SPONSOR: Sen. S. McBride & Rep. Harris & Rep. Heffernan
Sens. Buckson, Gay, Hansen, Hoffner, Huxtable, Lockman, Mantzavinos, Pinkney, Poore, Sokola, Sturgeon, Townsend, Walsh; Reps. Baumbach, Griffith, Jones Giltner, Lambert, Morrison, Neal, Osienski, Phillips, Romer

DELAWARE STATE SENATE
152nd GENERAL ASSEMBLY

SENATE SUBSTITUTE NO. 1
FOR
SENATE BILL NO. 13

AN ACT TO AMEND TITLES 16 AND 30 OF THE DELAWARE CODE RELATING TO HOSPITAL QUALITY ASSESSMENTS AND ESTABLISHMENT OF A HOSPITAL QUALITY AND HEALTH EQUITY FUND AND HOSPITAL QUALITY AND HEALTH EQUITY ASSESSMENT COMMISSION.

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 10, Title 16 of the Delaware Code by designating §§ 1001 through 1015 of Title 16 as part of Subchapter I and by making deletions as shown by strike through and insertions as shown by underline as follows:

Subchapter I. General Provisions.

Section 2. Amend Chapter 10, Title 16 of the Delaware Code by making insertions as shown by underline and deletions as shown by strikethrough as follows:

Subchapter II. Hospital Quality Assessment.

§ 1031. Definitions.

As used in this subchapter:

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

(2) "Commission" means the Hospital Quality and Health Equity Assessment Commission established under § 1045 of this title.

(3) "Department" means the Department of Health and Social Services.

(4)a. "Hospital" means a facility classified under § 1001(b) of this title.

b. "Hospital" does not include any of the following:

1. An entity operated by the United States or the agencies or instrumentalities of the United States.

2. An entity operated by this State, the political subdivisions of this State, or the agencies or instrumentalities of this State.

(5) "Hospital Quality and Health Equity Fund" or "Fund" means the fund established under § 1042 of this title.

(6) "Initial enactment period" means the fiscal year of July 1, 2025, through June 30, 2026.

(7) "Net patient revenues" means the hospital's total patient revenues determined and reported in one or more Medicare Cost Reports under 42 C.F.R. § 413.24 and associated with specified services, less total patient revenues not received due to any of the following

a. Bad debt and uncollectable accounts.

b. Contractual adjustments.

c. Charity discounts.

d. Teaching allowances.

e. Policy discounts.

f. Administrative adjustments.

g. Implicit price concessions.

h. Other deductions from revenue.

(8) "Secretary" means the Secretary of the Department of Health and Social Services.

(9)a. "Specified services" means all of the following:

1. Inpatient hospital services, as that term is used in 42 U.S.C. § 1396b(w)(7)(A)(i) and 42 C.F.R. § 433.56(a)(1).

2. Outpatient hospital services, as that term is used in 42 U.S.C. §1396b(w)(7)(A)(ii) and 42 C.F.R. § 433.56(a)(2).

b. "Specified services" does not include nursing facility services, skilled nursing facility services, or physician services.

(10) "Taxable year" means the period of time for determining the tax due under this subchapter, as follows:

a. For the initial enactment period and the first 2 fiscal years after the initial enactment period, the fiscal year beginning on July 1, 2021, through June 30, 2022.

b. For each subsequent 3-year period after the period under paragraph (10)a. of this section, the 1-year period beginning and ending 3 years after the immediately preceding period of time for determining the tax due under this subchapter, beginning with the period of time of July 1, 2024, through June 30, 2025.

§ 1032. Hospital quality and health equity assessment; passing on of cost of assessment prohibited.

(a)(1) Subject to paragraph (a)(2) of this section and § 1034 of this title, beginning with the initial enactment period, a hospital engaged in providing specified services in this State, whether on a for-profit or not-for-profit basis, shall pay to this State an assessment equal to the following percentage of the hospital's net patient revenues during the taxable year:

a. For the initial enactment period, the percentage is 1.79%.

b. For each subsequent fiscal year after the initial enactment period, the percentage is 3.58%.

(2) Whether inpatient services associated with a patient admission were provided during the taxable year is determined consistent with the requirements of the Medicare Cost Report under 42 C.F.R. § 413.24.

(b)(1) Except as provided under paragraph (b)(3) of this section and subject to § 1034 of this title, the assessment imposed by this section must be paid in 4 equal installments, each consisting of 1/4 of the assessment imposed under subsection (a) of this section.

(2) Except as provided under paragraph (b)(3) of this section and subject to § 1034 of this title, the payments under paragraph (b)(1) of this section are due on September 15, December 15, March 15, and June 15, or as otherwise allowed by the Department.

(3) During the initial enactment period, the assessment imposed under subsection (a) of this section must be paid in 2 equal installments each consisting of 1/2 of the assessment imposed under subsection (a) of this section.

(4) The payments under paragraphs (b)(1) through (3) of this section must be made on forms prescribed by the Department.

(c)(1) For a hospital that did not file a cost report in a taxable year, the first full year in which the hospital first files a cost report is treated as the hospital's taxable year or, if available, partial data may be annualized.

(2) On and after the first update of the taxable year after a hospital under paragraph (c)(1) of this section has begun filing cost reports, the hospital's taxable year is the same period as other hospitals.

(d)(1) If a hospital subject to an assessment imposed under subsection (a) of this section merges with another hospital, the combined entity's net patient revenues equals the sum of the net patient revenues of the pre-merger component entities.

(2)a. If a hospital subject to an assessment imposed under subsection (a) of this section begins or ceases to conduct hospital operations or does not conduct hospital operations throughout a calendar or fiscal year under a valid state license, the Department shall adjust the hospital's assessment by multiplying the assessment computed under this

section by a fraction, the numerator of which is the number of days in the year during which the hospital conducts hospital business, operates a hospital, and maintains licensure, and the denominator of which is 365.

b. The hospital shall pay the required assessment, as computed under paragraph (d)(2)a. of this section, on the date and in pro rata installments as required by the Department for that portion of the state fiscal year during which the hospital operated and maintained state licensure, to the extent not previously paid.

(e) A hospital subject to the assessment imposed under subsection (a) of this section may not pass on the cost of the assessment to any patient, insurer, self-insured program, or other responsible party.

§ 1033. Disposition of revenues remitted; hold harmless prohibited.

(a) Revenues remitted to the State in payment of the assessment imposed under § 1032 of this title must, not later than the last day of the month in which the assessment is collected, be transferred by the Department to the Hospital Quality and Health Equity Fund.

(b)(1) A hospital subject to the assessment imposed under § 1032 of this title may not be guaranteed any repayment or otherwise held harmless of the hospital's assessment imposed under § 1032 of this title in derogation of 42 C.F.R. 433.68(f)(related to permissible health care-related taxes).

(2) An expenditure of funds from the Hospital Quality and Health Equity Fund may not be authorized if the expenditure creates an indirect guarantee to hold harmless under 42 C.F.R. 433.68(f)(3)(i).

§ 1034. Implementation; authorized modifications; suspension of assessment in certain circumstances.

(a) The Department shall seek a waiver, state plan amendment, preprint approval, or any other authorization from CMS to the extent necessary to implement this subchapter.

(b) Notwithstanding any other law to the contrary, the Department shall administer this subchapter in a manner which meets any and all eligibility requirements necessary for federal financial participation under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 through 1396w-7.

(c) Under § 1045(e) of this title and on the occurrence of an event under subsection (d) of this section, the Commission may make modifications of this subchapter and subchapter III of this chapter necessary to assure continued eligibility under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 through 1396w-7, including modifications to the following:

(1) The rate of assessment imposed under § 1032 of this title. The rate of assessment is not to exceed 6%.

(2) The taxable year.

(3) The tax basis.

(4) The definition of hospital or specified services.

(5) The remittance schedule under § 1032 of this title.

(6) The proportion and methodology for distributing the funds from the Hospital Quality and Health Equity Fund.

(d) If the Commission determines, and certifies in a notice to the Registrar of Regulations, that any of the following events have occurred, the Commission may act under subsection (c) of this section:

(1) CMS provides notice or advice that the assessment imposed under § 1032 of this section is impermissible under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 through 1396w-7.

(2) CMS provides notice or advice that CMS is not likely to permit the State to use the assessment imposed under § 1032 of this title for the State's share of Medicaid program expenditures without a loss of federal matching funds.

(3) The Department provides notice to the Commission that the Department has reason to believe that CMS will provide the notice or advice under paragraphs (d)(1) or (d)(2) of this section in response to the Department's efforts to implement this subchapter.

(e) The assessment imposed under § 1032 of this title is suspended, and a hospital does not have an obligation to pay the assessment, when the Commission certifies in a notice to the Registrar of Regulations that any of the following apply:

(1) A federal law or rule change by CMS prohibits the type of assessment imposed under § 1032 of this title or otherwise declares the type of assessment under § 1032 of this title impermissible under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 through 1396w-7.

(2) CMS does not permit the State to use the assessment imposed under § 1032 of this title for the State's share of Medicaid program expenditures without a loss of federal matching funds and this subchapter cannot be modified under subsection (c) of this section in a manner that meets and preserves eligibility under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 through 1396w-7.

(f) The Registrar of Regulations shall publish in the next issue of the Register of Regulations a certification under subsection (d) or (e) of this section provided to the Registrar of Regulations.

§ 1035. Penalties.

In addition to the penalties authorized under Chapter 5 of Title 30, if a hospital fails to pay the assessment imposed under § 1032 of this title when due, or a hospital fails to timely prepare and submit the form required under § 1032(b) of this title, the Department may do any of the following:

(1) Withhold any Medicaid payments to the hospital, including any payments due to the hospital for Medicaid patients from a managed care company under contract to the Division of Medicaid and Medical Assistance, until the quality assessment amount is paid in full.

(2) Suspend or revoke the hospital's license.

(3) Develop a plan that requires the hospital to pay any delinquent quality assessment and penalty amounts in installments.

(4) Take any other action authorized by the Department by regulation.

§ 1036. Regulatory authority.

The Department may adopt regulations to implement, administer, and enforce this subchapter.

Section 3. Amend Chapter 10, Title 16 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

Subchapter III. Hospital Quality and Health Equity Fund.

§ 1041. Definitions.

As used in this subchapter:

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

(2) "Commission" means the Hospital Quality and Health Equity Assessment Commission established under § 1045 of this title.

(3) "Department" means the Department of Health and Social Services.

(4) "Disproportionate share hospital payment adjustment" means adjustments in payment for inpatient hospital services furnished by disproportionate share hospitals, as disproportionate share hospitals are described in Section 1923 of the Social Security Act, 42 U.S.C. 1396r-4.

(5) "Initial enactment period" means the period of July 1, 2025, through June 30, 2026.

(6) "Uniform payment increase" means a payment of an equal dollar amount per unit of service delivered.

(7) "Unit of service" means each day or visit.

§ 1042. Hospital Quality and Health Equity Fund establishment and funding.

(a) There is established in the State Treasury and in the accounting system of this State a special fund to be known as the "Hospital Quality and Health Equity Fund" ("Fund").

(b) All of the following must be deposited into the Fund:

(1) The assessments collected under subchapter II of this chapter.

(2) Interest credited to the Fund under § 1042(c) of this title.

(c) The State Treasurer shall invest the Fund consistent with the investment policies established by the Cash Management Policy Board and credit interest to the Fund monthly consistent with the rate established by the Cash Management Policy Board.

§ 1043. Use of Fund; payments.

(a) Except as otherwise provided under this section, monies deposited into the Fund must be used by the Department exclusively to secure federal matching funds available through this State's Medicaid plan and any applicable waivers and, together with the federal matching funds, must be used exclusively by the Department, including any managed care companies under contract to the Division of Medicaid and Medical Assistance, as follows:

(1) Seventy-two percent of the funds must be used to increase payments to hospitals as provided under subsection (b) of this section relating to payments to hospitals.

(2) Twenty-eight percent of the funds must be used to make or increase payments for other approved uses of the funds under subsection (c) of this section.

(3) To reimburse any funds advanced from the Department's Medicaid budget appropriations that were used to make the payments under paragraphs (a)(1) and (2) of this section.

(b) All of the following apply to funds required to be used to increase payments to hospitals under paragraph (a)(1) of this section:

(1) Funds required to be used to increase payments to hospitals under paragraph (a)(1) of this section must be divided into an inpatient and outpatient payment pool of funds in the same proportion that the inpatient services and outpatient services represent in the total amount assessed each fiscal year under the assessment imposed under § 1032 of this title.

(2) The funds annually allocated to the inpatient pool of funds must be used as follows:

a. Ninety percent of the inpatient payment pool of funds must be used to fund a uniform payment increase for each acute care inpatient day provided to an individual enrolled in Medicaid managed care.

b. Six percent of the inpatient payment pool of funds must be used to fund a uniform payment increase for each inpatient rehabilitation day provided by a hospital distinct part unit or freestanding rehabilitation hospital to an individual enrolled in Medicaid managed care.

c. Four percent of the inpatient payment pool of funds must be used to fund a uniform payment increase for each behavioral health day provided by a hospital distinct part unit or freestanding behavioral health hospital to an individual enrolled in Medicaid managed care.

(3) The funds annually allocated to the outpatient pool of funds must be used as follows:

a. Ninety-nine- and one-half percent of the outpatient payment pool of funds must be used to fund a uniform payment increase for each outpatient hospital visit provided to an individual enrolled in Medicaid managed care.

b. One half of one percent of the outpatient payment pool of funds must be used to fund a uniform payment increase for each partial hospitalization program service provided to an individual enrolled in Medicaid managed care.

(c) The approved uses of the funds under paragraph (a)(2) of this section are as follows:

(1) To reimburse the Department for administrative expenses associated with implementing and administering the assessment imposed under § 1032 of this title, including the costs of any staff or consultants engaged by the Department.

(2) To reimburse Medicaid managed care plans for additional administrative expenses incurred that are associated with the implementation of this section and § 1032 of this title, to the extent and in such amounts authorized by the Department.

(3) To develop or enhance funding for Medicaid initiatives, as determined by the Department. Funds may not be used to supplant or replace appropriations for programs in existence on [the effective date of this Act], except that funds not to exceed 25% may be used to support the general operations of the Medicaid program.

(4) Notwithstanding the requirement that funds be used exclusively to secure federal matching funds, to reimburse the expenses of the Commission.

(d) If the assessment imposed by § 1032 of this title and the payments under paragraphs (a)(1) and (2) of this section are suspended under § 1034 of this title, any monies remaining in the Fund must be distributed as follows:

(1) If the total of all monies remaining in the Fund is equal to or less than the State share of the payments advanced from the Department's Medicaid budget appropriation to make the payments referred to under paragraphs (a)(1) and (2) of this section and not already reimbursed from the Fund, the Department shall receive the entirety of the monies remaining in the Fund as reimbursement for the State share of the payments.

(2) If the total of all monies remaining in the Fund are greater than the State share of the payments referred to under paragraphs (a)(1) and (2) of this section and not already reimbursed from the Fund, the remaining monies must be distributed back to the applicable hospitals generally and proportionately on the same basis as the assessments were collected in the last calendar quarter before the suspension of the assessment imposed by § 1032 of this title and the payments under paragraphs (a)(1) and (2) of this section.

(e) Before receiving payment under this section, a hospital shall attest in writing to the Department that an oral or written, formal or informal agreement or arrangement does not exist to share, redirect, or redistribute Medicaid payments which would result in violation of federal or state law.

§ 1044. Additional requirements for use of the Fund.

(a) For each fiscal year beginning with the initial enactment period, the Department shall make an additional payment, either as a direct disbursement from the Fund or through additional or increased Medicaid reimbursements, to the acute care hospital in an amount equal to the average disproportionate share hospital payment adjustment the hospital received for the 3 years before [the effective date of this Act], less any disproportionate share hospital payment adjustment the hospital remains eligible to receive, if an acute care hospital meets all of the following:

(1) The acute care hospital received a disproportionate share hospital payment adjustment for the year before [the effective date of this Act].

(2) The acute care hospital continues to meet the requirements to qualify as a disproportionate share hospital under Section 1923(d) of the Social Security Act, 42 U.S.C. § 1396r-4(d).

(3) The acute care hospital is determined to be ineligible to receive disproportionate share hospital payment adjustment in an amount equal to the average disproportionate share hospital payment adjustment received by the hospital for the 3 years before [the effective date of this Act] due to the limit on the amount of payment to a hospital under Section 1923(g) of the Social Security Act, 42 U.S.C. § 1396r-4(g).

(b) Before making payments from the Fund under § 1043(a)(1) of this title, the Department shall engage with hospitals to ensure that valid data is used to develop the uniform payment increase under § 1043 of this title. At a minimum, the Department shall do all of the following, as available:

(1) Provide hospitals receiving payments with a thorough written description of the methodology used to identify days and discharges.

(2) Provide hospitals receiving payments with a thorough written description of the methodology used to attribute days and discharges to the hospitals.

(3) Provide hospitals receiving payments with day and discharge counts for the hospitals.

(4) Work with hospitals receiving payments, or designated representatives of the hospitals receiving payments, to attempt to identify the source of any discrepancies between data provided under paragraph (b)(3) of this section and internal hospital data.

§ 1045. Hospital Quality and Health Equity Assessment Commission.

(a) Establishment; composition – The Hospital Quality and Health Equity Assessment Commission is established, consisting of the following members, or a designee of a member serving by virtue of position:

(1) The Secretary of the Department of Health and Social Services.

(2) The Director of the Division of Medicaid and Medical Assistance.

(3) The Director of the Office of Management and Budget.

(4) The Chair of the Senate's Health and Social Services Committee.

(5) The Chair of the House of Representatives' Health and Human Development Committee.

(6) One member of the House of Representatives Minority Caucus, appointed by the Speaker of the House of Representatives.

(7) One member of the Senate Minority Caucus, appointed by President Pro Tempore of the Senate.

(8) The Chief Executive Officer of the Delaware Healthcare Association.

(9) The Chair of the Delaware Healthcare Association's Board of Directors.

(10) Two members of facilities subject to payment of the assessment, one of whom must be a member qualified to represent the interests of behavioral or rehabilitation hospitals, appointed by the Governor from a list recommended by the Delaware Healthcare Association.

(b) Term of appointment; compensation; administrative support –

(1) Members of the Commission appointed to the Commission and not serving by virtue of their position serve for a term of 2 years, or until a successor is appointed, and may be reappointed for subsequent terms.

(2) Members of the Commission serve without compensation.

(3) The Department shall provide administrative support for the Commission, and all expenses of the Commission, including fees for consultants, if determined necessary, may be paid from the Fund as authorized in § 1043(c)(4) of this title.

(c) Chair; quorum –

(1) The Secretary of the Department of Health and Social Services shall serve as Chair of the Commission.

(2) A majority of the members, whether present in person or virtually, constitute a quorum for the transaction of business.

(d) Duties and authority of the Commission –

(1) The Commission shall meet as follows:

a. At least once before the date the first remittance of the assessment imposed under § 1032 of this title is due and, thereafter, at least once a year.

b. At the call of the Chair for the purpose of reviewing implementation of the assessment and taking actions necessary in furtherance of this subchapter and subchapter II of this chapter.

(2) At each Commission meeting under subsection (d)(1)a. of this section, the Division of Medicaid and Medical Assistance shall report to the Commission as to the following:

a. A description of the assessment and its implementation for the ensuing fiscal year.

b. Projections of the Federal Medical Assistance Percentage (FMAP).

c. Projections of each hospital's estimated assessment.

d. A summary of the Fund balance and expenditures made or budgeted during the current fiscal year and the projected Fund balance and expenditures planned in the ensuing fiscal year.

e. Any draft or submitted preprints, Medicaid plan amendments, or other submissions made or prepared by the State to CMS to establish or implement the assessment.

f. The status of any discussions or negotiations with CMS related to the assessment and any modifications necessary to assure continued eligibility under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 through 1396w-7.

g. Any matters communicated by CMS relating to potential changes to federal rules or eligibility criteria that may affect implementation of the assessment or the expenditure of monies from the Fund.

h. The status of updates to tax data to account for new facilities, closed facilities, merged facilities, and triennial base-year updates.

i. The mechanism and process for hospitals to verify any data submitted by the State to CMS.

(e) Modifications necessary for eligibility –

(1) The Commission has the authority specified in § 1034 of this title to develop and implement modifications of subchapter II of this chapter and this subchapter necessary to assure the assessment imposed under § 1032 of this title meets eligibility requirements for federal financial participation under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 through 1396w-7.

(2) Within 90 days of the receipt of information from the Division of Medicaid and Medical Assistance or CMS that either the assessment or the expenditure of money from the Fund does not satisfy eligibility requirements for federal financial participation, or the modifications are necessary to assure continued eligibility for federal financial participation, the Division of Medicaid and Medical Assistance and the Delaware Health Care Commission shall collaborate and develop necessary modifications for consideration by the Commission.

(3) The Commission shall meet to develop and approve modifications of subchapter II of this chapter and this subchapter. A modification of subchapter II of this chapter or this subchapter requires the affirmative vote of a majority of all members of the Commission.

(4) The Commission shall submit a report to the General Assembly detailing any modifications of subchapter II of this chapter or this subchapter approved by the Commission. The Commission shall submit the report to all of the following:

a. The President Pro Tempore and Secretary of the Senate, for distribution to all Senators.

b. The Speaker and Chief Clerk of the House of Representatives, for distribution to all Representatives.

c. The Controller General.

d. The Director and Librarian of the Division of Research of Legislative Council.

e. The Registrar of Regulations, for publication in the Register of Regulations.

(5) A modification of subchapter II of this chapter or this subchapter contained in a report presented to the General Assembly under paragraph (e)(4) of this section takes effect as of July 1 of the ensuing fiscal year unless rejected in full by an act of the General Assembly before July 1 of the ensuing fiscal year.

(f) Proceedings before Commission –

(1) Meetings of the Commission to develop and approve modifications of subchapter II of this chapter or this subchapter are closed to the public unless determined otherwise by the Chair.

(2) Any patient information and financial, utilization, or other data is confidential and not subject to disclosure under Chapter 100 of Title 29.

§ 1046. Regulatory authority.

The Department may adopt regulations to implement, administer, and enforce this subchapter.

Section 4. This Act takes effect on enactment and is to be implemented for fiscal years beginning after June 30, 2025.

Section 5. The Department of Health and Social Services may adopt regulations necessary to implement this Act. Regulations necessary for the initial enactment period beginning July 1, 2025, must be adopted on or before March 1, 2025.

Section 6. This Act may be cited as the “Protect Medicaid Act of 2024”.

SYNOPSIS

Healthcare facility assessments are currently the second largest source of funding for states’ shares of Medicaid costs, behind general funds. Today, 49 states have at least one facility assessment in place, including Delaware, while 34 states and Washington D.C. have 3 or more provider taxes. Delaware is one of only 6 states without a facility assessment on hospitals, causing the state to miss out on critical Medicaid funding that most states are already able to access.

This Act is a substitute for Senate Bill No. 13. Like Senate Bill No. 13, this Act creates the Hospital Quality Assessment, which places a 3.58% assessment on Delaware hospitals' net patient revenues.

Funds generated by the Hospital Quality Assessment must be utilized in one of two ways:

(1) To increase the inpatient and outpatient payments to hospitals.

(2) To develop or enhance funding for Medicaid initiatives, unlocking federal matching dollars. Funds may not be used to supplant or replace appropriations for programs in existence on the effective date of this Act, except for 25% of these funds, which may be used to support the general operations of the Medicaid program.

Like Senate Bill No. 13, this Act also creates the Hospital Quality and Health Equity Assessment Commission ("Commission"), which includes state agency and hospital representation. The Commission is required to meet at least annually to monitor the implementation of the assessment. If the Centers for Medicare & Medicaid Services (CMS) determines that either the assessment or the expenditure of money does not satisfy eligibility requirements for federal financial participation or that modifications are necessary to assure continued eligibility for federal financial participation, the Commission shall develop and approve modifications to Subchapters II and III of Chapter 10 of Tile 16 of the Delaware Code and submit the modifications to the General Assembly.

This Act differs from Senate Bill No. 13 as follows:

(1) By directing the Department of Health and Social Services ("Department") to administer the Hospital Quality Assessment.

(2) By establishing a different method of calculating the assessment for a hospital that begins or ceases hospital operations or does not conduct hospital operations through a calendar year or fiscal year.

(3) By prohibiting a hospital subject to the Hospital Quality Assessment from passing on the cost of the assessment to any patient, insurer, self-insured program, or other responsible party.

(4) By requiring a hospital subject to the Hospital Quality Assessment to attest in writing to the Department that an oral or written, formal or informal agreement or arrangement does not exist to share, redirect, or redistribute Medicaid payments which would result in violation of federal or state law.

(5) By updating the split in percentages of the funds collected from the Hospital Quality Assessment to reflect the wide range of federal match levels for services. The expected amount to be collected by the Assessment does not change as the result of the update.

(6) By requiring the Registrar of Regulations to publish in the Register of Regulations a certification by the Commission under § 1034(d) and (e) of Title 16 of the Delaware Code, as contained in this Act.

(7) By providing that appointments of members of the Minority Caucus of the House of Representatives and Senate are to be made by the Speaker of the House of Representatives and President Pro Tempore of the Senate, respectively.

(8) By making modifications to the requirements for meetings of the Commission.

(9) By providing that modifications to Subchapters II and III of Chapter 10 of Tile 16 of the Delaware Code recommended by the Commission take effect as of July 1 of the ensuing fiscal year unless rejected in full by an act of the General Assembly before that ensuing fiscal year.

This Act requires a greater than majority vote for passage because § 11 of Article VIII of the Delaware Constitution requires the affirmative vote of three-fifths of the members elected to each house of the General Assembly to impose or levy a tax or license fee.

This Act may be cited as the "Protect Medicaid Act of 2024".

Author: Senator S. McBride