

By: Representative McGee

To: Medicaid

HOUSE BILL NO. 1146

1 AN ACT TO BRING FORWARD SECTION 43-13-145, MISSISSIPPI CODE
2 OF 1972, WHICH PROVIDES FOR ASSESSMENTS ON CERTAIN HEALTH CARE
3 FACILITIES TO PROVIDE FUNDING FOR THE MEDICAID PROGRAM, FOR THE
4 PURPOSE OF POSSIBLE AMENDMENT; AND FOR RELATED PURPOSES.

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

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

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

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

16 (i) The United States Veterans Administration or
17 other agency or department of the United States government; or
18 (ii) The State Veterans Affairs Board.

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

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

28 (i) The United States Veterans Administration or
29 other agency or department of the United States government;
30 (ii) The State Veterans Affairs Board; or
31 (iii) The University of Mississippi Medical
32 Center.

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

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

43 (ii) The University of Mississippi Medical Center;

44 or

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

48 (4) Hospital assessment.



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



93 B for dually eligible beneficiaries in the same manner that was in
94 effect on January 1, 2008, the sum that otherwise would have been
95 used in the formula under this subparagraph (i) shall be reduced
96 by Seven Million Dollars (\$7,000,000.00).

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

116 (iii) In addition to the assessments provided in
117 subparagraphs (i) and (ii), an additional annual assessment on

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

132 (b) Definitions.

133 (i) [Deleted]

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

135 1. "Non-Medicare hospital inpatient day"

136 means total hospital inpatient days including subcomponent days
137 less Medicare inpatient days including subcomponent days from the
138 hospital's most recent Medicare cost report for the second
139 calendar year preceding the beginning of the state fiscal year, on
140 file with CMS per the CMS HCRIS database, or cost report submitted
141 to the Division if the HCRIS database is not available to the
142 division, as of June 1 of each year.



143 a. Total hospital inpatient days shall
144 be the sum of Worksheet S-3, Part 1, column 8 row 14, column 8 row
145 16, and column 8 row 17, excluding column 8 rows 5 and 6.

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

163 (c) The assessment provided in this subsection is
164 intended to satisfy and not be in addition to the assessment and
165 intergovernmental transfers provided in Section 43-13-117(A)(18).
166 Nothing in this section shall be construed to authorize any state
167 agency, division or department, or county, municipality or other



168 local governmental unit to license for revenue, levy or impose any
169 other tax, fee or assessment upon hospitals in this state not
170 authorized by a specific statute.

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

175 (e) Multihospital systems, closure, merger, change of
176 ownership and new hospitals.

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

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

191 (iii) The division shall determine the tax for new
192 hospitals and hospitals that undergo a change of ownership in

193 accordance with this section, using the best available
194 information, as determined by the division.

195 (f) Applicability.

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

198 (i) The assessment is determined to be an
199 impermissible tax under Title XIX of the Social Security Act; or
200 (ii) CMS revokes its approval of the division's
201 2009 Medicaid State Plan Amendment for the methodology for DSH
202 payments to hospitals under Section 43-13-117(A) (18) .

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

212 (6) [Deleted]

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

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



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

219 (9) (a) If a health care facility that is liable for
220 payment of an assessment levied by the division does not pay the
221 assessment when it is due, the division shall give written notice
222 to the health care facility demanding payment of the assessment
223 within ten (10) days from the date of delivery of the notice. If
224 the health care facility fails or refuses to pay the assessment
225 after receiving the notice and demand from the division, the
226 division shall withhold from any Medicaid reimbursement payments
227 that are due to the health care facility the amount of the unpaid
228 assessment and a penalty of ten percent (10%) of the amount of the
229 assessment, plus the legal rate of interest until the assessment
230 is paid in full. If the health care facility does not participate
231 in the Medicaid program, the division shall turn over to the
232 Office of the Attorney General the collection of the unpaid
233 assessment by civil action. In any such civil action, the Office
234 of the Attorney General shall collect the amount of the unpaid
235 assessment and a penalty of ten percent (10%) of the amount of the
236 assessment, plus the legal rate of interest until the assessment
237 is paid in full.

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

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

262 (10) (a) To further the provisions of Section
263 43-13-117(A)(18), the Division of Medicaid shall submit to the
264 Centers for Medicare and Medicaid Services (CMS) any documents
265 regarding the hospital assessment established under subsection (4)
266 of this section. In addition to defining the assessment



267 established in subsection (4) of this section if necessary, the
268 documents shall describe any supplement payment programs and/or
269 payment methodologies as authorized in Section 43-13-117(A) (18) if
270 necessary.

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

283 (11) The division shall implement DSH and supplemental
284 payment calculation methodologies that result in the maximization
285 of available federal funds.

286 (12) The DSH payments shall be paid on or before December
287 31, March 31, and June 30 of each fiscal year, in increments of
288 one-third (1/3) of the total calculated DSH amounts. Supplemental
289 payments developed pursuant to Section 43-13-117(A) (18) shall be
290 paid monthly.

291 (13) Payment.

292 (a) The hospital assessment as described in subsection
293 (4) for the nonfederal share necessary to maximize the Medicare
294 Upper Payments Limits (UPL) Program payments and hospital access
295 payments and such other supplemental payments as may be developed
296 pursuant to Section 43-3-117(A)(18) shall be assessed and
297 collected monthly no later than the fifteenth calendar day of each
298 month.

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

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

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

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



317 State of Mississippi to fund the state share of the hospital's
318 supplemental and/or MHAP payments.

319 (16) This section shall stand repealed on July 1, 2028.

320 **SECTION 2.** This act shall take effect and be in force from
321 and after July 1, 2025.

