HB0113S01 compared with HB0113

~~{deleted text}~~ shows text that was in HB0113 but was deleted in HB0113S01.

Inserted text shows text that was not in HB0113 but was inserted into HB0113S01.

DISCLAIMER: This document is provided to assist you in your comparison of the two bills. Sometimes this automated comparison will NOT be completely accurate. Therefore, you need to read the actual bills. This automatically generated document could contain inaccuracies caused by: limitations of the compare program; bad input data; or other causes.

Representative Francis D. Gibson proposes the following substitute bill:

NURSING CARE FACILITY AMENDMENTS

2017 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Francis D. Gibson

Senate Sponsor: _____

LONG TITLE

General Description:

This bill amends provisions in the Utah Health Code related to nursing care facilities.

Highlighted Provisions:

This bill:

- allows the Department of Health to consider the quality of nursing care facilities in a county when determining whether to certify additional Medicaid beds in the county;
- makes technical changes;
- changes the Nursing Care Facilities Account to an expendable special revenue fund; and
- removes the sunset review for the certification of Medicaid beds in nursing care facilities.

Money Appropriated in this Bill:

None

Other Special Clauses:

~~{ None}~~ This bill provides a special effective date.

Utah Code Sections Affected:

AMENDS:

26-18-503, as last amended by Laws of Utah 2016, Chapter 276

26-18-504, as last amended by Laws of Utah 2008, Chapters 347 and 382

26-18-505, as last amended by Laws of Utah 2016, Chapter 276

26-21-23, as last amended by Laws of Utah 2016, Chapters 276 and 357

26-35a-104, as enacted by Laws of Utah 2004, Chapter 284

26-35a-106, as last amended by Laws of Utah 2016, Chapter 276

26-35a-107, as last amended by Laws of Utah 2011, Chapter 297

63I-1-226, as last amended by Laws of Utah 2016, Chapters 89, 170, 279, and 327

Uncodified Material Affected:

ENACTS UNCODIFIED MATERIAL

Be it enacted by the Legislature of the state of Utah:

Section 1. Section **26-18-503** is amended to read:

26-18-503. Authorization to renew, transfer, or increase Medicaid certified programs -- Reimbursement methodology.

(1) (a) The division may renew Medicaid certification of a certified program if the program, without lapse in service to Medicaid recipients, has its nursing care facility program certified by the division at the same physical facility as long as the licensed and certified bed capacity at the facility has not been expanded, unless the director has approved additional beds in accordance with Subsection (5).

(b) The division may renew Medicaid certification of a nursing care facility program that is not currently certified if:

(i) since the day on which the program last operated with Medicaid certification:

(A) the physical facility where the program operated has functioned solely and continuously as a nursing care facility; and

(B) the owner of the program has not, under this section or Section 26-18-505, transferred to another nursing care facility program the license for any of the Medicaid beds in the program; and

(ii) the number of beds granted renewed Medicaid certification does not exceed the number of beds certified at the time the program last operated with Medicaid certification, excluding a period of time where the program operated with temporary certification under Subsection 26-18-504(4).

(2) (a) The division may issue a Medicaid certification for a new nursing care facility program if a current owner of the Medicaid certified program transfers its ownership of the Medicaid certification to the new nursing care facility program and the new nursing care facility program meets all of the following conditions:

(i) the new nursing care facility program operates at the same physical facility as the previous Medicaid certified program;

(ii) the new nursing care facility program gives a written assurance to the director in accordance with Subsection (4);

(iii) the new nursing care facility program receives the Medicaid certification within one year of the date the previously certified program ceased to provide medical assistance to a Medicaid recipient; and

(iv) the licensed and certified bed capacity at the facility has not been expanded, unless the director has approved additional beds in accordance with Subsection (5).

(b) A nursing care facility program that receives Medicaid certification under the provisions of Subsection (2)(a) does not assume the Medicaid liabilities of the previous nursing care facility program if the new nursing care facility program:

(i) is not owned in whole or in part by the previous nursing care facility program; or

(ii) is not a successor in interest of the previous nursing care facility program.

(3) The division may issue a Medicaid certification to a nursing care facility program that was previously a certified program but now resides in a new or renovated physical facility if the nursing care facility program meets all of the following:

(a) the nursing care facility program met all applicable requirements for Medicaid certification at the time of closure;

(b) the new or renovated physical facility is in the same county or within a five-mile

radius of the original physical facility;

(c) the time between which the certified program ceased to operate in the original facility and will begin to operate in the new physical facility is not more than three years;

(d) if Subsection (3)(c) applies, the certified program notifies the department within 90 days after ceasing operations in its original facility, of its intent to retain its Medicaid certification;

(e) the provider gives written assurance to the director in accordance with Subsection (4) that no third party has a legitimate claim to operate a certified program at the previous physical facility; and

(f) the bed capacity in the physical facility has not been expanded unless the director has approved additional beds in accordance with Subsection (5).

(4) (a) The entity requesting Medicaid certification under Subsections (2) and (3) shall give written assurances satisfactory to the director or the director's designee that:

(i) no third party has a legitimate claim to operate the certified program;

(ii) the requesting entity agrees to defend and indemnify the department against any claims by a third party who may assert a right to operate the certified program; and

(iii) if a third party is found, by final agency action of the department after exhaustion of all administrative and judicial appeal rights, to be entitled to operate a certified program at the physical facility the certified program shall voluntarily comply with Subsection (4)(b).

(b) If a finding is made under the provisions of Subsection (4)(a)(iii):

(i) the certified program shall immediately surrender its Medicaid certification and comply with division rules regarding billing for Medicaid and the provision of services to Medicaid patients; and

(ii) the department shall transfer the surrendered Medicaid certification to the third party who prevailed under Subsection (4)(a)(iii).

(5) (a) As provided in Subsection 26-18-502(2)(b), the director may approve additional nursing care facility programs for Medicaid certification, or additional beds for Medicaid certification within an existing nursing care facility program, if a nursing care facility or other interested party requests Medicaid certification for a nursing care facility program or additional beds within an existing nursing care facility program, and the nursing care facility program or other interested party complies with this section.

(b) The nursing care facility or other interested party requesting Medicaid certification for a nursing care facility program or additional beds within an existing nursing care facility program under Subsection (5)(a) shall submit to the director:

(i) proof of the following as reasonable evidence that bed capacity provided by Medicaid certified programs within the county or group of counties impacted by the requested additional Medicaid certification is insufficient:

(A) nursing care facility occupancy levels for all existing and proposed facilities will be at least 90% for the next three years;

(B) current nursing care facility occupancy is 90% or more; or

(C) there is no other nursing care facility within a 35-mile radius of the nursing care facility requesting the additional certification; and

(ii) an independent analysis demonstrating that at projected occupancy rates the nursing care facility's after-tax net income is sufficient for the facility to be financially viable.

(c) Any request for additional beds as part of a renovation project are limited to the maximum number of beds allowed in Subsection (7).

[~~(c)~~] (d) The director shall determine whether to issue additional Medicaid certification by considering:

(i) whether bed capacity provided by certified programs within the county or group of counties impacted by the requested additional Medicaid certification is insufficient, based on the information submitted to the director under Subsection (5)(b);

(ii) whether the county or group of counties impacted by the requested additional Medicaid certification is underserved by specialized or unique services that would be provided by the nursing care facility;

(iii) whether any Medicaid certified beds are subject to a claim by a previous certified program that may reopen under the provisions of Subsections (2) and (3); [~~and~~]

(iv) how additional bed capacity should be added to the long-term care delivery system to best meet the needs of Medicaid recipients[~~, which may include the renovation of aging nursing care facilities, as permitted by Subsection (7).~~]; and

(v) (A) whether the existing certified programs within the county or group of counties have provided services of sufficient quality to merit at least a two-star rating in the Medicare Five-Star Quality Rating System over the previous three-year period; and

(B) information obtained under Subsection (9).

(6) The department shall adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to adjust the Medicaid nursing care facility property reimbursement methodology to:

(a) only pay that portion of the property component of rates, representing actual bed usage by Medicaid clients as a percentage of the greater of:

(i) actual occupancy; or

(ii) (A) for a nursing care facility other than a facility described in Subsection (6)(a)(ii)(B), 85% of total bed capacity; or

(B) for a rural nursing care facility, 65% of total bed capacity; and

(b) not allow for increases in reimbursement for property values without major renovation or replacement projects as defined by the department by rule.

(7) (a) Notwithstanding Subsection 26-18-504(4), if a nursing care facility does not seek Medicaid certification for a bed under Subsections (1) through (6), the department shall grant Medicaid certification for additional beds in an existing Medicaid certified nursing care facility that has 90 or fewer licensed beds, including Medicaid certified beds, in the facility if:

(i) the nursing care facility program was previously a certified program for all beds but now resides in a new facility or in a facility that underwent major renovations involving major structural changes, [~~and~~] with 50% or greater facility square footage design changes, requiring review and approval by the department;

(ii) the nursing care facility meets the quality of care regulations issued by the Center for Medicare and Medicaid Services; and

(iii) the total number of additional beds in the facility granted Medicaid certification under this section does not exceed 10% of the number of licensed beds in the facility.

(b) The department may not revoke the Medicaid certification of a bed under this Subsection (7) as long as the provisions of Subsection (7)(a)(ii) are met.

(8) (a) If a nursing care facility or other interested party indicates in its request for additional Medicaid certification under Subsection (5)(a) that the facility will offer specialized or unique services, but the facility does not offer those services after receiving additional Medicaid certification, the director [~~may~~] shall revoke the additional Medicaid certification.

[~~(b) If a nursing care facility or other interested party obtains Medicaid certification for~~

~~a nursing care facility program or additional beds within an existing nursing care facility program under Subsection (5), but Medicaid reimbursement is not received for a bed within three years of the date on which Medicaid certification was obtained for the bed under Subsection (5), Medicaid certification for the bed is revoked.~~]

(b) The nursing care facility program shall obtain Medicaid certification for any additional Medicaid beds approved under Subsection (5) or (7) within three years of the date of the director's approval, or the approval is void.

(9) (a) If the director makes an initial determination that quality standards under Subsection (5)(d)(v) have not been met in a rural county or group of rural counties over the previous three-year period, the director shall, before approving certification of additional Medicaid beds in the rural county or group of counties:

(i) notify the certified program that has not met the quality standards in Subsection (5)(d)(v) that the director intends to certify additional Medicaid beds under the provisions of Subsection (5)(d)(v); and

(ii) consider additional information submitted to the director by the certified program in a rural county that has not met the quality standards under Subsection (5)(d)(v).

(b) The notice under Subsection (9)(a) does not give the certified program that has not met the quality standards under Subsection (5)(d)(v), the right to legally challenge or appeal the director's decision to certify additional Medicaid beds under Subsection (5)(d)(v).

Section 2. Section **26-18-504** is amended to read:

26-18-504. Appeals of division decision -- Rulemaking authority -- Application of act.

(1) A decision by the director under this part to deny Medicaid certification for a nursing care facility program or to deny additional bed capacity for an existing certified program is subject to review under the procedures and requirements of Title 63G, Chapter 4, Administrative Procedures Act.

(2) The department shall make rules to administer and enforce this part in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

[~~(3) A nursing care facility may receive Medicaid certification under the rules in effect prior to July 1, 2004 if the nursing care facility, prior to May 4, 2004:~~]

[~~(a) (i) paid applicable fees to the department; and~~]

[~~(ii) submits construction plans to the department; or~~]

[~~(b) is in a current phase of construction approved by the department.~~]

[~~(4)~~] (3) (a) In the event the department is at risk for a federal disallowance with regard to a Medicaid recipient being served in a nursing care facility program that is not Medicaid certified, the department may grant temporary Medicaid certification to that facility for up to 24 months.

(b) (i) The department may extend a temporary Medicaid certification granted to a facility under Subsection [~~(4)~~] (3)(a):

(A) for the number of beds in the nursing care facility occupied by a Medicaid recipient; and

(B) for the period of time during which the Medicaid recipient resides at the facility.

(ii) A temporary Medicaid certification granted under this Subsection [~~(4)~~] (3) is revoked upon:

(A) the discharge of the patient from the facility; or

(B) the patient no longer residing at the facility for any reason.

(c) The department may place conditions on the temporary certification granted under Subsections [~~(4)~~] (3)(a) and (b), such as:

(i) not allowing additional admissions of Medicaid recipients to the program; and

(ii) not paying for the care of the patient after October 1, 2008, with state only dollars.

Section 3. Section **26-18-505** is amended to read:

26-18-505. Authorization to sell or transfer licensed Medicaid beds -- Duties of transferor -- Duties of transferee -- Duties of division.

(1) This section provides a method to transfer or sell the license for a Medicaid bed from a nursing care facility program to another entity that is in addition to the authorization to transfer under Section 26-18-503.

(2) (a) A nursing care facility program may transfer or sell one or more of its licenses for Medicaid beds in accordance with Subsection (2)(b) if:

(i) at the time of the transfer, and with respect to the license for the Medicaid bed that will be transferred, the nursing care facility program that will transfer the Medicaid license meets all applicable regulations for Medicaid certification;

(ii) [~~30 days prior to the transfer,~~] the nursing care facility program gives a written

assurance, which is postmarked or has proof of delivery 30 days before the transfer, to the director and to the transferee in accordance with Subsection 26-18-503(4);

(iii) [~~30 days prior to the transfer,~~] the nursing care facility program that will transfer the license for a Medicaid bed notifies the division in writing, which is postmarked or has proof of delivery 30 days before the transfer, of:

(A) the number of bed licenses that will be transferred;

(B) the date of the transfer; and

(C) the identity and location of the entity receiving the transferred licenses; and

(iv) if the nursing care facility program for which the license will be transferred or purchased is located in an urban county with a nursing care facility average annual occupancy rate over the previous two years less than or equal to 75%, the nursing care facility program transferring or selling the license demonstrates to the satisfaction of the director that the sale or transfer:

(A) will not result in an excessive number of Medicaid certified beds within the county or group of counties that would be impacted by the transfer or sale; and

(B) best meets the needs of Medicaid recipients.

(b) Except as provided in Subsection (2)(c), a nursing care facility program may transfer or sell one or more of its licenses for Medicaid beds to:

(i) a nursing care facility program that has the same owner or successor in interest of the same owner;

(ii) a nursing care facility program that has a different owner; or

[~~(iii) notwithstanding Section 26-18-502, an entity that intends to establish a nursing care facility program; or~~]

[~~(iv) notwithstanding Section 26-18-502,~~]

(iii) a related-party nonnursing-care-facility entity that wants to hold one or more of the licenses for a [~~future~~] nursing care facility program not yet identified, as long as:

(A) the licenses are subsequently transferred or sold to a nursing care facility program within three years; and

(B) the nursing care facility program notifies the director of the transfer or sale in accordance with Subsection (2)(a)(iii).

(c) A nursing care facility program may not transfer or sell one or more of its licenses

for Medicaid beds to an entity under Subsection (2)(b)(i), (ii), or (iii)[~~, or (iv)~~] that is located in a rural county unless the entity requests, and the director issues, Medicaid certification for the beds under Subsection 26-18-503(5).

(3) [~~An~~] A nursing care facility program or entity under Subsection (2)(b)(i), (ii), or (iii)[~~, or (iv)~~] that receives or purchases a license for a Medicaid bed under Subsection (2)(b):

(a) may receive a license for a Medicaid bed from more than one nursing care facility program;

[~~(b) within 14 days of seeking Medicaid certification of beds in the nursing care facility program, give the division notice of the total number of licenses~~]

(b) ~~{may}~~shall give the division notice, which is postmarked or has proof of delivery within 14 days of the nursing care facility program or entity seeking Medicaid certification of beds in the nursing care facility program or entity, of the total number of licenses for Medicaid beds that the entity received and who it received the licenses from;

(c) may only seek Medicaid certification for the number of licensed beds in the nursing care facility program equal to the total number of licenses for Medicaid beds received by the entity;

(d) [~~notwithstanding Section 26-18-502,~~] does not have to demonstrate need or seek approval for the Medicaid licensed bed under Subsection 26-18-503(5), except as provided in Subsections (2)(a)(iv) and (2)(c);

(e) shall meet the standards for Medicaid certification other than those in Subsection 26-18-503(5), including personnel, services, contracts, and licensing of facilities under Chapter 21, Health Care Facility Licensing and Inspection Act; and

(f) shall obtain Medicaid certification for the licensed Medicaid beds within three years of the date of transfer as documented under Subsection (2)(a)(iii)(B).

(4) (a) When the division receives notice of a transfer of a license for a Medicaid bed under Subsection (2)(a)(iii)(A), the department shall reduce the number of licenses for Medicaid beds at the transferring nursing care facility:

(i) equal to the number of licenses transferred; and

(ii) effective on the date of the transfer as reported under Subsection (2)(a)(iii)(B).

(b) For purposes of Section 26-18-502, the division shall approve Medicaid certification for the receiving nursing care facility program or entity:

(i) in accordance with the formula established in Subsection (3)(c); and

(ii) if:

(A) the nursing care facility seeks Medicaid certification for the transferred licenses within the time limit required by Subsection (3)(f); and

(B) the nursing care facility program meets other requirements for Medicaid certification under Subsection (3)(e).

(c) A license for a Medicaid bed may not be approved for Medicaid certification without meeting the requirements of Sections 26-18-502 and 26-18-503 if:

(i) the license for a Medicaid bed is transferred under this section but the receiving entity does not obtain Medicaid certification for the licensed bed within the time required by Subsection (3)(f); or

(ii) the license for a Medicaid bed is transferred under this section but the license is no longer eligible for Medicaid certification [~~as a result of the conversion factor established in Subsection (3)(c)~~].

Section 4. Section **26-21-23** is amended to read:

26-21-23. Licensing of a new nursing care facility -- Approval for a licensed bed in an existing nursing care facility -- Fine for excess Medicare inpatient revenue.

(1) Notwithstanding Section 26-21-2, as used in this section:

(a) "Medicaid" means the Medicaid program, as that term is defined in Section 26-18-2.

(b) "Medicaid certification" means the same as that term is defined in Section 26-18-501.

(c) "Nursing care facility" and "small health care facility":

(i) mean the following facilities licensed by the department under this chapter:

(A) a skilled nursing facility;

(B) an intermediate care facility; or

(C) a small health care facility with four to 16 beds functioning as a skilled nursing facility; and

(ii) do not mean:

(A) an intermediate care facility for the intellectually disabled;

(B) a critical access hospital that meets the criteria of 42 U.S.C. 1395i-4(c)(2) (1998);

(C) a small health care facility that is hospital based; or

(D) a small health care facility other than a skilled nursing care facility with no more than 16 beds.

(d) "Rural county" means the same as that term is defined in Section 26-18-501.

(2) Except as provided in Subsection (6) and Section 26-21-28, a new nursing care facility shall be approved for a health facility license only if:

(a) under the provisions of Section 26-18-503 the facility's nursing care facility program has received Medicaid certification or will receive Medicaid certification for each bed in the facility;

(b) the facility's nursing care facility program has received or will receive approval for Medicaid certification under Subsection 26-18-503(5), if the facility is located in a rural county; or

(c) (i) the applicant submits to the department the information described in Subsection (3); and

(ii) based on that information, and in accordance with Subsection (4), the department determines that approval of the license best meets the needs of the current and future patients of nursing care facilities within the area impacted by the new facility.

(3) A new nursing care facility seeking licensure under Subsection (2) shall submit to the department the following information:

(a) proof of the following as reasonable evidence that bed capacity provided by nursing care facilities within the county or group of counties that would be impacted by the facility is insufficient:

(i) nursing care facility occupancy within the county or group of counties:

(A) has been at least 75% during each of the past two years for all existing facilities combined; and

(B) is projected to be at least 75% for all nursing care facilities combined that have been approved for licensure but are not yet operational;

(ii) there is no other nursing care facility within a 35-mile radius of the new nursing care facility seeking licensure under Subsection (2); and

(b) a feasibility study that:

(i) shows the facility's annual Medicare inpatient revenue, including Medicare

Advantage revenue, will not exceed 49% of the facility's annual total revenue during each of the first three years of operation;

(ii) shows the facility will be financially viable if the annual occupancy rate is at least 88%;

(iii) shows the facility will be able to achieve financial viability;

(iv) shows the facility will not:

(A) have an adverse impact on existing or proposed nursing care facilities within the county or group of counties that would be impacted by the facility; or

(B) be within a three-mile radius of an existing nursing care facility or a new nursing care facility that has been approved for licensure but is not yet operational;

(v) is based on reasonable and verifiable demographic and economic assumptions;

(vi) is based on data consistent with department or other publicly available data; and

(vii) is based on existing sources of revenue.

(4) When determining under Subsection (2)(c) whether approval of a license for a new nursing care facility best meets the needs of the current and future patients of nursing care facilities within the area impacted by the new facility, the department shall consider:

(a) whether the county or group of counties that would be impacted by the facility is underserved by specialized or unique services that would be provided by the facility; and

(b) how additional bed capacity should be added to the long-term care delivery system to best meet the needs of current and future nursing care facility patients within the impacted area.

(5) The [~~division~~] department may approve the addition of a licensed bed in an existing nursing care facility only if:

(a) each time the facility seeks approval for the addition of a licensed bed, the facility satisfies each requirement for licensure of a new nursing care facility in Subsections (2)(c), (3), and (4); or

(b) the bed has been approved for Medicaid certification under Section 26-18-503 or 26-18-505.

(6) Subsection (2) does not apply to a nursing care facility that:

(a) has, by the effective date of this act, submitted to the department schematic drawings, and paid applicable fees, for a particular site or a site within a three-mile radius of

that site;

(b) before July 1, 2016:

(i) filed an application with the department for licensure under this section and paid all related fees due to the department; and

(ii) submitted to the department architectural plans and specifications, as defined by the department by administrative rule, for the facility;

(c) applies for a license within three years of closing for renovation;

(d) replaces a nursing care facility that:

(i) closed within the past three years; or

(ii) is located within five miles of the facility;

(e) is undergoing a change of ownership, even if a government entity designates the facility as a new nursing care facility; or

(f) is a state-owned veterans home, regardless of who operates the home.

(7) (a) For each year the annual Medicare inpatient revenue, including Medicare Advantage revenue, of a nursing care facility approved for a health facility license under Subsection (2)(c) exceeds 49% of the facility's total revenue for the year, the facility shall be subject to a fine of $50,000, payable to the department.

(b) A nursing care facility approved for a health facility license under Subsection (2)(c) shall submit to the department the information necessary for the department to annually determine whether the facility is subject to the fine in Subsection (7)(a).

(c) The department:

(i) shall make rules, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, specifying the information a nursing care facility shall submit to the department under Subsection (7)(b);

(ii) shall annually determine whether a facility is subject to the fine in Subsection (7)(a);

(iii) may take one or more of the actions in Section 26-21-11 or 26-23-6 against a facility for nonpayment of a fine due under Subsection (7)(a); and

(iv) shall deposit fines paid to the department under Subsection (7)(a) into the Nursing Care Facilities [~~Account~~] Provider Assessment ~~{Expendable Revenue }~~Fund, created by Section 26-35a-106.

Section 5. Section **26-35a-104** is amended to read:

26-35a-104. Collection, remittance, and payment of nursing care facilities assessment.

(1) (a) Beginning July 1, 2004, an assessment is imposed upon each nursing care facility in the amount designated in Subsection (1)(c).

(b) (i) The department shall establish by rule, a uniform rate per non-Medicare patient day that may not exceed 6% of the total gross revenue for services provided to patients of all nursing care facilities licensed in this state.

(ii) For purposes of Subsection (1)(b)(i), total revenue does not include charitable contribution received by a nursing care facility.

(c) The department shall calculate the assessment imposed under Subsection (1)(a) by multiplying the total number of patient days of care provided to non-Medicare patients by the nursing care facility, as provided to the department pursuant to Subsection (3)(a), by the uniform rate established by the department pursuant to Subsection (1)(b).

(2) (a) The assessment imposed by this chapter is due and payable on a monthly basis on or before the last day of the month next succeeding each monthly period.

(b) The collecting agent for this assessment shall be the department which is vested with the administration and enforcement of this chapter, including the right to audit records of a nursing care facility related to patient days of care for the facility.

(c) The department shall forward proceeds from the assessment imposed by this chapter to the state treasurer for deposit in the [~~restricted account~~] expendable special revenue fund as specified in Section 26-35a-106.

(3) Each nursing care facility shall, on or before the end of the month next succeeding each calendar monthly period, file with the department:

(a) a report which includes:

(i) the total number of patient days of care the facility provided to non-Medicare patients during the preceding month;

(ii) the total gross revenue the facility earned as compensation for services provided to patients during the preceding month; and

(iii) any other information required by the department; and

(b) a return for the monthly period, and shall remit with the return the assessment

required by this chapter to be paid for the period covered by the return.

(4) Each return shall contain information and be in the form the department prescribes by rule.

(5) The assessment as computed in the return is an allowable cost for Medicaid reimbursement purposes.

(6) The department may by rule, extend the time for making returns and paying the assessment.

(7) Each nursing care facility that fails to pay any assessment required to be paid to the state, within the time required by this chapter, or that fails to file a return as required by this chapter, shall pay, in addition to the assessment, penalties and interest as provided in Section 26-35a-105.

Section 6. Section **26-35a-106** is amended to read:

26-35a-106. Nursing Care Facilities Provider Assessment Expendable Revenue Fund -- Creation -- Deposits -- Uses.

(1) [~~(a)~~] There is created [~~a restricted account in the General Fund~~] an expendable special revenue fund~~{ in the General Fund}~~ known as the "Nursing Care Facilities [~~Account~~] Provider Assessment~~{ Expendable Revenue}~~ Fund" consisting of:

[~~(i) proceeds from the assessment imposed by Section 26-35a-104 which shall be deposited in the restricted account to be used for the purpose described in Subsection (1)(b);~~]

(a) the assessments collected by the department under this chapter;

[~~(ii)~~] (b) fines paid by nursing care facilities for excessive Medicare inpatient revenue under Section [~~26-18-506~~] 26-21-23;

~~{ (c) money in the restricted account in the General Fund known as the "Nursing Care Facilities Account";~~

~~}~~ [~~(iii)~~] (~~{d}~~c) money appropriated or otherwise made available by the Legislature; [~~and~~]

[~~(iv)~~] (~~{e}~~d) any interest earned on the [~~account.~~] fund; and

(~~{f}~~e) penalties levied with the administration of this chapter.

[~~(b) (i)~~] (2) Money in the [~~account~~] fund shall only be used by the Medicaid program:

[~~(A)~~] (a) to the extent authorized by federal law, to obtain federal financial participation in the Medicaid program;

[~~(B)~~] (b) to provide the increased level of hospice reimbursement resulting from the

nursing care facilities assessment imposed under Section 26-35a-104;

[~~(C)~~] (c) for the Medicaid program to make quality incentive payments to nursing care facilities, subject to approval of a Medicaid state plan amendment to do so by the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services; [~~and~~]

[~~(D) {~~] ~~(d)~~ ~~in the manner described in Subsection {~~] (1)(b)(ii)~~.~~] ~~{ (3).}~~

[~~(ii) {~~] ~~(3)~~ ~~The money appropriated from the restricted account to the department:~~]

[~~(A)~~] (~~{a}~~d) [~~shall be used only~~] to increase the rates paid [~~prior to~~] before July 1, 2004, to nursing care facilities for providing services pursuant to the Medicaid program [~~and for administrative expenses as described in Subsection {~~] (1)(b)(ii)(C)]~~;~~ ~~{(3)(c)}~~and~~{;}~~

[~~(B) {~~] ~~(b)~~ ~~may not be used to replace existing state expenditures paid to nursing care facilities for providing services pursuant to the Medicaid program, except for increased costs due to hospice reimbursement under Subsection {~~] (1)(b)(i)(B); and]~~ { (2)(b).}~~

[~~(C)~~] (~~{c}~~e) [~~may be used~~] for administrative expenses, if the administrative expenses for the fiscal year do not exceed 3% of the money deposited into the [~~restricted account~~] fund during the fiscal year~~{[.]; and~~

~~(d) may be used to make quality incentive payments}~~.

(3) The department may not spend the money in the fund to replace existing state expenditures paid to nursing care facilities for providing services under the Medicaid program, except for increased costs due to hospice reimbursement under Subsection (2)(~~{c}~~b).

[~~(2) Money shall be appropriated from the restricted account to the department for the purposes described in Subsection (1)(b) in accordance with Title 63J, Chapter 1, Budgetary Procedures Act.~~]

Section 7. Section **26-35a-107** is amended to read:

26-35a-107. Adjustment to nursing care facility Medicaid reimbursement rates.

If federal law or regulation prohibits the money in the Nursing Care Facilities [~~Account~~] Provider Assessment ~~{Expendable Revenue }~~Fund from being used in the manner set forth in Subsection 26-35a-106(1)(b), the rates paid to nursing care facilities for providing services pursuant to the Medicaid program shall be changed [~~as follows~~]:

(1) except as otherwise provided in Subsection (2), to the rates paid to nursing care facilities on June 30, 2004; or

(2) if the Legislature or the department has on or after July 1, 2004, changed the rates paid to facilities through a manner other than the use of expenditures from the Nursing Care Facilities [~~Account~~] Provider Assessment ~~{Expendable Revenue }~~Fund, to the rates provided for by the Legislature or the department.

Section 8. Section **63I-1-226** is amended to read:

63I-1-226. Repeal dates, Title 26.

(1) Title 26, Chapter 9f, Utah Digital Health Service Commission Act, is repealed July 1, 2025.

(2) Section 26-10-11 is repealed July 1, 2020.

[~~(3) Section 26-21-23, Licensing of non-Medicaid nursing care facility beds, is repealed July 1, 2018.~~]

[~~(4)~~] (3) Title 26, Chapter 33a, Utah Health Data Authority Act, is repealed July 1, 2024.

[~~(5)~~] (4) Title 26, Chapter 36a, Hospital Provider Assessment Act, is repealed July 1, 2019.

[~~(6)~~] (5) Title 26, Chapter 36b, Inpatient Hospital Assessment Act, is repealed July 1, 2021.

[~~(7)~~] (6) Section 26-38-2.5 is repealed July 1, 2017.

[~~(8)~~] (7) Section 26-38-2.6 is repealed July 1, 2017.

[~~(9)~~] (8) Title 26, Chapter 52, Autism Treatment Account, is repealed July 1, 2016.

[~~(10)~~] (9) Title 26, Chapter 56, Hemp Extract Registration Act, is repealed July 1, 2021.

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~~**Legislative Review Note**~~

~~**Office of Legislative Research and General Counsel)**~~ Section 9. **Transfer of funds into Expendable Special Revenue Account.**

The Department of Finance shall transfer the remaining fund balance in the "Nursing Care Facilities Account" at fiscal year-end 2017 into the "Nursing Care Facilities Provider

Assessment Fund."

Section 10. **Effective date.**

This bill takes effect on July 1, 2017.