

By: Representatives Brown, Sykes

To: Medicaid

COMMITTEE SUBSTITUTE  
FOR  
HOUSE BILL NO. 1242

1 AN ACT TO AMEND SECTION 43-13-145, MISSISSIPPI CODE OF 1972,  
2 TO EXTEND THE DATE OF THE REPEALER ON THE PROVISIONS THAT LEVY  
3 ASSESSMENTS ON CERTAIN HEALTH CARE FACILITIES TO PROVIDE FUNDING  
4 FOR THE MEDICAID PROGRAM; AND FOR RELATED PURPOSES.

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

6 **SECTION 1.** Section 43-13-145, Mississippi Code of 1972, is  
7 amended as follows:

8 43-13-145. (1) (a) Upon each nursing facility licensed by  
9 the State of Mississippi, there is levied an assessment in an  
10 amount set by the division, equal to the maximum rate allowed by  
11 federal law or regulation, for each licensed and occupied bed of  
12 the facility.

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

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

18 (ii) The State Veterans Affairs Board; or



19 (iii) The University of Mississippi Medical  
20 Center.

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

26 (b) An intermediate care facility for individuals with  
27 intellectual disabilities is exempt from the assessment levied  
28 under this subsection if the facility is operated under the  
29 direction and control of:

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

32 (ii) The State Veterans Affairs Board; or

33 (iii) The University of Mississippi Medical  
34 Center.

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

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



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

45 (ii) The University of Mississippi Medical Center;  
46 or

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

50 (4) Hospital assessment.

51 (a) (i) Subject to and upon fulfillment of the  
52 requirements and conditions of paragraph (f) below, and  
53 notwithstanding any other provisions of this section, effective  
54 for state fiscal year 2016 \* \* \* through fiscal year \* \* \* 2021,  
55 an annual assessment on each hospital licensed in the state is  
56 imposed on each non-Medicare hospital inpatient day as defined  
57 below at a rate that is determined by dividing the sum prescribed  
58 in this subparagraph (i), plus the nonfederal share necessary to  
59 maximize the Disproportionate Share Hospital (DSH) and inpatient  
60 Medicare Upper Payment Limits (UPL) Program payments and inpatient  
61 hospital access payments, by the total number of non-Medicare  
62 hospital inpatient days as defined below for all licensed  
63 Mississippi hospitals, except as provided in paragraph (d) below.  
64 If the state matching funds percentage for the Mississippi  
65 Medicaid program is sixteen percent (16%) or less, the sum used in  
66 the formula under this subparagraph (i) shall be Seventy-four  
67 Million Dollars (\$74,000,000.00). If the state matching funds



68 percentage for the Mississippi Medicaid program is twenty-four  
69 percent (24%) or higher, the sum used in the formula under this  
70 subparagraph (i) shall be One Hundred Four Million Dollars  
71 (\$104,000,000.00). If the state matching funds percentage for the  
72 Mississippi Medicaid program is between sixteen percent (16%) and  
73 twenty-four percent (24%), the sum used in the formula under this  
74 subparagraph (i) shall be a pro rata amount determined as follows:  
75 the current state matching funds percentage rate minus sixteen  
76 percent (16%) divided by eight percent (8%) multiplied by Thirty  
77 Million Dollars (\$30,000,000.00) and add that amount to  
78 Seventy-four Million Dollars (\$74,000,000.00). However, no  
79 assessment in a quarter under this subparagraph (i) may exceed the  
80 assessment in the previous quarter by more than Three Million  
81 Seven Hundred Fifty Thousand Dollars (\$3,750,000.00) (which would  
82 be Fifteen Million Dollars (\$15,000,000.00) on an annualized  
83 basis). The division shall publish the state matching funds  
84 percentage rate applicable to the Mississippi Medicaid program on  
85 the tenth day of the first month of each quarter and the  
86 assessment determined under the formula prescribed above shall be  
87 applicable in the quarter following any adjustment in that state  
88 matching funds percentage rate. The division shall notify each  
89 hospital licensed in the state as to any projected increases or  
90 decreases in the assessment determined under this subparagraph  
91 (i). However, if the Centers for Medicare and Medicaid Services  
92 (CMS) does not approve the provision in Section 43-13-117(39)



93 requiring the division to reimburse crossover claims for inpatient  
94 hospital services and crossover claims covered under Medicare Part  
95 B for dually eligible beneficiaries in the same manner that was in  
96 effect on January 1, 2008, the sum that otherwise would have been  
97 used in the formula under this subparagraph (i) shall be reduced  
98 by Seven Million Dollars (\$7,000,000.00).

99 (ii) In addition to the assessment provided under  
100 subparagraph (i), effective for state fiscal year 2016 \* \* \*  
101 through fiscal year \* \* \* 2021, an additional annual assessment on  
102 each hospital licensed in the state is imposed on each  
103 non-Medicare hospital inpatient day as defined below at a rate  
104 that is determined by dividing twenty-five percent (25%) of any  
105 provider reductions in the Medicaid program as authorized in  
106 Section 43-13-117(F) for that fiscal year up to the following  
107 maximum amount, plus the nonfederal share necessary to maximize  
108 the Disproportionate Share Hospital (DSH) and inpatient Medicare  
109 Upper Payment Limits (UPL) Program payments and inpatient hospital  
110 access payments, by the total number of non-Medicare hospital  
111 inpatient days as defined below for all licensed Mississippi  
112 hospitals: in fiscal year 2010, the maximum amount shall be  
113 Twenty-four Million Dollars (\$24,000,000.00); in fiscal year 2011,  
114 the maximum amount shall be Thirty-two Million Dollars  
115 (\$32,000,000.00); and in fiscal year 2012 and thereafter, the  
116 maximum amount shall be Forty Million Dollars (\$40,000,000.00).



117 Any such deficit in the Medicaid program shall be reviewed by the  
118 PEER Committee as provided in Section 43-13-117(F).

119 (iii) In addition to the assessments provided in  
120 subparagraphs (i) and (ii), effective for state fiscal year  
121 2016 \* \* \* through fiscal year \* \* \* 2021, an additional annual  
122 assessment on each hospital licensed in the state is imposed  
123 pursuant to the provisions of Section 43-13-117(F) if the cost  
124 containment measures described therein have been implemented and  
125 there are insufficient funds in the Health Care Trust Fund to  
126 reconcile any remaining deficit in any fiscal year. If the  
127 Governor institutes any other additional cost containment measures  
128 on any program or programs authorized under the Medicaid program  
129 pursuant to Section 43-13-117(F), hospitals shall be responsible  
130 for twenty-five percent (25%) of any such additional imposed  
131 provider cuts, which shall be in the form of an additional  
132 assessment not to exceed the twenty-five percent (25%) of provider  
133 expenditure reductions. Such additional assessment shall be  
134 imposed on each non-Medicare hospital inpatient day in the same  
135 manner as assessments are imposed under subparagraphs (i) and  
136 (ii).

137 (b) Payment and definitions.

138 (i) The hospital assessment as described in this  
139 subsection (4) \* \* \* shall be assessed and collected monthly no  
140 later than the fifteenth calendar day of each month; provided,  
141 however, that the first three (3) monthly payments shall be



142 assessed but not be collected until collection is satisfied for  
143 the third monthly (September) payment and the second three (3)  
144 monthly payments shall be assessed but not be collected until  
145 collection is satisfied for the sixth monthly (December) payment  
146 and provided that the portion of the assessment related to the DSH  
147 payments shall be paid in three (3) one-third (1/3) installments  
148 due no later than the fifteenth calendar day of the payment month  
149 of the DSH payments required by Section 43-13-117(A)(18), which  
150 shall be paid during the second, third and fourth quarters of the  
151 state fiscal year, and provided that the assessment related to any  
152 inpatient UPL payment(s) shall be paid no later than the fifteenth  
153 calendar day of the payment month of the UPL payment(s) and  
154 provided assessments related to inpatient hospital access payments  
155 will be collected beginning the initial month that the division  
156 funds MHAP.

157 (ii) Definitions. For purposes of this subsection  
158 (4):

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

163 a. Total hospital inpatient days shall  
164 be the sum of Worksheet S-3, Part 1, column 8 row 14, column 8 row  
165 16, and column 8 row 17, excluding column 8 rows 5 and 6.



166                                   b. Hospital Medicare inpatient days  
167 shall be the sum of Worksheet S-3, Part 1, column 6 row 14, column  
168 6 row 16.00, and column 6 row 17, excluding column 6 rows 5 and 6.

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

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

183                                   (c) The assessment provided in this subsection is  
184 intended to satisfy and not be in addition to the assessment and  
185 intergovernmental transfers provided in Section 43-13-117(A)(18).  
186 Nothing in this section shall be construed to authorize any state  
187 agency, division or department, or county, municipality or other  
188 local governmental unit to license for revenue, levy or impose any  
189 other tax, fee or assessment upon hospitals in this state not  
190 authorized by a specific statute.





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

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

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

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

211 (f) Applicability.

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

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



216 (ii) CMS revokes its approval of the division's  
217 2009 Medicaid State Plan Amendment for the methodology for DSH  
218 payments to hospitals under Section 43-13-117(A) (18).

219 This subsection (4) is repealed on July 1, \* \* \* 2021.

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

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

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

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

238 (9) (a) If a health care facility that is liable for  
239 payment of an assessment levied by the division does not pay the  
240 assessment when it is due, the division shall give written notice



241 to the health care facility by certified or registered mail  
242 demanding payment of the assessment within ten (10) days from the  
243 date of delivery of the notice. If the health care facility fails  
244 or refuses to pay the assessment after receiving the notice and  
245 demand from the division, the division shall withhold from any  
246 Medicaid reimbursement payments that are due to the health care  
247 facility the amount of the unpaid assessment and a penalty of ten  
248 percent (10%) of the amount of the assessment, plus the legal rate  
249 of interest until the assessment is paid in full. If the health  
250 care facility does not participate in the Medicaid program, the  
251 division shall turn over to the Office of the Attorney General the  
252 collection of the unpaid assessment by civil action. In any such  
253 civil action, the Office of the Attorney General shall collect the  
254 amount of the unpaid assessment and a penalty of ten percent (10%)  
255 of the amount of the assessment, plus the legal rate of interest  
256 until the assessment is paid in full.

257 (b) As an additional or alternative method for  
258 collecting unpaid assessments levied by the division, if a health  
259 care facility fails or refuses to pay the assessment after  
260 receiving notice and demand from the division, the division may  
261 file a notice of a tax lien with the chancery clerk of the county  
262 in which the health care facility is located, for the amount of  
263 the unpaid assessment and a penalty of ten percent (10%) of the  
264 amount of the assessment, plus the legal rate of interest until  
265 the assessment is paid in full. Immediately upon receipt of



266 notice of the tax lien for the assessment, the chancery clerk  
267 shall forward the notice to the circuit clerk who shall enter the  
268 notice of the tax lien as a judgment upon the judgment roll and  
269 show in the appropriate columns the name of the health care  
270 facility as judgment debtor, the name of the division as judgment  
271 creditor, the amount of the unpaid assessment, and the date and  
272 time of enrollment. The judgment shall be valid as against  
273 mortgagees, pledgees, entrusters, purchasers, judgment creditors  
274 and other persons from the time of filing with the clerk. The  
275 amount of the judgment shall be a debt due the State of  
276 Mississippi and remain a lien upon the tangible property of the  
277 health care facility until the judgment is satisfied. The  
278 judgment shall be the equivalent of any enrolled judgment of a  
279 court of record and shall serve as authority for the issuance of  
280 writs of execution, writs of attachment or other remedial writs.

281 (10) As soon as possible after July 1, 2009, the Division of  
282 Medicaid shall submit to the Centers for Medicare and Medicaid  
283 Services (CMS) a state plan amendment or amendments (SPA)  
284 regarding the hospital assessment established under subsection (4)  
285 of this section. In addition to defining the assessment  
286 established in subsection (4) of this section, the state plan  
287 amendment or amendments shall include any amendments necessary to  
288 provide for the following additional annual Medicare Upper Payment  
289 Limits (UPL) Program and Disproportionate Share Hospital (DSH)



290 payments to hospitals located in Mississippi that participate in  
291 the Medicaid program:

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

298 (b) General acute care hospitals licensed within the  
299 class of state hospitals shall receive an additional inpatient UPL  
300 payment equal to twenty-eight percent (28%) of their fiscal year  
301 2013 inpatient payments, excluding DSH and UPL payments.

302 (c) General acute care hospitals licensed within the  
303 class of nonstate government hospitals shall receive an additional  
304 inpatient UPL payment determined by multiplying inpatient  
305 payments, excluding DSH and UPL, by the uniform percentage  
306 necessary to exhaust the maximum amount of inpatient UPL payments  
307 permissible under federal regulations. (For state fiscal year  
308 2015 and fiscal year 2016, the state shall use 2013 inpatient  
309 payment data).

310 (d) In addition to other payments provided above, all  
311 hospitals licensed within the class of private hospitals shall  
312 receive an additional inpatient UPL payment determined by  
313 multiplying inpatient payments, excluding DSH and UPL, by the  
314 uniform percentage necessary to exhaust the maximum amount of UPL



315 inpatient payments permissible under federal regulations. For  
316 state fiscal year 2015 and fiscal year 2016, the state shall use  
317 2013 data.

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

330 (11) The portion of the hospital assessment provided in  
331 subsection (4) of this section associated with the MHAP shall not  
332 be in effect or implemented until the approval by CMS for the MHAP  
333 is obtained.

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

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



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

341 (14) The hospital assessment as described in subsection (4)  
342 above shall be assessed and collected monthly no later than the  
343 fifteenth calendar day of each month; provided, however, that the  
344 first three (3) monthly payments shall be assessed but not be  
345 collected until collection is satisfied for the third monthly  
346 (September) payment and the second three (3) monthly payments  
347 shall be assessed but not be collected until collection is  
348 satisfied for the sixth monthly (December) payment and provided  
349 that the portion of the assessment related to the DSH payments  
350 shall be paid in three (3) one-third (1/3) installments due no  
351 later than the fifteenth calendar day of the payment month of the  
352 DSH payments required by Section 43-13-117(A) (18), which shall be  
353 paid during the second, third and fourth quarters of the state  
354 fiscal year, and provided that the assessment related to any  
355 inpatient UPL payment(s) shall be paid no later than the fifteenth  
356 calendar day of the payment month of the UPL payment(s) and  
357 provided assessments related to MHAP will be collected beginning  
358 the initial month that the division funds MHAP.

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



363           (16) Nothing in this section shall prevent the Division of  
364 Medicaid from facilitating participation in Medicaid supplemental  
365 hospital payment programs by a hospital located in a county  
366 contiguous to the State of Mississippi that is also authorized by  
367 federal law to submit intergovernmental transfers (IGTs) to the  
368 State of Mississippi to fund the state share of the hospital's  
369 supplemental and/or MHAP payments.

370           (17) Subsections (10) through (16) of this section shall  
371 stand repealed on July 1, \* \* \* 2021.

372           **SECTION 2.** This act shall take effect and be in force from  
373 and after July 1, 2018.

