

By: Representative McGee

To: Medicaid

HOUSE BILL NO. 970

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO EXTEND THE DATE OF THE REPEALER ON THE SERVICES AND MANAGED
3 CARE PROVISIONS IN THE MEDICAID PROGRAM; TO AMEND SECTION
4 43-13-145, MISSISSIPPI CODE OF 1972, TO EXTEND THE DATE OF THE
5 REPEALER ON THE MEDICAID PROVIDER ASSESSMENT PROVISIONS; AND FOR
6 RELATED PURPOSES.

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

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

10 43-13-117. (A) Medicaid as authorized by this article shall
11 include payment of part or all of the costs, at the discretion of
12 the division, with approval of the Governor and the Centers for
13 Medicare and Medicaid Services, of the following types of care and
14 services rendered to eligible applicants who have been determined
15 to be eligible for that care and services, within the limits of
16 state appropriations and federal matching funds:

17 (1) Inpatient hospital services.

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



21 (b) No service benefits or reimbursement
22 limitations in this subsection (A)(1) shall apply to payments
23 under an APR-DRG or Ambulatory Payment Classification (APC) model
24 or a managed care program or similar model described in subsection
25 (H) of this section unless specifically authorized by the
26 division.

27 (2) Outpatient hospital services.

28 (a) Emergency services.

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

44 (c) The division is authorized to implement an
45 Ambulatory Payment Classification (APC) methodology for outpatient



46 hospital services. The division shall give rural hospitals that
47 have fifty (50) or fewer licensed beds the option to not be
48 reimbursed for outpatient hospital services using the APC
49 methodology, but reimbursement for outpatient hospital services
50 provided by those hospitals shall be based on one hundred one
51 percent (101%) of the rate established under Medicare for
52 outpatient hospital services. Those hospitals choosing to not be
53 reimbursed under the APC methodology shall remain under cost-based
54 reimbursement for a two-year period.

55 (d) No service benefits or reimbursement
56 limitations in this subsection (A) (2) shall apply to payments
57 under an APR-DRG or APC model or a managed care program or similar
58 model described in subsection (H) of this section unless
59 specifically authorized by the division.

60 (3) Laboratory and x-ray services.

61 (4) Nursing facility services.

62 (a) The division shall make full payment to
63 nursing facilities for each day, not exceeding forty-two (42) days
64 per year, that a patient is absent from the facility on home
65 leave. Payment may be made for the following home leave days in
66 addition to the forty-two-day limitation: Christmas, the day
67 before Christmas, the day after Christmas, Thanksgiving, the day
68 before Thanksgiving and the day after Thanksgiving.

69 (b) From and after July 1, 1997, the division
70 shall implement the integrated case-mix payment and quality



71 monitoring system, which includes the fair rental system for
72 property costs and in which recapture of depreciation is
73 eliminated. The division may reduce the payment for hospital
74 leave and therapeutic home leave days to the lower of the case-mix
75 category as computed for the resident on leave using the
76 assessment being utilized for payment at that point in time, or a
77 case-mix score of 1.000 for nursing facilities, and shall compute
78 case-mix scores of residents so that only services provided at the
79 nursing facility are considered in calculating a facility's per
80 diem.

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

84 (d) On or after January 1, 2015, the division
85 shall update the case-mix payment system resource utilization
86 grouper and classifications and fair rental reimbursement system.
87 The division shall develop and implement a payment add-on to
88 reimburse nursing facilities for ventilator-dependent resident
89 services.

90 (e) The division shall develop and implement, not
91 later than January 1, 2001, a case-mix payment add-on determined
92 by time studies and other valid statistical data that will
93 reimburse a nursing facility for the additional cost of caring for
94 a resident who has a diagnosis of Alzheimer's or other related
95 dementia and exhibits symptoms that require special care. Any



96 such case-mix add-on payment shall be supported by a determination
97 of additional cost. The division shall also develop and implement
98 as part of the fair rental reimbursement system for nursing
99 facility beds, an Alzheimer's resident bed depreciation enhanced
100 reimbursement system that will provide an incentive to encourage
101 nursing facilities to convert or construct beds for residents with
102 Alzheimer's or other related dementia.

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

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

111 (5) Periodic screening and diagnostic services for
112 individuals under age twenty-one (21) years as are needed to
113 identify physical and mental defects and to provide health care
114 treatment and other measures designed to correct or ameliorate
115 defects and physical and mental illness and conditions discovered
116 by the screening services, regardless of whether these services
117 are included in the state plan. The division may include in its
118 periodic screening and diagnostic program those discretionary
119 services authorized under the federal regulations adopted to
120 implement Title XIX of the federal Social Security Act, as



121 amended. The division, in obtaining physical therapy services,
122 occupational therapy services, and services for individuals with
123 speech, hearing and language disorders, may enter into a
124 cooperative agreement with the State Department of Education for
125 the provision of those services to handicapped students by public
126 school districts using state funds that are provided from the
127 appropriation to the Department of Education to obtain federal
128 matching funds through the division. The division, in obtaining
129 medical and mental health assessments, treatment, care and
130 services for children who are in, or at risk of being put in, the
131 custody of the Mississippi Department of Human Services may enter
132 into a cooperative agreement with the Mississippi Department of
133 Human Services for the provision of those services using state
134 funds that are provided from the appropriation to the Department
135 of Human Services to obtain federal matching funds through the
136 division.

137 (6) Physician services. Fees for physician's services
138 that are covered only by Medicaid shall be reimbursed at ninety
139 percent (90%) of the rate established on January 1, 2018, and as
140 may be adjusted each July thereafter, under Medicare. The
141 division may provide for a reimbursement rate for physician's
142 services of up to one hundred percent (100%) of the rate
143 established under Medicare for physician's services that are
144 provided after the normal working hours of the physician, as
145 determined in accordance with regulations of the division. The



146 division may reimburse eligible providers, as determined by the
147 division, for certain primary care services at one hundred percent
148 (100%) of the rate established under Medicare. The division shall
149 reimburse obstetricians and gynecologists for certain primary care
150 services as defined by the division at one hundred percent (100%)
151 of the rate established under Medicare.

152 (7) (a) Home health services for eligible persons, not
153 to exceed in cost the prevailing cost of nursing facility
154 services. All home health visits must be precertified as required
155 by the division. In addition to physicians, certified registered
156 nurse practitioners, physician assistants and clinical nurse
157 specialists are authorized to prescribe or order home health
158 services and plans of care, sign home health plans of care,
159 certify and recertify eligibility for home health services and
160 conduct the required initial face-to-face visit with the recipient
161 of the services.

162 (b) [Repealed]

163 (8) Emergency medical transportation services as
164 determined by the division.

165 (9) Prescription drugs and other covered drugs and
166 services as determined by the division.

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



171 The division may seek to establish relationships with other
172 states in order to lower acquisition costs of prescription drugs
173 to include single-source and innovator multiple-source drugs or
174 generic drugs. In addition, if allowed by federal law or
175 regulation, the division may seek to establish relationships with
176 and negotiate with other countries to facilitate the acquisition
177 of prescription drugs to include single-source and innovator
178 multiple-source drugs or generic drugs, if that will lower the
179 acquisition costs of those prescription drugs.

180 The division may allow for a combination of prescriptions for
181 single-source and innovator multiple-source drugs and generic
182 drugs to meet the needs of the beneficiaries.

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

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



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

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

205 The division is authorized to develop and implement a program
206 of payment for additional pharmacist services as determined by the
207 division.

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

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

217 The division shall develop and implement a method or methods
218 by which the division will provide on a regular basis to Medicaid
219 providers who are authorized to prescribe drugs, information about
220 the costs to the Medicaid program of single-source drugs and



221 innovator multiple-source drugs, and information about other drugs
222 that may be prescribed as alternatives to those single-source
223 drugs and innovator multiple-source drugs and the costs to the
224 Medicaid program of those alternative drugs.

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

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

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

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

241 The division shall allow certain drugs, including
242 physician-administered drugs, and implantable drug system devices,
243 and medical supplies, with limited distribution or limited access
244 for beneficiaries and administered in an appropriate clinical



245 setting, to be reimbursed as either a medical claim or pharmacy
246 claim, as determined by the division.

247 It is the intent of the Legislature that the division and any
248 managed care entity described in subsection (H) of this section
249 encourage the use of Alpha-Hydroxyprogesterone Caproate (17P) to
250 prevent recurrent preterm birth.

251 (10) Dental and orthodontic services to be determined
252 by the division.

253 The division shall increase the amount of the reimbursement
254 rate for diagnostic and preventative dental services for each of
255 the fiscal years 2022, 2023 and 2024 by five percent (5%) above
256 the amount of the reimbursement rate for the previous fiscal year.
257 The division shall increase the amount of the reimbursement rate
258 for restorative dental services for each of the fiscal years 2023,
259 2024 and 2025 by five percent (5%) above the amount of the
260 reimbursement rate for the previous fiscal year. It is the intent
261 of the Legislature that the reimbursement rate revision for
262 preventative dental services will be an incentive to increase the
263 number of dentists who actively provide Medicaid services. This
264 dental services reimbursement rate revision shall be known as the
265 "James Russell Dumas Medicaid Dental Services Incentive Program."

266 The Medical Care Advisory Committee, assisted by the Division
267 of Medicaid, shall annually determine the effect of this incentive
268 by evaluating the number of dentists who are Medicaid providers,
269 the number who and the degree to which they are actively billing



270 Medicaid, the geographic trends of where dentists are offering
271 what types of Medicaid services and other statistics pertinent to
272 the goals of this legislative intent. This data shall annually be
273 presented to the Chair of the Senate Medicaid Committee and the
274 Chair of the House Medicaid Committee.

275 The division shall include dental services as a necessary
276 component of overall health services provided to children who are
277 eligible for services.

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

287 (12) Intermediate care facility services.

288 (a) The division shall make full payment to all
289 intermediate care facilities for individuals with intellectual
290 disabilities for each day, not exceeding sixty-three (63) days per
291 year, that a patient is absent from the facility on home leave.
292 Payment may be made for the following home leave days in addition
293 to the sixty-three-day limitation: Christmas, the day before



294 Christmas, the day after Christmas, Thanksgiving, the day before
295 Thanksgiving and the day after Thanksgiving.

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

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

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

305 (14) Clinic services. Preventive, diagnostic,
306 therapeutic, rehabilitative or palliative services that are
307 furnished by a facility that is not part of a hospital but is
308 organized and operated to provide medical care to outpatients.
309 Clinic services include, but are not limited to:

310 (a) Services provided by ambulatory surgical
311 centers (ACSS) as defined in Section 41-75-1(a); and

312 (b) Dialysis center services.

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



318 (16) Mental health services. Certain services provided
319 by a psychiatrist shall be reimbursed at up to one hundred percent
320 (100%) of the Medicare rate. Approved therapeutic and case
321 management services (a) provided by an approved regional mental
322 health/intellectual disability center established under Sections
323 41-19-31 through 41-19-39, or by another community mental health
324 service provider meeting the requirements of the Department of
325 Mental Health to be an approved mental health/intellectual
326 disability center if determined necessary by the Department of
327 Mental Health, using state funds that are provided in the
328 appropriation to the division to match federal funds, or (b)
329 provided by a facility that is certified by the State Department
330 of Mental Health to provide therapeutic and case management
331 services, to be reimbursed on a fee for service basis, or (c)
332 provided in the community by a facility or program operated by the
333 Department of Mental Health. Any such services provided by a
334 facility described in subparagraph (b) must have the prior
335 approval of the division to be reimbursable under this section.

336 (17) Durable medical equipment services and medical
337 supplies. Precertification of durable medical equipment and
338 medical supplies must be obtained as required by the division.
339 The Division of Medicaid may require durable medical equipment
340 providers to obtain a surety bond in the amount and to the
341 specifications as established by the Balanced Budget Act of 1997.
342 A maximum dollar amount of reimbursement for noninvasive



343 ventilators or ventilation treatments properly ordered and being
344 used in an appropriate care setting shall not be set by any health
345 maintenance organization, coordinated care organization,
346 provider-sponsored health plan, or other organization paid for
347 services on a capitated basis by the division under any managed
348 care program or coordinated care program implemented by the
349 division under this section. Reimbursement by these organizations
350 to durable medical equipment suppliers for home use of noninvasive
351 and invasive ventilators shall be on a continuous monthly payment
352 basis for the duration of medical need throughout a patient's
353 valid prescription period.

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



367 in Section 1903 of the federal Social Security Act and any
368 applicable regulations.

369 (b) (i) 1. The division may establish a Medicare
370 Upper Payment Limits Program, as defined in Section 1902(a)(30) of
371 the federal Social Security Act and any applicable federal
372 regulations, or an allowable delivery system or provider payment
373 initiative authorized under 42 CFR 438.6(c), for hospitals,
374 nursing facilities and physicians employed or contracted by
375 hospitals.

376 2. The division shall establish a
377 Medicaid Supplemental Payment Program, as permitted by the federal
378 Social Security Act and a comparable allowable delivery system or
379 provider payment initiative authorized under 42 CFR 438.6(c), for
380 emergency ambulance transportation providers in accordance with
381 this subsection (A)(18)(b).

382 (ii) The division shall assess each hospital,
383 nursing facility, and emergency ambulance transportation provider
384 for the sole purpose of financing the state portion of the
385 Medicare Upper Payment Limits Program or other program(s)
386 authorized under this subsection (A)(18)(b). The hospital
387 assessment shall be as provided in Section 43-13-145(4)(a), and
388 the nursing facility and the emergency ambulance transportation
389 assessments, if established, shall be based on Medicaid
390 utilization or other appropriate method, as determined by the
391 division, consistent with federal regulations. The assessments



392 will remain in effect as long as the state participates in the
393 Medicare Upper Payment Limits Program or other program(s)
394 authorized under this subsection (A) (18) (b). In addition to the
395 hospital assessment provided in Section 43-13-145(4) (a), hospitals
396 with physicians participating in the Medicare Upper Payment Limits
397 Program or other program(s) authorized under this subsection
398 (A) (18) (b) shall be required to participate in an
399 intergovernmental transfer or assessment, as determined by the
400 division, for the purpose of financing the state portion of the
401 physician UPL payments or other payment(s) authorized under this
402 subsection (A) (18) (b).

403 (iii) Subject to approval by the Centers for
404 Medicare and Medicaid Services (CMS) and the provisions of this
405 subsection (A) (18) (b), the division shall make additional
406 reimbursement to hospitals, nursing facilities, and emergency
407 ambulance transportation providers for the Medicare Upper Payment
408 Limits Program or other program(s) authorized under this
409 subsection (A) (18) (b), and, if the program is established for
410 physicians, shall make additional reimbursement for physicians, as
411 defined in Section 1902(a) (30) of the federal Social Security Act
412 and any applicable federal regulations, provided the assessment in
413 this subsection (A) (18) (b) is in effect.

414 (iv) Notwithstanding any other provision of
415 this article to the contrary, effective upon implementation of the
416 Mississippi Hospital Access Program (MHAP) provided in



417 subparagraph (c) (i) below, the hospital portion of the inpatient
418 Upper Payment Limits Program shall transition into and be replaced
419 by the MHAP program. However, the division is authorized to
420 develop and implement an alternative fee-for-service Upper Payment
421 Limits model in accordance with federal laws and regulations if
422 necessary to preserve supplemental funding. Further, the
423 division, in consultation with the hospital industry shall develop
424 alternative models for distribution of medical claims and
425 supplemental payments for inpatient and outpatient hospital
426 services, and such models may include, but shall not be limited to
427 the following: increasing rates for inpatient and outpatient
428 services; creating a low-income utilization pool of funds to
429 reimburse hospitals for the costs of uncompensated care, charity
430 care and bad debts as permitted and approved pursuant to federal
431 regulations and the Centers for Medicare and Medicaid Services;
432 supplemental payments based upon Medicaid utilization, quality,
433 service lines and/or costs of providing such services to Medicaid
434 beneficiaries and to uninsured patients. The goals of such
435 payment models shall be to ensure access to inpatient and
436 outpatient care and to maximize any federal funds that are
437 available to reimburse hospitals for services provided. Any such
438 documents required to achieve the goals described in this
439 paragraph shall be submitted to the Centers for Medicare and
440 Medicaid Services, with a proposed effective date of July 1, 2019,
441 to the extent possible, but in no event shall the effective date



442 of such payment models be later than July 1, 2020. The Chairmen
443 of the Senate and House Medicaid Committees shall be provided a
444 copy of the proposed payment model(s) prior to submission.
445 Effective July 1, 2018, and until such time as any payment
446 model(s) as described above become effective, the division, in
447 consultation with the hospital industry, is authorized to
448 implement a transitional program for inpatient and outpatient
449 payments and/or supplemental payments (including, but not limited
450 to, MHAP and directed payments), to redistribute available
451 supplemental funds among hospital providers, provided that when
452 compared to a hospital's prior year supplemental payments,
453 supplemental payments made pursuant to any such transitional
454 program shall not result in a decrease of more than five percent
455 (5%) and shall not increase by more than the amount needed to
456 maximize the distribution of the available funds.

457 (v) 1. To preserve and improve access to
458 ambulance transportation provider services, the division shall
459 seek CMS approval to make ambulance service access payments as set
460 forth in this subsection (A) (18) (b) for all covered emergency
461 ambulance services rendered on or after July 1, 2022, and shall
462 make such ambulance service access payments for all covered
463 services rendered on or after the effective date of CMS approval.

464 2. The division shall calculate the
465 ambulance service access payment amount as the balance of the
466 portion of the Medical Care Fund related to ambulance



467 transportation service provider assessments plus any federal
468 matching funds earned on the balance, up to, but not to exceed,
469 the upper payment limit gap for all emergency ambulance service
470 providers.

471 3. a. Except for ambulance services
472 exempt from the assessment provided in this paragraph (18)(b), all
473 ambulance transportation service providers shall be eligible for
474 ambulance service access payments each state fiscal year as set
475 forth in this paragraph (18)(b).

476 b. In addition to any other funds
477 paid to ambulance transportation service providers for emergency
478 medical services provided to Medicaid beneficiaries, each eligible
479 ambulance transportation service provider shall receive ambulance
480 service access payments each state fiscal year equal to the
481 ambulance transportation service provider's upper payment limit
482 gap. Subject to approval by the Centers for Medicare and Medicaid
483 Services, ambulance service access payments shall be made no less
484 than on a quarterly basis.

485 c. As used in this paragraph
486 (18)(b)(v), the term "upper payment limit gap" means the
487 difference between the total amount that the ambulance
488 transportation service provider received from Medicaid and the
489 average amount that the ambulance transportation service provider
490 would have received from commercial insurers for those services
491 reimbursed by Medicaid.



492 4. An ambulance service access payment
493 shall not be used to offset any other payment by the division for
494 emergency or nonemergency services to Medicaid beneficiaries.

495 (c) (i) Not later than December 1, 2015, the
496 division shall, subject to approval by the Centers for Medicare
497 and Medicaid Services (CMS), establish, implement and operate a
498 Mississippi Hospital Access Program (MHAP) for the purpose of
499 protecting patient access to hospital care through hospital
500 inpatient reimbursement programs provided in this section designed
501 to maintain total hospital reimbursement for inpatient services
502 rendered by in-state hospitals and the out-of-state hospital that
503 is authorized by federal law to submit intergovernmental transfers
504 (IGTs) to the State of Mississippi and is classified as Level I
505 trauma center located in a county contiguous to the state line at
506 the maximum levels permissible under applicable federal statutes
507 and regulations, at which time the current inpatient Medicare
508 Upper Payment Limits (UPL) Program for hospital inpatient services
509 shall transition to the MHAP.

510 (ii) Subject to approval by the Centers for
511 Medicare and Medicaid Services (CMS), the MHAP shall provide
512 increased inpatient capitation (PMPM) payments to managed care
513 entities contracting with the division pursuant to subsection (H)
514 of this section to support availability of hospital services or
515 such other payments permissible under federal law necessary to
516 accomplish the intent of this subsection.



517 (iii) The intent of this subparagraph (c) is
518 that effective for all inpatient hospital Medicaid services during
519 state fiscal year 2016, and so long as this provision shall remain
520 in effect hereafter, the division shall to the fullest extent
521 feasible replace the additional reimbursement for hospital
522 inpatient services under the inpatient Medicare Upper Payment
523 Limits (UPL) Program with additional reimbursement under the MHAP
524 and other payment programs for inpatient and/or outpatient
525 payments which may be developed under the authority of this
526 paragraph.

527 (iv) The division shall assess each hospital
528 as provided in Section 43-13-145(4) (a) for the purpose of
529 financing the state portion of the MHAP, supplemental payments and
530 such other purposes as specified in Section 43-13-145. The
531 assessment will remain in effect as long as the MHAP and
532 supplemental payments are in effect.

533 (19) (a) Perinatal risk management services. The
534 division shall promulgate regulations to be effective from and
535 after October 1, 1988, to establish a comprehensive perinatal
536 system for risk assessment of all pregnant and infant Medicaid
537 recipients and for management, education and follow-up for those
538 who are determined to be at risk. Services to be performed
539 include case management, nutrition assessment/counseling,
540 psychosocial assessment/counseling and health education. The
541 division shall contract with the State Department of Health to



542 provide services within this paragraph (Perinatal High Risk
543 Management/Infant Services System (PHRM/ISS)). The State
544 Department of Health shall be reimbursed on a full reasonable cost
545 basis for services provided under this subparagraph (a).

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

558 Qualifications for persons providing service coordination shall be
559 determined by the State Department of Health and the Division of
560 Medicaid.

561 (20) Home- and community-based services for physically
562 disabled approved services as allowed by a waiver from the United
563 States Department of Health and Human Services for home- and
564 community-based services for physically disabled people using
565 state funds that are provided from the appropriation to the State
566 Department of Rehabilitation Services and used to match federal



567 funds under a cooperative agreement between the division and the
568 department, provided that funds for these services are
569 specifically appropriated to the Department of Rehabilitation
570 Services.

571 (21) Nurse practitioner services. Services furnished
572 by a registered nurse who is licensed and certified by the
573 Mississippi Board of Nursing as a nurse practitioner, including,
574 but not limited to, nurse anesthetists, nurse midwives, family
575 nurse practitioners, family planning nurse practitioners,
576 pediatric nurse practitioners, obstetrics-gynecology nurse
577 practitioners and neonatal nurse practitioners, under regulations
578 adopted by the division. Reimbursement for those services shall
579 not exceed ninety percent (90%) of the reimbursement rate for
580 comparable services rendered by a physician. The division may
581 provide for a reimbursement rate for nurse practitioner services
582 of up to one hundred percent (100%) of the reimbursement rate for
583 comparable services rendered by a physician for nurse practitioner
584 services that are provided after the normal working hours of the
585 nurse practitioner, as determined in accordance with regulations
586 of the division.

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



592 qualified health centers shall be reimbursed by the Medicaid
593 prospective payment system as approved by the Centers for Medicare
594 and Medicaid Services. The division shall recognize federally
595 qualified health centers (FQHCs), rural health clinics (RHCs) and
596 community mental health centers (CMHCs) as both an originating and
597 distant site provider for the purposes of telehealth
598 reimbursement. The division is further authorized and directed to
599 reimburse FQHCs, RHCs and CMHCs for both distant site and
600 originating site services when such services are appropriately
601 provided by the same organization.

602 (23) Inpatient psychiatric services.

603 (a) Inpatient psychiatric services to be
604 determined by the division for recipients under age twenty-one
605 (21) that are provided under the direction of a physician in an
606 inpatient program in a licensed acute care psychiatric facility or
607 in a licensed psychiatric residential treatment facility, before
608 the recipient reaches age twenty-one (21) or, if the recipient was
609 receiving the services immediately before he or she reached age
610 twenty-one (21), before the earlier of the date he or she no
611 longer requires the services or the date he or she reaches age
612 twenty-two (22), as provided by federal regulations. From and
613 after January 1, 2015, the division shall update the fair rental
614 reimbursement system for psychiatric residential treatment
615 facilities. Precertification of inpatient days and residential
616 treatment days must be obtained as required by the division. From



617 and after July 1, 2009, all state-owned and state-operated
618 facilities that provide inpatient psychiatric services to persons
619 under age twenty-one (21) who are eligible for Medicaid
620 reimbursement shall be reimbursed for those services on a full
621 reasonable cost basis.

622 (b) The division may reimburse for services
623 provided by a licensed freestanding psychiatric hospital to
624 Medicaid recipients over the age of twenty-one (21) in a method
625 and manner consistent with the provisions of Section 43-13-117.5.

626 (24) [Deleted]

627 (25) [Deleted]

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

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



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

646 (29) The Division of Medicaid may apply for a waiver
647 from the United States Department of Health and Human Services for
648 home- and community-based services for developmentally disabled
649 people using state funds that are provided from the appropriation
650 to the State Department of Mental Health and/or funds transferred
651 to the department by a political subdivision or instrumentality of
652 the state and used to match federal funds under a cooperative
653 agreement between the division and the department, provided that
654 funds for these services are specifically appropriated to the
655 Department of Mental Health and/or transferred to the department
656 by a political subdivision or instrumentality of the state.

657 (30) Pediatric skilled nursing services as determined
658 by the division and in a manner consistent with regulations
659 promulgated by the Mississippi State Department of Health.

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



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

672 (33) Podiatrist services.

673 (34) Assisted living services as provided through
674 home- and community-based services under Title XIX of the federal
675 Social Security Act, as amended, subject to the availability of
676 funds specifically appropriated for that purpose by the
677 Legislature.

678 (35) Services and activities authorized in Sections
679 43-27-101 and 43-27-103, using state funds that are provided from
680 the appropriation to the Mississippi Department of Human Services
681 and used to match federal funds under a cooperative agreement
682 between the division and the department.

683 (36) Nonemergency transportation services for
684 Medicaid-eligible persons as determined by the division. The PEER
685 Committee shall conduct a performance evaluation of the
686 nonemergency transportation program to evaluate the administration
687 of the program and the providers of transportation services to
688 determine the most cost-effective ways of providing nonemergency
689 transportation services to the patients served under the program.
690 The performance evaluation shall be completed and provided to the



691 members of the Senate Medicaid Committee and the House Medicaid
692 Committee not later than January 1, 2019, and every two (2) years
693 thereafter.

694 (37) [Deleted]

695 (38) Chiropractic services. A chiropractor's manual
696 manipulation of the spine to correct a subluxation, if x-ray
697 demonstrates that a subluxation exists and if the subluxation has
698 resulted in a neuromusculoskeletal condition for which
699 manipulation is appropriate treatment, and related spinal x-rays
700 performed to document these conditions. Reimbursement for
701 chiropractic services shall not exceed Seven Hundred Dollars
702 (\$700.00) per year per beneficiary.

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

711 (40) [Deleted]

712 (41) Services provided by the State Department of
713 Rehabilitation Services for the care and rehabilitation of persons
714 with spinal cord injuries or traumatic brain injuries, as allowed
715 under waivers from the United States Department of Health and



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

722 (42) [Deleted]

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

728 (44) Nursing facility services for the severely
729 disabled.

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

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

736 (45) Physician assistant services. Services furnished
737 by a physician assistant who is licensed by the State Board of
738 Medical Licensure and is practicing with physician supervision
739 under regulations adopted by the board, under regulations adopted
740 by the division. Reimbursement for those services shall not



741 exceed ninety percent (90%) of the reimbursement rate for
742 comparable services rendered by a physician. The division may
743 provide for a reimbursement rate for physician assistant services
744 of up to one hundred percent (100%) or the reimbursement rate for
745 comparable services rendered by a physician for physician
746 assistant services that are provided after the normal working
747 hours of the physician assistant, as determined in accordance with
748 regulations of the division.

749 (46) The division shall make application to the federal
750 Centers for Medicare and Medicaid Services (CMS) for a waiver to
751 develop and provide services for children with serious emotional
752 disturbances as defined in Section 43-14-1(1), which may include
753 home- and community-based services, case management services or
754 managed care services through mental health providers certified by
755 the Department of Mental Health. The division may implement and
756 provide services under this waived program only if funds for
757 these services are specifically appropriated for this purpose by
758 the Legislature, or if funds are voluntarily provided by affected
759 agencies.

760 (47) (a) The division may develop and implement
761 disease management programs for individuals with high-cost chronic
762 diseases and conditions, including the use of grants, waivers,
763 demonstrations or other projects as necessary.

764 (b) Participation in any disease management
765 program implemented under this paragraph (47) is optional with the



766 individual. An individual must affirmatively elect to participate
767 in the disease management program in order to participate, and may
768 elect to discontinue participation in the program at any time.

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

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

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

779 (49) The division may establish copayments and/or
780 coinsurance for any Medicaid services for which copayments and/or
781 coinsurance are allowable under federal law or regulation.

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

789 (51) Upon determination of Medicaid eligibility and in
790 association with annual redetermination of Medicaid eligibility,



791 beneficiaries shall be encouraged to undertake a physical
792 examination that will establish a base-line level of health and
793 identification of a usual and customary source of care (a medical
794 home) to aid utilization of disease management tools. This
795 physical examination and utilization of these disease management
796 tools shall be consistent with current United States Preventive
797 Services Task Force or other recognized authority recommendations.

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

801 (52) Notwithstanding any provisions of this article,
802 the division may pay enhanced reimbursement fees related to trauma
803 care, as determined by the division in conjunction with the State
804 Department of Health, using funds appropriated to the State
805 Department of Health for trauma care and services and used to
806 match federal funds under a cooperative agreement between the
807 division and the State Department of Health. The division, in
808 conjunction with the State Department of Health, may use grants,
809 waivers, demonstrations, enhanced reimbursements, Upper Payment
810 Limits Programs, supplemental payments, or other projects as
811 necessary in the development and implementation of this
812 reimbursement program.

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



816 (54) [Deleted]

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

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

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



841 malignancy, chronic end-stage cardiovascular or cerebral vascular
842 disease, or any other disease, illness or condition which a
843 physician diagnoses as terminal.

844 (58) Treatment services for persons with opioid
845 dependency or other highly addictive substance use disorders. The
846 division is authorized to reimburse eligible providers for
847 treatment of opioid dependency and other highly addictive
848 substance use disorders, as determined by the division. Treatment
849 related to these conditions shall not count against any physician
850 visit limit imposed under this section.

851 (59) The division shall allow beneficiaries between the
852 ages of ten (10) and eighteen (18) years to receive vaccines
853 through a pharmacy venue. The division and the State Department
854 of Health shall coordinate and notify OB-GYN providers that the
855 Vaccines for Children program is available to providers free of
856 charge.

857 (60) Border city university-affiliated pediatric
858 teaching hospital.

859 (a) Payments may only be made to a border city
860 university-affiliated pediatric teaching hospital if the Centers
861 for Medicare and Medicaid Services (CMS) approve an increase in
862 the annual request for the provider payment initiative authorized
863 under 42 CFR Section 438.6(c) in an amount equal to or greater
864 than the estimated annual payment to be made to the border city
865 university-affiliated pediatric teaching hospital. The estimate



866 shall be based on the hospital's prior year Mississippi managed
867 care utilization.

868 (b) As used in this paragraph (60), the term
869 "border city university-affiliated pediatric teaching hospital"
870 means an out-of-state hospital located within a city bordering the
871 eastern bank of the Mississippi River and the State of Mississippi
872 that submits to the division a copy of a current and effective
873 affiliation agreement with an accredited university and other
874 documentation establishing that the hospital is
875 university-affiliated, is licensed and designated as a pediatric
876 hospital or pediatric primary hospital within its home state,
877 maintains at least five (5) different pediatric specialty training
878 programs, and maintains at least one hundred (100) operated beds
879 dedicated exclusively for the treatment of patients under the age
880 of twenty-one (21) years.

881 (c) The cost of providing services to Mississippi
882 Medicaid beneficiaries under the age of twenty-one (21) years who
883 are treated by a border city university-affiliated pediatric
884 teaching hospital shall not exceed the cost of providing the same
885 services to individuals in hospitals in the state.

886 (d) It is the intent of the Legislature that
887 payments shall not result in any in-state hospital receiving
888 payments lower than they would otherwise receive if not for the
889 payments made to any border city university-affiliated pediatric
890 teaching hospital.



891 (e) This paragraph (60) shall stand repealed on
892 July 1, 2024.

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

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

908 (D) (1) As used in this subsection (D), the following terms
909 shall be defined as provided in this paragraph, except as
910 otherwise provided in this subsection:

911 (a) "Committees" means the Medicaid Committees of
912 the House of Representatives and the Senate, and "committee" means
913 either one of those committees.

914 (b) "Rate change" means an increase, decrease or
915 other change in the payments or rates of reimbursement, or a



916 change in any payment methodology that results in an increase,
917 decrease or other change in the payments or rates of
918 reimbursement, to any Medicaid provider that renders any services
919 authorized to be provided to Medicaid recipients under this
920 article.

921 (2) Whenever the Division of Medicaid proposes a rate
922 change, the division shall give notice to the chairmen of the
923 committees at least thirty (30) calendar days before the proposed
924 rate change is scheduled to take effect. The division shall
925 furnish the chairmen with a concise summary of each proposed rate
926 change along with the notice, and shall furnish the chairmen with
927 a copy of any proposed rate change upon request. The division
928 also shall provide a summary and copy of any proposed rate change
929 to any other member of the Legislature upon request.

930 (3) If the chairman of either committee or both
931 chairmen jointly object to the proposed rate change or any part
932 thereof, the chairman or chairmen shall notify the division and
933 provide the reasons for their objection in writing not later than
934 seven (7) calendar days after receipt of the notice from the
935 division. The chairman or chairmen may make written
936 recommendations to the division for changes to be made to a
937 proposed rate change.

938 (4) (a) The chairman of either committee or both
939 chairmen jointly may hold a committee meeting to review a proposed
940 rate change. If either chairman or both chairmen decide to hold a



941 meeting, they shall notify the division of their intention in
942 writing within seven (7) calendar days after receipt of the notice
943 from the division, and shall set the date and time for the meeting
944 in their notice to the division, which shall not be later than
945 fourteen (14) calendar days after receipt of the notice from the
946 division.

947 (b) After the committee meeting, the committee or
948 committees may object to the proposed rate change or any part
949 thereof. The committee or committees shall notify the division
950 and the reasons for their objection in writing not later than
951 seven (7) calendar days after the meeting. The committee or
952 committees may make written recommendations to the division for
953 changes to be made to a proposed rate change.

954 (5) If both chairmen notify the division in writing
955 within seven (7) calendar days after receipt of the notice from
956 the division that they do not object to the proposed rate change
957 and will not be holding a meeting to review the proposed rate
958 change, the proposed rate change will take effect on the original
959 date as scheduled by the division or on such other date as
960 specified by the division.

961 (6) (a) If there are any objections to a proposed rate
962 change or any part thereof from either or both of the chairmen or
963 the committees, the division may withdraw the proposed rate
964 change, make any of the recommended changes to the proposed rate
965 change, or not make any changes to the proposed rate change.



966 (b) If the division does not make any changes to
967 the proposed rate change, it shall notify the chairmen of that
968 fact in writing, and the proposed rate change shall take effect on
969 the original date as scheduled by the division or on such other
970 date as specified by the division.

971 (c) If the division makes any changes to the
972 proposed rate change, the division shall notify the chairmen of
973 its actions in writing, and the revised proposed rate change shall
974 take effect on the date as specified by the division.

975 (7) Nothing in this subsection (D) shall be construed
976 as giving the chairmen or the committees any authority to veto,
977 nullify or revise any rate change proposed by the division. The
978 authority of the chairmen or the committees under this subsection
979 shall be limited to reviewing, making objections to and making
980 recommendations for changes to rate changes proposed by the
981 division.

982 (E) Notwithstanding any provision of this article, no new
983 groups or categories of recipients and new types of care and
984 services may be added without enabling legislation from the
985 Mississippi Legislature, except that the division may authorize
986 those changes without enabling legislation when the addition of
987 recipients or services is ordered by a court of proper authority.

988 (F) The executive director shall keep the Governor advised
989 on a timely basis of the funds available for expenditure and the
990 projected expenditures. Notwithstanding any other provisions of



991 this article, if current or projected expenditures of the division
992 are reasonably anticipated to exceed the amount of funds
993 appropriated to the division for any fiscal year, the Governor,
994 after consultation with the executive director, shall take all
995 appropriate measures to reduce costs, which may include, but are
996 not limited to:

997 (1) Reducing or discontinuing any or all services that
998 are deemed to be optional under Title XIX of the Social Security
999 Act;

1000 (2) Reducing reimbursement rates for any or all service
1001 types;

1002 (3) Imposing additional assessments on health care
1003 providers; or

1004 (4) Any additional cost-containment measures deemed
1005 appropriate by the Governor.

1006 To the extent allowed under federal law, any reduction to
1007 services or reimbursement rates under this subsection (F) shall be
1008 accompanied by a reduction, to the fullest allowable amount, to
1009 the profit margin and administrative fee portions of capitated
1010 payments to organizations described in paragraph (1) of subsection
1011 (H).

1012 Beginning in fiscal year 2010 and in fiscal years thereafter,
1013 when Medicaid expenditures are projected to exceed funds available
1014 for the fiscal year, the division shall submit the expected
1015 shortfall information to the PEER Committee not later than



1016 December 1 of the year in which the shortfall is projected to
1017 occur. PEER shall review the computations of the division and
1018 report its findings to the Legislative Budget Office not later
1019 than January 7 in any year.

1020 (G) Notwithstanding any other provision of this article, it
1021 shall be the duty of each provider participating in the Medicaid
1022 program to keep and maintain books, documents and other records as
1023 prescribed by the Division of Medicaid in accordance with federal
1024 laws and regulations.

1025 (H) (1) Notwithstanding any other provision of this
1026 article, the division is authorized to implement (a) a managed
1027 care program, (b) a coordinated care program, (c) a coordinated
1028 care organization program, (d) a health maintenance organization
1029 program, (e) a patient-centered medical home program, (f) an
1030 accountable care organization program, (g) provider-sponsored
1031 health plan, or (h) any combination of the above programs. As a
1032 condition for the approval of any program under this subsection
1033 (H) (1), the division shall require that no managed care program,
1034 coordinated care program, coordinated care organization program,
1035 health maintenance organization program, or provider-sponsored
1036 health plan may:

1037 (a) Pay providers at a rate that is less than the
1038 Medicaid All Patient Refined Diagnosis Related Groups (APR-DRG)
1039 reimbursement rate;



1040 (b) Override the medical decisions of hospital
1041 physicians or staff regarding patients admitted to a hospital for
1042 an emergency medical condition as defined by 42 US Code Section
1043 1395dd. This restriction (b) does not prohibit the retrospective
1044 review of the appropriateness of the determination that an
1045 emergency medical condition exists by chart review or coding
1046 algorithm, nor does it prohibit prior authorization for
1047 nonemergency hospital admissions;

1048 (c) Pay providers at a rate that is less than the
1049 normal Medicaid reimbursement rate. It is the intent of the
1050 Legislature that all managed care entities described in this
1051 subsection (H), in collaboration with the division, develop and
1052 implement innovative payment models that incentivize improvements
1053 in health care quality, outcomes, or value, as determined by the
1054 division. Participation in the provider network of any managed
1055 care, coordinated care, provider-sponsored health plan, or similar
1056 contractor shall not be conditioned on the provider's agreement to
1057 accept such alternative payment models;

1058 (d) Implement a prior authorization and
1059 utilization review program for medical services, transportation
1060 services and prescription drugs that is more stringent than the
1061 prior authorization processes used by the division in its
1062 administration of the Medicaid program. Not later than December
1063 2, 2021, the contractors that are receiving capitated payments
1064 under a managed care delivery system established under this



1065 subsection (H) shall submit a report to the Chairmen of the House
1066 and Senate Medicaid Committees on the status of the prior
1067 authorization and utilization review program for medical services,
1068 transportation services and prescription drugs that is required to
1069 be implemented under this subparagraph (d);

1070 (e) [Deleted]

1071 (f) Implement a preferred drug list that is more
1072 stringent than the mandatory preferred drug list established by
1073 the division under subsection (A) (9) of this section;

1074 (g) Implement a policy which denies beneficiaries
1075 with hemophilia access to the federally funded hemophilia
1076 treatment centers as part of the Medicaid Managed Care network of
1077 providers.

1078 Each health maintenance organization, coordinated care
1079 organization, provider-sponsored health plan, or other
1080 organization paid for services on a capitated basis by the
1081 division under any managed care program or coordinated care
1082 program implemented by the division under this section shall use a
1083 clear set of level of care guidelines in the determination of
1084 medical necessity and in all utilization management practices,
1085 including the prior authorization process, concurrent reviews,
1086 retrospective reviews and payments, that are consistent with
1087 widely accepted professional standards of care. Organizations
1088 participating in a managed care program or coordinated care
1089 program implemented by the division may not use any additional



1090 criteria that would result in denial of care that would be
1091 determined appropriate and, therefore, medically necessary under
1092 those levels of care guidelines.

1093 (2) Notwithstanding any provision of this section, the
1094 recipients eligible for enrollment into a Medicaid Managed Care
1095 Program authorized under this subsection (H) may include only
1096 those categories of recipients eligible for participation in the
1097 Medicaid Managed Care Program as of January 1, 2021, the
1098 Children's Health Insurance Program (CHIP), and the CMS-approved
1099 Section 1115 demonstration waivers in operation as of January 1,
1100 2021. No expansion of Medicaid Managed Care Program contracts may
1101 be implemented by the division without enabling legislation from
1102 the Mississippi Legislature.

1103 (3) (a) Any contractors receiving capitated payments
1104 under a managed care delivery system established in this section
1105 shall provide to the Legislature and the division statistical data
1106 to be shared with provider groups in order to improve patient
1107 access, appropriate utilization, cost savings and health outcomes
1108 not later than October 1 of each year. Additionally, each
1109 contractor shall disclose to the Chairmen of the Senate and House
1110 Medicaid Committees the administrative expenses costs for the
1111 prior calendar year, and the number of full-equivalent employees
1112 located in the State of Mississippi dedicated to the Medicaid and
1113 CHIP lines of business as of June 30 of the current year.



1114 (b) The division and the contractors participating
1115 in the managed care program, a coordinated care program or a
1116 provider-sponsored health plan shall be subject to annual program
1117 reviews or audits performed by the Office of the State Auditor,
1118 the PEER Committee, the Department of Insurance and/or independent
1119 third parties.

1120 (c) Those reviews shall include, but not be
1121 limited to, at least two (2) of the following items:

1122 (i) The financial benefit to the State of
1123 Mississippi of the managed care program,

1124 (ii) The difference between the premiums paid
1125 to the managed care contractors and the payments made by those
1126 contractors to health care providers,

1127 (iii) Compliance with performance measures
1128 required under the contracts,

1129 (iv) Administrative expense allocation
1130 methodologies,

1131 (v) Whether nonprovider payments assigned as
1132 medical expenses are appropriate,

1133 (vi) Capitated arrangements with related
1134 party subcontractors,

1135 (vii) Reasonableness of corporate
1136 allocations,

1137 (viii) Value-added benefits and the extent to
1138 which they are used,



1139 (ix) The effectiveness of subcontractor
1140 oversight, including subcontractor review,

1141 (x) Whether health care outcomes have been
1142 improved, and

1143 (xi) The most common claim denial codes to
1144 determine the reasons for the denials.

1145 The audit reports shall be considered public documents and
1146 shall be posted in their entirety on the division's website.

1147 (4) All health maintenance organizations, coordinated
1148 care organizations, provider-sponsored health plans, or other
1149 organizations paid for services on a capitated basis by the
1150 division under any managed care program or coordinated care
1151 program implemented by the division under this section shall
1152 reimburse all providers in those organizations at rates no lower
1153 than those provided under this section for beneficiaries who are
1154 not participating in those programs.

1155 (5) No health maintenance organization, coordinated
1156 care organization, provider-sponsored health plan, or other
1157 organization paid for services on a capitated basis by the
1158 division under any managed care program or coordinated care
1159 program implemented by the division under this section shall
1160 require its providers or beneficiaries to use any pharmacy that
1161 ships, mails or delivers prescription drugs or legend drugs or
1162 devices.



1163 (6) (a) Not later than December 1, 2021, the
1164 contractors who are receiving capitated payments under a managed
1165 care delivery system established under this subsection (H) shall
1166 develop and implement a uniform credentialing process for
1167 providers. Under that uniform credentialing process, a provider
1168 who meets the criteria for credentialing will be credentialed with
1169 all of those contractors and no such provider will have to be
1170 separately credentialed by any individual contractor in order to
1171 receive reimbursement from the contractor. Not later than
1172 December 2, 2021, those contractors shall submit a report to the
1173 Chairmen of the House and Senate Medicaid Committees on the status
1174 of the uniform credentialing process for providers that is
1175 required under this subparagraph (a).

1176 (b) If those contractors have not implemented a
1177 uniform credentialing process as described in subparagraph (a) by
1178 December 1, 2021, the division shall develop and implement, not
1179 later than July 1, 2022, a single, consolidated credentialing
1180 process by which all providers will be credentialed. Under the
1181 division's single, consolidated credentialing process, no such
1182 contractor shall require its providers to be separately
1183 credentialed by the contractor in order to receive reimbursement
1184 from the contractor, but those contractors shall recognize the
1185 credentialing of the providers by the division's credentialing
1186 process.



1187 (c) The division shall require a uniform provider
1188 credentialing application that shall be used in the credentialing
1189 process that is established under subparagraph (a) or (b). If the
1190 contractor or division, as applicable, has not approved or denied
1191 the provider credentialing application within sixty (60) days of
1192 receipt of the completed application that includes all required
1193 information necessary for credentialing, then the contractor or
1194 division, upon receipt of a written request from the applicant and
1195 within five (5) business days of its receipt, shall issue a
1196 temporary provider credential/enrollment to the applicant if the
1197 applicant has a valid Mississippi professional or occupational
1198 license to provide the health care services to which the
1199 credential/enrollment would apply. The contractor or the division
1200 shall not issue a temporary credential/enrollment if the applicant
1201 has reported on the application a history of medical or other
1202 professional or occupational malpractice claims, a history of
1203 substance abuse or mental health issues, a criminal record, or a
1204 history of medical or other licensing board, state or federal
1205 disciplinary action, including any suspension from participation
1206 in a federal or state program. The temporary
1207 credential/enrollment shall be effective upon issuance and shall
1208 remain in effect until the provider's credentialing/enrollment
1209 application is approved or denied by the contractor or division.
1210 The contractor or division shall render a final decision regarding
1211 credentialing/enrollment of the provider within sixty (60) days



1212 from the date that the temporary provider credential/enrollment is
1213 issued to the applicant.

1214 (d) If the contractor or division does not render
1215 a final decision regarding credentialing/enrollment of the
1216 provider within the time required in subparagraph (c), the
1217 provider shall be deemed to be credentialed by and enrolled with
1218 all of the contractors and eligible to receive reimbursement from
1219 the contractors.

1220 (7) (a) Each contractor that is receiving capitated
1221 payments under a managed care delivery system established under
1222 this subsection (H) shall provide to each provider for whom the
1223 contractor has denied the coverage of a procedure that was ordered
1224 or requested by the provider for or on behalf of a patient, a
1225 letter that provides a detailed explanation of the reasons for the
1226 denial of coverage of the procedure and the name and the
1227 credentials of the person who denied the coverage. The letter
1228 shall be sent to the provider in electronic format.

1229 (b) After a contractor that is receiving capitated
1230 payments under a managed care delivery system established under
1231 this subsection (H) has denied coverage for a claim submitted by a
1232 provider, the contractor shall issue to the provider within sixty
1233 (60) days a final ruling of denial of the claim that allows the
1234 provider to have a state fair hearing and/or agency appeal with
1235 the division. If a contractor does not issue a final ruling of
1236 denial within sixty (60) days as required by this subparagraph



1237 (b), the provider's claim shall be deemed to be automatically
1238 approved and the contractor shall pay the amount of the claim to
1239 the provider.

1240 (c) After a contractor has issued a final ruling
1241 of denial of a claim submitted by a provider, the division shall
1242 conduct a state fair hearing and/or agency appeal on the matter of
1243 the disputed claim between the contractor and the provider within
1244 sixty (60) days, and shall render a decision on the matter within
1245 thirty (30) days after the date of the hearing and/or appeal.

1246 (8) It is the intention of the Legislature that the
1247 division evaluate the feasibility of using a single vendor to
1248 administer pharmacy benefits provided under a managed care
1249 delivery system established under this subsection (H). Providers
1250 of pharmacy benefits shall cooperate with the division in any
1251 transition to a carve-out of pharmacy benefits under managed care.

1252 (9) The division shall evaluate the feasibility of
1253 using a single vendor to administer dental benefits provided under
1254 a managed care delivery system established in this subsection (H).
1255 Providers of dental benefits shall cooperate with the division in
1256 any transition to a carve-out of dental benefits under managed
1257 care.

1258 (10) It is the intent of the Legislature that any
1259 contractor receiving capitated payments under a managed care
1260 delivery system established in this section shall implement



1261 innovative programs to improve the health and well-being of
1262 members diagnosed with prediabetes and diabetes.

1263 (11) It is the intent of the Legislature that any
1264 contractors receiving capitated payments under a managed care
1265 delivery system established under this subsection (H) shall work
1266 with providers of Medicaid services to improve the utilization of
1267 long-acting reversible contraceptives (LARCs). Not later than
1268 December 1, 2021, any contractors receiving capitated payments
1269 under a managed care delivery system established under this
1270 subsection (H) shall provide to the Chairmen of the House and
1271 Senate Medicaid Committees and House and Senate Public Health
1272 Committees a report of LARC utilization for State Fiscal Years
1273 2018 through 2020 as well as any programs, initiatives, or efforts
1274 made by the contractors and providers to increase LARC
1275 utilization. This report shall be updated annually to include
1276 information for subsequent state fiscal years.

1277 (12) The division is authorized to make not more than
1278 one (1) emergency extension of the contracts that are in effect on
1279 July 1, 2021, with contractors who are receiving capitated
1280 payments under a managed care delivery system established under
1281 this subsection (H), as provided in this paragraph (12). The
1282 maximum period of any such extension shall be one (1) year, and
1283 under any such extensions, the contractors shall be subject to all
1284 of the provisions of this subsection (H). The extended contracts



1285 shall be revised to incorporate any provisions of this subsection
1286 (H).

1287 (I) [Deleted]

1288 (J) There shall be no cuts in inpatient and outpatient
1289 hospital payments, or allowable days or volumes, as long as the
1290 hospital assessment provided in Section 43-13-145 is in effect.
1291 This subsection (J) shall not apply to decreases in payments that
1292 are a result of: reduced hospital admissions, audits or payments
1293 under the APR-DRG or APC models, or a managed care program or
1294 similar model described in subsection (H) of this section.

1295 (K) In the negotiation and execution of such contracts
1296 involving services performed by actuarial firms, the Executive
1297 Director of the Division of Medicaid may negotiate a limitation on
1298 liability to the state of prospective contractors.

1299 (L) The Division of Medicaid shall reimburse for services
1300 provided to eligible Medicaid beneficiaries by a licensed birthing
1301 center in a method and manner to be determined by the division in
1302 accordance with federal laws and federal regulations. The
1303 division shall seek any necessary waivers, make any required
1304 amendments to its State Plan or revise any contracts authorized
1305 under subsection (H) of this section as necessary to provide the
1306 services authorized under this subsection. As used in this
1307 subsection, the term "birthing centers" shall have the meaning as
1308 defined in Section 41-77-1(a), which is a publicly or privately
1309 owned facility, place or institution constructed, renovated,



1310 leased or otherwise established where nonemergency births are
1311 planned to occur away from the mother's usual residence following
1312 a documented period of prenatal care for a normal uncomplicated
1313 pregnancy which has been determined to be low risk through a
1314 formal risk-scoring examination.

1315 (M) This section shall stand repealed on July 1, * * * 2028.

1316 **SECTION 2.** Section 43-13-145, Mississippi Code of 1972, is
1317 amended as follows:

1318 43-13-145. (1) (a) Upon each nursing facility licensed by
1319 the State of Mississippi, there is levied an assessment in an
1320 amount set by the division, equal to the maximum rate allowed by
1321 federal law or regulation, for each licensed and occupied bed of
1322 the facility.

1323 (b) A nursing facility is exempt from the assessment
1324 levied under this subsection if the facility is operated under the
1325 direction and control of:

1326 (i) The United States Veterans Administration or
1327 other agency or department of the United States government; or

1328 (ii) The State Veterans Affairs Board.

1329 (2) (a) Upon each intermediate care facility for
1330 individuals with intellectual disabilities licensed by the State
1331 of Mississippi, there is levied an assessment in an amount set by
1332 the division, equal to the maximum rate allowed by federal law or
1333 regulation, for each licensed and occupied bed of the facility.



1334 (b) An intermediate care facility for individuals with
1335 intellectual disabilities is exempt from the assessment levied
1336 under this subsection if the facility is operated under the
1337 direction and control of:

1338 (i) The United States Veterans Administration or
1339 other agency or department of the United States government;

1340 (ii) The State Veterans Affairs Board; or

1341 (iii) The University of Mississippi Medical
1342 Center.

1343 (3) (a) Upon each psychiatric residential treatment
1344 facility licensed by the State of Mississippi, there is levied an
1345 assessment in an amount set by the division, equal to the maximum
1346 rate allowed by federal law or regulation, for each licensed and
1347 occupied bed of the facility.

1348 (b) A psychiatric residential treatment facility is
1349 exempt from the assessment levied under this subsection if the
1350 facility is operated under the direction and control of:

1351 (i) The United States Veterans Administration or
1352 other agency or department of the United States government;

1353 (ii) The University of Mississippi Medical Center;
1354 or

1355 (iii) A state agency or a state facility that
1356 either provides its own state match through intergovernmental
1357 transfer or certification of funds to the division.

1358 (4) Hospital assessment.



1359 (a) (i) Subject to and upon fulfillment of the
1360 requirements and conditions of paragraph (f) below, and
1361 notwithstanding any other provisions of this section, an annual
1362 assessment on each hospital licensed in the state is imposed on
1363 each non-Medicare hospital inpatient day as defined below at a
1364 rate that is determined by dividing the sum prescribed in this
1365 subparagraph (i), plus the nonfederal share necessary to maximize
1366 the Disproportionate Share Hospital (DSH) and Medicare Upper
1367 Payment Limits (UPL) Program payments and hospital access payments
1368 and such other supplemental payments as may be developed pursuant
1369 to Section 43-13-117(A)(18), by the total number of non-Medicare
1370 hospital inpatient days as defined below for all licensed
1371 Mississippi hospitals, except as provided in paragraph (d) below.
1372 If the state-matching funds percentage for the Mississippi
1373 Medicaid program is sixteen percent (16%) or less, the sum used in
1374 the formula under this subparagraph (i) shall be Seventy-four
1375 Million Dollars (\$74,000,000.00). If the state-matching funds
1376 percentage for the Mississippi Medicaid program is twenty-four
1377 percent (24%) or higher, the sum used in the formula under this
1378 subparagraph (i) shall be One Hundred Four Million Dollars
1379 (\$104,000,000.00). If the state-matching funds percentage for the
1380 Mississippi Medicaid program is between sixteen percent (16%) and
1381 twenty-four percent (24%), the sum used in the formula under this
1382 subparagraph (i) shall be a pro rata amount determined as follows:
1383 the current state-matching funds percentage rate minus sixteen



1384 percent (16%) divided by eight percent (8%) multiplied by Thirty
1385 Million Dollars (\$30,000,000.00) and add that amount to
1386 Seventy-four Million Dollars (\$74,000,000.00). However, no
1387 assessment in a quarter under this subparagraph (i) may exceed the
1388 assessment in the previous quarter by more than Three Million
1389 Seven Hundred Fifty Thousand Dollars (\$3,750,000.00) (which would
1390 be Fifteen Million Dollars (\$15,000,000.00) on an annualized
1391 basis). The division shall publish the state-matching funds
1392 percentage rate applicable to the Mississippi Medicaid program on
1393 the tenth day of the first month of each quarter and the
1394 assessment determined under the formula prescribed above shall be
1395 applicable in the quarter following any adjustment in that
1396 state-matching funds percentage rate. The division shall notify
1397 each hospital licensed in the state as to any projected increases
1398 or decreases in the assessment determined under this subparagraph
1399 (i). However, if the Centers for Medicare and Medicaid Services
1400 (CMS) does not approve the provision in Section 43-13-117(39)
1401 requiring the division to reimburse crossover claims for inpatient
1402 hospital services and crossover claims covered under Medicare Part
1403 B for dually eligible beneficiaries in the same manner that was in
1404 effect on January 1, 2008, the sum that otherwise would have been
1405 used in the formula under this subparagraph (i) shall be reduced
1406 by Seven Million Dollars (\$7,000,000.00).

1407 (ii) In addition to the assessment provided under
1408 subparagraph (i), an additional annual assessment on each hospital



1409 licensed in the state is imposed on each non-Medicare hospital
1410 inpatient day as defined below at a rate that is determined by
1411 dividing twenty-five percent (25%) of any provider reductions in
1412 the Medicaid program as authorized in Section 43-13-117(F) for
1413 that fiscal year up to the following maximum amount, plus the
1414 nonfederal share necessary to maximize the Disproportionate Share
1415 Hospital (DSH) and inpatient Medicare Upper Payment Limits (UPL)
1416 Program payments and inpatient hospital access payments, by the
1417 total number of non-Medicare hospital inpatient days as defined
1418 below for all licensed Mississippi hospitals: in fiscal year
1419 2010, the maximum amount shall be Twenty-four Million Dollars
1420 (\$24,000,000.00); in fiscal year 2011, the maximum amount shall be
1421 Thirty-two Million Dollars (\$32,000,000.00); and in fiscal year
1422 2012 and thereafter, the maximum amount shall be Forty Million
1423 Dollars (\$40,000,000.00). Any such deficit in the Medicaid
1424 program shall be reviewed by the PEER Committee as provided in
1425 Section 43-13-117(F).

1426 (iii) In addition to the assessments provided in
1427 subparagraphs (i) and (ii), an additional annual assessment on
1428 each hospital licensed in the state is imposed pursuant to the
1429 provisions of Section 43-13-117(F) if the cost-containment
1430 measures described therein have been implemented and there are
1431 insufficient funds in the Health Care Trust Fund to reconcile any
1432 remaining deficit in any fiscal year. If the Governor institutes
1433 any other additional cost-containment measures on any program or



1434 programs authorized under the Medicaid program pursuant to Section
1435 43-13-117(F), hospitals shall be responsible for twenty-five
1436 percent (25%) of any such additional imposed provider cuts, which
1437 shall be in the form of an additional assessment not to exceed the
1438 twenty-five percent (25%) of provider expenditure reductions.
1439 Such additional assessment shall be imposed on each non-Medicare
1440 hospital inpatient day in the same manner as assessments are
1441 imposed under subparagraphs (i) and (ii).

1442 (b) Definitions.

1443 (i) [Deleted]

1444 (ii) For purposes of this subsection (4):

1445 1. "Non-Medicare hospital inpatient day"

1446 means total hospital inpatient days including subcomponent days
1447 less Medicare inpatient days including subcomponent days from the
1448 hospital's most recent Medicare cost report for the second
1449 calendar year preceding the beginning of the state fiscal year, on
1450 file with CMS per the CMS HCRIS database, or cost report submitted
1451 to the Division if the HCRIS database is not available to the
1452 division, as of June 1 of each year.

1453 a. Total hospital inpatient days shall
1454 be the sum of Worksheet S-3, Part 1, column 8 row 14, column 8 row
1455 16, and column 8 row 17, excluding column 8 rows 5 and 6.

1456 b. Hospital Medicare inpatient days
1457 shall be the sum of Worksheet S-3, Part 1, column 6 row 14, column
1458 6 row 16.00, and column 6 row 17, excluding column 6 rows 5 and 6.



1459 c. Inpatient days shall not include
1460 residential treatment or long-term care days.

1461 2. "Subcomponent inpatient day" means the
1462 number of days of care charged to a beneficiary for inpatient
1463 hospital rehabilitation and psychiatric care services in units of
1464 full days. A day begins at midnight and ends twenty-four (24)
1465 hours later. A part of a day, including the day of admission and
1466 day on which a patient returns from leave of absence, counts as a
1467 full day. However, the day of discharge, death, or a day on which
1468 a patient begins a leave of absence is not counted as a day unless
1469 discharge or death occur on the day of admission. If admission
1470 and discharge or death occur on the same day, the day is
1471 considered a day of admission and counts as one (1) subcomponent
1472 inpatient day.

1473 (c) The assessment provided in this subsection is
1474 intended to satisfy and not be in addition to the assessment and
1475 intergovernmental transfers provided in Section 43-13-117(A)(18).
1476 Nothing in this section shall be construed to authorize any state
1477 agency, division or department, or county, municipality or other
1478 local governmental unit to license for revenue, levy or impose any
1479 other tax, fee or assessment upon hospitals in this state not
1480 authorized by a specific statute.

1481 (d) Hospitals operated by the United States Department
1482 of Veterans Affairs and state-operated facilities that provide



1483 only inpatient and outpatient psychiatric services shall not be
1484 subject to the hospital assessment provided in this subsection.

1485 (e) Multihospital systems, closure, merger, change of
1486 ownership and new hospitals.

1487 (i) If a hospital conducts, operates or maintains
1488 more than one (1) hospital licensed by the State Department of
1489 Health, the provider shall pay the hospital assessment for each
1490 hospital separately.

1491 (ii) Notwithstanding any other provision in this
1492 section, if a hospital subject to this assessment operates or
1493 conducts business only for a portion of a fiscal year, the
1494 assessment for the state fiscal year shall be adjusted by
1495 multiplying the assessment by a fraction, the numerator of which
1496 is the number of days in the year during which the hospital
1497 operates, and the denominator of which is three hundred sixty-five
1498 (365). Immediately upon ceasing to operate, the hospital shall
1499 pay the assessment for the year as so adjusted (to the extent not
1500 previously paid).

1501 (iii) The division shall determine the tax for new
1502 hospitals and hospitals that undergo a change of ownership in
1503 accordance with this section, using the best available
1504 information, as determined by the division.

1505 (f) Applicability.

1506 The hospital assessment imposed by this subsection shall not
1507 take effect and/or shall cease to be imposed if:



1508 (i) The assessment is determined to be an
1509 impermissible tax under Title XIX of the Social Security Act; or

1510 (ii) CMS revokes its approval of the division's
1511 2009 Medicaid State Plan Amendment for the methodology for DSH
1512 payments to hospitals under Section 43-13-117(A) (18).

1513 (5) Each health care facility that is subject to the
1514 provisions of this section shall keep and preserve such suitable
1515 books and records as may be necessary to determine the amount of
1516 assessment for which it is liable under this section. The books
1517 and records shall be kept and preserved for a period of not less
1518 than five (5) years, during which time those books and records
1519 shall be open for examination during business hours by the
1520 division, the Department of Revenue, the Office of the Attorney
1521 General and the State Department of Health.

1522 (6) [Deleted]

1523 (7) All assessments collected under this section shall be
1524 deposited in the Medical Care Fund created by Section 43-13-143.

1525 (8) The assessment levied under this section shall be in
1526 addition to any other assessments, taxes or fees levied by law,
1527 and the assessment shall constitute a debt due the State of
1528 Mississippi from the time the assessment is due until it is paid.

1529 (9) (a) If a health care facility that is liable for
1530 payment of an assessment levied by the division does not pay the
1531 assessment when it is due, the division shall give written notice
1532 to the health care facility demanding payment of the assessment



1533 within ten (10) days from the date of delivery of the notice. If
1534 the health care facility fails or refuses to pay the assessment
1535 after receiving the notice and demand from the division, the
1536 division shall withhold from any Medicaid reimbursement payments
1537 that are due to the health care facility the amount of the unpaid
1538 assessment and a penalty of ten percent (10%) of the amount of the
1539 assessment, plus the legal rate of interest until the assessment
1540 is paid in full. If the health care facility does not participate
1541 in the Medicaid program, the division shall turn over to the
1542 Office of the Attorney General the collection of the unpaid
1543 assessment by civil action. In any such civil action, the Office
1544 of the Attorney General shall collect the amount of the unpaid
1545 assessment and a penalty of ten percent (10%) of the amount of the
1546 assessment, plus the legal rate of interest until the assessment
1547 is paid in full.

1548 (b) As an additional or alternative method for
1549 collecting unpaid assessments levied by the division, if a health
1550 care facility fails or refuses to pay the assessment after
1551 receiving notice and demand from the division, the division may
1552 file a notice of a tax lien with the chancery clerk of the county
1553 in which the health care facility is located, for the amount of
1554 the unpaid assessment and a penalty of ten percent (10%) of the
1555 amount of the assessment, plus the legal rate of interest until
1556 the assessment is paid in full. Immediately upon receipt of
1557 notice of the tax lien for the assessment, the chancery clerk



1558 shall forward the notice to the circuit clerk who shall enter the
1559 notice of the tax lien as a judgment upon the judgment roll and
1560 show in the appropriate columns the name of the health care
1561 facility as judgment debtor, the name of the division as judgment
1562 creditor, the amount of the unpaid assessment, and the date and
1563 time of enrollment. The judgment shall be valid as against
1564 mortgagees, pledgees, entrusters, purchasers, judgment creditors
1565 and other persons from the time of filing with the clerk. The
1566 amount of the judgment shall be a debt due the State of
1567 Mississippi and remain a lien upon the tangible property of the
1568 health care facility until the judgment is satisfied. The
1569 judgment shall be the equivalent of any enrolled judgment of a
1570 court of record and shall serve as authority for the issuance of
1571 writs of execution, writs of attachment or other remedial writs.

1572 (10) (a) To further the provisions of Section
1573 43-13-117(A)(18), the Division of Medicaid shall submit to the
1574 Centers for Medicare and Medicaid Services (CMS) any documents
1575 regarding the hospital assessment established under subsection (4)
1576 of this section. In addition to defining the assessment
1577 established in subsection (4) of this section if necessary, the
1578 documents shall describe any supplement payment programs and/or
1579 payment methodologies as authorized in Section 43-13-117(A)(18) if
1580 necessary.

1581 (b) All hospitals satisfying the minimum federal DSH
1582 eligibility requirements (Section 1923(d) of the Social Security



1583 Act) may, subject to OBRA 1993 payment limitations, receive a DSH
1584 payment. This DSH payment shall expend the balance of the federal
1585 DSH allotment and associated state share not utilized in DSH
1586 payments to state-owned institutions for treatment of mental
1587 diseases. The payment to each hospital shall be calculated by
1588 applying a uniform percentage to the uninsured costs of each
1589 eligible hospital, excluding state-owned institutions for
1590 treatment of mental diseases; however, that percentage for a
1591 state-owned teaching hospital located in Hinds County shall be
1592 multiplied by a factor of two (2).

1593 (11) The division shall implement DSH and supplemental
1594 payment calculation methodologies that result in the maximization
1595 of available federal funds.

1596 (12) The DSH payments shall be paid on or before December
1597 31, March 31, and June 30 of each fiscal year, in increments of
1598 one-third (1/3) of the total calculated DSH amounts. Supplemental
1599 payments developed pursuant to Section 43-13-117(A)(18) shall be
1600 paid monthly.

1601 (13) Payment.

1602 (a) The hospital assessment as described in subsection
1603 (4) for the nonfederal share necessary to maximize the Medicare
1604 Upper Payments Limits (UPL) Program payments and hospital access
1605 payments and such other supplemental payments as may be developed
1606 pursuant to Section 43-3-117(A)(18) shall be assessed and



1607 collected monthly no later than the fifteenth calendar day of each
1608 month.

1609 (b) The hospital assessment as described in subsection
1610 (4) for the nonfederal share necessary to maximize the
1611 Disproportionate Share Hospital (DSH) payments shall be assessed
1612 and collected on December 15, March 15 and June 15.

1613 (c) The annual hospital assessment and any additional
1614 hospital assessment as described in subsection (4) shall be
1615 assessed and collected on September 15 and on the 15th of each
1616 month from December through June.

1617 (14) If for any reason any part of the plan for annual DSH
1618 and supplemental payment programs to hospitals provided under
1619 subsection (10) of this section and/or developed pursuant to
1620 Section 43-13-117(A)(18) is not approved by CMS, the remainder of
1621 the plan shall remain in full force and effect.

1622 (15) Nothing in this section shall prevent the Division of
1623 Medicaid from facilitating participation in Medicaid supplemental
1624 hospital payment programs by a hospital located in a county
1625 contiguous to the State of Mississippi that is also authorized by
1626 federal law to submit intergovernmental transfers (IGTs) to the
1627 State of Mississippi to fund the state share of the hospital's
1628 supplemental and/or MHAP payments.

1629 (16) This section shall stand repealed on July 1, * * *
1630 2028.



1631 **SECTION 3.** This act shall take effect and be in force from
1632 and after July 1, 2024.

