REPORT OF CONFERENCE COMMITTEE

MR. SPEAKER AND MR. PRESIDENT:

We, the undersigned conferees, have had under consideration the amendments to the following entitled BILL:

H. B. No. 1275: Medicaid; extend repealer on Medicaid services and make technical amendments.

We, therefore, respectfully submit the following report and recommendation:

1. That the Senate recede from its Amendment No. 1.

2. That the House and Senate adopt the following amendment:

Amend by striking all after the enacting clause and inserting in lieu thereof the following:

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

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

(1) Inpatient hospital services.

(a) The division shall allow thirty (30) days of inpatient hospital care annually for all Medicaid recipients. Medicaid recipients requiring transplants shall not have those days included in the transplant hospital stay count against the

thirty-day limit for inpatient hospital care. Precertification of inpatient days must be obtained as required by the division.

(b) From and after July 1, 1994, the Executive Director of the Division of Medicaid shall amend the Mississippi Title XIX Inpatient Hospital Reimbursement Plan to remove the occupancy rate penalty from the calculation of the Medicaid Capital Cost Component utilized to determine total hospital costs allocated to the Medicaid program.

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

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

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

(2) Outpatient hospital services.

(a) Emergency services. *** * ***

(b) Other outpatient hospital services. The division shall allow benefits for other medically necessary outpatient hospital services (such as chemotherapy, radiation, surgery and therapy), including outpatient services in a clinic or other facility that is not located inside the hospital, but that has been designated as an outpatient facility by the hospital, and that was in operation or under construction on July 1, 2009, provided that the costs and charges associated with the operation of the hospital clinic are included in the hospital's cost report. In addition, the Medicare thirty-five-mile rule will apply to those hospital clinics not located inside the hospital that are constructed after July 1, 2009. Where the same services are reimbursed as clinic services, the division may revise the rate or methodology of outpatient reimbursement to maintain consistency, efficiency, economy and quality of care.

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

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

(3) Laboratory and x-ray services.

(4) Nursing facility services.

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

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

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

(d) *** * *** <u>On or after January 1, 2015, the division shall update the case-mix payment system resource utilization grouper and classifications and fair rental</u>

reimbursement system. The division shall develop and implement a payment add-on to reimburse nursing facilities for ventilator dependent resident services.

(e) The division shall develop and implement, not later than January 1, 2001, a case-mix payment add-on determined by time studies and other valid statistical data that will reimburse a nursing facility for the additional cost of caring for a resident who has a diagnosis of Alzheimer's or other related dementia and exhibits symptoms that require special care. Any such case-mix add-on payment shall be supported by a determination of additional cost. The division shall also develop and implement as part of the fair rental reimbursement system for nursing facility beds, an Alzheimer's resident bed depreciation enhanced reimbursement system that will provide an incentive to encourage nursing facilities to convert or construct beds for residents with Alzheimer's or other related dementia.

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

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

(5) Periodic screening and diagnostic services for individuals under age twenty-one (21) years as are needed to identify physical and mental defects and to provide health care treatment and other measures designed to correct or ameliorate defects and physical and mental illness and conditions discovered by the screening services, regardless of whether these services are included in the state plan. The division may include in its periodic screening and diagnostic program those discretionary services authorized under the federal regulations adopted to implement Title XIX of the federal Social Security Act, as amended. The division, in obtaining physical therapy services, occupational therapy services, and services for individuals with speech, hearing and language disorders, may enter into a cooperative agreement with the State Department of Education for the provision of those services to handicapped students by public school districts using state funds that are provided from the appropriation to the Department of Education to obtain federal matching funds through the division. The division, in obtaining medical and mental health assessments, treatment, care and services for children who are in, or at risk of being put in, the custody of the Mississippi Department of Human Services may enter into a cooperative agreement with the Mississippi Department of Human Services for the provision of those services using state funds that are provided from the appropriation to the Department

of Human Services to obtain federal matching funds through the division.

(6) Physician's services. The division shall allow twelve (12) physician visits annually. The division may develop and implement a different reimbursement model or schedule for physician's services provided by physicians based at an academic health care center and by physicians at rural health centers that are associated with an academic health care center. From and after January 1, 2010, all fees for physicians' services that are covered only by Medicaid shall be increased to ninety percent (90%) of the rate established on January 1, 2010, and as may be adjusted each July thereafter, under Medicare. The division may provide for a reimbursement rate for physician's services of up to one hundred percent (100%) of the rate established under Medicare for physician's services that are provided after the normal working hours of the physician, as determined in accordance with regulations of the division. The division may reimburse eligible providers as determined by the Patient Protection and Affordable Care Act for certain primary care services as defined by the act at one hundred percent (100%) of the rate established under Medicare.

(7) (a) Home health services for eligible persons, not to exceed in cost the prevailing cost of nursing facility services, not to exceed twenty-five (25) visits per year. All

home health visits must be precertified as required by the division.

(b) [Repealed]

(8) Emergency medical transportation services. On January 1, 1994, emergency medical transportation services shall be reimbursed at seventy percent (70%) of the rate established under Medicare (Title XVIII of the federal Social Security Act, as amended). "Emergency medical transportation services" shall mean, but shall not be limited to, the following services by a properly permitted ambulance operated by a properly licensed provider in accordance with the Emergency Medical Services Act of 1974 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids, (vi) disposable supplies, (vii) similar services.

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

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

The division may seek to establish relationships with other states in order to lower acquisition costs of prescription drugs to include single source and innovator multiple source drugs or generic drugs. In addition, if allowed by federal law or regulation, the division may seek to establish relationships with

and negotiate with other countries to facilitate the acquisition of prescription drugs to include single source and innovator multiple source drugs or generic drugs, if that will lower the acquisition costs of those prescription drugs.

The division shall allow for a combination of prescriptions for single source and innovator multiple source drugs and generic drugs to meet the needs of the beneficiaries, not to exceed five (5) prescriptions per month for each noninstitutionalized Medicaid beneficiary, with not more than two (2) of those prescriptions being for single source or innovator multiple source drugs unless the single source or innovator multiple source drug is less expensive than the generic equivalent.

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

Drugs prescribed for a resident of a psychiatric residential treatment facility must be provided in true unit doses when available. The division may require that drugs not covered by Medicare Part D for a resident of a long-term care facility be provided in true unit doses when available. Those drugs that were originally billed to the division but are not used by a resident in any of those facilities shall be returned to the billing pharmacy for credit to the division, in accordance with the guidelines of the State Board of Pharmacy and any requirements of federal law and regulation. Drugs shall be dispensed to a

recipient and only one (1) dispensing fee per month may be charged. The division shall develop a methodology for reimbursing for restocked drugs, which shall include a restock fee as determined by the division not exceeding Seven Dollars and Eighty-two Cents ($7.82).

The voluntary preferred drug list shall be expanded to function in the interim in order to have a manageable prior authorization system, thereby minimizing disruption of service to beneficiaries.

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

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

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

The division shall develop a pharmacy policy in which drugs in tamper-resistant packaging that are prescribed for a resident of a nursing facility but are not dispensed to the resident shall

be returned to the pharmacy and not billed to Medicaid, in accordance with guidelines of the State Board of Pharmacy.

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

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

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

Payment for other covered drugs, other than multisource drugs with CMS upper limits, shall not exceed the lower of the estimated acquisition cost as determined by the division, plus a dispensing

fee or the providers' usual and customary charge to the general public.

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

The dispensing fee for each new or refill prescription, including nonlegend or over-the-counter drugs covered by the division, shall be not less than Three Dollars and Ninety-one Cents ($3.91), as determined by the division.

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

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

(10) (a) Dental care that is an adjunct to treatment of an acute medical or surgical condition; services of oral surgeons and dentists in connection with surgery related to the jaw or any structure contiguous to the jaw or the reduction of any fracture of the jaw or any facial bone; and emergency dental extractions and treatment related thereto. On July 1, 2007, fees for dental care and surgery under authority of this paragraph (10) shall be reimbursed as provided in subparagraph (b). It is the

intent of the Legislature that this rate revision for dental services will be an incentive designed to increase the number of dentists who actively provide Medicaid services. This dental services rate revision shall be known as the "James Russell Dumas Medicaid Dental Incentive Program."

The division shall annually determine the effect of this incentive by evaluating the number of dentists who are Medicaid providers, the number who and the degree to which they are actively billing Medicaid, the geographic trends of where dentists are offering what types of Medicaid services and other statistics pertinent to the goals of this legislative intent. This data shall be presented to the Chair of the Senate Public Health and Welfare Committee and the Chair of the House Medicaid Committee.

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

(c) For fiscal year 2008, the amount of state funds appropriated for reimbursement for dental care and surgery shall be increased by ten percent (10%) of the amount of state

fund expenditures for that purpose for fiscal year 2007. For each of fiscal years 2009 and 2010, the amount of state funds appropriated for reimbursement for dental care and surgery shall be increased by ten percent (10%) of the amount of state fund expenditures for that purpose for the preceding fiscal year.

(d) The division shall establish an annual benefit limit of Two Thousand Five Hundred Dollars ($2,500.00) in dental expenditures per Medicaid-eligible recipient; however, a recipient may exceed the annual limit on dental expenditures provided in this paragraph with prior approval of the division.

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

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

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

(12) Intermediate care facility services.

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

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

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

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

(14) Clinic services. Such diagnostic, preventive, therapeutic, rehabilitative or palliative services furnished to an outpatient by or under the supervision of a physician or dentist in a facility that is not a part of a hospital but that is organized and operated to provide medical care to outpatients. Clinic services shall include any services reimbursed as outpatient hospital services that may be rendered in such a facility, including those that become so after July 1, 1991. On

July 1, 1999, all fees for physicians' services reimbursed under authority of this paragraph (14) shall be reimbursed at ninety percent (90%) of the rate established on January 1, 1999, and as may be adjusted each July thereafter, under Medicare (Title XVIII of the federal Social Security Act, as amended). The division may develop and implement a different reimbursement model or schedule for physician's services provided by physicians based at an academic health care center and by physicians at rural health centers that are associated with an academic health care center. The division may provide for a reimbursement rate for physician's clinic services of up to one hundred percent (100%) of the rate established under Medicare for physician's services that are provided after the normal working hours of the physician, as determined in accordance with regulations of the division.

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

(16) Mental health services. Approved therapeutic and case management services (a) provided by an approved regional mental health/intellectual disability center established under Sections 41-19-31 through 41-19-39, or by another community mental health service provider meeting the requirements of the Department of Mental Health to be an approved mental health/intellectual

disability center if determined necessary by the Department of Mental Health, using state funds that are provided in the appropriation to the division to match federal funds, or (b) provided by a facility that is certified by the State Department of Mental Health to provide therapeutic and case management services, to be reimbursed on a fee for service basis, or (c) provided in the community by a facility or program operated by the Department of Mental Health. Any such services provided by a facility described in subparagraph (b) must have the prior approval of the division to be reimbursable under this section. After June 30, 1997, mental health services provided by regional mental health/intellectual disability centers established under Sections 41-19-31 through 41-19-39, or by hospitals as defined in Section 41-9-3(a) and/or their subsidiaries and divisions, or by psychiatric residential treatment facilities as defined in Section 43-11-1, or by another community mental health service provider meeting the requirements of the Department of Mental Health to be an approved mental health/intellectual disability center if determined necessary by the Department of Mental Health, shall not be included in or provided under any capitated managed care pilot program provided for under paragraph (24) of this section.

(17) Durable medical equipment services and medical supplies. Precertification of durable medical equipment and medical supplies must be obtained as required by the division. The Division of Medicaid may require durable medical equipment

providers to obtain a surety bond in the amount and to the specifications as established by the Balanced Budget Act of 1997.

(18) (a) Notwithstanding any other provision of this section to the contrary, as provided in the Medicaid state plan amendment or amendments as defined in Section 43-13-145(10), the division shall make additional reimbursement to hospitals that serve a disproportionate share of low-income patients and that meet the federal requirements for those payments as provided in Section 1923 of the federal Social Security Act and any applicable regulations. It is the intent of the Legislature that the division shall draw down all available federal funds allotted to the state for disproportionate share hospitals. However, from and after January 1, 1999, public hospitals participating in the Medicaid disproportionate share program may be required to participate in an intergovernmental transfer program as provided in Section 1903 of the federal Social Security Act and any applicable regulations.

(b) The division shall establish a Medicare Upper Payment Limits Program, as defined in Section 1902(a)(30) of the federal Social Security Act and any applicable federal regulations, for hospitals, and may establish a Medicare Upper Payment Limits Program for nursing facilities, and may establish a Medicare Upper Payment Limits Program for physicians employed or contracted by public hospitals. Upon successful implementation of a Medicare Upper Payment program for physicians employed by public

hospitals, the division may develop a plan for implementing an Upper Payment Limit program for physicians employed by other classes of hospitals. The division shall assess each hospital and, if the program is established for nursing facilities, shall assess each nursing facility, for the sole purpose of financing the state portion of the Medicare Upper Payment Limits Program. The hospital assessment shall be as provided in Section 43-13-145(4)(a) and the nursing facility assessment, if established, shall be based on Medicaid utilization or other appropriate method consistent with federal regulations. The assessment will remain in effect as long as the state participates in the Medicare Upper Payment Limits Program. Public hospitals with physicians participating in the Medicare Upper Payment Limits Program shall be required to participate in an intergovernmental transfer program. As provided in the Medicaid state plan amendment or amendments as defined in Section 43-13-145(10), the division shall make additional reimbursement to hospitals and, if the program is established for nursing facilities, shall make additional reimbursement to nursing facilities, for the Medicare Upper Payment Limits, and, if the program is established for physicians, shall make additional reimbursement for physicians, as defined in Section 1902(a)(30) of the federal Social Security Act and any applicable federal regulations.

(19) (a) Perinatal risk management services. The division shall promulgate regulations to be effective from and

after October 1, 1988, to establish a comprehensive perinatal system for risk assessment of all pregnant and infant Medicaid recipients and for management, education and follow-up for those who are determined to be at risk. Services to be performed include case management, nutrition assessment/counseling, psychosocial assessment/counseling and health education. The division shall contract with the State Department of Health to provide the services within this paragraph (Perinatal High Risk Management/Infant Services System (PHRM/ISS). The State Department of Health as the agency for PHRM/ISS for the Division of Medicaid shall be reimbursed on a full reasonable cost basis.

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

determined by the State Department of Health and the Division of Medicaid.

(20) Home- and community-based services for physically disabled approved services as allowed by a waiver from the United States Department of Health and Human Services for home- and community-based services for physically disabled people using state funds that are provided from the appropriation to the State Department of Rehabilitation Services and used to match federal funds under a cooperative agreement between the division and the department, provided that funds for these services are specifically appropriated to the Department of Rehabilitation Services.

(21) Nurse practitioner services. Services furnished by a registered nurse who is licensed and certified by the Mississippi Board of Nursing as a nurse practitioner, including, but not limited to, nurse anesthetists, nurse midwives, family nurse practitioners, family planning nurse practitioners, pediatric nurse practitioners, obstetrics-gynecology nurse practitioners and neonatal nurse practitioners, under regulations adopted by the division. Reimbursement for those services shall not exceed ninety percent (90%) of the reimbursement rate for comparable services rendered by a physician. The division may provide for a reimbursement rate for nurse practitioner services of up to one hundred percent (100%) of the reimbursement rate for comparable services rendered by a physician for nurse practitioner

services that are provided after the normal working hours of the nurse practitioner, as determined in accordance with regulations of the division.

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

(23) Inpatient psychiatric services. Inpatient psychiatric services to be determined by the division for recipients under age twenty-one (21) that are provided under the direction of a physician in an inpatient program in a licensed acute care psychiatric facility or in a licensed psychiatric residential treatment facility, before the recipient reaches age twenty-one (21) or, if the recipient was receiving the services immediately before he or she reached age twenty-one (21), before the earlier of the date he or she no longer requires the services or the date he or she reaches age twenty-two (22), as provided by federal regulations. From and after January 1, 2015, the division shall update the fair rental reimbursement system for psychiatric residential treatment facilities. Precertification of inpatient days and residential treatment days must be obtained as required by the division. From and after July 1, 2009, all state-owned and state-operated facilities that provide inpatient psychiatric services to persons under age twenty-one (21) who are eligible for

Medicaid reimbursement shall be reimbursed for those services on a full reasonable cost basis.

(24) [Deleted]

(25) [Deleted]

(26) Hospice care. As used in this paragraph, the term "hospice care" means a coordinated program of active professional medical attention within the home and outpatient and inpatient care that treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social and economic stresses that are experienced during the final stages of illness and during dying and bereavement and meets the Medicare requirements for participation as a hospice as provided in federal regulations.

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

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

(29) The Division of Medicaid may apply for a waiver from the United States Department of Health and Human Services for home- and community-based services for developmentally disabled

people using state funds that are provided from the appropriation to the State Department of Mental Health and/or funds transferred to the department by a political subdivision or instrumentality of the state and used to match federal funds under a cooperative agreement between the division and the department, provided that funds for these services are specifically appropriated to the Department of Mental Health and/or transferred to the department by a political subdivision or instrumentality of the state.

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

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

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

(33) Podiatrist services.

(34) Assisted living services as provided through home- and community-based services under Title XIX of the federal

Social Security Act, as amended, subject to the availability of funds specifically appropriated for that purpose by the Legislature.

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

(36) Nonemergency transportation services for Medicaid-eligible persons, to be provided by the Division of Medicaid. The division may contract with additional entities to administer nonemergency transportation services as it deems necessary. All providers shall have a valid driver's license, vehicle inspection sticker, valid vehicle license tags and a standard liability insurance policy covering the vehicle. The division may pay providers a flat fee based on mileage tiers, or in the alternative, may reimburse on actual miles traveled. The division may apply to the Center for Medicare and Medicaid Services (CMS) for a waiver to draw federal matching funds for nonemergency transportation services as a covered service instead of an administrative cost. The PEER Committee shall conduct a performance evaluation of the nonemergency transportation program to evaluate the administration of the program and the providers of transportation services to determine the most cost-effective ways of providing nonemergency transportation services to the patients

served under the program. The performance evaluation shall be completed and provided to the members of the Senate Public Health and Welfare Committee and the House Medicaid Committee not later than January 15, 2008.

(37) [Deleted]

(38) Chiropractic services. A chiropractor's manual manipulation of the spine to correct a subluxation, if x-ray demonstrates that a subluxation exists and if the subluxation has resulted in a neuromusculoskeletal condition for which manipulation is appropriate treatment, and related spinal x-rays performed to document these conditions. Reimbursement for chiropractic services shall not exceed Seven Hundred Dollars ($700.00) per year per beneficiary.

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

(40) [Deleted]

(41) Services provided by the State Department of Rehabilitation Services for the care and rehabilitation of persons with spinal cord injuries or traumatic brain injuries, as allowed

under waivers from the United States Department of Health and Human Services, using up to seventy-five percent (75%) of the funds that are appropriated to the Department of Rehabilitation Services from the Spinal Cord and Head Injury Trust Fund established under Section 37-33-261 and used to match federal funds under a cooperative agreement between the division and the department.

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

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

(44) Nursing facility services for the severely disabled.

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

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

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

(46) The division shall make application to the federal Centers for Medicare and Medicaid Services (CMS) for a waiver to develop and provide services for children with serious emotional disturbances as defined in Section 43-14-1(1), which may include

home- and community-based services, case management services or managed care services through mental health providers certified by the Department of Mental Health. The division may implement and provide services under this waivered program only if funds for these services are specifically appropriated for this purpose by the Legislature, or if funds are voluntarily provided by affected agencies.

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

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

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

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

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

(49) The division shall establish copayments and/or coinsurance for all Medicaid services for which copayments and/or coinsurance are allowable under federal law or regulation, and shall set the amount of the copayment and/or coinsurance for each of those services at the maximum amount allowable under federal law or regulation.

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

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

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

(52) Notwithstanding any provisions of this article, the division may pay enhanced reimbursement fees related to trauma care, as determined by the division in conjunction with the State Department of Health, using funds appropriated to the State Department of Health for trauma care and services and used to match federal funds under a cooperative agreement between the division and the State Department of Health. The division, in conjunction with the State Department of Health, may use grants, waivers, demonstrations, or other projects as necessary in the development and implementation of this reimbursement program.

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

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

and implementation of this adult foster care services pilot program.

(55) Therapy services. The plan of care for therapy services may be developed to cover a period of treatment for up to six (6) months, but in no event shall the plan of care exceed a six-month period of treatment. The projected period of treatment must be indicated on the initial plan of care and must be updated with each subsequent revised plan of care. Based on medical necessity, the division shall approve certification periods for less than or up to six (6) months, but in no event shall the certification period exceed the period of treatment indicated on the plan of care. The appeal process for any reduction in therapy services shall be consistent with the appeal process in federal regulations.

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

(57) No Medicaid benefit shall restrict coverage for medically appropriate treatment prescribed by a physician and agreed to by a fully informed individual, or if the individual lacks legal capacity to consent by a person who has legal authority to consent on his or her behalf, based on an individual's diagnosis with a terminal condition. As used in this

paragraph (57), "terminal condition" means any aggressive malignancy, chronic end-stage cardiovascular or cerebral vascular disease, or any other disease, illness or condition which a physician diagnoses as terminal.

(B) Notwithstanding any other provision of this article to the contrary, the division shall reduce the rate of reimbursement to providers for any service provided under this section by five percent (5%) of the allowed amount for that service. However, the reduction in the reimbursement rates required by this subsection (B) shall not apply to inpatient hospital services, nursing facility services, intermediate care facility services, psychiatric residential treatment facility services, pharmacy services provided under subsection (A)(9) of this section, or any service provided by the University of Mississippi Medical Center or a state agency, a state facility or a public agency that either provides its own state match through intergovernmental transfer or certification of funds to the division, or a service for which the federal government sets the reimbursement methodology and rate. From and after January 1, 2010, the reduction in the reimbursement rates required by this subsection (B) shall not apply to physicians' services. In addition, the reduction in the reimbursement rates required by this subsection (B) shall not apply to case management services and home-delivered meals provided under the home- and community-based services program for the elderly and disabled by a planning and development district

(PDD). Planning and development districts participating in the home- and community-based services program for the elderly and disabled as case management providers shall be reimbursed for case management services at the maximum rate approved by the Centers for Medicare and Medicaid Services (CMS).

(C) The division may pay to those providers who participate in and accept patient referrals from the division's emergency room redirection program a percentage, as determined by the division, of savings achieved according to the performance measures and reduction of costs required of that program. Federally qualified health centers may participate in the emergency room redirection program, and the division may pay those centers a percentage of any savings to the Medicaid program achieved by the centers' accepting patient referrals through the program, as provided in this subsection (C).

(D) Notwithstanding any provision of this article, except as authorized in the following subsection and in Section 43-13-139, neither (a) the limitations on quantity or frequency of use of or the fees or charges for any of the care or services available to recipients under this section, nor (b) the payments, payment methodology as provided below in this subsection (D), or rates of reimbursement to providers rendering care or services authorized under this section to recipients, may be increased, decreased or otherwise changed from the levels in effect on July 1, 1999, unless they are authorized by an amendment to this section by the

Legislature. However, the restriction in this subsection shall not prevent the division from changing the payments, payment methodology as provided below in this subsection (D), or rates of reimbursement to providers without an amendment to this section whenever those changes are required by federal law or regulation, or whenever those changes are necessary to correct administrative errors or omissions in calculating those payments or rates of reimbursement. The prohibition on any changes in payment methodology provided in this subsection (D) shall apply only to payment methodologies used for determining the rates of reimbursement for inpatient hospital services, outpatient hospital services, nursing facility services, and/or pharmacy services, except as required by federal law, and the federally mandated rebasing of rates as required by the Centers for Medicare and Medicaid Services (CMS) shall not be considered payment methodology for purposes of this subsection (D). No service benefits or reimbursement limitations in this section shall apply to payments under an APR-DRG or APC model or a managed care program or similar model described in subsection (H) of this section.

(E) Notwithstanding any provision of this article, no new groups or categories of recipients and new types of care and services may be added without enabling legislation from the Mississippi Legislature, except that the division may authorize

those changes without enabling legislation when the addition of recipients or services is ordered by a court of proper authority.

(F) The executive director shall keep the Governor advised on a timely basis of the funds available for expenditure and the projected expenditures. If current or projected expenditures of the division are reasonably anticipated to exceed the amount of funds appropriated to the division for any fiscal year, the Governor, after consultation with the executive director, shall discontinue any or all of the payment of the types of care and services as provided in this section that are deemed to be optional services under Title XIX of the federal Social Security Act, as amended, and when necessary, shall institute any other cost containment measures on any program or programs authorized under the article to the extent allowed under the federal law governing that program or programs. However, the Governor shall not be authorized to discontinue or eliminate any service under this section that is mandatory under federal law, or to discontinue or eliminate, or adjust income limits or resource limits for, any eligibility category or group under Section 43-13-115. Beginning in fiscal year 2010 and in fiscal years thereafter, when Medicaid expenditures are projected to exceed funds available for any quarter in the fiscal year, the division shall submit the expected shortfall information to the PEER Committee, which shall review the computations of the division and report its findings to the Legislative Budget Office within thirty

(30) days of such notification by the division, and not later than January 7 in any year. If expenditure reductions or cost containments are implemented, the Governor may implement a maximum amount of state share expenditure reductions to providers, of which hospitals will be responsible for twenty-five percent (25%) of provider reductions as follows: in fiscal year 2010, the maximum amount shall be Twenty-four Million Dollars ($24,000,000.00); in fiscal year 2011, the maximum amount shall be Thirty-two Million Dollars ($32,000,000.00); and in fiscal year 2012 and thereafter, the maximum amount shall be Forty Million Dollars ($40,000,000.00). However, instead of implementing cuts, the hospital share shall be in the form of an additional assessment not to exceed Ten Million Dollars ($10,000,000.00) as provided in Section 43-13-145(4)(a)(ii). If Medicaid expenditures are projected to exceed the amount of funds appropriated to the division in any fiscal year in excess of the expenditure reductions to providers, then funds shall be transferred by the State Fiscal Officer from the Health Care Trust Fund into the Health Care Expendable Fund and to the Governor's Office, Division of Medicaid, from the Health Care Expendable Fund, in the amount and at such time as requested by the Governor to reconcile the deficit. If the cost containment measures described above have been implemented and there are insufficient funds in the Health Care Trust Fund to reconcile any remaining deficit in any fiscal year, the Governor shall institute any other additional cost

containment measures on any program or programs authorized under this article to the extent allowed under federal law. Hospitals shall be responsible for twenty-five percent (25%) of any additional imposed provider cuts. However, instead of implementing hospital expenditure reductions, the hospital reductions shall be in the form of an additional assessment not to exceed twenty-five percent (25%) of provider expenditure reductions as provided in Section 43-13-145(4)(a)(ii). It is the intent of the Legislature that the expenditures of the division during any fiscal year shall not exceed the amounts appropriated to the division for that fiscal year.

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

(H) (1) Notwithstanding any other provision of this article, the division is authorized to implement (a) a managed care program, (b) a coordinated care program, (c) a coordinated

care organization program, (d) a health maintenance organization program, (e) a patient-centered medical home program, (f) an accountable care organization program, or (g) any combination of the above programs. Managed care programs, coordinated care programs, coordinated care organization programs, health maintenance organization programs, patient-centered medical home programs, * * * accountable care organization programs, or * * * any combination of the above programs or other similar programs implemented by the division under this section shall be limited to * * * the greater of (i) forty-five percent (45%) of the total enrollment of * * * Medicaid beneficiaries, or (ii) the categories of beneficiaries participating in the program as of January 1, 2014, plus the categories of beneficiaries composed primarily of persons younger than nineteen (19) years of age, and the division is authorized to enroll categories of beneficiaries in such program(s) as long as the * * * appropriate limitations * * * are not exceeded in the aggregate. As a condition for the approval of any program under this paragraph (H)(1), the division shall require that no program may:

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

(b) Override the medical decisions of hospital physicians or staff regarding patients admitted to a hospital.

This restriction (b) does not prohibit prior authorization for nonemergency hospital visitation;

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

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

(e) Implement a prior authorization program for prescription drugs that is more stringent than the prior authorization processes used by the division in its administration of the Medicaid program;

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

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

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

(2) No later than December 31, 2015, the division shall develop and submit to the Senate Public Health Committee and the

House Medicaid Committee a proposed plan outlining the advantages and disadvantages of inpatient hospital services being included in a managed care program, including any effect on UPL payments to hospitals and ways to offset any reductions that might occur as a result of changes to the program.

(3) Any contractors providing direct patient care under a managed care program established in this section shall provide to the Legislature and the division statistical data to be shared with provider groups in order to improve patient access, appropriate utilization, cost savings and health outcomes.

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

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

(I) [Deleted]

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

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

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

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

(2) The transportation services under the program shall be provided by any reasonable provider, which may include (a) public

entities or (b) private entities and individuals who are in the business of providing nonemergency transportation, including faith-based organizations, and the division shall reimburse those entities and individuals or faith-based organizations for providing the transportation services in accordance with a mutually agreed upon reimbursement schedule.

(3) The program shall be funded from monies that are appropriated or otherwise made available to the division. The funds shall be appropriated to the division specifically to cover the cost of this program and shall not be a part of the division's regular appropriation for the operation of the federal-state Medicaid program.

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

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

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

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

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

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

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

(iii) Establishing reasonable fees, charges and rates for medical services and drugs; in doing so, the division shall fix all of those fees, charges and rates at the minimum levels absolutely necessary to provide the medical assistance authorized by this article, and shall not change any of those fees, charges or rates except as may be authorized in Section 43-13-117;

(iv) Providing for fair and impartial hearings;

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

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

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

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

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

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

(e) To make reports to the United States Department of Health and Human Services as from time to time may be required by

that federal department and to the Mississippi Legislature as provided in this section;

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

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

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

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

(j) To recover any and all payments incorrectly made by the division to a recipient or provider from the recipient or provider receiving the payments. The division shall be authorized to collect any overpayments to providers thirty (30) days after the conclusion of any administrative appeal unless the matter is appealed to a court of proper jurisdiction and bond is posted. Any appeal filed after July 1, 2014, shall be to the Chancery Court of Hinds County, Mississippi. To recover those payments, the division may use the following methods, in addition to any other methods available to the division:

(i) The division shall report to the Department of Revenue the name of any current or former Medicaid recipient who

has received medical services rendered during a period of established Medicaid ineligibility and who has not reimbursed the division for the related medical service payment(s). The Department of Revenue shall withhold from the state tax refund of the individual, and pay to the division, the amount of the payment(s) for medical services rendered to the ineligible individual that have not been reimbursed to the division for the related medical service payment(s).

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

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

(l) Have full, complete and plenary power and authority to conduct such investigations as it may deem necessary and requisite of alleged or suspected violations or abuses of the

provisions of this article or of the regulations adopted under this article, including, but not limited to, fraudulent or unlawful act or deed by applicants for Medicaid or other benefits, or payments made to any person, firm or corporation under the terms, conditions and authority of this article, to suspend or disqualify any provider of services, applicant or recipient for gross abuse, fraudulent or unlawful acts for such periods, including permanently, and under such conditions as the division deems proper and just, including the imposition of a legal rate of interest on the amount improperly or incorrectly paid. Recipients who are found to have misused or abused Medicaid benefits may be locked into one (1) physician and/or one (1) pharmacy of the recipient's choice for a reasonable amount of time in order to educate and promote appropriate use of medical services, in accordance with federal regulations. If an administrative hearing becomes necessary, the division may, if the provider does not succeed in his or her defense, tax the costs of the administrative hearing, including the costs of the court reporter or stenographer and transcript, to the provider. The convictions of a recipient or a provider in a state or federal court for abuse, fraudulent or unlawful acts under this chapter shall constitute an automatic disqualification of the recipient or automatic disqualification of the provider from participation under the Medicaid program.

A conviction, for the purposes of this chapter, shall include a judgment entered on a plea of nolo contendere or a

nonadjudicated guilty plea and shall have the same force as a judgment entered pursuant to a guilty plea or a conviction following trial. A certified copy of the judgment of the court of competent jurisdiction of the conviction shall constitute prima facie evidence of the conviction for disqualification purposes;

(m) Establish and provide such methods of administration as may be necessary for the proper and efficient operation of the Medicaid program, fully utilizing computer equipment as may be necessary to oversee and control all current expenditures for purposes of this article, and to closely monitor and supervise all recipient payments and vendors rendering services under this article. Notwithstanding any other provision of state law, the division is authorized to enter into a ten-year contract(s) with a vendor(s) to provide services described in this paragraph (m). Effective July 1, 2014, and notwithstanding any provision of law to the contrary, the division is authorized to extend its Fiscal Agent and Eligibility Determination System contracts expiring on July 1, 2014, for a period not to exceed three (3) years without complying with the requirements provided in Section 25-9-120 and the Personal Service Contract Review Board procurement regulations;

(n) To cooperate and contract with the federal government for the purpose of providing Medicaid to Vietnamese and Cambodian refugees, under the provisions of Public Law 94-23 and Public Law 94-24, including any amendments to those laws, only to

the extent that the Medicaid assistance and the administrative cost related thereto are one hundred percent (100%) reimbursable by the federal government. For the purposes of Section 43-13-117, persons receiving Medicaid under Public Law 94-23 and Public Law 94-24, including any amendments to those laws, shall not be considered a new group or category of recipient; and

(o) The division shall impose penalties upon Medicaid only, Title XIX participating long-term care facilities found to be in noncompliance with division and certification standards in accordance with federal and state regulations, including interest at the same rate calculated by the United States Department of Health and Human Services and/or the Centers for Medicare and Medicaid Services (CMS) under federal regulations.

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

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

(4) The division and its hearing officers shall have power to preserve and enforce order during hearings; to issue subpoenas

for, to administer oaths to and to compel the attendance and testimony of witnesses, or the production of books, papers, documents and other evidence, or the taking of depositions before any designated individual competent to administer oaths; to examine witnesses; and to do all things conformable to law that may be necessary to enable them effectively to discharge the duties of their office. In compelling the attendance and testimony of witnesses, or the production of books, papers, documents and other evidence, or the taking of depositions, as authorized by this section, the division or its hearing officers may designate an individual employed by the division or some other suitable person to execute and return that process, whose action in executing and returning that process shall be as lawful as if done by the sheriff or some other proper officer authorized to execute and return process in the county where the witness may reside. In carrying out the investigatory powers under the provisions of this article, the executive director or other designated person or persons may examine, obtain, copy or reproduce the books, papers, documents, medical charts, prescriptions and other records relating to medical care and services furnished by the provider to a recipient or designated recipients of Medicaid services under investigation. In the absence of the voluntary submission of the books, papers, documents, medical charts, prescriptions and other records, the Governor, the executive director, or other designated person may

issue and serve subpoenas instantly upon the provider, his or her agent, servant or employee for the production of the books, papers, documents, medical charts, prescriptions or other records during an audit or investigation of the provider. If any provider or his or her agent, servant or employee refuses to produce the records after being duly subpoenaed, the executive director may certify those facts and institute contempt proceedings in the manner, time and place as authorized by law for administrative proceedings. As an additional remedy, the division may recover all amounts paid to the provider covering the period of the audit or investigation, inclusive of a legal rate of interest and a reasonable attorney's fee and costs of court if suit becomes necessary. Division staff shall have immediate access to the provider's physical location, facilities, records, documents, books, and any other records relating to medical care and services rendered to recipients during regular business hours.

(5) If any person in proceedings before the division disobeys or resists any lawful order or process, or misbehaves during a hearing or so near the place thereof as to obstruct the hearing, or neglects to produce, after having been ordered to do so, any pertinent book, paper or document, or refuses to appear after having been subpoenaed, or upon appearing refuses to take the oath as a witness, or after having taken the oath refuses to be examined according to law, the executive director shall certify the facts to any court having jurisdiction in the place in which

it is sitting, and the court shall thereupon, in a summary manner, hear the evidence as to the acts complained of, and if the evidence so warrants, punish that person in the same manner and to the same extent as for a contempt committed before the court, or commit that person upon the same condition as if the doing of the forbidden act had occurred with reference to the process of, or in the presence of, the court.

(6) In suspending or terminating any provider from participation in the Medicaid program, the division shall preclude the provider from submitting claims for payment, either personally or through any clinic, group, corporation or other association to the division or its fiscal agents for any services or supplies provided under the Medicaid program except for those services or supplies provided before the suspension or termination. No clinic, group, corporation or other association that is a provider of services shall submit claims for payment to the division or its fiscal agents for any services or supplies provided by a person within that organization who has been suspended or terminated from participation in the Medicaid program except for those services or supplies provided before the suspension or termination. When this provision is violated by a provider of services that is a clinic, group, corporation or other association, the division may suspend or terminate that organization from participation. Suspension may be applied by the division to all known affiliates of a provider, provided that each decision to include an affiliate is made on a

case-by-case basis after giving due regard to all relevant facts and circumstances. The violation, failure or inadequacy of performance may be imputed to a person with whom the provider is affiliated where that conduct was accomplished within the course of his or her official duty or was effectuated by him or her with the knowledge or approval of that person.

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

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

(b) Previous or current exclusion, suspension, termination from or the involuntary withdrawing from participation in the Medicaid program, any other state's Medicaid program, Medicare or any other public or private health or health insurance program. If the division ascertains that a provider has been convicted of a felony under federal or state law for an offense that the division determines is detrimental to the best interest of the program or of Medicaid beneficiaries, the division may

refuse to enter into an agreement with that provider, or may terminate or refuse to renew an existing agreement.

(c) Conviction under federal or state law of a criminal offense relating to the delivery of any goods, services or supplies, including the performance of management or administrative services relating to the delivery of the goods, services or supplies, under the Medicaid program, any other state's Medicaid program, Medicare or any other public or private health or health insurance program.

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

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

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

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

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

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

(j) Revocation of license or certification.

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

(l) Failure to meet any condition of enrollment.

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

43-13-125. (1) If Medicaid is provided to a recipient under this article for injuries, disease or sickness caused under circumstances creating a cause of action in favor of the recipient against any person, firm *** * ***, corporation, political subdivision or other state agency, then the division shall be entitled to recover the proceeds that may result from the exercise of any rights of recovery that the recipient may have against any such person, firm *** * ***, corporation, political subdivision or other state agency, to the extent of the Division of Medicaid's interest on behalf of the recipient. The recipient shall execute and deliver instruments and papers to do whatever is necessary to secure those rights and shall do nothing after Medicaid is provided to prejudice the subrogation rights of the division. Court orders or agreements for reimbursement of Medicaid's

interest shall direct those payments to the Division of Medicaid, which shall be authorized to endorse any and all, including, but not limited to, multipayee checks, drafts, money orders, or other negotiable instruments representing Medicaid payment recoveries that are received. In accordance with Section 43-13-305, endorsement of multipayee checks, drafts, money orders or other negotiable instruments by the Division of Medicaid shall be deemed endorsed by the recipient. All payments must be remitted to the division within sixty (60) days from the date of a settlement or the entry of a final judgment; failure to do so hereby authorizes the division to assert its rights under Sections 43-13-307 and 43-13-315, plus interest.

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

(2) The acceptance of Medicaid under this article or the making of a claim under this article shall not affect the right of a recipient or his or her legal representative to recover Medicaid's interest as an element of damages in any action at law; however, a copy of the pleadings shall be certified to the division at the time of the institution of suit, and proof of that notice shall be filed of record in that action. The division may, at any time before the trial on the facts, join in that

action or may intervene in that action. Any amount recovered by a recipient or his or her legal representative shall be applied as follows:

(a) The reasonable costs of the collection, including attorney's fees, as approved and allowed by the court in which that action is pending, or in case of settlement without suit, by the legal representative of the division;

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

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

(3) No compromise of any claim by the recipient or his or her legal representative shall be binding upon or affect the rights of the division against the third party unless the division, with the approval of the Governor, has entered into the compromise in writing. The recipient or his or her legal representative maintain the absolute duty to notify the division of the institution of legal proceedings, and the third party and his or her insurer maintain the absolute duty to notify the division of a proposed compromise for which the division has an interest. The aforementioned absolute duties may not be delegated or assigned by contract or otherwise. Any compromise effected by the recipient or his or her legal representative with the third party in the absence of advance notification to and approved by

the division shall constitute conclusive evidence of the liability of the third party, and the division, in litigating its claim against the third party, shall be required only to prove the amount and correctness of its claim relating to the injury, disease or sickness. If the recipient or his or her legal representative fails to notify the division of the institution of legal proceedings against a third party for which the division has a cause of action, the facts relating to negligence and the liability of the third party, if judgment is rendered for the recipient, shall constitute conclusive evidence of liability in a subsequent action maintained by the division and only the amount and correctness of the division's claim relating to injuries, disease or sickness shall be tried before the court. The division shall be authorized in bringing that action against the third party and his or her insurer jointly or against the insurer alone.

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

(5) Any amounts recovered by the division under this section shall, by the division, be placed to the credit of the funds appropriated for benefits under this article proportionate to the

amounts provided by the state and federal governments respectively.

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

43-13-145. (1) (a) Upon each nursing facility licensed by the State of Mississippi, there is levied an assessment in an amount set by the division, equal to the maximum rate allowed by federal law or regulation, for each licensed and occupied bed of the facility.

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

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

(ii) The State Veterans Affairs Board; or

(iii) The University of Mississippi Medical Center.

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

(b) An intermediate care facility for * * * individuals with intellectual disabilities is exempt from the assessment

levied under this subsection if the facility is operated under the direction and control of:

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

(ii) The State Veterans Affairs Board; or

(iii) The University of Mississippi Medical Center.

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

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

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

(ii) The University of Mississippi Medical Center; or

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

(4) Hospital assessment.

(a) (i) Subject to and upon fulfillment of the requirements and conditions of paragraph (f) below, and

notwithstanding any other provisions of this section, effective for state fiscal year 2013 * * *, fiscal year 2014, fiscal year 2015 and fiscal year 2016, an annual assessment on each hospital licensed in the state is imposed on each non-Medicare hospital inpatient day as defined below at a rate that is determined by dividing the sum prescribed in this subparagraph (i), plus the nonfederal share necessary to maximize the Disproportionate Share Hospital (DSH) and inpatient Medicare Upper Payment Limits (UPL) payments, by the total number of non-Medicare hospital inpatient days as defined below for all licensed Mississippi hospitals, except as provided in paragraph (d) below. If the state matching funds percentage for the Mississippi Medicaid program is sixteen percent (16%) or less, the sum used in the formula under this subparagraph (i) shall be Seventy-four Million Dollars ($74,000,000.00). If the state matching funds percentage for the Mississippi Medicaid program is twenty-four percent (24%) or higher, the sum used in the formula under this subparagraph (i) shall be One Hundred Four Million Dollars ($104,000,000.00). If the state matching funds percentage for the Mississippi Medicaid program is between sixteen percent (16%) and twenty-four percent (24%), the sum used in the formula under this subparagraph (i) shall be a pro rata amount determined as follows: the current state matching funds percentage rate minus sixteen percent (16%) divided by eight percent (8%) multiplied by Thirty Million Dollars ($30,000,000.00) and add that amount to Seventy-four Million

Dollars ($74,000,000.00). However, no assessment in a quarter under this subparagraph (i) may exceed the assessment in the previous quarter by more than Three Million Seven Hundred Fifty Thousand Dollars ($3,750,000.00) (which would be Fifteen Million Dollars ($15,000,000.00) on an annualized basis). The division shall publish the state matching funds percentage rate applicable to the Mississippi Medicaid program on the tenth day of the first month of each quarter and the assessment determined under the formula prescribed above shall be applicable in the quarter following any adjustment in that state matching funds percentage rate. The division shall notify each hospital licensed in the state as to any projected increases or decreases in the assessment determined under this subparagraph (i). However, if the Centers for Medicare and Medicaid Services (CMS) does not approve the provision in Section 43-13-117(39) requiring the division to reimburse crossover claims for inpatient hospital services and crossover claims covered under Medicare Part B for dually eligible beneficiaries in the same manner that was in effect on January 1, 2008, the sum that otherwise would have been used in the formula under this subparagraph (i) shall be reduced by Seven Million Dollars ($7,000,000.00).

(ii) In addition to the assessment provided under subparagraph (i), effective for state fiscal year 2013 *** * ***, fiscal year 2014, fiscal year 2015 and fiscal year 2016, an additional annual assessment on each hospital licensed in the

state is imposed on each non-Medicare hospital inpatient day as defined below at a rate that is determined by dividing twenty-five percent (25%) of any provider reductions in the Medicaid program as authorized in Section 43-13-117(F) for that fiscal year up to the following maximum amount, plus the nonfederal share necessary to maximize the Disproportionate Share Hospital (DSH) and inpatient Medicare Upper Payment Limits (UPL) payments, by the total number of non-Medicare hospital inpatient days as defined below for all licensed Mississippi hospitals: in fiscal year 2010, the maximum amount shall be Twenty-four Million Dollars ($24,000,000.00); in fiscal year 2011, the maximum amount shall be Thirty-two Million Dollars ($32,000,000.00); and in fiscal year 2012 and thereafter, the maximum amount shall be Forty Million Dollars ($40,000,000.00). Any such deficit in the Medicaid program shall be reviewed by the PEER Committee as provided in Section 43-13-117(F).

(iii) In addition to the assessments provided in subparagraphs (i) and (ii), effective for state fiscal year * * * 2015 and fiscal year * * * 2016, an additional annual assessment on each hospital licensed in the state is imposed pursuant to the provisions of Section 43-13-117(F) if the cost containment measures described therein have been implemented and there are insufficient funds in the Health Care Trust Fund to reconcile any remaining deficit in any fiscal year. If the Governor institutes any other additional cost containment measures on any program or

programs authorized under the Medicaid program pursuant to Section 43-13-117(F), hospitals shall be responsible for twenty-five percent (25%) of any such additional imposed provider cuts, which shall be in the form of an additional assessment not to exceed the twenty-five percent (25%) of provider expenditure reductions. Such additional assessment shall be imposed on each non-Medicare hospital inpatient day in the same manner as assessments are imposed under subparagraphs (i) and (ii).

(b) Payment and definitions.

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

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

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

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

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

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

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

(c) The assessment provided in this subsection is intended to satisfy and not be in addition to the assessment and intergovernmental transfers provided in Section 43-13-117(A)(18). Nothing in this section shall be construed to authorize any state agency, division or department, or county, municipality or other local governmental unit to license for revenue, levy or impose any

other tax, fee or assessment upon hospitals in this state not authorized by a specific statute.

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

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

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

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

(f) Applicability.

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

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

(ii) CMS revokes its approval of the division's 2009 Medicaid State Plan Amendment for the methodology for DSH and inpatient UPL payments to hospitals under Section 43-13-117(A)(18).

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

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

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

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

(8) The assessment levied under this section shall be in addition to any other assessments, taxes or fees levied by law,

and the assessment shall constitute a debt due the State of Mississippi from the time the assessment is due until it is paid.

(9) (a) If a health care facility that is liable for payment of an assessment levied by the division does not pay the assessment when it is due, the division shall give written notice to the health care facility by certified or registered mail demanding payment of the assessment within ten (10) days from the date of delivery of the notice. If the health care facility fails or refuses to pay the assessment after receiving the notice and demand from the division, the division shall withhold from any Medicaid reimbursement payments that are due to the health care facility the amount of the unpaid assessment and a penalty of ten percent (10%) of the amount of the assessment, plus the legal rate of interest until the assessment is paid in full. If the health care facility does not participate in the Medicaid program, the division shall turn over to the Office of the Attorney General the collection of the unpaid assessment by civil action. In any such civil action, the Office of the Attorney General shall collect the amount of the unpaid assessment and a penalty of ten percent (10%) of the amount of the assessment, plus the legal rate of interest until the assessment is paid in full.

(b) As an additional or alternative method for collecting unpaid assessments levied by the division, if a health care facility fails or refuses to pay the assessment after receiving notice and demand from the division, the division may

file a notice of a tax lien with the chancery clerk of the county in which the health care facility is located, for the amount of the unpaid assessment and a penalty of ten percent (10%) of the amount of the assessment, plus the legal rate of interest until the assessment is paid in full. Immediately upon receipt of notice of the tax lien for the assessment, the chancery clerk shall forward the notice to the circuit clerk who shall enter the notice of the tax lien as a judgment upon the judgment roll and show in the appropriate columns the name of the health care facility as judgment debtor, the name of the division as judgment creditor, the amount of the unpaid assessment, and the date and time of enrollment. The judgment shall be valid as against mortgagees, pledgees, entrusters, purchasers, judgment creditors and other persons from the time of filing with the clerk. The amount of the judgment shall be a debt due the State of Mississippi and remain a lien upon the tangible property of the health care facility until the judgment is satisfied. The judgment shall be the equivalent of any enrolled judgment of a court of record and shall serve as authority for the issuance of writs of execution, writs of attachment or other remedial writs.

(10) As soon as possible after July 1, 2009, the Division of Medicaid shall submit to the Centers for Medicare and Medicaid Services (CMS) a state plan amendment or amendments (SPA) regarding the hospital assessment established under subsection (4) of this section. In addition to defining the assessment

established in subsection (4) of this section, the state plan amendment or amendments shall include any amendments necessary to provide for the following additional annual Medicare Upper Payment Limits (UPL) and Disproportionate Share Hospital (DSH) payments to hospitals located in Mississippi that participate in the Medicaid program:

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

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

(c) General acute care hospitals licensed within the class of nonstate government hospitals shall receive an additional inpatient UPL payment determined by multiplying inpatient payments, excluding DSH and UPL, by the uniform percentage necessary to exhaust the maximum amount of inpatient UPL payments permissible under federal regulations. (For state fiscal

year * * * 2015 and fiscal year * * * 2016, the state shall use * * * 2013 inpatient payment data).

* * *

(* * *d) In addition to other payments provided above, all hospitals licensed within the class of private hospitals * * * shall receive an additional inpatient UPL payment determined by multiplying inpatient payments, excluding DSH and UPL, by the uniform percentage necessary to exhaust the maximum amount of UPL inpatient payments permissible under federal regulations. For state fiscal year * * * 2015 and fiscal year * * * 2016, the state shall use * * * 2013 data.

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

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

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

(13) The DSH and inpatient UPL payments shall be paid on or before December 31, March 31, and June 30 of each fiscal year, in increments of one-third (1/3) of the total calculated DSH and inpatient UPL amounts.

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

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

(16) Nothing in this section shall prevent the Division of Medicaid from facilitating participation in Medicaid supplemental hospital payment programs by a hospital located in a county contiguous to the State of Mississippi that is also authorized by federal law to submit intergovernmental transfers (IGTs) to the

State of Mississippi to fund the state share of the hospital's supplemental payments.

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

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

41-86-9. On January 1, 2013, the Mississippi Children's Health Insurance Program and the current contract for insurance services shall be transferred from the State and School Employees Health Insurance Management Board to the Division of Medicaid, and the division shall be responsible for the implementation and administration of the Mississippi Children's Health Insurance Program in accordance with federal law and regulations and this chapter from and after January 1, 2013. The Health Insurance Management Board shall be responsible for any audit or claims processing issues for the period during which the board administered the program. Effective January 1, 2015, and notwithstanding any other provision of law to the contrary, the division is authorized to operate the program as described under Section 43-13-117(H).

SECTION 7. Not later than December 15, 2014, the Division of Medicaid shall prepare and deliver a report to the Chairmen of the Senate Public Health and Welfare Committee and the House Medicaid Committee on the impact of referrals by physicians for advanced imaging services using equipment owned in full or in part by the

referring physician. The report shall include data on referral patterns that may indicate fraud or abuse.

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

Further, amend by striking the title in its entirety and inserting in lieu thereof the following:

AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO EXTEND THE AUTOMATIC REPEALER ON THE STATUTE THAT PROVIDES HEALTH CARE SERVICES COVERED UNDER THE MEDICAID PROGRAM; TO DELETE THE LIMITATION ON EMERGENCY ROOM VISITS COVERED UNDER THE MEDICAID PROGRAM; TO DIRECT THE DIVISION TO UPDATE THE CASE-MIX PAYMENT SYSTEM FOR NURSING SERVICES; TO DIRECT THE DIVISION TO UPDATE THE FAIR RENTAL REIMBURSEMENT SYSTEM FOR INTERMEDIATE CARE FACILITIES FOR THE INTELLECTUALLY DISABLED; TO AUTHORIZE A MEDICARE UPPER PAYMENT LIMITS PROGRAM FOR PHYSICIANS EMPLOYED BY PUBLIC HOSPITALS AND AUTHORIZE THE UPL PROGRAM FOR PHYSICIANS EMPLOYED BY PRIVATE HOSPITALS; TO DIRECT THE DIVISION TO UPDATE THE FAIR RENTAL REIMBURSEMENT SYSTEM FOR PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES; TO REVISE THE CAP ON ENROLLMENT IN MEDICAID MANAGED CARE OR SIMILAR PROGRAMS; TO DIRECT THE DIVISION TO DEVELOP A PLAN FOR CERTAIN RECIPIENTS UNDER THE MANAGED CARE PROGRAM; TO DIRECT MEDICAID MANAGED CARE PROGRAMS TO PROVIDE STATISTICAL DATA TO THE LEGISLATURE AND THE DIVISION ON A REASONABLE TIMELINE; TO REVISE LANGUAGE RELATING TO THE MEDICAID REIMBURSEMENT FOR FREESTANDING PSYCHIATRIC HOSPITALS; TO PROVIDE THAT THE MEDICAID PLAN SHALL NOT RESTRICT COVERAGE FOR PHYSICIAN PRESCRIBED TREATMENT BASED UPON THE INDIVIDUAL'S DIAGNOSIS WITH A TERMINAL CONDITION; TO AUTHORIZE THE DIVISION TO REIMBURSE FOR CERTAIN PRIMARY CARE SERVICES AT THE MEDICARE RATE; TO CLARIFY THAT THE STATE DEPARTMENT OF HEALTH SHALL BE REIMBURSED ON A FULL REASONABLE COST BASIS FOR PHRM/ISS SERVICES; TO AMEND SECTION 43-13-119, MISSISSIPPI CODE OF 1972, TO EXTEND THE AUTOMATIC REPEALER ON THE TRANSPORTATION PROGRAM FOR RECIPIENTS RECEIVING NECESSARY DIALYSIS SERVICES; TO AMEND SECTION 43-13-121, MISSISSIPPI CODE OF 1972, TO AUTHORIZE THE DIVISION OF MEDICAID TO EXTEND ITS FISCAL AGENT AND ELIGIBILITY DETERMINATION SYSTEM CONTRACTS WITHOUT ISSUING FORMAL REQUESTS FOR PROPOSALS; TO PROVIDE FOR THE VENUE OF CIVIL ACTIONS AGAINST THE DIVISION BY PROVIDERS; TO AMEND SECTION 43-13-125, MISSISSIPPI CODE OF 1972, TO CLARIFY THE RIGHTS OF THE DIVISION OF MEDICAID WITH RESPECT TO A CLAIM AGAINST A THIRD PARTY; TO AMEND SECTION 43-13-145, MISSISSIPPI CODE OF 1972, TO EXTEND THE DATE OF THE REPEALERS ON THE ANNUAL ASSESSMENT ON LICENSED HOSPITALS IN MISSISSIPPI TO

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

CONFEREES FOR THE HOUSE	CONFEREES FOR THE SENATE
X (SIGNED) Howell	X (SIGNED) Kirby
X (SIGNED) Barker	X (SIGNED) Bryan
X (SIGNED) White	X (SIGNED) Burton