis by up to 80% and the rate of surgical necrotizing enterocolitis by more than 90%.

(10) Infants with a wide range of congenital or acquired conditions can benefit from the use of medically prescribed pasteurized donor human milk as a component of treatment when their mothers' own milk is unavailable or cannot meet all of their needs.

(11) Neonatal abstinence syndrome has tripled in the last 10 years, including a seven-fold increase in neonatal intensive care unit stays for drug-exposed infants who suffer from feeding intolerance and many other side effects. The use of pasteurized donor human milk to meet the nutritional needs of infants with neonatal abstinence syndrome reduces their symptoms and decreases the need for additional medical intervention and treatment.

(12) Medical assistance coverage for prescribed and medically necessary pasteurized donor human milk for inpatient and outpatient infants is necessary to improve health outcomes and reduce medical treatment costs in this Commonwealth.

(13) This act has the following purposes:

(i) Promoting the health of medically fragile infants through access to evidence-based pasteurized donor human milk when medically prescribed and necessary.

(ii) Substantially reducing the incidence of necrotizing enterocolitis in infants with risk factors for the disease.

(iii) Improving medical outcomes for infants with serious health conditions where access to pasteurized donor human milk will aid in their recovery.

(iv) Reducing the symptomology of neonatal abstinence syndrome for drug-exposed infants to decrease the need for extensive medical intervention and treatment.

(v) Requiring medical assistance coverage for medically necessary pasteurized donor human milk for inpatient and outpatient infants when needed.

(vi) Providing public awareness of the availability of pasteurized donor human milk and educating families and health care providers about this life-saving medicine.

(vii) Improving short-term and long-term health outcomes for the smallest and most fragile residents of this Commonwealth by providing needed access to pasteurized donor human milk not only to reduce health care costs but, most importantly, to save lives.

Compiler's Note: Act 32 added section 443.14 of Act 21.