

By: Representative Howell

To: Medicaid; Appropriations

HOUSE BILL NO. 1275  
(As Sent to Governor)

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,  
2 TO EXTEND THE AUTOMATIC REPEALER ON THE STATUTE THAT PROVIDES  
3 HEALTH CARE SERVICES COVERED UNDER THE MEDICAID PROGRAM; TO DELETE  
4 THE LIMITATION ON EMERGENCY ROOM VISITS COVERED UNDER THE MEDICAID  
5 PROGRAM; TO DIRECT THE DIVISION TO UPDATE THE CASE-MIX PAYMENT  
6 SYSTEM FOR NURSING SERVICES; TO DIRECT THE DIVISION TO UPDATE THE  
7 FAIR RENTAL REIMBURSEMENT SYSTEM FOR INTERMEDIATE CARE FACILITIES  
8 FOR THE INTELLECTUALLY DISABLED; TO AUTHORIZE A MEDICARE UPPER  
9 PAYMENT LIMITS PROGRAM FOR PHYSICIANS EMPLOYED BY PUBLIC HOSPITALS  
10 AND AUTHORIZE THE UPL PROGRAM FOR PHYSICIANS EMPLOYED BY PRIVATE  
11 HOSPITALS; TO DIRECT THE DIVISION TO UPDATE THE FAIR RENTAL  
12 REIMBURSEMENT SYSTEM FOR PSYCHIATRIC RESIDENTIAL TREATMENT  
13 FACILITIES; TO REVISE THE CAP ON ENROLLMENT IN MEDICAID MANAGED  
14 CARE OR SIMILAR PROGRAMS; TO DIRECT THE DIVISION TO DEVELOP A PLAN  
15 FOR CERTAIN RECIPIENTS UNDER THE MANAGED CARE PROGRAM; TO DIRECT  
16 MEDICAID MANAGED CARE PROGRAMS TO PROVIDE STATISTICAL DATA TO THE  
17 LEGISLATURE AND THE DIVISION ON A REASONABLE TIMELINE; TO REVISE  
18 LANGUAGE RELATING TO THE MEDICAID REIMBURSEMENT FOR FREESTANDING  
19 PSYCHIATRIC HOSPITALS; TO PROVIDE THAT THE MEDICAID PLAN SHALL NOT  
20 RESTRICT COVERAGE FOR PHYSICIAN PRESCRIBED TREATMENT BASED UPON  
21 THE INDIVIDUAL'S DIAGNOSIS WITH A TERMINAL CONDITION; TO AUTHORIZE  
22 THE DIVISION TO REIMBURSE FOR CERTAIN PRIMARY CARE SERVICES AT THE  
23 MEDICARE RATE; TO CLARIFY THAT THE STATE DEPARTMENT OF HEALTH  
24 SHALL BE REIMBURSED ON A FULL REASONABLE COST BASIS FOR PHRM/ISS  
25 SERVICES; TO AMEND SECTION 43-13-119, MISSISSIPPI CODE OF 1972, TO  
26 EXTEND THE AUTOMATIC REPEALER ON THE TRANSPORTATION PROGRAM FOR  
27 RECIPIENTS RECEIVING NECESSARY DIALYSIS SERVICES; TO AMEND SECTION  
28 43-13-121, MISSISSIPPI CODE OF 1972, TO AUTHORIZE THE DIVISION OF  
29 MEDICAID TO EXTEND ITS FISCAL AGENT AND ELIGIBILITY DETERMINATION  
30 SYSTEM CONTRACTS WITHOUT ISSUING FORMAL REQUESTS FOR PROPOSALS; TO  
31 PROVIDE FOR THE VENUE OF CIVIL ACTIONS AGAINST THE DIVISION BY  
32 PROVIDERS; TO AMEND SECTION 43-13-125, MISSISSIPPI CODE OF 1972,  
33 TO CLARIFY THE RIGHTS OF THE DIVISION OF MEDICAID WITH RESPECT TO  
34 A CLAIM AGAINST A THIRD PARTY; TO AMEND SECTION 43-13-145,



35 MISSISSIPPI CODE OF 1972, TO EXTEND THE DATE OF THE REPEALERS ON  
36 THE ANNUAL ASSESSMENT ON LICENSED HOSPITALS IN MISSISSIPPI TO  
37 PROVIDE FUNDING FOR THE MEDICAID PROGRAM, ON ADMINISTRATIVE  
38 PROVISIONS RELATING TO THE HOSPITAL ASSESSMENT, AND ON THE PAYMENT  
39 OF ADDITIONAL ANNUAL MEDICARE UPPER PAYMENT LIMITS AND  
40 DISPROPORTIONATE SHARE HOSPITAL PAYMENTS TO MISSISSIPPI HOSPITALS  
41 THAT PARTICIPATE IN THE MEDICAID PROGRAM; TO AMEND SECTION  
42 41-86-9, MISSISSIPPI CODE OF 1972, TO PROVIDE FOR OPERATION OF THE  
43 CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) BY THE DIVISION OF  
44 MEDICAID; TO DIRECT THE DIVISION OF MEDICAID TO PREPARE A REPORT  
45 TO THE LEGISLATURE ON THE IMPACT OF REFERRALS BY PHYSICIANS FOR  
46 ADVANCED IMAGING SERVICES USING EQUIPMENT OWNED IN FULL OR IN PART  
47 BY THE REFERRING PHYSICIAN; AND FOR RELATED PURPOSES.

48 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

49 **SECTION 1.** Section 43-13-117, Mississippi Code of 1972, is  
50 amended as follows:

51 43-13-117. (A) Medicaid as authorized by this article shall  
52 include payment of part or all of the costs, at the discretion of  
53 the division, with approval of the Governor, of the following  
54 types of care and services rendered to eligible applicants who  
55 have been determined to be eligible for that care and services,  
56 within the limits of state appropriations and federal matching  
57 funds:

58 (1) Inpatient hospital services.

59 (a) The division shall allow thirty (30) days of  
60 inpatient hospital care annually for all Medicaid recipients.  
61 Medicaid recipients requiring transplants shall not have those  
62 days included in the transplant hospital stay count against the  
63 thirty-day limit for inpatient hospital care. Precertification of  
64 inpatient days must be obtained as required by the division.

65 (b) From and after July 1, 1994, the Executive  
66 Director of the Division of Medicaid shall amend the Mississippi



67 Title XIX Inpatient Hospital Reimbursement Plan to remove the  
68 occupancy rate penalty from the calculation of the Medicaid  
69 Capital Cost Component utilized to determine total hospital costs  
70 allocated to the Medicaid program.

71 (c) Hospitals will receive an additional payment  
72 for the implantable programmable baclofen drug pump used to treat  
73 spasticity that is implanted on an inpatient basis. The payment  
74 pursuant to written invoice will be in addition to the facility's  
75 per diem reimbursement and will represent a reduction of costs on  
76 the facility's annual cost report, and shall not exceed Ten  
77 Thousand Dollars (\$10,000.00) per year per recipient.

78 (d) The division is authorized to implement an  
79 All-Patient Refined-Diagnosis Related Groups (APR-DRG)  
80 reimbursement methodology for inpatient hospital services.

81 (e) No service benefits or reimbursement  
82 limitations in this section shall apply to payments under an  
83 APR-DRG or Ambulatory Payment Classification (APC) model or a  
84 managed care program or similar model described in subsection (H)  
85 of this section.

86 (2) Outpatient hospital services.

87 (a) Emergency services. \* \* \*

88 (b) Other outpatient hospital services. The  
89 division shall allow benefits for other medically necessary  
90 outpatient hospital services (such as chemotherapy, radiation,  
91 surgery and therapy), including outpatient services in a clinic or



92 other facility that is not located inside the hospital, but that  
93 has been designated as an outpatient facility by the hospital, and  
94 that was in operation or under construction on July 1, 2009,  
95 provided that the costs and charges associated with the operation  
96 of the hospital clinic are included in the hospital's cost report.  
97 In addition, the Medicare thirty-five-mile rule will apply to  
98 those hospital clinics not located inside the hospital that are  
99 constructed after July 1, 2009. Where the same services are  
100 reimbursed as clinic services, the division may revise the rate or  
101 methodology of outpatient reimbursement to maintain consistency,  
102 efficiency, economy and quality of care.

103 (c) The division is authorized to implement an  
104 Ambulatory Payment Classification (APC) methodology for outpatient  
105 hospital services.

106 (d) No service benefits or reimbursement  
107 limitations in this section shall apply to payments under an  
108 APR-DRG or APC model or a managed care program or similar model  
109 described in subsection (H) of this section.

110 (3) Laboratory and x-ray services.

111 (4) Nursing facility services.

112 (a) The division shall make full payment to  
113 nursing facilities for each day, not exceeding fifty-two (52) days  
114 per year, that a patient is absent from the facility on home  
115 leave. Payment may be made for the following home leave days in  
116 addition to the fifty-two-day limitation: Christmas, the day



117 before Christmas, the day after Christmas, Thanksgiving, the day  
118 before Thanksgiving and the day after Thanksgiving.

119 (b) From and after July 1, 1997, the division  
120 shall implement the integrated case-mix payment and quality  
121 monitoring system, which includes the fair rental system for  
122 property costs and in which recapture of depreciation is  
123 eliminated. The division may reduce the payment for hospital  
124 leave and therapeutic home leave days to the lower of the case-mix  
125 category as computed for the resident on leave using the  
126 assessment being utilized for payment at that point in time, or a  
127 case-mix score of 1.000 for nursing facilities, and shall compute  
128 case-mix scores of residents so that only services provided at the  
129 nursing facility are considered in calculating a facility's per  
130 diem.

131 (c) From and after July 1, 1997, all state-owned  
132 nursing facilities shall be reimbursed on a full reasonable cost  
133 basis.

134 (d) \* \* \* On or after January 1, 2015, the  
135 division shall update the case-mix payment system resource  
136 utilization grouper and classifications and fair rental  
137 reimbursement system. The division shall develop and implement a  
138 payment add-on to reimburse nursing facilities for ventilator  
139 dependent resident services.

140 (e) The division shall develop and implement, not  
141 later than January 1, 2001, a case-mix payment add-on determined



142 by time studies and other valid statistical data that will  
143 reimburse a nursing facility for the additional cost of caring for  
144 a resident who has a diagnosis of Alzheimer's or other related  
145 dementia and exhibits symptoms that require special care. Any  
146 such case-mix add-on payment shall be supported by a determination  
147 of additional cost. The division shall also develop and implement  
148 as part of the fair rental reimbursement system for nursing  
149 facility beds, an Alzheimer's resident bed depreciation enhanced  
150 reimbursement system that will provide an incentive to encourage  
151 nursing facilities to convert or construct beds for residents with  
152 Alzheimer's or other related dementia.

153 (f) The division shall develop and implement an  
154 assessment process for long-term care services. The division may  
155 provide the assessment and related functions directly or through  
156 contract with the area agencies on aging.

157 The division shall apply for necessary federal waivers to  
158 assure that additional services providing alternatives to nursing  
159 facility care are made available to applicants for nursing  
160 facility care.

161 (5) Periodic screening and diagnostic services for  
162 individuals under age twenty-one (21) years as are needed to  
163 identify physical and mental defects and to provide health care  
164 treatment and other measures designed to correct or ameliorate  
165 defects and physical and mental illness and conditions discovered  
166 by the screening services, regardless of whether these services



167 are included in the state plan. The division may include in its  
168 periodic screening and diagnostic program those discretionary  
169 services authorized under the federal regulations adopted to  
170 implement Title XIX of the federal Social Security Act, as  
171 amended. The division, in obtaining physical therapy services,  
172 occupational therapy services, and services for individuals with  
173 speech, hearing and language disorders, may enter into a  
174 cooperative agreement with the State Department of Education for  
175 the provision of those services to handicapped students by public  
176 school districts using state funds that are provided from the  
177 appropriation to the Department of Education to obtain federal  
178 matching funds through the division. The division, in obtaining  
179 medical and mental health assessments, treatment, care and  
180 services for children who are in, or at risk of being put in, the  
181 custody of the Mississippi Department of Human Services may enter  
182 into a cooperative agreement with the Mississippi Department of  
183 Human Services for the provision of those services using state  
184 funds that are provided from the appropriation to the Department  
185 of Human Services to obtain federal matching funds through the  
186 division.

187 (6) Physician's services. The division shall allow  
188 twelve (12) physician visits annually. The division may develop  
189 and implement a different reimbursement model or schedule for  
190 physician's services provided by physicians based at an academic  
191 health care center and by physicians at rural health centers that



192 are associated with an academic health care center. From and  
193 after January 1, 2010, all fees for physicians' services that are  
194 covered only by Medicaid shall be increased to ninety percent  
195 (90%) of the rate established on January 1, 2010, and as may be  
196 adjusted each July thereafter, under Medicare. The division may  
197 provide for a reimbursement rate for physician's services of up to  
198 one hundred percent (100%) of the rate established under Medicare  
199 for physician's services that are provided after the normal  
200 working hours of the physician, as determined in accordance with  
201 regulations of the division. The division may reimburse eligible  
202 providers as determined by the Patient Protection and Affordable  
203 Care Act for certain primary care services as defined by the act  
204 at one hundred percent (100%) of the rate established under  
205 Medicare.

206 (7) (a) Home health services for eligible persons, not  
207 to exceed in cost the prevailing cost of nursing facility  
208 services, not to exceed twenty-five (25) visits per year. All  
209 home health visits must be precertified as required by the  
210 division.

211 (b) [Repealed]

212 (8) Emergency medical transportation services. On  
213 January 1, 1994, emergency medical transportation services shall  
214 be reimbursed at seventy percent (70%) of the rate established  
215 under Medicare (Title XVIII of the federal Social Security Act, as  
216 amended). "Emergency medical transportation services" shall mean,





217 but shall not be limited to, the following services by a properly  
218 permitted ambulance operated by a properly licensed provider in  
219 accordance with the Emergency Medical Services Act of 1974  
220 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced  
221 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,  
222 (vi) disposable supplies, (vii) similar services.

223 (9) (a) Legend and other drugs as may be determined by  
224 the division.

225 The division shall establish a mandatory preferred drug list.  
226 Drugs not on the mandatory preferred drug list shall be made  
227 available by utilizing prior authorization procedures established  
228 by the division.

229 The division may seek to establish relationships with other  
230 states in order to lower acquisition costs of prescription drugs  
231 to include single source and innovator multiple source drugs or  
232 generic drugs. In addition, if allowed by federal law or  
233 regulation, the division may seek to establish relationships with  
234 and negotiate with other countries to facilitate the acquisition  
235 of prescription drugs to include single source and innovator  
236 multiple source drugs or generic drugs, if that will lower the  
237 acquisition costs of those prescription drugs.

238 The division shall allow for a combination of prescriptions  
239 for single source and innovator multiple source drugs and generic  
240 drugs to meet the needs of the beneficiaries, not to exceed five  
241 (5) prescriptions per month for each noninstitutionalized Medicaid



242 beneficiary, with not more than two (2) of those prescriptions  
243 being for single source or innovator multiple source drugs unless  
244 the single source or innovator multiple source drug is less  
245 expensive than the generic equivalent.

246 The executive director may approve specific maintenance drugs  
247 for beneficiaries with certain medical conditions, which may be  
248 prescribed and dispensed in three-month supply increments.

249 Drugs prescribed for a resident of a psychiatric residential  
250 treatment facility must be provided in true unit doses when  
251 available. The division may require that drugs not covered by  
252 Medicare Part D for a resident of a long-term care facility be  
253 provided in true unit doses when available. Those drugs that were  
254 originally billed to the division but are not used by a resident  
255 in any of those facilities shall be returned to the billing  
256 pharmacy for credit to the division, in accordance with the  
257 guidelines of the State Board of Pharmacy and any requirements of  
258 federal law and regulation. Drugs shall be dispensed to a  
259 recipient and only one (1) dispensing fee per month may be  
260 charged. The division shall develop a methodology for reimbursing  
261 for restocked drugs, which shall include a restock fee as  
262 determined by the division not exceeding Seven Dollars and  
263 Eighty-two Cents (\$7.82).

264 The voluntary preferred drug list shall be expanded to  
265 function in the interim in order to have a manageable prior



266 authorization system, thereby minimizing disruption of service to  
267 beneficiaries.

268       Except for those specific maintenance drugs approved by the  
269 executive director, the division shall not reimburse for any  
270 portion of a prescription that exceeds a thirty-one-day supply of  
271 the drug based on the daily dosage.

272       The division shall develop and implement a program of payment  
273 for additional pharmacist services, with payment to be based on  
274 demonstrated savings, but in no case shall the total payment  
275 exceed twice the amount of the dispensing fee.

276       All claims for drugs for dually eligible Medicare/Medicaid  
277 beneficiaries that are paid for by Medicare must be submitted to  
278 Medicare for payment before they may be processed by the  
279 division's online payment system.

280       The division shall develop a pharmacy policy in which drugs  
281 in tamper-resistant packaging that are prescribed for a resident  
282 of a nursing facility but are not dispensed to the resident shall  
283 be returned to the pharmacy and not billed to Medicaid, in  
284 accordance with guidelines of the State Board of Pharmacy.

285       The division shall develop and implement a method or methods  
286 by which the division will provide on a regular basis to Medicaid  
287 providers who are authorized to prescribe drugs, information about  
288 the costs to the Medicaid program of single source drugs and  
289 innovator multiple source drugs, and information about other drugs  
290 that may be prescribed as alternatives to those single source



291 drugs and innovator multiple source drugs and the costs to the  
292 Medicaid program of those alternative drugs.

293 Notwithstanding any law or regulation, information obtained  
294 or maintained by the division regarding the prescription drug  
295 program, including trade secrets and manufacturer or labeler  
296 pricing, is confidential and not subject to disclosure except to  
297 other state agencies.

298 (b) Payment by the division for covered  
299 multisource drugs shall be limited to the lower of the upper  
300 limits established and published by the Centers for Medicare and  
301 Medicaid Services (CMS) plus a dispensing fee, or the estimated  
302 acquisition cost (EAC) as determined by the division, plus a  
303 dispensing fee, or the providers' usual and customary charge to  
304 the general public.

305 Payment for other covered drugs, other than multisource drugs  
306 with CMS upper limits, shall not exceed the lower of the estimated  
307 acquisition cost as determined by the division, plus a dispensing  
308 fee or the providers' usual and customary charge to the general  
309 public.

310 Payment for nonlegend or over-the-counter drugs covered by  
311 the division shall be reimbursed at the lower of the division's  
312 estimated shelf price or the providers' usual and customary charge  
313 to the general public.

314 The dispensing fee for each new or refill prescription,  
315 including nonlegend or over-the-counter drugs covered by the



316 division, shall be not less than Three Dollars and Ninety-one  
317 Cents (\$3.91), as determined by the division.

318 The division shall not reimburse for single source or  
319 innovator multiple source drugs if there are equally effective  
320 generic equivalents available and if the generic equivalents are  
321 the least expensive.

322 It is the intent of the Legislature that the pharmacists  
323 providers be reimbursed for the reasonable costs of filling and  
324 dispensing prescriptions for Medicaid beneficiaries.

325 (10) (a) Dental care that is an adjunct to treatment  
326 of an acute medical or surgical condition; services of oral  
327 surgeons and dentists in connection with surgery related to the  
328 jaw or any structure contiguous to the jaw or the reduction of any  
329 fracture of the jaw or any facial bone; and emergency dental  
330 extractions and treatment related thereto. On July 1, 2007, fees  
331 for dental care and surgery under authority of this paragraph (10)  
332 shall be reimbursed as provided in subparagraph (b). It is the  
333 intent of the Legislature that this rate revision for dental  
334 services will be an incentive designed to increase the number of  
335 dentists who actively provide Medicaid services. This dental  
336 services rate revision shall be known as the "James Russell Dumas  
337 Medicaid Dental Incentive Program."

338 The division shall annually determine the effect of this  
339 incentive by evaluating the number of dentists who are Medicaid  
340 providers, the number who and the degree to which they are



341 actively billing Medicaid, the geographic trends of where dentists  
342 are offering what types of Medicaid services and other statistics  
343 pertinent to the goals of this legislative intent. This data  
344 shall be presented to the Chair of the Senate Public Health and  
345 Welfare Committee and the Chair of the House Medicaid Committee.

346 (b) The Division of Medicaid shall establish a fee  
347 schedule, to be effective from and after July 1, 2007, for dental  
348 services. The schedule shall provide for a fee for each dental  
349 service that is equal to a percentile of normal and customary  
350 private provider fees, as defined by the Ingenix Customized Fee  
351 Analyzer Report, which percentile shall be determined by the  
352 division. The schedule shall be reviewed annually by the division  
353 and dental fees shall be adjusted to reflect the percentile  
354 determined by the division.

355 (c) For fiscal year 2008, the amount of state  
356 funds appropriated for reimbursement for dental care and surgery  
357 shall be increased by ten percent (10%) of the amount of state  
358 fund expenditures for that purpose for fiscal year 2007. For each  
359 of fiscal years 2009 and 2010, the amount of state funds  
360 appropriated for reimbursement for dental care and surgery shall  
361 be increased by ten percent (10%) of the amount of state fund  
362 expenditures for that purpose for the preceding fiscal year.

363 (d) The division shall establish an annual benefit  
364 limit of Two Thousand Five Hundred Dollars (\$2,500.00) in dental  
365 expenditures per Medicaid-eligible recipient; however, a recipient



366 may exceed the annual limit on dental expenditures provided in  
367 this paragraph with prior approval of the division.

368 (e) The division shall include dental services as  
369 a necessary component of overall health services provided to  
370 children who are eligible for services.

371 (f) This paragraph (10) shall stand repealed on  
372 July 1, \* \* \* 2016.

373 (11) Eyeglasses for all Medicaid beneficiaries who have  
374 (a) had surgery on the eyeball or ocular muscle that results in a  
375 vision change for which eyeglasses or a change in eyeglasses is  
376 medically indicated within six (6) months of the surgery and is in  
377 accordance with policies established by the division, or (b) one  
378 (1) pair every five (5) years and in accordance with policies  
379 established by the division. In either instance, the eyeglasses  
380 must be prescribed by a physician skilled in diseases of the eye  
381 or an optometrist, whichever the beneficiary may select.

382 (12) Intermediate care facility services.

383 (a) The division shall make full payment to all  
384 intermediate care facilities for \* \* \* individuals with  
385 intellectual disabilities for each day, not exceeding eighty-four  
386 (84) days per year, that a patient is absent from the facility on  
387 home leave. Payment may be made for the following home leave days  
388 in addition to the eighty-four-day limitation: Christmas, the day  
389 before Christmas, the day after Christmas, Thanksgiving, the day  
390 before Thanksgiving and the day after Thanksgiving.



391 (b) All state-owned intermediate care facilities  
392 for \* \* \* individuals with intellectual disabilities shall be  
393 reimbursed on a full reasonable cost basis.

394 (c) Effective January 1, 2015, the division shall  
395 update the fair rental reimbursement system for intermediate care  
396 facilities for individuals with intellectual disabilities.

397 (13) Family planning services, including drugs,  
398 supplies and devices, when those services are under the  
399 supervision of a physician or nurse practitioner.

400 (14) Clinic services. Such diagnostic, preventive,  
401 therapeutic, rehabilitative or palliative services furnished to an  
402 outpatient by or under the supervision of a physician or dentist  
403 in a facility that is not a part of a hospital but that is  
404 organized and operated to provide medical care to outpatients.  
405 Clinic services shall include any services reimbursed as  
406 outpatient hospital services that may be rendered in such a  
407 facility, including those that become so after July 1, 1991. On  
408 July 1, 1999, all fees for physicians' services reimbursed under  
409 authority of this paragraph (14) shall be reimbursed at ninety  
410 percent (90%) of the rate established on January 1, 1999, and as  
411 may be adjusted each July thereafter, under Medicare (Title XVIII  
412 of the federal Social Security Act, as amended). The division may  
413 develop and implement a different reimbursement model or schedule  
414 for physician's services provided by physicians based at an  
415 academic health care center and by physicians at rural health





416 centers that are associated with an academic health care center.  
417 The division may provide for a reimbursement rate for physician's  
418 clinic services of up to one hundred percent (100%) of the rate  
419 established under Medicare for physician's services that are  
420 provided after the normal working hours of the physician, as  
421 determined in accordance with regulations of the division.

422 (15) Home- and community-based services for the elderly  
423 and disabled, as provided under Title XIX of the federal Social  
424 Security Act, as amended, under waivers, subject to the  
425 availability of funds specifically appropriated for that purpose  
426 by the Legislature.

427 (16) Mental health services. Approved therapeutic and  
428 case management services (a) provided by an approved regional  
429 mental health/intellectual disability center established under  
430 Sections 41-19-31 through 41-19-39, or by another community mental  
431 health service provider meeting the requirements of the Department  
432 of Mental Health to be an approved mental health/intellectual  
433 disability center if determined necessary by the Department of  
434 Mental Health, using state funds that are provided in the  
435 appropriation to the division to match federal funds, or (b)  
436 provided by a facility that is certified by the State Department  
437 of Mental Health to provide therapeutic and case management  
438 services, to be reimbursed on a fee for service basis, or (c)  
439 provided in the community by a facility or program operated by the  
440 Department of Mental Health. Any such services provided by a



441 facility described in subparagraph (b) must have the prior  
442 approval of the division to be reimbursable under this section.  
443 After June 30, 1997, mental health services provided by regional  
444 mental health/intellectual disability centers established under  
445 Sections 41-19-31 through 41-19-39, or by hospitals as defined in  
446 Section 41-9-3(a) and/or their subsidiaries and divisions, or by  
447 psychiatric residential treatment facilities as defined in Section  
448 43-11-1, or by another community mental health service provider  
449 meeting the requirements of the Department of Mental Health to be  
450 an approved mental health/intellectual disability center if  
451 determined necessary by the Department of Mental Health, shall not  
452 be included in or provided under any capitated managed care pilot  
453 program provided for under paragraph (24) of this section.

454 (17) Durable medical equipment services and medical  
455 supplies. Precertification of durable medical equipment and  
456 medical supplies must be obtained as required by the division.  
457 The Division of Medicaid may require durable medical equipment  
458 providers to obtain a surety bond in the amount and to the  
459 specifications as established by the Balanced Budget Act of 1997.

460 (18) (a) Notwithstanding any other provision of this  
461 section to the contrary, as provided in the Medicaid state plan  
462 amendment or amendments as defined in Section 43-13-145(10), the  
463 division shall make additional reimbursement to hospitals that  
464 serve a disproportionate share of low-income patients and that  
465 meet the federal requirements for those payments as provided in



466 Section 1923 of the federal Social Security Act and any applicable  
467 regulations. It is the intent of the Legislature that the  
468 division shall draw down all available federal funds allotted to  
469 the state for disproportionate share hospitals. However, from and  
470 after January 1, 1999, public hospitals participating in the  
471 Medicaid disproportionate share program may be required to  
472 participate in an intergovernmental transfer program as provided  
473 in Section 1903 of the federal Social Security Act and any  
474 applicable regulations.

475 (b) The division shall establish a Medicare Upper  
476 Payment Limits Program, as defined in Section 1902(a)(30) of the  
477 federal Social Security Act and any applicable federal  
478 regulations, for hospitals, and may establish a Medicare Upper  
479 Payment Limits Program for nursing facilities, and may establish a  
480 Medicare Upper Payment Limits Program for physicians employed or  
481 contracted by public hospitals. Upon successful implementation of  
482 a Medicare Upper Payment program for physicians employed by public  
483 hospitals, the division may develop a plan for implementing an  
484 Upper Payment Limit program for physicians employed by other  
485 classes of hospitals. The division shall assess each hospital  
486 and, if the program is established for nursing facilities, shall  
487 assess each nursing facility, for the sole purpose of financing  
488 the state portion of the Medicare Upper Payment Limits Program.  
489 The hospital assessment shall be as provided in Section  
490 43-13-145(4)(a) and the nursing facility assessment, if



491 established, shall be based on Medicaid utilization or other  
492 appropriate method consistent with federal regulations. The  
493 assessment will remain in effect as long as the state participates  
494 in the Medicare Upper Payment Limits Program. Public hospitals  
495 with physicians participating in the Medicare Upper Payment Limits  
496 Program shall be required to participate in an intergovernmental  
497 transfer program. As provided in the Medicaid state plan  
498 amendment or amendments as defined in Section 43-13-145(10), the  
499 division shall make additional reimbursement to hospitals and, if  
500 the program is established for nursing facilities, shall make  
501 additional reimbursement to nursing facilities, for the Medicare  
502 Upper Payment Limits, and, if the program is established for  
503 physicians, shall make additional reimbursement for physicians, as  
504 defined in Section 1902(a)(30) of the federal Social Security Act  
505 and any applicable federal regulations.

506 (19) (a) Perinatal risk management services. The  
507 division shall promulgate regulations to be effective from and  
508 after October 1, 1988, to establish a comprehensive perinatal  
509 system for risk assessment of all pregnant and infant Medicaid  
510 recipients and for management, education and follow-up for those  
511 who are determined to be at risk. Services to be performed  
512 include case management, nutrition assessment/counseling,  
513 psychosocial assessment/counseling and health education. The  
514 division shall contract with the State Department of Health to  
515 provide the services within this paragraph (Perinatal High Risk



516 Management/Infant Services System (PHRM/ISS). The State  
517 Department of Health as the agency for PHRM/ISS for the Division  
518 of Medicaid shall be reimbursed on a full reasonable cost basis.

519 (b) Early intervention system services. The  
520 division shall cooperate with the State Department of Health,  
521 acting as lead agency, in the development and implementation of a  
522 statewide system of delivery of early intervention services, under  
523 Part C of the Individuals with Disabilities Education Act (IDEA).  
524 The State Department of Health shall certify annually in writing  
525 to the executive director of the division the dollar amount of  
526 state early intervention funds available that will be utilized as  
527 a certified match for Medicaid matching funds. Those funds then  
528 shall be used to provide expanded targeted case management  
529 services for Medicaid eligible children with special needs who are  
530 eligible for the state's early intervention system.

531 Qualifications for persons providing service coordination shall be  
532 determined by the State Department of Health and the Division of  
533 Medicaid.

534 (20) Home- and community-based services for physically  
535 disabled approved services as allowed by a waiver from the United  
536 States Department of Health and Human Services for home- and  
537 community-based services for physically disabled people using  
538 state funds that are provided from the appropriation to the State  
539 Department of Rehabilitation Services and used to match federal  
540 funds under a cooperative agreement between the division and the



541 department, provided that funds for these services are  
542 specifically appropriated to the Department of Rehabilitation  
543 Services.

544 (21) Nurse practitioner services. Services furnished  
545 by a registered nurse who is licensed and certified by the  
546 Mississippi Board of Nursing as a nurse practitioner, including,  
547 but not limited to, nurse anesthetists, nurse midwives, family  
548 nurse practitioners, family planning nurse practitioners,  
549 pediatric nurse practitioners, obstetrics-gynecology nurse  
550 practitioners and neonatal nurse practitioners, under regulations  
551 adopted by the division. Reimbursement for those services shall  
552 not exceed ninety percent (90%) of the reimbursement rate for  
553 comparable services rendered by a physician. The division may  
554 provide for a reimbursement rate for nurse practitioner services  
555 of up to one hundred percent (100%) of the reimbursement rate for  
556 comparable services rendered by a physician for nurse practitioner  
557 services that are provided after the normal working hours of the  
558 nurse practitioner, as determined in accordance with regulations  
559 of the division.

560 (22) Ambulatory services delivered in federally  
561 qualified health centers, rural health centers and clinics of the  
562 local health departments of the State Department of Health for  
563 individuals eligible for Medicaid under this article based on  
564 reasonable costs as determined by the division.



565           (23) Inpatient psychiatric services. Inpatient  
566 psychiatric services to be determined by the division for  
567 recipients under age twenty-one (21) that are provided under the  
568 direction of a physician in an inpatient program in a licensed  
569 acute care psychiatric facility or in a licensed psychiatric  
570 residential treatment facility, before the recipient reaches age  
571 twenty-one (21) or, if the recipient was receiving the services  
572 immediately before he or she reached age twenty-one (21), before  
573 the earlier of the date he or she no longer requires the services  
574 or the date he or she reaches age twenty-two (22), as provided by  
575 federal regulations. From and after January 1, 2015, the division  
576 shall update the fair rental reimbursement system for psychiatric  
577 residential treatment facilities. Precertification of inpatient  
578 days and residential treatment days must be obtained as required  
579 by the division. From and after July 1, 2009, all state-owned and  
580 state-operated facilities that provide inpatient psychiatric  
581 services to persons under age twenty-one (21) who are eligible for  
582 Medicaid reimbursement shall be reimbursed for those services on a  
583 full reasonable cost basis.

584           (24) [Deleted]

585           (25) [Deleted]

586           (26) Hospice care. As used in this paragraph, the term  
587 "hospice care" means a coordinated program of active professional  
588 medical attention within the home and outpatient and inpatient  
589 care that treats the terminally ill patient and family as a unit,



590 employing a medically directed interdisciplinary team. The  
591 program provides relief of severe pain or other physical symptoms  
592 and supportive care to meet the special needs arising out of  
593 physical, psychological, spiritual, social and economic stresses  
594 that are experienced during the final stages of illness and during  
595 dying and bereavement and meets the Medicare requirements for  
596 participation as a hospice as provided in federal regulations.

597 (27) Group health plan premiums and cost sharing if it  
598 is cost-effective as defined by the United States Secretary of  
599 Health and Human Services.

600 (28) Other health insurance premiums that are  
601 cost-effective as defined by the United States Secretary of Health  
602 and Human Services. Medicare eligible must have Medicare Part B  
603 before other insurance premiums can be paid.

604 (29) The Division of Medicaid may apply for a waiver  
605 from the United States Department of Health and Human Services for  
606 home- and community-based services for developmentally disabled  
607 people using state funds that are provided from the appropriation  
608 to the State Department of Mental Health and/or funds transferred  
609 to the department by a political subdivision or instrumentality of  
610 the state and used to match federal funds under a cooperative  
611 agreement between the division and the department, provided that  
612 funds for these services are specifically appropriated to the  
613 Department of Mental Health and/or transferred to the department  
614 by a political subdivision or instrumentality of the state.





615 (30) Pediatric skilled nursing services for eligible  
616 persons under twenty-one (21) years of age.

617 (31) Targeted case management services for children  
618 with special needs, under waivers from the United States  
619 Department of Health and Human Services, using state funds that  
620 are provided from the appropriation to the Mississippi Department  
621 of Human Services and used to match federal funds under a  
622 cooperative agreement between the division and the department.

623 (32) Care and services provided in Christian Science  
624 Sanatoria listed and certified by the Commission for Accreditation  
625 of Christian Science Nursing Organizations/Facilities, Inc.,  
626 rendered in connection with treatment by prayer or spiritual means  
627 to the extent that those services are subject to reimbursement  
628 under Section 1903 of the federal Social Security Act.

629 (33) Podiatrist services.

630 (34) Assisted living services as provided through  
631 home- and community-based services under Title XIX of the federal  
632 Social Security Act, as amended, subject to the availability of  
633 funds specifically appropriated for that purpose by the  
634 Legislature.

635 (35) Services and activities authorized in Sections  
636 43-27-101 and 43-27-103, using state funds that are provided from  
637 the appropriation to the Mississippi Department of Human Services  
638 and used to match federal funds under a cooperative agreement  
639 between the division and the department.



640 (36) Nonemergency transportation services for  
641 Medicaid-eligible persons, to be provided by the Division of  
642 Medicaid. The division may contract with additional entities to  
643 administer nonemergency transportation services as it deems  
644 necessary. All providers shall have a valid driver's license,  
645 vehicle inspection sticker, valid vehicle license tags and a  
646 standard liability insurance policy covering the vehicle. The  
647 division may pay providers a flat fee based on mileage tiers, or  
648 in the alternative, may reimburse on actual miles traveled. The  
649 division may apply to the Center for Medicare and Medicaid  
650 Services (CMS) for a waiver to draw federal matching funds for  
651 nonemergency transportation services as a covered service instead  
652 of an administrative cost. The PEER Committee shall conduct a  
653 performance evaluation of the nonemergency transportation program  
654 to evaluate the administration of the program and the providers of  
655 transportation services to determine the most cost-effective ways  
656 of providing nonemergency transportation services to the patients  
657 served under the program. The performance evaluation shall be  
658 completed and provided to the members of the Senate Public Health  
659 and Welfare Committee and the House Medicaid Committee not later  
660 than January 15, 2008.

661 (37) [Deleted]

662 (38) Chiropractic services. A chiropractor's manual  
663 manipulation of the spine to correct a subluxation, if x-ray  
664 demonstrates that a subluxation exists and if the subluxation has



665 resulted in a neuromusculoskeletal condition for which  
666 manipulation is appropriate treatment, and related spinal x-rays  
667 performed to document these conditions. Reimbursement for  
668 chiropractic services shall not exceed Seven Hundred Dollars  
669 (\$700.00) per year per beneficiary.

670 (39) Dually eligible Medicare/Medicaid beneficiaries.  
671 The division shall pay the Medicare deductible and coinsurance  
672 amounts for services available under Medicare, as determined by  
673 the division. From and after July 1, 2009, the division shall  
674 reimburse crossover claims for inpatient hospital services and  
675 crossover claims covered under Medicare Part B in the same manner  
676 that was in effect on January 1, 2008, unless specifically  
677 authorized by the Legislature to change this method.

678 (40) [Deleted]

679 (41) Services provided by the State Department of  
680 Rehabilitation Services for the care and rehabilitation of persons  
681 with spinal cord injuries or traumatic brain injuries, as allowed  
682 under waivers from the United States Department of Health and  
683 Human Services, using up to seventy-five percent (75%) of the  
684 funds that are appropriated to the Department of Rehabilitation  
685 Services from the Spinal Cord and Head Injury Trust Fund  
686 established under Section 37-33-261 and used to match federal  
687 funds under a cooperative agreement between the division and the  
688 department.



689           (42) Notwithstanding any other provision in this  
690 article to the contrary, the division may develop a population  
691 health management program for women and children health services  
692 through the age of one (1) year. This program is primarily for  
693 obstetrical care associated with low birth weight and preterm  
694 babies. The division may apply to the federal Centers for  
695 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or  
696 any other waivers that may enhance the program. In order to  
697 effect cost savings, the division may develop a revised payment  
698 methodology that may include at-risk capitated payments, and may  
699 require member participation in accordance with the terms and  
700 conditions of an approved federal waiver.

701           (43) The division shall provide reimbursement,  
702 according to a payment schedule developed by the division, for  
703 smoking cessation medications for pregnant women during their  
704 pregnancy and other Medicaid-eligible women who are of  
705 child-bearing age.

706           (44) Nursing facility services for the severely  
707 disabled.

708                   (a) Severe disabilities include, but are not  
709 limited to, spinal cord injuries, closed-head injuries and  
710 ventilator dependent patients.

711                   (b) Those services must be provided in a long-term  
712 care nursing facility dedicated to the care and treatment of  
713 persons with severe disabilities.



714           (45) Physician assistant services. Services furnished  
715 by a physician assistant who is licensed by the State Board of  
716 Medical Licensure and is practicing with physician supervision  
717 under regulations adopted by the board, under regulations adopted  
718 by the division. Reimbursement for those services shall not  
719 exceed ninety percent (90%) of the reimbursement rate for  
720 comparable services rendered by a physician. The division may  
721 provide for a reimbursement rate for physician assistant services  
722 of up to one hundred percent (100%) or the reimbursement rate for  
723 comparable services rendered by a physician for physician  
724 assistant services that are provided after the normal working  
725 hours of the physician assistant, as determined in accordance with  
726 regulations of the division.

727           (46) The division shall make application to the federal  
728 Centers for Medicare and Medicaid Services (CMS) for a waiver to  
729 develop and provide services for children with serious emotional  
730 disturbances as defined in Section 43-14-1(1), which may include  
731 home- and community-based services, case management services or  
732 managed care services through mental health providers certified by  
733 the Department of Mental Health. The division may implement and  
734 provide services under this waived program only if funds for  
735 these services are specifically appropriated for this purpose by  
736 the Legislature, or if funds are voluntarily provided by affected  
737 agencies.



738           (47) (a) Notwithstanding any other provision in this  
739 article to the contrary, the division may develop and implement  
740 disease management programs for individuals with high-cost chronic  
741 diseases and conditions, including the use of grants, waivers,  
742 demonstrations or other projects as necessary.

743           (b) Participation in any disease management  
744 program implemented under this paragraph (47) is optional with the  
745 individual. An individual must affirmatively elect to participate  
746 in the disease management program in order to participate, and may  
747 elect to discontinue participation in the program at any time.

748           (48) Pediatric long-term acute care hospital services.

749           (a) Pediatric long-term acute care hospital  
750 services means services provided to eligible persons under  
751 twenty-one (21) years of age by a freestanding Medicare-certified  
752 hospital that has an average length of inpatient stay greater than  
753 twenty-five (25) days and that is primarily engaged in providing  
754 chronic or long-term medical care to persons under twenty-one (21)  
755 years of age.

756           (b) The services under this paragraph (48) shall  
757 be reimbursed as a separate category of hospital services.

758           (49) The division shall establish copayments and/or  
759 coinsurance for all Medicaid services for which copayments and/or  
760 coinsurance are allowable under federal law or regulation, and  
761 shall set the amount of the copayment and/or coinsurance for each



762 of those services at the maximum amount allowable under federal  
763 law or regulation.

764 (50) Services provided by the State Department of  
765 Rehabilitation Services for the care and rehabilitation of persons  
766 who are deaf and blind, as allowed under waivers from the United  
767 States Department of Health and Human Services to provide  
768 home- and community-based services using state funds that are  
769 provided from the appropriation to the State Department of  
770 Rehabilitation Services or if funds are voluntarily provided by  
771 another agency.

772 (51) Upon determination of Medicaid eligibility and in  
773 association with annual redetermination of Medicaid eligibility,  
774 beneficiaries shall be encouraged to undertake a physical  
775 examination that will establish a base-line level of health and  
776 identification of a usual and customary source of care (a medical  
777 home) to aid utilization of disease management tools. This  
778 physical examination and utilization of these disease management  
779 tools shall be consistent with current United States Preventive  
780 Services Task Force or other recognized authority recommendations.

781 For persons who are determined ineligible for Medicaid, the  
782 division will provide information and direction for accessing  
783 medical care and services in the area of their residence.

784 (52) Notwithstanding any provisions of this article,  
785 the division may pay enhanced reimbursement fees related to trauma  
786 care, as determined by the division in conjunction with the State



787 Department of Health, using funds appropriated to the State  
788 Department of Health for trauma care and services and used to  
789 match federal funds under a cooperative agreement between the  
790 division and the State Department of Health. The division, in  
791 conjunction with the State Department of Health, may use grants,  
792 waivers, demonstrations, or other projects as necessary in the  
793 development and implementation of this reimbursement program.

794 (53) Targeted case management services for high-cost  
795 beneficiaries shall be developed by the division for all services  
796 under this section.

797 (54) Adult foster care services pilot program. Social  
798 and protective services on a pilot program basis in an approved  
799 foster care facility for vulnerable adults who would otherwise  
800 need care in a long-term care facility, to be implemented in an  
801 area of the state with the greatest need for such program, under  
802 the Medicaid Waivers for the Elderly and Disabled program or an  
803 assisted living waiver. The division may use grants, waivers,  
804 demonstrations or other projects as necessary in the development  
805 and implementation of this adult foster care services pilot  
806 program.

807 (55) Therapy services. The plan of care for therapy  
808 services may be developed to cover a period of treatment for up to  
809 six (6) months, but in no event shall the plan of care exceed a  
810 six-month period of treatment. The projected period of treatment  
811 must be indicated on the initial plan of care and must be updated





812 with each subsequent revised plan of care. Based on medical  
813 necessity, the division shall approve certification periods for  
814 less than or up to six (6) months, but in no event shall the  
815 certification period exceed the period of treatment indicated on  
816 the plan of care. The appeal process for any reduction in therapy  
817 services shall be consistent with the appeal process in federal  
818 regulations.

819 (56) Prescribed pediatric extended care centers  
820 services for medically dependent or technologically dependent  
821 children with complex medical conditions that require continual  
822 care as prescribed by the child's attending physician, as  
823 determined by the division.

824 (57) No Medicaid benefit shall restrict coverage for  
825 medically appropriate treatment prescribed by a physician and  
826 agreed to by a fully informed individual, or if the individual  
827 lacks legal capacity to consent by a person who has legal  
828 authority to consent on his or her behalf, based on an  
829 individual's diagnosis with a terminal condition. As used in this  
830 paragraph (57), "terminal condition" means any aggressive  
831 malignancy, chronic end-stage cardiovascular or cerebral vascular  
832 disease, or any other disease, illness or condition which a  
833 physician diagnoses as terminal.

834 (B) Notwithstanding any other provision of this article to  
835 the contrary, the division shall reduce the rate of reimbursement  
836 to providers for any service provided under this section by five



837 percent (5%) of the allowed amount for that service. However, the  
838 reduction in the reimbursement rates required by this subsection  
839 (B) shall not apply to inpatient hospital services, nursing  
840 facility services, intermediate care facility services,  
841 psychiatric residential treatment facility services, pharmacy  
842 services provided under subsection (A)(9) of this section, or any  
843 service provided by the University of Mississippi Medical Center  
844 or a state agency, a state facility or a public agency that either  
845 provides its own state match through intergovernmental transfer or  
846 certification of funds to the division, or a service for which the  
847 federal government sets the reimbursement methodology and rate.  
848 From and after January 1, 2010, the reduction in the reimbursement  
849 rates required by this subsection (B) shall not apply to  
850 physicians' services. In addition, the reduction in the  
851 reimbursement rates required by this subsection (B) shall not  
852 apply to case management services and home-delivered meals  
853 provided under the home- and community-based services program for  
854 the elderly and disabled by a planning and development district  
855 (PDD). Planning and development districts participating in the  
856 home- and community-based services program for the elderly and  
857 disabled as case management providers shall be reimbursed for case  
858 management services at the maximum rate approved by the Centers  
859 for Medicare and Medicaid Services (CMS).

860 (C) The division may pay to those providers who participate  
861 in and accept patient referrals from the division's emergency room



862 redirection program a percentage, as determined by the division,  
863 of savings achieved according to the performance measures and  
864 reduction of costs required of that program. Federally qualified  
865 health centers may participate in the emergency room redirection  
866 program, and the division may pay those centers a percentage of  
867 any savings to the Medicaid program achieved by the centers'  
868 accepting patient referrals through the program, as provided in  
869 this subsection (C).

870 (D) Notwithstanding any provision of this article, except as  
871 authorized in the following subsection and in Section 43-13-139,  
872 neither (a) the limitations on quantity or frequency of use of or  
873 the fees or charges for any of the care or services available to  
874 recipients under this section, nor (b) the payments, payment  
875 methodology as provided below in this subsection (D), or rates of  
876 reimbursement to providers rendering care or services authorized  
877 under this section to recipients, may be increased, decreased or  
878 otherwise changed from the levels in effect on July 1, 1999,  
879 unless they are authorized by an amendment to this section by the  
880 Legislature. However, the restriction in this subsection shall  
881 not prevent the division from changing the payments, payment  
882 methodology as provided below in this subsection (D), or rates of  
883 reimbursement to providers without an amendment to this section  
884 whenever those changes are required by federal law or regulation,  
885 or whenever those changes are necessary to correct administrative  
886 errors or omissions in calculating those payments or rates of



887 reimbursement. The prohibition on any changes in payment  
888 methodology provided in this subsection (D) shall apply only to  
889 payment methodologies used for determining the rates of  
890 reimbursement for inpatient hospital services, outpatient hospital  
891 services, nursing facility services, and/or pharmacy services,  
892 except as required by federal law, and the federally mandated  
893 rebasing of rates as required by the Centers for Medicare and  
894 Medicaid Services (CMS) shall not be considered payment  
895 methodology for purposes of this subsection (D). No service  
896 benefits or reimbursement limitations in this section shall apply  
897 to payments under an APR-DRG or APC model or a managed care  
898 program or similar model described in subsection (H) of this  
899 section.

900 (E) Notwithstanding any provision of this article, no new  
901 groups or categories of recipients and new types of care and  
902 services may be added without enabling legislation from the  
903 Mississippi Legislature, except that the division may authorize  
904 those changes without enabling legislation when the addition of  
905 recipients or services is ordered by a court of proper authority.

906 (F) The executive director shall keep the Governor advised  
907 on a timely basis of the funds available for expenditure and the  
908 projected expenditures. If current or projected expenditures of  
909 the division are reasonably anticipated to exceed the amount of  
910 funds appropriated to the division for any fiscal year, the  
911 Governor, after consultation with the executive director, shall



912 discontinue any or all of the payment of the types of care and  
913 services as provided in this section that are deemed to be  
914 optional services under Title XIX of the federal Social Security  
915 Act, as amended, and when necessary, shall institute any other  
916 cost containment measures on any program or programs authorized  
917 under the article to the extent allowed under the federal law  
918 governing that program or programs. However, the Governor shall  
919 not be authorized to discontinue or eliminate any service under  
920 this section that is mandatory under federal law, or to  
921 discontinue or eliminate, or adjust income limits or resource  
922 limits for, any eligibility category or group under Section  
923 43-13-115. Beginning in fiscal year 2010 and in fiscal years  
924 thereafter, when Medicaid expenditures are projected to exceed  
925 funds available for any quarter in the fiscal year, the division  
926 shall submit the expected shortfall information to the PEER  
927 Committee, which shall review the computations of the division and  
928 report its findings to the Legislative Budget Office within thirty  
929 (30) days of such notification by the division, and not later than  
930 January 7 in any year. If expenditure reductions or cost  
931 containments are implemented, the Governor may implement a maximum  
932 amount of state share expenditure reductions to providers, of  
933 which hospitals will be responsible for twenty-five percent (25%)  
934 of provider reductions as follows: in fiscal year 2010, the  
935 maximum amount shall be Twenty-four Million Dollars  
936 (\$24,000,000.00); in fiscal year 2011, the maximum amount shall be



937 Thirty-two Million Dollars (\$32,000,000.00); and in fiscal year  
938 2012 and thereafter, the maximum amount shall be Forty Million  
939 Dollars (\$40,000,000.00). However, instead of implementing cuts,  
940 the hospital share shall be in the form of an additional  
941 assessment not to exceed Ten Million Dollars (\$10,000,000.00) as  
942 provided in Section 43-13-145(4)(a)(ii). If Medicaid expenditures  
943 are projected to exceed the amount of funds appropriated to the  
944 division in any fiscal year in excess of the expenditure  
945 reductions to providers, then funds shall be transferred by the  
946 State Fiscal Officer from the Health Care Trust Fund into the  
947 Health Care Expendable Fund and to the Governor's Office, Division  
948 of Medicaid, from the Health Care Expendable Fund, in the amount  
949 and at such time as requested by the Governor to reconcile the  
950 deficit. If the cost containment measures described above have  
951 been implemented and there are insufficient funds in the Health  
952 Care Trust Fund to reconcile any remaining deficit in any fiscal  
953 year, the Governor shall institute any other additional cost  
954 containment measures on any program or programs authorized under  
955 this article to the extent allowed under federal law. Hospitals  
956 shall be responsible for twenty-five percent (25%) of any  
957 additional imposed provider cuts. However, instead of  
958 implementing hospital expenditure reductions, the hospital  
959 reductions shall be in the form of an additional assessment not to  
960 exceed twenty-five percent (25%) of provider expenditure  
961 reductions as provided in Section 43-13-145(4)(a)(ii). It is the



962 intent of the Legislature that the expenditures of the division  
963 during any fiscal year shall not exceed the amounts appropriated  
964 to the division for that fiscal year.

965 (G) Notwithstanding any other provision of this article, it  
966 shall be the duty of each nursing facility, intermediate care  
967 facility for \* \* \* individuals with intellectual disabilities,  
968 psychiatric residential treatment facility, and nursing facility  
969 for the severely disabled that is participating in the Medicaid  
970 program to keep and maintain books, documents and other records as  
971 prescribed by the Division of Medicaid in substantiation of its  
972 cost reports for a period of three (3) years after the date of  
973 submission to the Division of Medicaid of an original cost report,  
974 or three (3) years after the date of submission to the Division of  
975 Medicaid of an amended cost report.

976 (H) (1) Notwithstanding any other provision of this  
977 article, the division is authorized to implement (a) a managed  
978 care program, (b) a coordinated care program, (c) a coordinated  
979 care organization program, (d) a health maintenance organization  
980 program, (e) a patient-centered medical home program, (f) an  
981 accountable care organization program, or (g) any combination of  
982 the above programs. Managed care programs, coordinated care  
983 programs, coordinated care organization programs, health  
984 maintenance organization programs, patient-centered medical home  
985 programs, \* \* \* accountable care organization programs, or \* \* \*  
986 any combination of the above programs or other similar programs



987 implemented by the division under this section shall be limited  
988 to \* \* \* the greater of (i) forty-five percent (45%) of the total  
989 enrollment of \* \* \* Medicaid beneficiaries, or (ii) the categories  
990 of beneficiaries participating in the program as of January 1,  
991 2014, plus the categories of beneficiaries composed primarily of  
992 persons younger than nineteen (19) years of age, and the division  
993 is authorized to enroll categories of beneficiaries in such  
994 program(s) as long as the \* \* \* appropriate limitations \* \* \* are  
995 not exceeded in the aggregate. As a condition for the approval of  
996 any program under this paragraph (H) (1), the division shall  
997 require that no program may:

998 (a) Pay providers at a rate that is less than the  
999 Medicaid All-Patient Refined-Diagnosis Related Groups (APR-DRG)  
1000 reimbursement rate;

1001 (b) Override the medical decisions of hospital  
1002 physicians or staff regarding patients admitted to a hospital.  
1003 This restriction (b) does not prohibit prior authorization for  
1004 nonemergency hospital visitation;

1005 (c) Result in any reduction in Medicare Upper  
1006 Payment Limits (UPL) payments to hospital providers in the  
1007 aggregate because of the program;

1008 (d) Pay providers at a rate that is less than the  
1009 normal Medicaid reimbursement rate;

1010 (e) Implement a prior authorization program for  
1011 prescription drugs that is more stringent than the prior





1012 authorization processes used by the division in its administration  
1013 of the Medicaid program;

1014 (f) Implement a policy that does not comply with  
1015 the prescription drugs payment requirements established in  
1016 subsection (A) (9) of this section;

1017 (g) Implement a preferred drug list that is more  
1018 stringent than the mandatory preferred drug list established by  
1019 the division under subsection (A) (9) of this section;

1020 (h) Implement a policy which denies beneficiaries  
1021 with hemophilia access to the federally funded hemophilia  
1022 treatment centers as part of the Medicaid Managed Care network of  
1023 providers. All Medicaid beneficiaries with hemophilia shall  
1024 receive unrestricted access to anti-hemophilia factor products  
1025 through noncapitated reimbursement programs.

1026 (2) No later than December 31, 2015, the division shall  
1027 develop and submit to the Senate Public Health Committee and the  
1028 House Medicaid Committee a proposed plan outlining the advantages  
1029 and disadvantages of inpatient hospital services being included in  
1030 a managed care program, including any effect on UPL payments to  
1031 hospitals and ways to offset any reductions that might occur as a  
1032 result of changes to the program.

1033 (3) Any contractors providing direct patient care under  
1034 a managed care program established in this section shall provide  
1035 to the Legislature and the division statistical data to be shared



1036 with provider groups in order to improve patient access,  
1037 appropriate utilization, cost savings and health outcomes.

1038 ( \* \* \*4) All health maintenance organizations,  
1039 coordinated care organizations or other organizations paid for  
1040 services on a capitated basis by the division under any managed  
1041 care program or coordinated care program implemented by the  
1042 division under this section shall reimburse all providers in those  
1043 organizations at rates no lower than those provided under this  
1044 section for beneficiaries who are not participating in those  
1045 programs.

1046 ( \* \* \*5) No health maintenance organization,  
1047 coordinated care organization or other organization paid for  
1048 services on a capitated basis by the division under any managed  
1049 care program or coordinated care program implemented by the  
1050 division under this section shall require its providers or  
1051 beneficiaries to use any pharmacy that ships, mails or delivers  
1052 prescription drugs or legend drugs or devices.

1053 (I) [Deleted]

1054 (J) There shall be no cuts in inpatient and outpatient  
1055 hospital payments, or allowable days or volumes, as long as the  
1056 hospital assessment provided in Section 43-13-145 is in effect.  
1057 This subsection (J) shall not apply to decreases in payments that  
1058 are a result of: reduced hospital admissions, audits or payments  
1059 under the APR-DRG or APC models, or a managed care program or  
1060 similar model described in subsection (G) of this section.



1061 (K) This section shall stand repealed on July 1, \* \* \* 2016.

1062 **SECTION 2.** Section 43-13-119, Mississippi Code of 1972, is  
1063 amended as follows:

1064 43-13-119. (1) The Division of Medicaid shall immediately  
1065 design and implement a temporary program to provide nonemergency  
1066 transportation to locations for necessary dialysis services for  
1067 end stage renal disease patients who are sixty-five (65) years of  
1068 age or older or are disabled as determined under Section  
1069 1614(a)(3) of the federal Social Security Act, as amended, whose  
1070 income did not exceed one hundred thirty-five percent (135%) of  
1071 the nonfarm official poverty level as defined by the Office of  
1072 Management and Budget, and whose resources did not exceed those  
1073 established by the division as of December 31, 2005, whose  
1074 eligibility was covered under the former category of eligibility  
1075 known as PLADs (Poverty Level Aged and Disabled).

1076 (2) The transportation services under the program shall be  
1077 provided by any reasonable provider, which may include (a) public  
1078 entities or (b) private entities and individuals who are in the  
1079 business of providing nonemergency transportation, including  
1080 faith-based organizations, and the division shall reimburse those  
1081 entities and individuals or faith-based organizations for  
1082 providing the transportation services in accordance with a  
1083 mutually agreed upon reimbursement schedule.

1084 (3) The program shall be funded from monies that are  
1085 appropriated or otherwise made available to the division. The



1086 funds shall be appropriated to the division specifically to cover  
1087 the cost of this program and shall not be a part of the division's  
1088 regular appropriation for the operation of the federal-state  
1089 Medicaid program.

1090 (4) The program is a separate program that is not part of or  
1091 connected to the Medicaid program, and the relationship of the  
1092 division to the program is only as the administering agent.

1093 (5) This section shall stand repealed on \* \* \* July 1, 2016.

1094 **SECTION 3.** Section 43-13-121, Mississippi Code of 1972, is  
1095 amended as follows:

1096 43-13-121. (1) The division shall administer the Medicaid  
1097 program under the provisions of this article, and may do the  
1098 following:

1099 (a) Adopt and promulgate reasonable rules, regulations  
1100 and standards, with approval of the Governor, and in accordance  
1101 with the Administrative Procedures Law, Section 25-43-1 et seq.:

1102 (i) Establishing methods and procedures as may be  
1103 necessary for the proper and efficient administration of this  
1104 article;

1105 (ii) Providing Medicaid to all qualified  
1106 recipients under the provisions of this article as the division  
1107 may determine and within the limits of appropriated funds;

1108 (iii) Establishing reasonable fees, charges and  
1109 rates for medical services and drugs; in doing so, the division  
1110 shall fix all of those fees, charges and rates at the minimum



1111 levels absolutely necessary to provide the medical assistance  
1112 authorized by this article, and shall not change any of those  
1113 fees, charges or rates except as may be authorized in Section  
1114 43-13-117;

1115 (iv) Providing for fair and impartial hearings;

1116 (v) Providing safeguards for preserving the  
1117 confidentiality of records; and

1118 (vi) For detecting and processing fraudulent  
1119 practices and abuses of the program;

1120 (b) Receive and expend state, federal and other funds  
1121 in accordance with court judgments or settlements and agreements  
1122 between the State of Mississippi and the federal government, the  
1123 rules and regulations promulgated by the division, with the  
1124 approval of the Governor, and within the limitations and  
1125 restrictions of this article and within the limits of funds  
1126 available for that purpose;

1127 (c) Subject to the limits imposed by this article, to  
1128 submit a Medicaid plan to the United States Department of Health  
1129 and Human Services for approval under the provisions of the  
1130 federal Social Security Act, to act for the state in making  
1131 negotiations relative to the submission and approval of that plan,  
1132 to make such arrangements, not inconsistent with the law, as may  
1133 be required by or under federal law to obtain and retain that  
1134 approval and to secure for the state the benefits of the  
1135 provisions of that law.



1136 No agreements, specifically including the general plan for  
1137 the operation of the Medicaid program in this state, shall be made  
1138 by and between the division and the United States Department of  
1139 Health and Human Services unless the Attorney General of the State  
1140 of Mississippi has reviewed the agreements, specifically including  
1141 the operational plan, and has certified in writing to the Governor  
1142 and to the executive director of the division that the agreements,  
1143 including the plan of operation, have been drawn strictly in  
1144 accordance with the terms and requirements of this article;

1145 (d) In accordance with the purposes and intent of this  
1146 article and in compliance with its provisions, provide for aged  
1147 persons otherwise eligible for the benefits provided under Title  
1148 XVIII of the federal Social Security Act by expenditure of funds  
1149 available for those purposes;

1150 (e) To make reports to the United States Department of  
1151 Health and Human Services as from time to time may be required by  
1152 that federal department and to the Mississippi Legislature as  
1153 provided in this section;

1154 (f) Define and determine the scope, duration and amount  
1155 of Medicaid that may be provided in accordance with this article  
1156 and establish priorities therefor in conformity with this article;

1157 (g) Cooperate and contract with other state agencies  
1158 for the purpose of coordinating Medicaid provided under this  
1159 article and eliminating duplication and inefficiency in the  
1160 Medicaid program;



1161 (h) Adopt and use an official seal of the division;

1162 (i) Sue in its own name on behalf of the State of  
1163 Mississippi and employ legal counsel on a contingency basis with  
1164 the approval of the Attorney General;

1165 (j) To recover any and all payments incorrectly made by  
1166 the division to a recipient or provider from the recipient or  
1167 provider receiving the payments. The division shall be authorized  
1168 to collect any overpayments to providers thirty (30) days after  
1169 the conclusion of any administrative appeal unless the matter is  
1170 appealed to a court of proper jurisdiction and bond is posted.

1171 Any appeal filed after July 1, 2014, shall be to the Chancery  
1172 Court of Hinds County, Mississippi. To recover those payments,  
1173 the division may use the following methods, in addition to any  
1174 other methods available to the division:

1175 (i) The division shall report to the Department of  
1176 Revenue the name of any current or former Medicaid recipient who  
1177 has received medical services rendered during a period of  
1178 established Medicaid ineligibility and who has not reimbursed the  
1179 division for the related medical service payment(s). The  
1180 Department of Revenue shall withhold from the state tax refund of  
1181 the individual, and pay to the division, the amount of the  
1182 payment(s) for medical services rendered to the ineligible  
1183 individual that have not been reimbursed to the division for the  
1184 related medical service payment(s).



1185                   (ii) The division shall report to the Department  
1186 of Revenue the name of any Medicaid provider to whom payments were  
1187 incorrectly made that the division has not been able to recover by  
1188 other methods available to the division. The Department of  
1189 Revenue shall withhold from the state tax refund of the provider,  
1190 and pay to the division, the amount of the payments that were  
1191 incorrectly made to the provider that have not been recovered by  
1192 other available methods;

1193                   (k) To recover any and all payments by the division  
1194 fraudulently obtained by a recipient or provider. Additionally,  
1195 if recovery of any payments fraudulently obtained by a recipient  
1196 or provider is made in any court, then, upon motion of the  
1197 Governor, the judge of the court may award twice the payments  
1198 recovered as damages;

1199                   (l) Have full, complete and plenary power and authority  
1200 to conduct such investigations as it may deem necessary and  
1201 requisite of alleged or suspected violations or abuses of the  
1202 provisions of this article or of the regulations adopted under  
1203 this article, including, but not limited to, fraudulent or  
1204 unlawful act or deed by applicants for Medicaid or other benefits,  
1205 or payments made to any person, firm or corporation under the  
1206 terms, conditions and authority of this article, to suspend or  
1207 disqualify any provider of services, applicant or recipient for  
1208 gross abuse, fraudulent or unlawful acts for such periods,  
1209 including permanently, and under such conditions as the division





1210 deems proper and just, including the imposition of a legal rate of  
1211 interest on the amount improperly or incorrectly paid. Recipients  
1212 who are found to have misused or abused Medicaid benefits may be  
1213 locked into one (1) physician and/or one (1) pharmacy of the  
1214 recipient's choice for a reasonable amount of time in order to  
1215 educate and promote appropriate use of medical services, in  
1216 accordance with federal regulations. If an administrative hearing  
1217 becomes necessary, the division may, if the provider does not  
1218 succeed in his or her defense, tax the costs of the administrative  
1219 hearing, including the costs of the court reporter or stenographer  
1220 and transcript, to the provider. The convictions of a recipient  
1221 or a provider in a state or federal court for abuse, fraudulent or  
1222 unlawful acts under this chapter shall constitute an automatic  
1223 disqualification of the recipient or automatic disqualification of  
1224 the provider from participation under the Medicaid program.

1225 A conviction, for the purposes of this chapter, shall include  
1226 a judgment entered on a plea of nolo contendere or a  
1227 nonadjudicated guilty plea and shall have the same force as a  
1228 judgment entered pursuant to a guilty plea or a conviction  
1229 following trial. A certified copy of the judgment of the court of  
1230 competent jurisdiction of the conviction shall constitute prima  
1231 facie evidence of the conviction for disqualification purposes;

1232 (m) Establish and provide such methods of  
1233 administration as may be necessary for the proper and efficient  
1234 operation of the Medicaid program, fully utilizing computer



1235 equipment as may be necessary to oversee and control all current  
1236 expenditures for purposes of this article, and to closely monitor  
1237 and supervise all recipient payments and vendors rendering  
1238 services under this article. Notwithstanding any other provision  
1239 of state law, the division is authorized to enter into a ten-year  
1240 contract(s) with a vendor(s) to provide services described in this  
1241 paragraph (m). Effective July 1, 2014, and notwithstanding any  
1242 provision of law to the contrary, the division is authorized to  
1243 extend its Fiscal Agent and Eligibility Determination System  
1244 contracts expiring on July 1, 2014, for a period not to exceed  
1245 three (3) years without complying with the requirements provided  
1246 in Section 25-9-120 and the Personal Service Contract Review Board  
1247 procurement regulations;

1248 (n) To cooperate and contract with the federal  
1249 government for the purpose of providing Medicaid to Vietnamese and  
1250 Cambodian refugees, under the provisions of Public Law 94-23 and  
1251 Public Law 94-24, including any amendments to those laws, only to  
1252 the extent that the Medicaid assistance and the administrative  
1253 cost related thereto are one hundred percent (100%) reimbursable  
1254 by the federal government. For the purposes of Section 43-13-117,  
1255 persons receiving Medicaid under Public Law 94-23 and Public Law  
1256 94-24, including any amendments to those laws, shall not be  
1257 considered a new group or category of recipient; and

1258 (o) The division shall impose penalties upon Medicaid  
1259 only, Title XIX participating long-term care facilities found to



1260 be in noncompliance with division and certification standards in  
1261 accordance with federal and state regulations, including interest  
1262 at the same rate calculated by the United States Department of  
1263 Health and Human Services and/or the Centers for Medicare and  
1264 Medicaid Services (CMS) under federal regulations.

1265 (2) The division also shall exercise such additional powers  
1266 and perform such other duties as may be conferred upon the  
1267 division by act of the Legislature.

1268 (3) The division, and the State Department of Health as the  
1269 agency for licensure of health care facilities and certification  
1270 and inspection for the Medicaid and/or Medicare programs, shall  
1271 contract for or otherwise provide for the consolidation of on-site  
1272 inspections of health care facilities that are necessitated by the  
1273 respective programs and functions of the division and the  
1274 department.

1275 (4) The division and its hearing officers shall have power  
1276 to preserve and enforce order during hearings; to issue subpoenas  
1277 for, to administer oaths to and to compel the attendance and  
1278 testimony of witnesses, or the production of books, papers,  
1279 documents and other evidence, or the taking of depositions before  
1280 any designated individual competent to administer oaths; to  
1281 examine witnesses; and to do all things conformable to law that  
1282 may be necessary to enable them effectively to discharge the  
1283 duties of their office. In compelling the attendance and  
1284 testimony of witnesses, or the production of books, papers,



1285 documents and other evidence, or the taking of depositions, as  
1286 authorized by this section, the division or its hearing officers  
1287 may designate an individual employed by the division or some other  
1288 suitable person to execute and return that process, whose action  
1289 in executing and returning that process shall be as lawful as if  
1290 done by the sheriff or some other proper officer authorized to  
1291 execute and return process in the county where the witness may  
1292 reside. In carrying out the investigatory powers under the  
1293 provisions of this article, the executive director or other  
1294 designated person or persons may examine, obtain, copy or  
1295 reproduce the books, papers, documents, medical charts,  
1296 prescriptions and other records relating to medical care and  
1297 services furnished by the provider to a recipient or designated  
1298 recipients of Medicaid services under investigation. In the  
1299 absence of the voluntary submission of the books, papers,  
1300 documents, medical charts, prescriptions and other records, the  
1301 Governor, the executive director, or other designated person may  
1302 issue and serve subpoenas instantly upon the provider, his or her  
1303 agent, servant or employee for the production of the books,  
1304 papers, documents, medical charts, prescriptions or other records  
1305 during an audit or investigation of the provider. If any provider  
1306 or his or her agent, servant or employee refuses to produce the  
1307 records after being duly subpoenaed, the executive director may  
1308 certify those facts and institute contempt proceedings in the  
1309 manner, time and place as authorized by law for administrative



1310 proceedings. As an additional remedy, the division may recover  
1311 all amounts paid to the provider covering the period of the audit  
1312 or investigation, inclusive of a legal rate of interest and a  
1313 reasonable attorney's fee and costs of court if suit becomes  
1314 necessary. Division staff shall have immediate access to the  
1315 provider's physical location, facilities, records, documents,  
1316 books, and any other records relating to medical care and services  
1317 rendered to recipients during regular business hours.

1318 (5) If any person in proceedings before the division  
1319 disobeys or resists any lawful order or process, or misbehaves  
1320 during a hearing or so near the place thereof as to obstruct the  
1321 hearing, or neglects to produce, after having been ordered to do  
1322 so, any pertinent book, paper or document, or refuses to appear  
1323 after having been subpoenaed, or upon appearing refuses to take  
1324 the oath as a witness, or after having taken the oath refuses to  
1325 be examined according to law, the executive director shall certify  
1326 the facts to any court having jurisdiction in the place in which  
1327 it is sitting, and the court shall thereupon, in a summary manner,  
1328 hear the evidence as to the acts complained of, and if the  
1329 evidence so warrants, punish that person in the same manner and to  
1330 the same extent as for a contempt committed before the court, or  
1331 commit that person upon the same condition as if the doing of the  
1332 forbidden act had occurred with reference to the process of, or in  
1333 the presence of, the court.



1334           (6) In suspending or terminating any provider from  
1335 participation in the Medicaid program, the division shall preclude  
1336 the provider from submitting claims for payment, either personally  
1337 or through any clinic, group, corporation or other association to  
1338 the division or its fiscal agents for any services or supplies  
1339 provided under the Medicaid program except for those services or  
1340 supplies provided before the suspension or termination. No  
1341 clinic, group, corporation or other association that is a provider  
1342 of services shall submit claims for payment to the division or its  
1343 fiscal agents for any services or supplies provided by a person  
1344 within that organization who has been suspended or terminated from  
1345 participation in the Medicaid program except for those services or  
1346 supplies provided before the suspension or termination. When this  
1347 provision is violated by a provider of services that is a clinic,  
1348 group, corporation or other association, the division may suspend  
1349 or terminate that organization from participation. Suspension may  
1350 be applied by the division to all known affiliates of a provider,  
1351 provided that each decision to include an affiliate is made on a  
1352 case-by-case basis after giving due regard to all relevant facts  
1353 and circumstances. The violation, failure or inadequacy of  
1354 performance may be imputed to a person with whom the provider is  
1355 affiliated where that conduct was accomplished within the course  
1356 of his or her official duty or was effectuated by him or her with  
1357 the knowledge or approval of that person.



1358           (7) The division may deny or revoke enrollment in the  
1359 Medicaid program to a provider if any of the following are found  
1360 to be applicable to the provider, his or her agent, a managing  
1361 employee or any person having an ownership interest equal to five  
1362 percent (5%) or greater in the provider:

1363           (a) Failure to truthfully or fully disclose any and all  
1364 information required, or the concealment of any and all  
1365 information required, on a claim, a provider application or a  
1366 provider agreement, or the making of a false or misleading  
1367 statement to the division relative to the Medicaid program.

1368           (b) Previous or current exclusion, suspension,  
1369 termination from or the involuntary withdrawing from participation  
1370 in the Medicaid program, any other state's Medicaid program,  
1371 Medicare or any other public or private health or health insurance  
1372 program. If the division ascertains that a provider has been  
1373 convicted of a felony under federal or state law for an offense  
1374 that the division determines is detrimental to the best interest  
1375 of the program or of Medicaid beneficiaries, the division may  
1376 refuse to enter into an agreement with that provider, or may  
1377 terminate or refuse to renew an existing agreement.

1378           (c) Conviction under federal or state law of a criminal  
1379 offense relating to the delivery of any goods, services or  
1380 supplies, including the performance of management or  
1381 administrative services relating to the delivery of the goods,  
1382 services or supplies, under the Medicaid program, any other



1383 state's Medicaid program, Medicare or any other public or private  
1384 health or health insurance program.

1385 (d) Conviction under federal or state law of a criminal  
1386 offense relating to the neglect or abuse of a patient in  
1387 connection with the delivery of any goods, services or supplies.

1388 (e) Conviction under federal or state law of a criminal  
1389 offense relating to the unlawful manufacture, distribution,  
1390 prescription or dispensing of a controlled substance.

1391 (f) Conviction under federal or state law of a criminal  
1392 offense relating to fraud, theft, embezzlement, breach of  
1393 fiduciary responsibility or other financial misconduct.

1394 (g) Conviction under federal or state law of a criminal  
1395 offense punishable by imprisonment of a year or more that involves  
1396 moral turpitude, or acts against the elderly, children or infirm.

1397 (h) Conviction under federal or state law of a criminal  
1398 offense in connection with the interference or obstruction of any  
1399 investigation into any criminal offense listed in paragraphs (c)  
1400 through (i) of this subsection.

1401 (i) Sanction for a violation of federal or state laws  
1402 or rules relative to the Medicaid program, any other state's  
1403 Medicaid program, Medicare or any other public health care or  
1404 health insurance program.

1405 (j) Revocation of license or certification.





1406 (k) Failure to pay recovery properly assessed or  
1407 pursuant to an approved repayment schedule under the Medicaid  
1408 program.

1409 (l) Failure to meet any condition of enrollment.

1410 **SECTION 4.** Section 43-13-125, Mississippi Code of 1972, is  
1411 amended as follows:

1412 43-13-125. (1) If Medicaid is provided to a recipient under  
1413 this article for injuries, disease or sickness caused under  
1414 circumstances creating a cause of action in favor of the recipient  
1415 against any person, firm \* \* \*, corporation, political subdivision  
1416 or other state agency, then the division shall be entitled to  
1417 recover the proceeds that may result from the exercise of any  
1418 rights of recovery that the recipient may have against any such  
1419 person, firm \* \* \*, corporation, political subdivision or other  
1420 state agency, to the extent of the Division of Medicaid's interest  
1421 on behalf of the recipient. The recipient shall execute and  
1422 deliver instruments and papers to do whatever is necessary to  
1423 secure those rights and shall do nothing after Medicaid is  
1424 provided to prejudice the subrogation rights of the division.  
1425 Court orders or agreements for reimbursement of Medicaid's  
1426 interest shall direct those payments to the Division of Medicaid,  
1427 which shall be authorized to endorse any and all, including, but  
1428 not limited to, multipayee checks, drafts, money orders, or other  
1429 negotiable instruments representing Medicaid payment recoveries  
1430 that are received. In accordance with Section 43-13-305,



1431 endorsement of multipayee checks, drafts, money orders or other  
1432 negotiable instruments by the Division of Medicaid shall be deemed  
1433 endorsed by the recipient. All payments must be remitted to the  
1434 division within sixty (60) days from the date of a settlement or  
1435 the entry of a final judgment; failure to do so hereby authorizes  
1436 the division to assert its rights under Sections 43-13-307 and  
1437 43-13-315, plus interest.

1438 The division, with the approval of the Governor, may  
1439 compromise or settle any such claim and execute a release of any  
1440 claim it has by virtue of this section at the division's sole  
1441 discretion. Nothing in this section shall be construed to require  
1442 the Division of Medicaid to compromise any such claim.

1443 (2) The acceptance of Medicaid under this article or the  
1444 making of a claim under this article shall not affect the right of  
1445 a recipient or his or her legal representative to recover  
1446 Medicaid's interest as an element of damages in any action at law;  
1447 however, a copy of the pleadings shall be certified to the  
1448 division at the time of the institution of suit, and proof of  
1449 that notice shall be filed of record in that action. The division  
1450 may, at any time before the trial on the facts, join in that  
1451 action or may intervene in that action. Any amount recovered by a  
1452 recipient or his or her legal representative shall be applied as  
1453 follows:

1454 (a) The reasonable costs of the collection, including  
1455 attorney's fees, as approved and allowed by the court in which



1456 that action is pending, or in case of settlement without suit, by  
1457 the legal representative of the division;

1458 (b) The amount of Medicaid's interest on behalf of the  
1459 recipient; or such \* \* \* amount as may be arrived at by the legal  
1460 representative of the division and the recipient's attorney \* \* \*;  
1461 and

1462 (c) Any excess shall be awarded to the recipient.

1463 (3) No compromise of any claim by the recipient or his or  
1464 her legal representative shall be binding upon or affect the  
1465 rights of the division against the third party unless the  
1466 division, with the approval of the Governor, has entered into the  
1467 compromise in writing. The recipient or his or her legal  
1468 representative maintain the absolute duty to notify the division  
1469 of the institution of legal proceedings, and the third party and  
1470 his or her insurer maintain the absolute duty to notify the  
1471 division of a proposed compromise for which the division has an  
1472 interest. The aforementioned absolute duties may not be delegated  
1473 or assigned by contract or otherwise. Any compromise effected by  
1474 the recipient or his or her legal representative with the third  
1475 party in the absence of advance notification to and approved by  
1476 the division shall constitute conclusive evidence of the liability  
1477 of the third party, and the division, in litigating its claim  
1478 against the third party, shall be required only to prove the  
1479 amount and correctness of its claim relating to the injury,  
1480 disease or sickness. If the recipient or his or her legal



1481 representative fails to notify the division of the institution of  
1482 legal proceedings against a third party for which the division has  
1483 a cause of action, the facts relating to negligence and the  
1484 liability of the third party, if judgment is rendered for the  
1485 recipient, shall constitute conclusive evidence of liability in a  
1486 subsequent action maintained by the division and only the amount  
1487 and correctness of the division's claim relating to injuries,  
1488 disease or sickness shall be tried before the court. The division  
1489 shall be authorized in bringing that action against the third  
1490 party and his or her insurer jointly or against the insurer alone.

1491 (4) Nothing in this section shall be construed to diminish  
1492 or otherwise restrict the subrogation rights of the Division of  
1493 Medicaid against a third party for Medicaid provided by the  
1494 Division of Medicaid to the recipient as a result of injuries,  
1495 disease or sickness caused under circumstances creating a cause of  
1496 action in favor of the recipient against such a third party.

1497 (5) Any amounts recovered by the division under this section  
1498 shall, by the division, be placed to the credit of the funds  
1499 appropriated for benefits under this article proportionate to the  
1500 amounts provided by the state and federal governments  
1501 respectively.

1502 **SECTION 5.** Section 43-13-145, Mississippi Code of 1972, is  
1503 amended as follows:

1504 43-13-145. (1) (a) Upon each nursing facility licensed by  
1505 the State of Mississippi, there is levied an assessment in an



1506 amount set by the division, equal to the maximum rate allowed by  
1507 federal law or regulation, for each licensed and occupied bed of  
1508 the facility.

1509 (b) A nursing facility is exempt from the assessment  
1510 levied under this subsection if the facility is operated under the  
1511 direction and control of:

1512 (i) The United States Veterans Administration or  
1513 other agency or department of the United States government;

1514 (ii) The State Veterans Affairs Board; or

1515 (iii) The University of Mississippi Medical  
1516 Center.

1517 (2) (a) Upon each intermediate care facility for \* \* \*  
1518 individuals with intellectual disabilities licensed by the State  
1519 of Mississippi, there is levied an assessment in an amount set by  
1520 the division, equal to the maximum rate allowed by federal law or  
1521 regulation, for each licensed and occupied bed of the facility.

1522 (b) An intermediate care facility for \* \* \* individuals  
1523 with intellectual disabilities is exempt from the assessment  
1524 levied under this subsection if the facility is operated under the  
1525 direction and control of:

1526 (i) The United States Veterans Administration or  
1527 other agency or department of the United States government;

1528 (ii) The State Veterans Affairs Board; or

1529 (iii) The University of Mississippi Medical  
1530 Center.



1531 (3) (a) Upon each psychiatric residential treatment  
1532 facility licensed by the State of Mississippi, there is levied an  
1533 assessment in an amount set by the division, equal to the maximum  
1534 rate allowed by federal law or regulation, for each licensed and  
1535 occupied bed of the facility.

1536 (b) A psychiatric residential treatment facility is  
1537 exempt from the assessment levied under this subsection if the  
1538 facility is operated under the direction and control of:

1539 (i) The United States Veterans Administration or  
1540 other agency or department of the United States government;

1541 (ii) The University of Mississippi Medical Center;  
1542 or

1543 (iii) A state agency or a state facility that  
1544 either provides its own state match through intergovernmental  
1545 transfer or certification of funds to the division.

1546 (4) Hospital assessment.

1547 (a) (i) Subject to and upon fulfillment of the  
1548 requirements and conditions of paragraph (f) below, and  
1549 notwithstanding any other provisions of this section, effective  
1550 for state fiscal year 2013 \* \* \*, fiscal year  
1551 2015 and fiscal year 2016, an annual assessment on each hospital  
1552 licensed in the state is imposed on each non-Medicare hospital  
1553 inpatient day as defined below at a rate that is determined by  
1554 dividing the sum prescribed in this subparagraph (i), plus the  
1555 nonfederal share necessary to maximize the Disproportionate Share



1556 Hospital (DSH) and inpatient Medicare Upper Payment Limits (UPL)  
1557 payments, by the total number of non-Medicare hospital inpatient  
1558 days as defined below for all licensed Mississippi hospitals,  
1559 except as provided in paragraph (d) below. If the state matching  
1560 funds percentage for the Mississippi Medicaid program is sixteen  
1561 percent (16%) or less, the sum used in the formula under this  
1562 subparagraph (i) shall be Seventy-four Million Dollars  
1563 (\$74,000,000.00). If the state matching funds percentage for the  
1564 Mississippi Medicaid program is twenty-four percent (24%) or  
1565 higher, the sum used in the formula under this subparagraph (i)  
1566 shall be One Hundred Four Million Dollars (\$104,000,000.00). If  
1567 the state matching funds percentage for the Mississippi Medicaid  
1568 program is between sixteen percent (16%) and twenty-four percent  
1569 (24%), the sum used in the formula under this subparagraph (i)  
1570 shall be a pro rata amount determined as follows: the current  
1571 state matching funds percentage rate minus sixteen percent (16%)  
1572 divided by eight percent (8%) multiplied by Thirty Million Dollars  
1573 (\$30,000,000.00) and add that amount to Seventy-four Million  
1574 Dollars (\$74,000,000.00). However, no assessment in a quarter  
1575 under this subparagraph (i) may exceed the assessment in the  
1576 previous quarter by more than Three Million Seven Hundred Fifty  
1577 Thousand Dollars (\$3,750,000.00) (which would be Fifteen Million  
1578 Dollars (\$15,000,000.00) on an annualized basis). The division  
1579 shall publish the state matching funds percentage rate applicable  
1580 to the Mississippi Medicaid program on the tenth day of the first



1581 month of each quarter and the assessment determined under the  
1582 formula prescribed above shall be applicable in the quarter  
1583 following any adjustment in that state matching funds percentage  
1584 rate. The division shall notify each hospital licensed in the  
1585 state as to any projected increases or decreases in the assessment  
1586 determined under this subparagraph (i). However, if the Centers  
1587 for Medicare and Medicaid Services (CMS) does not approve the  
1588 provision in Section 43-13-117(39) requiring the division to  
1589 reimburse crossover claims for inpatient hospital services and  
1590 crossover claims covered under Medicare Part B for dually eligible  
1591 beneficiaries in the same manner that was in effect on January 1,  
1592 2008, the sum that otherwise would have been used in the formula  
1593 under this subparagraph (i) shall be reduced by Seven Million  
1594 Dollars (\$7,000,000.00).

1595 (ii) In addition to the assessment provided under  
1596 subparagraph (i), effective for state fiscal year 2013 \* \* \*,  
1597 fiscal year 2014, fiscal year 2015 and fiscal year 2016, an  
1598 additional annual assessment on each hospital licensed in the  
1599 state is imposed on each non-Medicare hospital inpatient day as  
1600 defined below at a rate that is determined by dividing twenty-five  
1601 percent (25%) of any provider reductions in the Medicaid program  
1602 as authorized in Section 43-13-117(F) for that fiscal year up to  
1603 the following maximum amount, plus the nonfederal share necessary  
1604 to maximize the Disproportionate Share Hospital (DSH) and  
1605 inpatient Medicare Upper Payment Limits (UPL) payments, by the





1606 total number of non-Medicare hospital inpatient days as defined  
1607 below for all licensed Mississippi hospitals: in fiscal year  
1608 2010, the maximum amount shall be Twenty-four Million Dollars  
1609 (\$24,000,000.00); in fiscal year 2011, the maximum amount shall be  
1610 Thirty-two Million Dollars (\$32,000,000.00); and in fiscal year  
1611 2012 and thereafter, the maximum amount shall be Forty Million  
1612 Dollars (\$40,000,000.00). Any such deficit in the Medicaid  
1613 program shall be reviewed by the PEER Committee as provided in  
1614 Section 43-13-117(F).

1615 (iii) In addition to the assessments provided in  
1616 subparagraphs (i) and (ii), effective for state fiscal year \* \* \*  
1617 2015 and fiscal year \* \* \* 2016, an additional annual assessment  
1618 on each hospital licensed in the state is imposed pursuant to the  
1619 provisions of Section 43-13-117(F) if the cost containment  
1620 measures described therein have been implemented and there are  
1621 insufficient funds in the Health Care Trust Fund to reconcile any  
1622 remaining deficit in any fiscal year. If the Governor institutes  
1623 any other additional cost containment measures on any program or  
1624 programs authorized under the Medicaid program pursuant to Section  
1625 43-13-117(F), hospitals shall be responsible for twenty-five  
1626 percent (25%) of any such additional imposed provider cuts, which  
1627 shall be in the form of an additional assessment not to exceed the  
1628 twenty-five percent (25%) of provider expenditure reductions.  
1629 Such additional assessment shall be imposed on each non-Medicare



1630 hospital inpatient day in the same manner as assessments are  
1631 imposed under subparagraphs (i) and (ii).

1632 (b) Payment and definitions.

1633 (i) Payment. Upon approval of the State Plan  
1634 Amendment for the division's DSH and inpatient UPL payment  
1635 methodology by CMS, the assessment shall be paid in three (3)  
1636 installments due no later than ten (10) days before the payment of  
1637 the DSH and UPL payments required by Section 43-13-117(A)(18),  
1638 which shall be paid during the second, third and fourth quarters  
1639 of the state fiscal year.

1640 (ii) Definitions. For purposes of this subsection  
1641 (4):

1642 1. "Non-Medicare hospital inpatient day"  
1643 means total hospital inpatient days including subcomponent days  
1644 less Medicare inpatient days including subcomponent days from the  
1645 hospital's \* \* \* 2013 Medicare cost report on file with CMS.

1646 a. Total hospital inpatient days shall  
1647 be the sum of Worksheet S-3, Part 1, column 6 row 12, column 6 row  
1648 14.00, and column 6 row 14.01, excluding column 6 rows 3 and 4.

1649 b. Hospital Medicare inpatient days  
1650 shall be the sum of Worksheet S-3, Part 1, column 4 row 12, column  
1651 4 row 14.00, and column 4 row 14.01, excluding column 4 rows 3 and  
1652 4.

1653 c. Inpatient days shall not include  
1654 residential treatment or long-term care days.



1655                   2. "Subcomponent inpatient day" means the  
1656 number of days of care charged to a beneficiary for inpatient  
1657 hospital rehabilitation and psychiatric care services in units of  
1658 full days. A day begins at midnight and ends twenty-four (24)  
1659 hours later. A part of a day, including the day of admission and  
1660 day on which a patient returns from leave of absence, counts as a  
1661 full day. However, the day of discharge, death, or a day on which  
1662 a patient begins a leave of absence is not counted as a day unless  
1663 discharge or death occur on the day of admission. If admission  
1664 and discharge or death occur on the same day, the day is  
1665 considered a day of admission and counts as one (1) subcomponent  
1666 inpatient day.

1667                   (c) The assessment provided in this subsection is  
1668 intended to satisfy and not be in addition to the assessment and  
1669 intergovernmental transfers provided in Section 43-13-117(A)(18).  
1670 Nothing in this section shall be construed to authorize any state  
1671 agency, division or department, or county, municipality or other  
1672 local governmental unit to license for revenue, levy or impose any  
1673 other tax, fee or assessment upon hospitals in this state not  
1674 authorized by a specific statute.

1675                   (d) Hospitals operated by the United States Department  
1676 of Veterans Affairs and state-operated facilities that provide  
1677 only inpatient and outpatient psychiatric services shall not be  
1678 subject to the hospital assessment provided in this subsection.



1679 (e) Multihospital systems, closure, merger and new  
1680 hospitals.

1681 (i) If a hospital conducts, operates or maintains  
1682 more than one (1) hospital licensed by the State Department of  
1683 Health, the provider shall pay the hospital assessment for each  
1684 hospital separately.

1685 (ii) Notwithstanding any other provision in this  
1686 section, if a hospital subject to this assessment operates or  
1687 conducts business only for a portion of a fiscal year, the  
1688 assessment for the state fiscal year shall be adjusted by  
1689 multiplying the assessment by a fraction, the numerator of which  
1690 is the number of days in the year during which the hospital  
1691 operates, and the denominator of which is three hundred sixty-five  
1692 (365). Immediately upon ceasing to operate, the hospital shall  
1693 pay the assessment for the year as so adjusted (to the extent not  
1694 previously paid).

1695 (f) Applicability.

1696 The hospital assessment imposed by this subsection shall not  
1697 take effect and/or shall cease to be imposed if:

1698 (i) The assessment is determined to be an  
1699 impermissible tax under Title XIX of the Social Security Act;  
1700 or \* \* \*

1701 (ii) CMS revokes its approval of the division's  
1702 2009 Medicaid State Plan Amendment for the methodology for DSH and



1703 inpatient UPL payments to hospitals under Section  
1704 43-13-117(A) (18).

1705 This subsection (4) is repealed on July 1, \* \* \* 2016.

1706 (5) Each health care facility that is subject to the  
1707 provisions of this section shall keep and preserve such suitable  
1708 books and records as may be necessary to determine the amount of  
1709 assessment for which it is liable under this section. The books  
1710 and records shall be kept and preserved for a period of not less  
1711 than five (5) years, during which time those books and records  
1712 shall be open for examination during business hours by the  
1713 division, the Department of Revenue, the Office of the Attorney  
1714 General and the State Department of Health.

1715 (6) Except as provided in subsection (4) of this section,  
1716 the assessment levied under this section shall be collected by the  
1717 division each month beginning on March 31, 2005.

1718 (7) All assessments collected under this section shall be  
1719 deposited in the Medical Care Fund created by Section 43-13-143.

1720 (8) The assessment levied under this section shall be in  
1721 addition to any other assessments, taxes or fees levied by law,  
1722 and the assessment shall constitute a debt due the State of  
1723 Mississippi from the time the assessment is due until it is paid.

1724 (9) (a) If a health care facility that is liable for  
1725 payment of an assessment levied by the division does not pay the  
1726 assessment when it is due, the division shall give written notice  
1727 to the health care facility by certified or registered mail



1728 demanding payment of the assessment within ten (10) days from the  
1729 date of delivery of the notice. If the health care facility fails  
1730 or refuses to pay the assessment after receiving the notice and  
1731 demand from the division, the division shall withhold from any  
1732 Medicaid reimbursement payments that are due to the health care  
1733 facility the amount of the unpaid assessment and a penalty of ten  
1734 percent (10%) of the amount of the assessment, plus the legal rate  
1735 of interest until the assessment is paid in full. If the health  
1736 care facility does not participate in the Medicaid program, the  
1737 division shall turn over to the Office of the Attorney General the  
1738 collection of the unpaid assessment by civil action. In any such  
1739 civil action, the Office of the Attorney General shall collect the  
1740 amount of the unpaid assessment and a penalty of ten percent (10%)  
1741 of the amount of the assessment, plus the legal rate of interest  
1742 until the assessment is paid in full.

1743           (b) As an additional or alternative method for  
1744 collecting unpaid assessments levied by the division, if a health  
1745 care facility fails or refuses to pay the assessment after  
1746 receiving notice and demand from the division, the division may  
1747 file a notice of a tax lien with the chancery clerk of the county  
1748 in which the health care facility is located, for the amount of  
1749 the unpaid assessment and a penalty of ten percent (10%) of the  
1750 amount of the assessment, plus the legal rate of interest until  
1751 the assessment is paid in full. Immediately upon receipt of  
1752 notice of the tax lien for the assessment, the chancery clerk



1753 shall forward the notice to the circuit clerk who shall enter the  
1754 notice of the tax lien as a judgment upon the judgment roll and  
1755 show in the appropriate columns the name of the health care  
1756 facility as judgment debtor, the name of the division as judgment  
1757 creditor, the amount of the unpaid assessment, and the date and  
1758 time of enrollment. The judgment shall be valid as against  
1759 mortgagees, pledgees, entrusters, purchasers, judgment creditors  
1760 and other persons from the time of filing with the clerk. The  
1761 amount of the judgment shall be a debt due the State of  
1762 Mississippi and remain a lien upon the tangible property of the  
1763 health care facility until the judgment is satisfied. The  
1764 judgment shall be the equivalent of any enrolled judgment of a  
1765 court of record and shall serve as authority for the issuance of  
1766 writs of execution, writs of attachment or other remedial writs.

1767 (10) As soon as possible after July 1, 2009, the Division of  
1768 Medicaid shall submit to the Centers for Medicare and Medicaid  
1769 Services (CMS) a state plan amendment or amendments (SPA)  
1770 regarding the hospital assessment established under subsection (4)  
1771 of this section. In addition to defining the assessment  
1772 established in subsection (4) of this section, the state plan  
1773 amendment or amendments shall include any amendments necessary to  
1774 provide for the following additional annual Medicare Upper Payment  
1775 Limits (UPL) and Disproportionate Share Hospital (DSH) payments to  
1776 hospitals located in Mississippi that participate in the Medicaid  
1777 program:



1778 (a) Privately operated and nonstate government  
1779 operated \* \* \* hospitals, within the meaning of 42 CFR Section  
1780 447.272, that have fifty (50) or fewer licensed beds as of January  
1781 1, 2009, shall receive an additional inpatient UPL payment equal  
1782 to sixty-five percent (65%) of their fiscal year \* \* \* 2013  
1783 hospital specific inpatient UPL gap, before any payments under  
1784 this subsection.

1785 (b) General acute care hospitals licensed within the  
1786 class of state hospitals shall receive an additional inpatient UPL  
1787 payment equal to twenty-eight percent (28%) of their fiscal  
1788 year \* \* \* 2013 inpatient payments, excluding DSH and UPL  
1789 payments.

1790 (c) General acute care hospitals licensed within the  
1791 class of nonstate government hospitals shall receive an additional  
1792 inpatient UPL payment determined by multiplying inpatient  
1793 payments, excluding DSH and UPL, by the uniform percentage  
1794 necessary to exhaust the maximum amount of inpatient UPL payments  
1795 permissible under federal regulations. (For state fiscal  
1796 year \* \* \* 2015 and fiscal year \* \* \* 2016, the state shall  
1797 use \* \* \* 2013 inpatient payment data).

1798 \* \* \*

1799 ( \* \* \* d) In addition to other payments provided above,  
1800 all hospitals licensed within the class of private hospitals \* \* \*  
1801 shall receive an additional inpatient UPL payment determined by  
1802 multiplying inpatient payments, excluding DSH and UPL, by the





1803 uniform percentage necessary to exhaust the maximum amount of UPL  
1804 inpatient payments permissible under federal regulations. For  
1805 state fiscal year \* \* \* 2015 and fiscal year \* \* \* 2016, the state  
1806 shall use \* \* \* 2013 data.

1807 ( \* \* \* e) All hospitals satisfying the minimum federal  
1808 DSH eligibility requirements (Section 1923(d) of the Social  
1809 Security Act) shall, subject to OBRA 1993 payment limitations,  
1810 receive an additional DSH payment. This additional DSH payment  
1811 shall expend the balance of the federal DSH allotment and  
1812 associated state share not utilized in DSH payments to state-owned  
1813 institutions for treatment of mental diseases. The payment to  
1814 each hospital shall be calculated by applying a uniform percentage  
1815 to the uninsured costs of each eligible hospital, excluding  
1816 state-owned institutions for treatment of mental diseases;  
1817 however, that percentage for a state-owned teaching hospital  
1818 located in Hinds County shall be multiplied by a factor of two  
1819 (2).

1820 (11) The hospital assessment provided in subsection (4) of  
1821 this section shall not be in effect or implemented until the SPA  
1822 is approved by CMS.

1823 (12) The division shall implement DSH and UPL calculation  
1824 methodologies that result in the maximization of available federal  
1825 funds.

1826 (13) The DSH and inpatient UPL payments shall be paid on or  
1827 before December 31, March 31, and June 30 of each fiscal year, in



1828 increments of one-third (1/3) of the total calculated DSH and  
1829 inpatient UPL amounts.

1830 (14) The hospital assessment as described in subsection (4)  
1831 above shall be assessed and collected quarterly a maximum of ten  
1832 (10) days before making the DSH and inpatient UPL payments;  
1833 provided, however, that the first quarterly payment shall be  
1834 assessed but not be collected until collection is made for the  
1835 second quarterly payment.

1836 (15) If for any reason any part of the plan for additional  
1837 annual DSH and inpatient UPL payments to hospitals provided under  
1838 subsection (10) of this section is not approved by CMS, the  
1839 remainder of the plan shall remain in full force and effect.

1840 (16) Nothing in this section shall prevent the Division of  
1841 Medicaid from facilitating participation in Medicaid supplemental  
1842 hospital payment programs by a hospital located in a county  
1843 contiguous to the State of Mississippi that is also authorized by  
1844 federal law to submit intergovernmental transfers (IGTs) to the  
1845 State of Mississippi to fund the state share of the hospital's  
1846 supplemental payments.

1847 (17) Subsections (10) through (16) of this section shall  
1848 stand repealed on July 1, \* \* \* 2016.

1849 **SECTION 6.** Section 41-86-9, Mississippi Code of 1972, is  
1850 amended as follows:

1851 41-86-9. On January 1, 2013, the Mississippi Children's  
1852 Health Insurance Program and the current contract for insurance



1853 services shall be transferred from the State and School Employees  
1854 Health Insurance Management Board to the Division of Medicaid, and  
1855 the division shall be responsible for the implementation and  
1856 administration of the Mississippi Children's Health Insurance  
1857 Program in accordance with federal law and regulations and this  
1858 chapter from and after January 1, 2013. The Health Insurance  
1859 Management Board shall be responsible for any audit or claims  
1860 processing issues for the period during which the board  
1861 administered the program. Effective January 1, 2015, and  
1862 notwithstanding any other provision of law to the contrary, the  
1863 division is authorized to operate the program as described under  
1864 Section 43-13-117(H).

1865 **SECTION 7.** Not later than December 15, 2014, the Division of  
1866 Medicaid shall prepare and deliver a report to the Chairmen of the  
1867 Senate Public Health and Welfare Committee and the House Medicaid  
1868 Committee on the impact of referrals by physicians for advanced  
1869 imaging services using equipment owned in full or in part by the  
1870 referring physician. The report shall include data on referral  
1871 patterns that may indicate fraud or abuse.

1872 **SECTION 8.** This act shall take effect and be in force from  
1873 and after July 1, 2014.

