CHAPTER 84
FORMERLY
SENATE BILL NO. 120
AS AMENDED BY
SENATE AMENDMENT NO. 1

AN ACT TO AMEND TITLE 30 OF THE DELAWARE CODE RELATING TO NURSING FACILITY QUALITY ASSESSMENT TAXES.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE (Three-fifths of all members elected to each house thereof concurring therein):

Section 1. Amend Chapter 65, Title 30 of the Delaware Code by making insertions as shown by underlining and deletions as shown by strike through as follows:

§ 6501. Definitions.

As used in this chapter:

(1) "A managed care company under contract to the Medicaid agency" means an entity that meets the definition of an MCO under 42 C.F.R. § 438.2 and has a contract with the Delaware Medicaid program.

(2) "CMS" means the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.

(3) "Continuing care retirement community" and "CCRC" means an entity providing nursing facility services together with assisted living or independent living on a contiguous campus with the number of assisted living and independent living beds in the aggregate being at least twice the number of nursing facility beds. For purposes of this definition contiguous means land adjoining or touching other property held by the same or related organization. Land divided by a public road shall be considered contiguous.

(4) "DHSS" means the Delaware Department of Health and Social Services.

(5) "Fiscal year" shall mean the time period from July 1 to June 30.

(6) The terms "Medicaid" and "medical assistance" mean the Medicaid program operated in Delaware by the DHSS under Title XIX of the federal Social Security Act [42 U.S.C. § 1396 et seq.].

(7) "Medicaid resident day" means a resident day paid for by the Delaware medical assistance program including a managed care company under contract to the Medicaid agency.

(8) <u>“Medicare Resident Day” means (i) a resident day paid for by the Medicare program, a Medicare Advantage program or Special Needs Plan, or (ii) a resident day in a facility for a resident enrolled in a Medicare hospice program under which hospice services are covered by the Medicare program while the facility is compensated for room and board services by the Medicaid program or another payer.</u>~~"Medicare resident day" means a resident day paid for by the Medicare program, a Medicare Advantage or special needs plan, or by a Medicare hospice program.~~

(9) "Non-Medicare resident day" means a resident day not paid for by the Medicare program, a Medicare Advantage or special needs plan, or by a Medicare hospice program.

(10) "Nursing facility" means a nursing facility as defined and licensed pursuant to Chapter 11 of Title 16. As used in this chapter, the term "nursing facility" shall include for-profit and nonprofit entities but shall exclude the Delaware Veterans Home and any state, federal or other public government-owned facilities and any facilities that exclusively serve children.

(11) "Nursing facility services" has the meaning given that term in 42 C.F.R. § 433.56, or any successor regulation or superseding statute.

(12) "Resident day" means a calendar day of care provided to a nursing facility resident, including the day of admission and excluding the day of discharge, provided that 1 resident day shall be deemed to exist when admission and discharge occur on the same day. A resident day includes a day on which a bed is held for a patient and for which the facility receives compensation for holding the bed.

§ 6502. Quality assessment

(a) Effective for assessment periods beginning on or after June 1, 2012, any nursing facility engaged in this State in providing nursing facility services with the exception of those exempted under subsection (d) of this

section, shall be charged a quarterly quality assessment as prescribed in subsection (b) of this section on nursing facility services provided by nursing facilities for the purpose of obtaining federal Medicaid matching funds under the State's Medicaid program. If an entity conducts, operates or maintains more than 1 nursing facility, the entity shall pay the quality assessment for each separately licensed nursing facility. The quality assessment shall be charged on a per non-Medicare resident day basis as set forth in subsection (b) of this section.

(b) The quality assessment fees for each non-Medicare resident day shall:

(1) ~~Shall for~~ For assessment periods ending prior to June 1, 2013, not exceed:

a. $14 per non-Medicare resident day for each nursing facility that is described in paragraph (d)(2) of this section; and

b. $16 per non-Medicare resident day for all other nursing facilities subject to the quality assessment; and

(2) ~~Shall for~~ For assessment periods beginning on and after June 1, 2013, be in amounts determined by the Secretaries of the Department of Finance and the Department of Health and Social Services on an annual basis, not later than May 1, which amounts shall not exceed ~~equal~~:

a. $~~9.35~~14.00 per non-Medicare resident day for each nursing facility that is described in paragraph (d)(2) of this section; and

b. $~~12~~26.00 per non-Medicare resident day for all other nursing facilities subject to the quality assessment.

(c) The quality assessment imposed by this section shall be payable on a calendar quarter basis using returns prescribed by the Department of Finance, which returns shall provide notice to nursing facilities by setting forth the quality assessment amounts determined as provided in §6502(b)(2), and shall be available not less than thirty (30) days prior to the start of the next calendar quarter. The assessment for each calendar quarter will be based upon non-Medicare resident days for the 3-month period ending prior to the start of the last month in the calendar quarter. Payments shall be due as follows:

(1) For calendar quarters that end prior to the date of notification by CMS of the approval of the waiver, and if required a state plan amendment, no later than 45 days after the date of the CMS approval letter;

(2) For calendar quarters that end after the date of notification by CMS of the approval of the waiver and any required state plan amendment:

a. For the calendar quarter ending June 30: no later than the fifteenth day of the last month of that quarter;

b. For all other calendar quarters: no later than 30 days after the end of the quarter.

(d) In accordance with the redistribution method set forth in 42 C.F.R. § 433.68(e)(1) and (2), DHSS shall seek a waiver from CMS of the broad-based and uniform provider assessment requirements of federal law to exclude certain nursing facilities from the quality assessment and to permit certain nursing facilities with a high volume of Medicaid resident days or facilities with a high number of total annual resident days to pay the quality assessment at a lesser amount per non-Medicare resident day. Such waiver shall seek authority from CMS for DHSS to:

(1) Exempt the following nursing facilities from the quality assessment:

a. Continuing care retirement communities as defined in § 6501 of this title; and

b. Nursing facilities with 46 or fewer beds.

(2) Lower the quality assessment for nursing facilities with greater than or equal to ~~45,000~~44,000 annual Medicaid resident days based upon the most recent cost report ending in the calendar year prior to the state fiscal year in which the assessment is applied.

(e) The Department of Finance shall, within 30 days after the return due date for each quarter, deposit the quality assessments collected as follows:

(1) 90% of the quality assessments shall be deposited to the Nursing Facility Quality Assessment Fund established pursuant to § 1180 of Title 16; and

(2) 10% of the quality assessments collected shall be deposited to the State's General Fund.

(f) The quality assessment fee imposed by this section shall be subject to and shall have available all provisions of Chapter 5 of this title regarding procedures, administration, and enforcement.

(g) Within 7 days of receiving notification from CMS of the approval of the waiver and if required a state plan amendment, DHSS shall notify the nursing facilities and the Department of Finance of:

(1) The CMS approval date, and

(2) The facilities that are subject to the quality assessment and those that are exempt and the reasons for the exemption, and

(3) The specific dollar amounts of the per non-Medicare resident day quality assessment to be charged in accordance with subsection (b) of this section, and

(4) Identify which facilities are subject to the differing assessment amounts specified in subsection (b) of this section, and

(5) The date the quality assessments are due to be paid by nursing facilities to the Department of Finance.

Section 2. This Act shall become effective for tax periods beginning after May 31, 2013.

Approved July 01, 2013