MISSISSIPPI LEGISLATURE REGULAR SESSION 2018

By: Representative Baker To: Medicaid

HOUSE BILL NO. 737

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO DELETE THE SPECIFIC SERVICES COVERED UNDER THE MEDICAID PROGRAM
3 AND PROVIDE THAT THE COVERED SERVICES WILL BE DETERMINED BY THE
4 DIVISION OF MEDICAID, WITH THE APPROVAL OF THE GOVERNOR; TO DELETE
5 THE REPEALER ON THAT SECTION; TO AMEND SECTIONS 41-86-9,
6 43-13-115, 43-13-145, 43-14-1, 83-5-601, 83-5-603 AND 83-5-607,
7 MISSISSIPPI CODE OF 1972, TO CONFORM TO THE PRECEDING PROVISIONS;
8 TO FURTHER AMEND SECTION 43-13-145, MISSISSIPPI CODE OF 1972, TO
9 EXTEND THE DATE OF THE REPEALER ON THAT SECTION; AND FOR RELATED
10 PURPOSES.

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

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

14 43-13-117. *** * *** Medicaid as authorized by this article
15 shall include payment of part or all of the costs *** * *** of
16 the *** * *** types of care and services <u>as determined by the</u>
17 <u>division, with the approval of the Governor, that are</u> rendered to
18 eligible applicants who have been determined to be eligible for
19 that care and services, within the limits of state appropriations
20 and federal matching funds *** * ***<u>.</u>

21 *** * ***

22 **SECTION 2.** Section 41-86-9, Mississippi Code of 1972, is
23 amended as follows:
24 41-86-9. On January 1, 2013, the Mississippi Children's
25 Health Insurance Program and the current contract for insurance
26 services shall be transferred from the State and School Employees
27 Health Insurance Management Board to the Division of Medicaid, and
28 the division shall be responsible for the implementation and
29 administration of the Mississippi Children's Health Insurance
30 Program in accordance with federal law and regulations and this
31 chapter from and after January 1, 2013. The Health Insurance
32 Management Board shall be responsible for any audit or claims
33 processing issues for the period during which the board
34 administered the program. *** * * ***
35 **SECTION 3.** Section 43-13-115, Mississippi Code of 1972, is
36 amended as follows:
37 43-13-115. Recipients of Medicaid shall be the following
38 persons only:
39 (1) Those who are qualified for public assistance
40 grants under provisions of Title IV-A and E of the federal Social
41 Security Act, as amended, including those statutorily deemed to be
42 IV-A and low-income families and children under Section 1931 of
43 the federal Social Security Act. For the purposes of this
44 paragraph (1) and paragraphs (8), (17) and (18) of this section,
45 any reference to Title IV-A or to Part A of Title IV of the
46 federal Social Security Act, as amended, or the state plan under

47 Title IV-A or Part A of Title IV, shall be considered as a
48 reference to Title IV-A of the federal Social Security Act, as
49 amended, and the state plan under Title IV-A, including the income
50 and resource standards and methodologies under Title IV-A and the
51 state plan, as they existed on July 16, 1996. The Department of
52 Human Services shall determine Medicaid eligibility for children
53 receiving public assistance grants under Title IV-E. The division
54 shall determine eligibility for low-income families under Section
55 1931 of the federal Social Security Act and shall redetermine
56 eligibility for those continuing under Title IV-A grants.
57 (2) Those qualified for Supplemental Security Income
58 (SSI) benefits under Title XVI of the federal Social Security Act,
59 as amended, and those who are deemed SSI eligible as contained in
60 federal statute. The eligibility of individuals covered in this
61 paragraph shall be determined by the Social Security
62 Administration and certified to the Division of Medicaid.
63 (3) Qualified pregnant women who would be eligible for
64 Medicaid as a low-income family member under Section 1931 of the
65 federal Social Security Act if her child were born. The
66 eligibility of the individuals covered under this paragraph shall
67 be determined by the division.
68 (4) [Deleted]
69 (5) A child born on or after October 1, 1984, to a
70 woman eligible for and receiving Medicaid under the state plan on
71 the date of the child's birth shall be deemed to have applied for

72 Medicaid and to have been found eligible for Medicaid under the
73 plan on the date of that birth, and will remain eligible for
74 Medicaid for a period of one (1) year so long as the child is a
75 member of the woman's household and the woman remains eligible for
76 Medicaid or would be eligible for Medicaid if pregnant. The
77 eligibility of individuals covered in this paragraph shall be
78 determined by the Division of Medicaid.

79 (6) Children certified by the State Department of Human
80 Services to the Division of Medicaid of whom the state and county
81 departments of human services have custody and financial
82 responsibility, and children who are in adoptions subsidized in
83 full or part by the Department of Human Services, including
84 special needs children in non-Title IV-E adoption assistance, who
85 are approvable under Title XIX of the Medicaid program. The
86 eligibility of the children covered under this paragraph shall be
87 determined by the State Department of Human Services.

88 (7) Persons certified by the Division of Medicaid who
89 are patients in a medical facility (nursing home, hospital,
90 tuberculosis sanatorium or institution for treatment of mental
91 diseases), and who, except for the fact that they are patients in
92 that medical facility, would qualify for grants under Title IV,
93 Supplementary Security Income (SSI) benefits under Title XVI or
94 state supplements, and those aged, blind and disabled persons who
95 would not be eligible for Supplemental Security Income (SSI)
96 benefits under Title XVI or state supplements if they were not

97 institutionalized in a medical facility but whose income is below
98 the maximum standard set by the Division of Medicaid, which
99 standard shall not exceed that prescribed by federal regulation.
100 (8) Children under eighteen (18) years of age and
101 pregnant women (including those in intact families) who meet the
102 financial standards of the state plan approved under Title IV-A of
103 the federal Social Security Act, as amended. The eligibility of
104 children covered under this paragraph shall be determined by the
105 Division of Medicaid.
106 (9) Individuals who are:
107 (a) Children born after September 30, 1983, who
108 have not attained the age of nineteen (19), with family income
109 that does not exceed one hundred percent (100%) of the nonfarm
110 official poverty level;
111 (b) Pregnant women, infants and children who have
112 not attained the age of six (6), with family income that does not
113 exceed one hundred thirty-three percent (133%) of the federal
114 poverty level; and
115 (c) Pregnant women and infants who have not
116 attained the age of one (1), with family income that does not
117 exceed one hundred eighty-five percent (185%) of the federal
118 poverty level.
119 The eligibility of individuals covered in (a), (b) and (c) of
120 this paragraph shall be determined by the division.

121 (10) Certain disabled children age eighteen (18) or
122 under who are living at home, who would be eligible, if in a
123 medical institution, for SSI or a state supplemental payment under
124 Title XVI of the federal Social Security Act, as amended, and
125 therefore for Medicaid under the plan, and for whom the state has
126 made a determination as required under Section 1902(e)(3)(b) of
127 the federal Social Security Act, as amended. The eligibility of
128 individuals under this paragraph shall be determined by the
129 Division of Medicaid.

130 (11) Until the end of the day on December 31, 2005,
131 individuals who are sixty-five (65) years of age or older or are
132 disabled as determined under Section 1614(a)(3) of the federal
133 Social Security Act, as amended, and whose income does not exceed
134 one hundred thirty-five percent (135%) of the nonfarm official
135 poverty level as defined by the Office of Management and Budget
136 and revised annually, and whose resources do not exceed those
137 established by the Division of Medicaid. The eligibility of
138 individuals covered under this paragraph shall be determined by
139 the Division of Medicaid. After December 31, 2005, only those
140 individuals covered under the 1115(c) Healthier Mississippi waiver
141 will be covered under this category.

142 Any individual who applied for Medicaid during the period
143 from July 1, 2004, through March 31, 2005, who otherwise would
144 have been eligible for coverage under this paragraph (11) if it
145 had been in effect at the time the individual submitted his or her

146 application and is still eligible for coverage under this
147 paragraph (11) on March 31, 2005, shall be eligible for Medicaid
148 coverage under this paragraph (11) from March 31, 2005, through
149 December 31, 2005. The division shall give priority in processing
150 the applications for those individuals to determine their
151 eligibility under this paragraph (11).
152 (12) Individuals who are qualified Medicare
153 beneficiaries (QMB) entitled to Part A Medicare as defined under
154 Section 301, Public Law 100-360, known as the Medicare
155 Catastrophic Coverage Act of 1988, and whose income does not
156 exceed one hundred percent (100%) of the nonfarm official poverty
157 level as defined by the Office of Management and Budget and
158 revised annually.
159 The eligibility of individuals covered under this paragraph
160 shall be determined by the Division of Medicaid, and those
161 individuals determined eligible shall receive Medicare
162 cost-sharing expenses only as more fully defined by the Medicare
163 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
164 1997.
165 (13) (a) Individuals who are entitled to Medicare Part
166 A as defined in Section 4501 of the Omnibus Budget Reconciliation
167 Act of 1990, and whose income does not exceed one hundred twenty
168 percent (120%) of the nonfarm official poverty level as defined by
169 the Office of Management and Budget and revised annually.

170 Eligibility for Medicaid benefits is limited to full payment of
171 Medicare Part B premiums.

172 (b) Individuals entitled to Part A of Medicare,
173 with income above one hundred twenty percent (120%), but less than
174 one hundred thirty-five percent (135%) of the federal poverty
175 level, and not otherwise eligible for Medicaid. Eligibility for
176 Medicaid benefits is limited to full payment of Medicare Part B
177 premiums. The number of eligible individuals is limited by the
178 availability of the federal capped allocation at one hundred
179 percent (100%) of federal matching funds, as more fully defined in
180 the Balanced Budget Act of 1997.

181 The eligibility of individuals covered under this paragraph
182 shall be determined by the Division of Medicaid.

183 (14) [Deleted]

184 (15) Disabled workers who are eligible to enroll in
185 Part A Medicare as required by Public Law 101-239, known as the
186 Omnibus Budget Reconciliation Act of 1989, and whose income does
187 not exceed two hundred percent (200%) of the federal poverty level
188 as determined in accordance with the Supplemental Security Income
189 (SSI) program. The eligibility of individuals covered under this
190 paragraph shall be determined by the Division of Medicaid and
191 those individuals shall be entitled to buy-in coverage of Medicare
192 Part A premiums only under the provisions of this paragraph (15).

193 (16) In accordance with the terms and conditions of
194 approved Title XIX waiver from the United States Department of

195 Health and Human Services, persons provided home- and
196 community-based services who are physically disabled and certified
197 by the Division of Medicaid as eligible due to applying the income
198 and deeming requirements as if they were institutionalized.
199 (17) In accordance with the terms of the federal
200 Personal Responsibility and Work Opportunity Reconciliation Act of
201 1996 (Public Law 104-193), persons who become ineligible for
202 assistance under Title IV-A of the federal Social Security Act, as
203 amended, because of increased income from or hours of employment
204 of the caretaker relative or because of the expiration of the
205 applicable earned income disregards, who were eligible for
206 Medicaid for at least three (3) of the six (6) months preceding
207 the month in which the ineligibility begins, shall be eligible for
208 Medicaid for up to twelve (12) months. The eligibility of the
209 individuals covered under this paragraph shall be determined by
210 the division.
211 (18) Persons who become ineligible for assistance under
212 Title IV-A of the federal Social Security Act, as amended, as a
213 result, in whole or in part, of the collection or increased
214 collection of child or spousal support under Title IV-D of the
215 federal Social Security Act, as amended, who were eligible for
216 Medicaid for at least three (3) of the six (6) months immediately
217 preceding the month in which the ineligibility begins, shall be
218 eligible for Medicaid for an additional four (4) months beginning
219 with the month in which the ineligibility begins. The eligibility

220 of the individuals covered under this paragraph shall be
221 determined by the division.
222 (19) Disabled workers, whose incomes are above the
223 Medicaid eligibility limits, but below two hundred fifty percent
224 (250%) of the federal poverty level, shall be allowed to purchase
225 Medicaid coverage on a sliding fee scale developed by the Division
226 of Medicaid.
227 (20) Medicaid eligible children under age eighteen (18)
228 shall remain eligible for Medicaid benefits until the end of a
229 period of twelve (12) months following an eligibility
230 determination, or until such time that the individual exceeds age
231 eighteen (18).
232 (21) Women of childbearing age whose family income does
233 not exceed one hundred eighty-five percent (185%) of the federal
234 poverty level. The eligibility of individuals covered under this
235 paragraph (21) shall be determined by the Division of Medicaid,
236 and those individuals determined eligible shall only receive
237 family planning services covered under Section 43-13-117 *** * *** and
238 not any other services covered under Medicaid. However, any
239 individual eligible under this paragraph (21) who is also eligible
240 under any other provision of this section shall receive the
241 benefits to which he or she is entitled under that other
242 provision, in addition to family planning services covered under
243 Section 43-13-117 *** * ***.

244 The Division of Medicaid shall apply to the United States
245 Secretary of Health and Human Services for a federal waiver of the
246 applicable provisions of Title XIX of the federal Social Security
247 Act, as amended, and any other applicable provisions of federal
248 law as necessary to allow for the implementation of this paragraph
249 (21). The provisions of this paragraph (21) shall be implemented
250 from and after the date that the Division of Medicaid receives the
251 federal waiver.

252 (22) Persons who are workers with a potentially severe
253 disability, as determined by the division, shall be allowed to
254 purchase Medicaid coverage. The term "worker with a potentially
255 severe disability" means a person who is at least sixteen (16)
256 years of age but under sixty-five (65) years of age, who has a
257 physical or mental impairment that is reasonably expected to cause
258 the person to become blind or disabled as defined under Section
259 1614(a) of the federal Social Security Act, as amended, if the
260 person does not receive items and services provided under
261 Medicaid.

262 The eligibility of persons under this paragraph (22) shall be
263 conducted as a demonstration project that is consistent with
264 Section 204 of the Ticket to Work and Work Incentives Improvement
265 Act of 1999, Public Law 106-170, for a certain number of persons
266 as specified by the division. The eligibility of individuals
267 covered under this paragraph (22) shall be determined by the
268 Division of Medicaid.

269 (23) Children certified by the Mississippi Department
270 of Human Services for whom the state and county departments of
271 human services have custody and financial responsibility who are
272 in foster care on their eighteenth birthday as reported by the
273 Mississippi Department of Human Services shall be certified
274 Medicaid eligible by the Division of Medicaid until their
275 twenty-first birthday.

276 (24) Individuals who have not attained age sixty-five
277 (65), are not otherwise covered by creditable coverage as defined
278 in the Public Health Services Act, and have been screened for
279 breast and cervical cancer under the Centers for Disease Control
280 and Prevention Breast and Cervical Cancer Early Detection Program
281 established under Title XV of the Public Health Service Act in
282 accordance with the requirements of that act and who need
283 treatment for breast or cervical cancer. Eligibility of
284 individuals under this paragraph (24) shall be determined by the
285 Division of Medicaid.

286 (25) The division shall apply to the Centers for
287 Medicare and Medicaid Services (CMS) for any necessary waivers to
288 provide services to individuals who are sixty-five (65) years of
289 age or older or are disabled as determined under Section
290 1614(a)(3) of the federal Social Security Act, as amended, and
291 whose income does not exceed one hundred thirty-five percent
292 (135%) of the nonfarm official poverty level as defined by the
293 Office of Management and Budget and revised annually, and whose

294 resources do not exceed those established by the Division of
295 Medicaid, and who are not otherwise covered by Medicare. Nothing
296 contained in this paragraph (25) shall entitle an individual to
297 benefits. The eligibility of individuals covered under this
298 paragraph shall be determined by the Division of Medicaid.
299 (26) The division shall apply to the Centers for
300 Medicare and Medicaid Services (CMS) for any necessary waivers to
301 provide services to individuals who are sixty-five (65) years of
302 age or older or are disabled as determined under Section
303 1614(a)(3) of the federal Social Security Act, as amended, who are
304 end stage renal disease patients on dialysis, cancer patients on
305 chemotherapy or organ transplant recipients on antirejection
306 drugs, whose income does not exceed one hundred thirty-five
307 percent (135%) of the nonfarm official poverty level as defined by
308 the Office of Management and Budget and revised annually, and
309 whose resources do not exceed those established by the division.
310 Nothing contained in this paragraph (26) shall entitle an
311 individual to benefits. The eligibility of individuals covered
312 under this paragraph shall be determined by the Division of
313 Medicaid.
314 (27) Individuals who are entitled to Medicare Part D
315 and whose income does not exceed one hundred fifty percent (150%)
316 of the nonfarm official poverty level as defined by the Office of
317 Management and Budget and revised annually. Eligibility for

318 payment of the Medicare Part D subsidy under this paragraph shall
319 be determined by the division.

320 The division shall redetermine eligibility for all categories
321 of recipients described in each paragraph of this section not less
322 frequently than required by federal law.

323 **SECTION 4.** Section 43-13-145, Mississippi Code of 1972, is
324 amended as follows:

325 43-13-145. (1) (a) Upon each nursing facility licensed by
326 the State of Mississippi, there is levied an assessment in an
327 amount set by the division, equal to the maximum rate allowed by
328 federal law or regulation, for each licensed and occupied bed of
329 the facility.

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

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

335 (ii) The State Veterans Affairs Board; or

336 (iii) The University of Mississippi Medical
337 Center.

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

343 (b) An intermediate care facility for individuals with
344 intellectual disabilities is exempt from the assessment levied
345 under this subsection if the facility is operated under the
346 direction and control of:
347 (i) The United States Veterans Administration or
348 other agency or department of the United States government;
349 (ii) The State Veterans Affairs Board; or
350 (iii) The University of Mississippi Medical
351 Center.
352 (3) (a) Upon each psychiatric residential treatment
353 facility licensed by the State of Mississippi, there is levied an
354 assessment in an amount set by the division, equal to the maximum
355 rate allowed by federal law or regulation, for each licensed and
356 occupied bed of the facility.
357 (b) A psychiatric residential treatment facility is
358 exempt from the assessment levied under this subsection if the
359 facility is operated under the direction and control of:
360 (i) The United States Veterans Administration or
361 other agency or department of the United States government;
362 (ii) The University of Mississippi Medical Center;
363 or
364 (iii) A state agency or a state facility that
365 either provides its own state match through intergovernmental
366 transfer or certification of funds to the division.
367 (4) Hospital assessment.

368 (a) (i) Subject to and upon fulfillment of the
369 requirements and conditions of paragraph (f) below, and
370 notwithstanding any other provisions of this section, effective
371 for state fiscal year 2016, fiscal year 2017 and fiscal year 2018,
372 an annual assessment on each hospital licensed in the state is
373 imposed on each non-Medicare hospital inpatient day as defined
374 below at a rate that is determined by dividing the sum prescribed
375 in this subparagraph (i), plus the nonfederal share necessary to
376 maximize the Disproportionate Share Hospital (DSH) and inpatient
377 Medicare Upper Payment Limits (UPL) Program payments and inpatient
378 hospital access payments, by the total number of non-Medicare
379 hospital inpatient days as defined below for all licensed
380 Mississippi hospitals, except as provided in paragraph (d) below.
381 If the state matching funds percentage for the Mississippi
382 Medicaid program is sixteen percent (16%) or less, the sum used in
383 the formula under this subparagraph (i) shall be Seventy-four
384 Million Dollars ($74,000,000.00). If the state matching funds
385 percentage for the Mississippi Medicaid program is twenty-four
386 percent (24%) or higher, the sum used in the formula under this
387 subparagraph (i) shall be One Hundred Four Million Dollars
388 ($104,000,000.00). If the state matching funds percentage for the
389 Mississippi Medicaid program is between sixteen percent (16%) and
390 twenty-four percent (24%), the sum used in the formula under this
391 subparagraph (i) shall be a pro rata amount determined as follows:
392 the current state matching funds percentage rate minus sixteen

393 percent (16%) divided by eight percent (8%) multiplied by Thirty
394 Million Dollars ($30,000,000.00) and add that amount to
395 Seventy-four Million Dollars ($74,000,000.00). However, no
396 assessment in a quarter under this subparagraph (i) may exceed the
397 assessment in the previous quarter by more than Three Million
398 Seven Hundred Fifty Thousand Dollars ($3,750,000.00) (which would
399 be Fifteen Million Dollars ($15,000,000.00) on an annualized
400 basis). The division shall publish the state matching funds
401 percentage rate applicable to the Mississippi Medicaid program on
402 the tenth day of the first month of each quarter and the
403 assessment determined under the formula prescribed above shall be
404 applicable in the quarter following any adjustment in that state
405 matching funds percentage rate. The division shall notify each
406 hospital licensed in the state as to any projected increases or
407 decreases in the assessment determined under this subparagraph
408 (i). However, if the Centers for Medicare and Medicaid Services
409 (CMS) does not approve the *** * *** <u>authority of</u> the division to
410 reimburse crossover claims for inpatient hospital services and
411 crossover claims covered under Medicare Part B for dually eligible
412 beneficiaries in the same manner that was in effect on January 1,
413 2008, the sum that otherwise would have been used in the formula
414 under this subparagraph (i) shall be reduced by Seven Million
415 Dollars ($7,000,000.00).
416 (ii) In addition to the assessment provided under
417 subparagraph (i), effective for state fiscal year 2016, fiscal

418 year 2017 and fiscal year 2018, an additional annual assessment on
419 each hospital licensed in the state is imposed on each
420 non-Medicare hospital inpatient day as defined below at a rate
421 that is determined by dividing twenty-five percent (25%) of any
422 provider reductions in the Medicaid program *** * *** for that fiscal
423 year up to the following maximum amount, plus the nonfederal share
424 necessary to maximize the Disproportionate Share Hospital (DSH)
425 and inpatient Medicare Upper Payment Limits (UPL) Program payments
426 and inpatient hospital access payments, by the total number of
427 non-Medicare hospital inpatient days as defined below for all
428 licensed Mississippi hospitals: in fiscal year 2010, the maximum
429 amount shall be Twenty-four Million Dollars ($24,000,000.00); in
430 fiscal year 2011, the maximum amount shall be Thirty-two Million
431 Dollars ($32,000,000.00); and in fiscal year 2012 and thereafter,
432 the maximum amount shall be Forty Million Dollars
433 ($40,000,000.00). Any such deficit in the Medicaid program shall
434 be reviewed by the PEER Committee *** * ***.
435 (iii) In addition to the assessments provided in
436 subparagraphs (i) and (ii), effective for state fiscal year 2016,
437 fiscal year 2017 and fiscal year 2018, an additional annual
438 assessment on each hospital licensed in the state is imposed *** * ***
439 if the cost containment measures described therein have been
440 implemented and there are insufficient funds in the Health Care
441 Trust Fund to reconcile any remaining deficit in any fiscal year.
442 If the Governor institutes any other additional cost containment

443 measures on any program or programs authorized under the Medicaid
444 program * * *, hospitals shall be responsible for twenty-five
445 percent (25%) of any such additional imposed provider cuts, which
446 shall be in the form of an additional assessment not to exceed the
447 twenty-five percent (25%) of provider expenditure reductions.
448 Such additional assessment shall be imposed on each non-Medicare
449 hospital inpatient day in the same manner as assessments are
450 imposed under subparagraphs (i) and (ii).

451 (b) Payment and definitions.

452 (i) The hospital assessment as described in this
453 subsection (4) * * * shall be assessed and collected monthly no
454 later than the fifteenth calendar day of each month; provided,
455 however, that the first three (3) monthly payments shall be
456 assessed but not be collected until collection is satisfied for
457 the third monthly (September) payment and the second three (3)
458 monthly payments shall be assessed but not be collected until
459 collection is satisfied for the sixth monthly (December) payment
460 and provided that the portion of the assessment related to the DSH
461 payments shall be paid in three (3) one-third (1/3) installments
462 due no later than the fifteenth calendar day of the payment month
463 of the DSH payments * * *, which shall be paid during the second,
464 third and fourth quarters of the state fiscal year, and provided
465 that the assessment related to any inpatient UPL payment(s) shall
466 be paid no later than the fifteenth calendar day of the payment
467 month of the UPL payment(s) and provided assessments related to

468 inpatient hospital access payments will be collected beginning the
469 initial month that the division funds MHAP.

470 (ii) Definitions. For purposes of this subsection
471 (4):

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

476 a. Total hospital inpatient days shall
477 be the sum of Worksheet S-3, Part 1, column 8 row 14, column 8 row
478 16, and column 8 row 17, excluding column 8 rows 5 and 6.

479 b. Hospital Medicare inpatient days
480 shall be the sum of Worksheet S-3, Part 1, column 6 row 14, column
481 6 row 16.00, and column 6 row 17, excluding column 6 rows 5 and 6.

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

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

493 and discharge or death occur on the same day, the day is
494 considered a day of admission and counts as one (1) subcomponent
495 inpatient day.

496 (c) The assessment provided in this subsection is
497 intended to satisfy and not be in addition to the assessment and
498 intergovernmental transfers *** * * ***. Nothing in this section shall
499 be construed to authorize any state agency, division or
500 department, or county, municipality or other local governmental
501 unit to license for revenue, levy or impose any other tax, fee or
502 assessment upon hospitals in this state not authorized by a
503 specific statute.

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

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

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

514 (ii) Notwithstanding any other provision in this
515 section, if a hospital subject to this assessment operates or
516 conducts business only for a portion of a fiscal year, the
517 assessment for the state fiscal year shall be adjusted by

518 multiplying the assessment by a fraction, the numerator of which
519 is the number of days in the year during which the hospital
520 operates, and the denominator of which is three hundred sixty-five
521 (365). Immediately upon ceasing to operate, the hospital shall
522 pay the assessment for the year as so adjusted (to the extent not
523 previously paid).

524 (f) Applicability.

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

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

529 (ii) CMS revokes its approval of the division's
530 2009 Medicaid State Plan Amendment for the methodology for DSH
531 payments to hospitals *** * ***.

532 This subsection (4) is repealed on July 1, *** * *** <u>2020</u>.

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

542 (6) Except as provided in subsection (4) of this section,
543 the assessment levied under this section shall be collected by the
544 division each month beginning on March 31, 2005.
545 (7) All assessments collected under this section shall be
546 deposited in the Medical Care Fund created by Section 43-13-143.
547 (8) The assessment levied under this section shall be in
548 addition to any other assessments, taxes or fees levied by law,
549 and the assessment shall constitute a debt due the State of
550 Mississippi from the time the assessment is due until it is paid.
551 (9) (a) If a health care facility that is liable for
552 payment of an assessment levied by the division does not pay the
553 assessment when it is due, the division shall give written notice
554 to the health care facility by certified or registered mail
555 demanding payment of the assessment within ten (10) days from the
556 date of delivery of the notice. If the health care facility fails
557 or refuses to pay the assessment after receiving the notice and
558 demand from the division, the division shall withhold from any
559 Medicaid reimbursement payments that are due to the health care
560 facility the amount of the unpaid assessment and a penalty of ten
561 percent (10%) of the amount of the assessment, plus the legal rate
562 of interest until the assessment is paid in full. If the health
563 care facility does not participate in the Medicaid program, the
564 division shall turn over to the Office of the Attorney General the
565 collection of the unpaid assessment by civil action. In any such
566 civil action, the Office of the Attorney General shall collect the

567 amount of the unpaid assessment and a penalty of ten percent (10%)
568 of the amount of the assessment, plus the legal rate of interest
569 until the assessment is paid in full.

570 (b) As an additional or alternative method for
571 collecting unpaid assessments levied by the division, if a health
572 care facility fails or refuses to pay the assessment after
573 receiving notice and demand from the division, the division may
574 file a notice of a tax lien with the chancery clerk of the county
575 in which the health care facility is located, for the amount of
576 the unpaid assessment and a penalty of ten percent (10%) of the
577 amount of the assessment, plus the legal rate of interest until
578 the assessment is paid in full. Immediately upon receipt of
579 notice of the tax lien for the assessment, the chancery clerk
580 shall forward the notice to the circuit clerk who shall enter the
581 notice of the tax lien as a judgment upon the judgment roll and
582 show in the appropriate columns the name of the health care
583 facility as judgment debtor, the name of the division as judgment
584 creditor, the amount of the unpaid assessment, and the date and
585 time of enrollment. The judgment shall be valid as against
586 mortgagees, pledgees, entrusters, purchasers, judgment creditors
587 and other persons from the time of filing with the clerk. The
588 amount of the judgment shall be a debt due the State of
589 Mississippi and remain a lien upon the tangible property of the
590 health care facility until the judgment is satisfied. The
591 judgment shall be the equivalent of any enrolled judgment of a

592 court of record and shall serve as authority for the issuance of
593 writs of execution, writs of attachment or other remedial writs.
594 (10) As soon as possible after July 1, 2009, the Division of
595 Medicaid shall submit to the Centers for Medicare and Medicaid
596 Services (CMS) a state plan amendment or amendments (SPA)
597 regarding the hospital assessment established under subsection (4)
598 of this section. In addition to defining the assessment
599 established in subsection (4) of this section, the state plan
600 amendment or amendments shall include any amendments necessary to
601 provide for the following additional annual Medicare Upper Payment
602 Limits (UPL) Program and Disproportionate Share Hospital (DSH)
603 payments to hospitals located in Mississippi that participate in
604 the Medicaid program:
605 (a) Privately operated and nonstate government operated
606 hospitals, within the meaning of 42 CFR Section 447.272, that have
607 fifty (50) or fewer licensed beds as of January 1, 2009, shall
608 receive an additional inpatient UPL payment equal to sixty-five
609 percent (65%) of their fiscal year 2013 hospital specific
610 inpatient UPL gap, before any payments under this subsection.
611 (b) General acute care hospitals licensed within the
612 class of state hospitals shall receive an additional inpatient UPL
613 payment equal to twenty-eight percent (28%) of their fiscal year
614 2013 inpatient payments, excluding DSH and UPL payments.
615 (c) General acute care hospitals licensed within the
616 class of nonstate government hospitals shall receive an additional

617 inpatient UPL payment determined by multiplying inpatient
618 payments, excluding DSH and UPL, by the uniform percentage
619 necessary to exhaust the maximum amount of inpatient UPL payments
620 permissible under federal regulations. (For state fiscal year
621 2015 and fiscal year 2016, the state shall use 2013 inpatient
622 payment data).
623 (d) In addition to other payments provided above, all
624 hospitals licensed within the class of private hospitals shall
625 receive an additional inpatient UPL payment determined by
626 multiplying inpatient payments, excluding DSH and UPL, by the
627 uniform percentage necessary to exhaust the maximum amount of UPL
628 inpatient payments permissible under federal regulations. For
629 state fiscal year 2015 and fiscal year 2016, the state shall use
630 2013 data.
631 (e) All hospitals satisfying the minimum federal DSH
632 eligibility requirements (Section 1923(d) of the Social Security
633 Act) shall, subject to OBRA 1993 payment limitations, receive an
634 additional DSH payment. This additional DSH payment shall expend
635 the balance of the federal DSH allotment and associated state
636 share not utilized in DSH payments to state-owned institutions for
637 treatment of mental diseases. The payment to each hospital shall
638 be calculated by applying a uniform percentage to the uninsured
639 costs of each eligible hospital, excluding state-owned
640 institutions for treatment of mental diseases; however, that

641 percentage for a state-owned teaching hospital located in Hinds
642 County shall be multiplied by a factor of two (2).
643 (11) The portion of the hospital assessment provided in
644 subsection (4) of this section associated with the MHAP shall not
645 be in effect or implemented until the approval by CMS for the MHAP
646 is obtained.
647 (12) The division shall implement DSH and UPL calculation
648 methodologies that result in the maximization of available federal
649 funds.
650 (13) The DSH and inpatient UPL payments shall be paid on or
651 before December 31, March 31, and June 30 of each fiscal year, in
652 increments of one-third (1/3) of the total calculated DSH and
653 inpatient UPL amounts.
654 (14) The hospital assessment as described in subsection (4)
655 above shall be assessed and collected monthly no later than the
656 fifteenth calendar day of each month; provided, however, that the
657 first three (3) monthly payments shall be assessed but not be
658 collected until collection is satisfied for the third monthly
659 (September) payment and the second three (3) monthly payments
660 shall be assessed but not be collected until collection is
661 satisfied for the sixth monthly (December) payment and provided
662 that the portion of the assessment related to the DSH payments
663 shall be paid in three (3) one-third (1/3) installments due no
664 later than the fifteenth calendar day of the payment month of the
665 DSH payments *** * ***, which shall be paid during the second, third

666 and fourth quarters of the state fiscal year, and provided that
667 the assessment related to any inpatient UPL payment(s) shall be
668 paid no later than the fifteenth calendar day of the payment month
669 of the UPL payment(s) and provided assessments related to MHAP
670 will be collected beginning the initial month that the division
671 funds MHAP.

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

676 (16) Nothing in this section shall prevent the Division of
677 Medicaid from facilitating participation in Medicaid supplemental
678 hospital payment programs by a hospital located in a county
679 contiguous to the State of Mississippi that is also authorized by
680 federal law to submit intergovernmental transfers (IGTs) to the
681 State of Mississippi to fund the state share of the hospital's
682 supplemental and/or MHAP payments.

683 (17) Subsections (10) through (16) of this section shall
684 stand repealed on July 1, *** 2020.

685 **SECTION 5.** Section 43-14-1, Mississippi Code of 1972, is
686 amended as follows:

687 43-14-1. (1) The purpose of this chapter is to provide for
688 the development, implementation and oversight of a coordinated
689 interagency system of necessary services and care for children and
690 youth, called the Mississippi Statewide System of Care, up to age

691 twenty-one (21) with serious emotional/behavioral disorders
692 including, but not limited to, conduct disorders, or mental
693 illness who require services from a multiple services and multiple
694 programs system, and who can be successfully diverted from
695 inappropriate institutional placement. The Mississippi Statewide
696 System of Care is to be conducted in the most fiscally responsible
697 (cost-efficient) manner possible, based on an individualized plan
698 of care which takes into account other available interagency
699 programs, including, but not limited to, Early Intervention Act of
700 Infants and Toddlers, Section 41-87-1 et seq., Early Periodic
701 Screening Diagnosis and Treatment, *** * *** waivered program for
702 home- and community-based services for developmentally disabled
703 people, *** * *** and waivered program for targeted case management
704 services for children with special needs, *** * *** those children
705 identified through the federal Individuals with Disabilities
706 Education Act of 1997 as having a serious emotional disorder
707 (EMD), the Mississippi Children's Health Insurance Program and
708 waivered programs for children with serious emotional
709 disturbances, *** * *** and is tied to clinically and functionally
710 appropriate outcomes. Some of the outcomes are to reduce the
711 number of inappropriate out-of-home placements inclusive of those
712 out-of-state and to reduce the number of inappropriate school
713 suspensions and expulsions for this population of children. This
714 coordinated interagency system of necessary services and care
715 shall be named the Mississippi Statewide System of Care. Children

716 to be served by this chapter who are eligible for Medicaid shall
717 be screened through the Medicaid Early Periodic Screening
718 Diagnosis and Treatment (EPSDT) and their needs for medically
719 necessary services shall be certified through the EPSDT process.
720 For purposes of this chapter, the Mississippi Statewide System of
721 Care is defined as a coordinated network of agencies and providers
722 working as a team to make a full range of mental health and other
723 necessary services available as needed by children with mental
724 health problems and their families. The Mississippi Statewide
725 System of Care shall be:
726 (a) Child centered, family focused, family driven and
727 youth guided;
728 (b) Community based;
729 (c) Culturally competent and responsive; and shall
730 provide for:
731 (i) Service coordination or case management;
732 (ii) Prevention and early identification and
733 intervention;
734 (iii) Smooth transitions among agencies and
735 providers, and to the transition-age and adult service systems;
736 (iv) Human rights protection and advocacy;
737 (v) Nondiscrimination in access to services;
738 (vi) A comprehensive array of services composed of
739 treatment and informal supports that are identified as best
740 practices and/or evidence-based practices;

741 (vii) Individualized service planning that uses a
742 strengths-based, wraparound process;
743 (viii) Services in the least restrictive
744 environment;
745 (ix) Family participation in all aspects of
746 planning, service delivery and evaluation; and
747 (x) Integrated services with coordinated planning
748 across child-serving agencies.
749 Mississippi Statewide System of Care services shall be
750 timely, intensive, coordinated and delivered in the community.
751 Mississippi Statewide System of Care services shall include, but
752 not be limited to, the following:
753 (a) Comprehensive crisis and emergency response
754 services;
755 (b) Intensive case management;
756 (c) Day treatment;
757 (d) Alcohol and drug abuse group services for youth;
758 (e) Individual, group and family therapy;
759 (f) Respite services;
760 (g) Supported employment services for youth;
761 (h) Family education and support and family partners;
762 (i) Youth development and support and youth partners;
763 (j) Positive behavioral supports (PBIS) in schools;
764 (k) Transition-age supported and independent living
765 services; and

766 (l) Vocational/technical education services for youth.

767 (2) There is established the Interagency Coordinating
768 Council for Children and Youth (hereinafter referred to as the
769 "ICCCY"). The ICCCY shall consist of the following membership:

770 (a) The State Superintendent of Public Education;

771 (b) The Executive Director of the Mississippi
772 Department of Mental Health;

773 (c) The Executive Director of the State Department of
774 Health;

775 (d) The Executive Director of the Department of Human
776 Services;

777 (e) The Executive Director of the Division of Medicaid,
778 Office of the Governor;

779 (f) The Executive Director of the State Department of
780 Rehabilitation Services;

781 (g) The Executive Director of Mississippi Families as
782 Allies for Children's Mental Health, Inc.;

783 (h) The Attorney General;

784 (i) A family member of a child or youth in the
785 population named in this chapter designated by Mississippi
786 Families as Allies;

787 (j) A youth or young adult in the population named in
788 this chapter designated by Mississippi Families as Allies;

789 (k) A local MAP team coordinator designated by the
790 Department of Mental Health;

791 (l) A child psychiatrist experienced in the public
792 mental health system designated by the Mississippi Psychiatric
793 Association;
794 (m) An individual with expertise and experience in
795 early childhood education designated jointly by the Department of
796 Mental Health and Mississippi Families as Allies;
797 (n) A representative of an organization that advocates
798 on behalf of disabled citizens in Mississippi designated by the
799 Department of Mental Health; and
800 (o) A faculty member or dean from a Mississippi
801 university specializing in training professionals who work in the
802 Mississippi Statewide System of Care designated by the Board of
803 Trustees of State Institutions of Higher Learning.
804 If a member of the council designates a representative to
805 attend council meetings, the designee shall bring full
806 decision-making authority of the member to the meeting. The
807 council shall select a chairman, who shall serve for a one-year
808 term and may not serve consecutive terms. The council shall adopt
809 internal organizational procedures necessary for efficient
810 operation of the council. Each member of the council shall
811 designate necessary staff of their departments to assist the ICCCY
812 in performing its duties and responsibilities. The ICCCY shall
813 meet and conduct business at least twice annually. The chairman
814 of the ICCCY shall notify all ICCCY members and all other persons

815 who request such notice as to the date, time, place and draft
816 agenda items for each meeting.
817 (3) The Interagency System of Care Council (ISCC) is created
818 to serve as the state management team for the ICCCY, with the
819 responsibility of collecting and analyzing data and funding
820 strategies necessary to improve the operation of the Mississippi
821 Statewide System of Care, and to make recommendations to the ICCCY
822 and to the Legislature concerning such strategies on, at a
823 minimum, an annual basis. The System of Care Council also has the
824 responsibility of coordinating the local Multidisciplinary
825 Assessment and Planning (MAP) teams and "A" teams and may apply
826 for grants from public and private sources necessary to carry out
827 its responsibilities. The Interagency System of Care Council
828 shall be comprised of one (1) member from each of the appropriate
829 child-serving divisions or sections of the State Department of
830 Health, the Department of Human Services (Division of Family and
831 Children Services and Division of Youth Services), the State
832 Department of Mental Health (Division of Children and Youth,
833 Bureau of Alcohol and Drug Abuse, and Bureau of Intellectual and
834 Developmental Disabilities), the State Department of Education
835 (Office of Special Education and Office of Healthy Schools), the
836 Division of Medicaid of the Governor's Office, the Department of
837 Rehabilitation Services, and the Attorney General's office.
838 Additional members shall include a family member of a child, youth
839 or transition-age youth representing a family education and

840 support 501(c)3 organization, working with the population named in
841 this chapter designated by Mississippi Families as Allies, an
842 individual with expertise and experience in early childhood
843 education designated jointly by the Department of Mental Health
844 and Mississippi Families as Allies, a local MAP team
845 representative and a local "A" team representative designated by
846 the Department of Mental Health, a probation officer designated by
847 the Department of Corrections, a family member and youth or young
848 adult designated by Mississippi Families as Allies for Children's
849 Mental Health, Inc., (MSFAA), and a family member other than a
850 MSFAA representative to be designated by the Department of Mental
851 Health and the Director of the Compulsory School Attendance
852 Enforcement of the State Department of Education. Appointments to
853 the Interagency System of Care Council shall be made within sixty
854 (60) days after June 30, 2010. The council shall organize by
855 selecting a chairman from its membership to serve on an annual
856 basis, and the chairman may not serve consecutive terms.
857 (4) (a) As part of the Mississippi Statewide System of
858 Care, there is established a statewide system of local
859 Multidisciplinary Assessment, Planning and Resource (MAP) teams.
860 The MAP teams shall be comprised of one (1) representative each at
861 the county level from the major child-serving public agencies for
862 education, human services, health, mental health and
863 rehabilitative services approved by respective state agencies of
864 the Department of Education, the Department of Human Services, the

865 Department of Health, the Department of Mental Health and the
866 Department of Rehabilitation Services. These agencies shall, by
867 policy, contract or regulation require participation on MAP teams
868 and "A" teams at the county level by the appropriate staff. Three
869 (3) additional members may be added to each team, one (1) of which
870 may be a representative of a family education/support 501(c)3
871 organization with statewide recognition and specifically
872 established for the population of children defined in Section
873 43-14-1. The remaining members will be representatives of
874 significant community-level stakeholders with resources that can
875 benefit the population of children defined in Section 43-14-1.
876 The Department of Education shall assist in recruiting and
877 identifying parents to participate on MAP teams and "A" teams.
878 (b) For each local existing MAP team that is
879 established pursuant to paragraph (a) of this subsection, there
880 shall also be established an "A" (Adolescent) team which shall
881 work with a MAP team. The "A" teams shall provide System of Care
882 services for youthful offenders who have serious behavioral or
883 emotional disorders. Each "A" team shall be comprised of, at a
884 minimum, the following five (5) members:
885 (i) A school counselor, mental health therapist or
886 social worker;
887 (ii) A community mental health professional;
888 (iii) A social services/child welfare
889 professional;

890 (iv) A youth court counselor; and
891 (v) A parent who had a child in the juvenile
892 justice system.
893 (c) The Interagency Coordinating Council for Children
894 and Youth and the Interagency System of Care Council shall work to
895 develop MAP teams statewide that will serve to become the single
896 point of entry for children and youth about to be placed in
897 out-of-home care for reasons other than parental abuse/neglect.
898 (5) The Interagency Coordinating Council for Children and
899 Youth may provide input to one another and to the ISCC relative to
900 how each agency utilizes its federal and state statutes, policy
901 requirements and funding streams to identify and/or serve children
902 and youth in the population defined in this section. The ICCCY
903 shall support the implementation of the plans of the respective
904 state agencies for comprehensive, community-based,
905 multidisciplinary care, treatment and placement of these children.
906 (6) The ICCCY shall oversee a pool of state funds that may
907 be contributed by each participating state agency and additional
908 funds from the Mississippi Tobacco Health Care Expenditure Fund,
909 subject to specific appropriation therefor by the Legislature.
910 Part of this pool of funds shall be available for increasing the
911 present funding levels by matching Medicaid funds in order to
912 increase the existing resources available for necessary
913 community-based services for Medicaid beneficiaries.

914 (7) The local interagency coordinating care MAP team or "A"
915 team will facilitate the development of the individualized System
916 of Care programs for the population targeted in this section.
917 (8) Each local MAP team and "A" team shall serve as the
918 single point of entry and re-entry to ensure that comprehensive
919 diagnosis and assessment occur and shall coordinate needed
920 services through the local MAP team and "A" team members and local
921 service providers for the children named in subsection (1). Local
922 children in crisis shall have first priority for access to the MAP
923 team and "A" team processes and local System of Care services.
924 (9) The Interagency Coordinating Council for Children and
925 Youth shall facilitate monitoring of the performance of local MAP
926 teams.
927 (10) Each ICCCY member named in subsection (2) of this
928 section shall enter into a binding memorandum of understanding to
929 participate in the further development and oversight of the
930 Mississippi Statewide System of Care for the children and youth
931 described in this section. The agreement shall outline the system
932 responsibilities in all operational areas, including ensuring
933 representation on MAP teams, funding, data collection, referral of
934 children to MAP teams and "A" teams, and training. The agreement
935 shall be signed and in effect by July 1 of each year.
936 **SECTION 6.** Section 83-5-601, Mississippi Code of 1972, is
937 amended as follows:

938 83-5-601. (1) In order to encourage and facilitate
939 collaboration between Mississippi Medicaid providers and managed
940 care entities contracting on a capitated basis with the Division
941 of Medicaid *** * ***, to align incentives in support of integrated
942 and coordinated health care delivery, and to encourage the
943 development of appropriate population or community health
944 strategies to better serve Medicaid beneficiaries and the state's
945 health care delivery system as a whole, the Legislature hereby
946 authorizes and encourages the creation of provider-sponsored
947 health plans as defined in Section 83-5-603.

948 (2) Whereas, for the reasons stated in subsection (1), the
949 authorization and development of provider-sponsored health plans
950 as defined in Section 83-5-603 are vital to the continued delivery
951 and improvement of health care in this state and otherwise in the
952 best interests of the state and its citizens, and notwithstanding
953 any other provision of law to the contrary, a provider-sponsored
954 health plan, and its owners, officers, directors, committee
955 members, agents, representatives, and employees, when performing
956 the functions authorized by this article, in carrying out the
957 terms of any contract with or program of the Division of Medicaid,
958 and in collaborating and communicating with hospitals, physicians,
959 and other providers for such purposes, shall be considered to be
960 acting pursuant to clearly expressed state policy as established
961 in this article under the supervision of the State of Mississippi

962 and shall be immune from liability under state or federal
963 antitrust laws while so acting.
964 **SECTION 7.** Section 83-5-603, Mississippi Code of 1972, is
965 amended as follows:
966 83-5-603. As used in this article, "Provider-Sponsored
967 Health Plan" means a Mississippi not-for-profit corporation formed
968 for the purposes of operating a not-for-profit health plan or
969 managed care entity, with its principal place of business within
970 the State of Mississippi, and which is owned and governed
971 exclusively by (a) not-for-profit Mississippi hospital or
972 physician industry or trade association in which the majority of
973 the hospitals or physicians within the state are members, or (b) a
974 combination of (i) not-for-profit Mississippi hospital or
975 physician industry or trade associations that represent a majority
976 of the hospitals or physicians within the state, and (ii) licensed
977 Mississippi hospitals or physicians who participate in the
978 Mississippi Medicaid Program. At least one (1) purpose of the
979 provider-sponsored health plan shall be to contract with the
980 Division of Medicaid to provide managed care services on a
981 capitated basis *** * * ***. To qualify as a provider-sponsored health
982 plan under this section, the entity must further meet the
983 requirements of Section 83-5-607.
984 **SECTION 8.** Section 83-5-607, Mississippi Code of 1972, is
985 amended as follows:
986 83-5-607. Provider-sponsored health plans shall:

987 (a) Demonstrate ownership or substantial representation
988 in governance and operations by licensed Mississippi hospitals and
989 physicians that participate in the Mississippi Medicaid Program.
990 Notwithstanding any other provision of law to the contrary, for
991 the purpose of meeting this requirement, hospitals owned by the
992 state and hospitals owned by local governmental entities are
993 authorized to provide funds for the establishment and operation of
994 provider-sponsored health plans, provided the hospital governing
995 body first determines that such participation is in the best
996 interest of the hospital and the communities it serves;
997 (b) Satisfy the minimum financial and reserve
998 requirements to be established by the Department of Insurance;
999 (c) Meet all contractual requirements for contracting
1000 with the Division of Medicaid to provide managed care or
1001 coordinated care services to Medicaid recipients *** * ***.
1002 Compliance with this requirement shall be determined and
1003 supervised by the Division of Medicaid. Nothing in this article
1004 shall be construed as giving the Department of Insurance
1005 responsibility or authority for the operation of the State
1006 Medicaid Program; and
1007 (d) Such other requirements as may be established by
1008 valid regulation of the Department of Insurance.
1009 **SECTION 9.** This act shall take effect and be in force from
1010 and after June 30, 2018.

ST: Medicaid; delete specific services covered under and authorize division to determine covered services.