By: Representative Shanks

To: Medicaid

HOUSE BILL NO. 762

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO EXTEND THE DATE OF THE REPEALER ON THE COMPREHENSIVE LIST OF
3 THE TYPES OF CARE AND SERVICES COVERED BY MEDICAID AND TO DELETE
4 THE DUPLICATE REPEALER ON THOSE PROVISIONS AUTHORIZING MEDICAID
5 COVERAGE FOR CERTAIN SERVICES PROVIDED AT OUT-OF-STATE BORDER CITY
6 UNIVERSITY-AFFILIATED PEDIATRIC TEACHING HOSPITALS; TO AMEND
7 SECTION 43-13-145, MISSISSIPPI CODE OF 1972, TO EXTEND THE DATE OF
8 THE REPEALER ON THE STATUTE REQUIRING THE LEVY ON CERTAIN LICENSED
9 HEALTH CARE FACILITIES OF AN ASSESSMENT TO BE DEPOSITED IN THE
10 MEDICAL CARE FUND IN THE STATE TREASURY; AND FOR RELATED PURPOSES.

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

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

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

21 (1) Inpatient hospital services.

22 (a) The division is authorized to implement an All
23 Patient Refined Diagnosis Related Groups (APR-DRG) reimbursement
24 methodology for inpatient hospital services.
25 (b) No service benefits or reimbursement
26 limitations in this subsection (A)(1) shall apply to payments
27 under an APR-DRG or Ambulatory Payment Classification (APC) model
28 or a managed care program or similar model described in subsection
29 (H) of this section unless specifically authorized by the
30 division.
31 (2) Outpatient hospital services.
32 (a) Emergency services.
33 (b) Other outpatient hospital services. The
34 division shall allow benefits for other medically necessary
35 outpatient hospital services (such as chemotherapy, radiation,
36 surgery and therapy), including outpatient services in a clinic or
37 other facility that is not located inside the hospital, but that
38 has been designated as an outpatient facility by the hospital, and
39 that was in operation or under construction on July 1, 2009,
40 provided that the costs and charges associated with the operation
41 of the hospital clinic are included in the hospital's cost report.
42 In addition, the Medicare thirty-five-mile rule will apply to
43 those hospital clinics not located inside the hospital that are
44 constructed after July 1, 2009. Where the same services are
45 reimbursed as clinic services, the division may revise the rate or

46 methodology of outpatient reimbursement to maintain consistency,
47 efficiency, economy and quality of care.
48 (c) The division is authorized to implement an
49 Ambulatory Payment Classification (APC) methodology for outpatient
50 hospital services. The division shall give rural hospitals that
51 have fifty (50) or fewer licensed beds the option to not be
52 reimbursed for outpatient hospital services using the APC
53 methodology, but reimbursement for outpatient hospital services
54 provided by those hospitals shall be based on one hundred one
55 percent (101%) of the rate established under Medicare for
56 outpatient hospital services. Those hospitals choosing to not be
57 reimbursed under the APC methodology shall remain under cost-based
58 reimbursement for a two-year period.
59 (d) No service benefits or reimbursement
60 limitations in this subsection (A)(2) shall apply to payments
61 under an APR-DRG or APC model or a managed care program or similar
62 model described in subsection (H) of this section unless
63 specifically authorized by the division.
64 (3) Laboratory and x-ray services.
65 (4) Nursing facility services.
66 (a) The division shall make full payment to
67 nursing facilities for each day, not exceeding forty-two (42) days
68 per year, that a patient is absent from the facility on home
69 leave. Payment may be made for the following home leave days in
70 addition to the forty-two-day limitation: Christmas, the day

71 before Christmas, the day after Christmas, Thanksgiving, the day
72 before Thanksgiving and the day after Thanksgiving.

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

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

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

94 (e) The division shall develop and implement, not
95 later than January 1, 2001, a case-mix payment add-on determined

96 by time studies and other valid statistical data that will
97 reimburse a nursing facility for the additional cost of caring for
98 a resident who has a diagnosis of Alzheimer's or other related
99 dementia and exhibits symptoms that require special care. Any
100 such case-mix add-on payment shall be supported by a determination
101 of additional cost. The division shall also develop and implement
102 as part of the fair rental reimbursement system for nursing
103 facility beds, an Alzheimer's resident bed depreciation enhanced
104 reimbursement system that will provide an incentive to encourage
105 nursing facilities to convert or construct beds for residents with
106 Alzheimer's or other related dementia.

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

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

115 (5) Periodic screening and diagnostic services for
116 individuals under age twenty-one (21) years as are needed to
117 identify physical and mental defects and to provide health care
118 treatment and other measures designed to correct or ameliorate
119 defects and physical and mental illness and conditions discovered
120 by the screening services, regardless of whether these services

121 are included in the state plan. The division may include in its
122 periodic screening and diagnostic program those discretionary
123 services authorized under the federal regulations adopted to
124 implement Title XIX of the federal Social Security Act, as
125 amended. The division, in obtaining physical therapy services,
126 occupational therapy services, and services for individuals with
127 speech, hearing and language disorders, may enter into a
128 cooperative agreement with the State Department of Education for
129 the provision of those services to handicapped students by public
130 school districts using state funds that are provided from the
131 appropriation to the Department of Education to obtain federal
132 matching funds through the division. The division, in obtaining
133 medical and mental health assessments, treatment, care and
134 services for children who are in, or at risk of being put in, the
135 custody of the Mississippi Department of Human Services may enter
136 into a cooperative agreement with the Mississippi Department of
137 Human Services for the provision of those services using state
138 funds that are provided from the appropriation to the Department
139 of Human Services to obtain federal matching funds through the
140 division.
141 (6) Physician services. Fees for physician's services
142 that are covered only by Medicaid shall be reimbursed at ninety
143 percent (90%) of the rate established on January 1, 2018, and as
144 may be adjusted each July thereafter, under Medicare. The
145 division may provide for a reimbursement rate for physician's

146 services of up to one hundred percent (100%) of the rate
147 established under Medicare for physician's services that are
148 provided after the normal working hours of the physician, as
149 determined in accordance with regulations of the division. The
150 division may reimburse eligible providers, as determined by the
151 division, for certain primary care services at one hundred percent
152 (100%) of the rate established under Medicare. The division shall
153 reimburse obstetricians and gynecologists for certain primary care
154 services as defined by the division at one hundred percent (100%)
155 of the rate established under Medicare.

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

166 (b) [Repealed]

167 (8) Emergency medical transportation services as
168 determined by the division.

169 (9) Prescription drugs and other covered drugs and
170 services as determined by the division.

171 The division shall establish a mandatory preferred drug list.
172 Drugs not on the mandatory preferred drug list shall be made
173 available by utilizing prior authorization procedures established
174 by the division.
175 The division may seek to establish relationships with other
176 states in order to lower acquisition costs of prescription drugs
177 to include single-source and innovator multiple-source drugs or
178 generic drugs. In addition, if allowed by federal law or
179 regulation, the division may seek to establish relationships with
180 and negotiate with other countries to facilitate the acquisition
181 of prescription drugs to include single-source and innovator
182 multiple-source drugs or generic drugs, if that will lower the
183 acquisition costs of those prescription drugs.
184 The division may allow for a combination of prescriptions for
185 single-source and innovator multiple-source drugs and generic
186 drugs to meet the needs of the beneficiaries.
187 The executive director may approve specific maintenance drugs
188 for beneficiaries with certain medical conditions, which may be
189 prescribed and dispensed in three-month supply increments.
190 Drugs prescribed for a resident of a psychiatric residential
191 treatment facility must be provided in true unit doses when
192 available. The division may require that drugs not covered by
193 Medicare Part D for a resident of a long-term care facility be
194 provided in true unit doses when available. Those drugs that were
195 originally billed to the division but are not used by a resident

196 in any of those facilities shall be returned to the billing
197 pharmacy for credit to the division, in accordance with the
198 guidelines of the State Board of Pharmacy and any requirements of
199 federal law and regulation. Drugs shall be dispensed to a
200 recipient and only one (1) dispensing fee per month may be
201 charged. The division shall develop a methodology for reimbursing
202 for restocked drugs, which shall include a restock fee as
203 determined by the division not exceeding Seven Dollars and
204 Eighty-two Cents ($7.82).
205 Except for those specific maintenance drugs approved by the
206 executive director, the division shall not reimburse for any
207 portion of a prescription that exceeds a thirty-one-day supply of
208 the drug based on the daily dosage.
209 The division is authorized to develop and implement a program
210 of payment for additional pharmacist services as determined by the
211 division.
212 All claims for drugs for dually eligible Medicare/Medicaid
213 beneficiaries that are paid for by Medicare must be submitted to
214 Medicare for payment before they may be processed by the
215 division's online payment system.
216 The division shall develop a pharmacy policy in which drugs
217 in tamper-resistant packaging that are prescribed for a resident
218 of a nursing facility but are not dispensed to the resident shall
219 be returned to the pharmacy and not billed to Medicaid, in
220 accordance with guidelines of the State Board of Pharmacy.

221 The division shall develop and implement a method or methods
222 by which the division will provide on a regular basis to Medicaid
223 providers who are authorized to prescribe drugs, information about
224 the costs to the Medicaid program of single-source drugs and
225 innovator multiple-source drugs, and information about other drugs
226 that may be prescribed as alternatives to those single-source
227 drugs and innovator multiple-source drugs and the costs to the
228 Medicaid program of those alternative drugs.
229 Notwithstanding any law or regulation, information obtained
230 or maintained by the division regarding the prescription drug
231 program, including trade secrets and manufacturer or labeler
232 pricing, is confidential and not subject to disclosure except to
233 other state agencies.
234 The dispensing fee for each new or refill prescription,
235 including nonlegend or over-the-counter drugs covered by the
236 division, shall be not less than Three Dollars and Ninety-one
237 Cents ($3.91), as determined by the division.
238 The division shall not reimburse for single-source or
239 innovator multiple-source drugs if there are equally effective
240 generic equivalents available and if the generic equivalents are
241 the least expensive.
242 It is the intent of the Legislature that the pharmacists
243 providers be reimbursed for the reasonable costs of filling and
244 dispensing prescriptions for Medicaid beneficiaries.

245 The division shall allow certain drugs, including
246 physician-administered drugs, and implantable drug system devices,
247 and medical supplies, with limited distribution or limited access
248 for beneficiaries and administered in an appropriate clinical
249 setting, to be reimbursed as either a medical claim or pharmacy
250 claim, as determined by the division.

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

255 (10) Dental and orthodontic services to be determined
256 by the division.

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

270 The Medical Care Advisory Committee, assisted by the Division
271 of Medicaid, shall annually determine the effect of this incentive
272 by evaluating the number of dentists who are Medicaid providers,
273 the number who and the degree to which they are actively billing
274 Medicaid, the geographic trends of where dentists are offering
275 what types of Medicaid services and other statistics pertinent to
276 the goals of this legislative intent. This data shall annually be
277 presented to the Chair of the Senate Medicaid Committee and the
278 Chair of the House Medicaid Committee.
279 The division shall include dental services as a necessary
280 component of overall health services provided to children who are
281 eligible for services.
282 (11) Eyeglasses for all Medicaid beneficiaries who have
283 (a) had surgery on the eyeball or ocular muscle that results in a
284 vision change for which eyeglasses or a change in eyeglasses is
285 medically indicated within six (6) months of the surgery and is in
286 accordance with policies established by the division, or (b) one
287 (1) pair every five (5) years and in accordance with policies
288 established by the division. In either instance, the eyeglasses
289 must be prescribed by a physician skilled in diseases of the eye
290 or an optometrist, whichever the beneficiary may select.
291 (12) Intermediate care facility services.
292 (a) The division shall make full payment to all
293 intermediate care facilities for individuals with intellectual
294 disabilities for each day, not exceeding sixty-three (63) days per

295 year, that a patient is absent from the facility on home leave.
296 Payment may be made for the following home leave days in addition
297 to the sixty-three-day limitation: Christmas, the day before
298 Christmas, the day after Christmas, Thanksgiving, the day before
299 Thanksgiving and the day after Thanksgiving.

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

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

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

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

314 (a) Services provided by ambulatory surgical
315 centers (ACSs) as defined in Section 41-75-1(a); and

316 (b) Dialysis center services.

317 (15) Home- and community-based services for the elderly
318 and disabled, as provided under Title XIX of the federal Social
319 Security Act, as amended, under waivers, subject to the

320 availability of funds specifically appropriated for that purpose
321 by the Legislature.
322 (16) Mental health services. Certain services provided
323 by a psychiatrist shall be reimbursed at up to one hundred percent
324 (100%) of the Medicare rate. Approved therapeutic and case
325 management services (a) provided by an approved regional mental
326 health/intellectual disability center established under Sections
327 41-19-31 through 41-19-39, or by another community mental health
328 service provider meeting the requirements of the Department of
329 Mental Health to be an approved mental health/intellectual
330 disability center if determined necessary by the Department of
331 Mental Health, using state funds that are provided in the
332 appropriation to the division to match federal funds, or (b)
333 provided by a facility that is certified by the State Department
334 of Mental Health to provide therapeutic and case management
335 services, to be reimbursed on a fee for service basis, or (c)
336 provided in the community by a facility or program operated by the
337 Department of Mental Health. Any such services provided by a
338 facility described in subparagraph (b) must have the prior
339 approval of the division to be reimbursable under this section.
340 (17) Durable medical equipment services and medical
341 supplies. Precertification of durable medical equipment and
342 medical supplies must be obtained as required by the division.
343 The Division of Medicaid may require durable medical equipment
344 providers to obtain a surety bond in the amount and to the

345 specifications as established by the Balanced Budget Act of 1997.
346 A maximum dollar amount of reimbursement for noninvasive
347 ventilators or ventilation treatments properly ordered and being
348 used in an appropriate care setting shall not be set by any health
349 maintenance organization, coordinated care organization,
350 provider-sponsored health plan, or other organization paid for
351 services on a capitated basis by the division under any managed
352 care program or coordinated care program implemented by the
353 division under this section. Reimbursement by these organizations
354 to durable medical equipment suppliers for home use of noninvasive
355 and invasive ventilators shall be on a continuous monthly payment
356 basis for the duration of medical need throughout a patient's
357 valid prescription period.
358 (18) (a) Notwithstanding any other provision of this
359 section to the contrary, as provided in the Medicaid state plan
360 amendment or amendments as defined in Section 43-13-145(10), the
361 division shall make additional reimbursement to hospitals that
362 serve a disproportionate share of low-income patients and that
363 meet the federal requirements for those payments as provided in
364 Section 1923 of the federal Social Security Act and any applicable
365 regulations. It is the intent of the Legislature that the
366 division shall draw down all available federal funds allotted to
367 the state for disproportionate share hospitals. However, from and
368 after January 1, 1999, public hospitals participating in the
369 Medicaid disproportionate share program may be required to

370 participate in an intergovernmental transfer program as provided
371 in Section 1903 of the federal Social Security Act and any
372 applicable regulations.
373 (b) (i) 1. The division may establish a Medicare
374 Upper Payment Limits Program, as defined in Section 1902(a)(30) of
375 the federal Social Security Act and any applicable federal
376 regulations, or an allowable delivery system or provider payment
377 initiative authorized under 42 CFR 438.6(c), for hospitals,
378 nursing facilities and physicians employed or contracted by
379 hospitals.
380 2. The division shall establish a
381 Medicaid Supplemental Payment Program, as permitted by the federal
382 Social Security Act and a comparable allowable delivery system or
383 provider payment initiative authorized under 42 CFR 438.6(c), for
384 emergency ambulance transportation providers in accordance with
385 this subsection (A)(18)(b).
386 (ii) The division shall assess each hospital,
387 nursing facility, and emergency ambulance transportation provider
388 for the sole purpose of financing the state portion of the
389 Medicare Upper Payment Limits Program or other program(s)
390 authorized under this subsection (A)(18)(b). The hospital
391 assessment shall be as provided in Section 43-13-145(4)(a), and
392 the nursing facility and the emergency ambulance transportation
393 assessments, if established, shall be based on Medicaid
394 utilization or other appropriate method, as determined by the

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

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

418 (iv) Notwithstanding any other provision of
419 this article to the contrary, effective upon implementation of the

420 Mississippi Hospital Access Program (MHAP) provided in
421 subparagraph (c)(i) below, the hospital portion of the inpatient
422 Upper Payment Limits Program shall transition into and be replaced
423 by the MHAP program. However, the division is authorized to
424 develop and implement an alternative fee-for-service Upper Payment
425 Limits model in accordance with federal laws and regulations if
426 necessary to preserve supplemental funding. Further, the
427 division, in consultation with the hospital industry shall develop
428 alternative models for distribution of medical claims and
429 supplemental payments for inpatient and outpatient hospital
430 services, and such models may include, but shall not be limited to
431 the following: increasing rates for inpatient and outpatient
432 services; creating a low-income utilization pool of funds to
433 reimburse hospitals for the costs of uncompensated care, charity
434 care and bad debts as permitted and approved pursuant to federal
435 regulations and the Centers for Medicare and Medicaid Services;
436 supplemental payments based upon Medicaid utilization, quality,
437 service lines and/or costs of providing such services to Medicaid
438 beneficiaries and to uninsured patients. The goals of such
439 payment models shall be to ensure access to inpatient and
440 outpatient care and to maximize any federal funds that are
441 available to reimburse hospitals for services provided. Any such
442 documents required to achieve the goals described in this
443 paragraph shall be submitted to the Centers for Medicare and
444 Medicaid Services, with a proposed effective date of July 1, 2019,

445 to the extent possible, but in no event shall the effective date
446 of such payment models be later than July 1, 2020. The Chairmen
447 of the Senate and House Medicaid Committees shall be provided a
448 copy of the proposed payment model(s) prior to submission.
449 Effective July 1, 2018, and until such time as any payment
450 model(s) as described above become effective, the division, in
451 consultation with the hospital industry, is authorized to
452 implement a transitional program for inpatient and outpatient
453 payments and/or supplemental payments (including, but not limited
454 to, MHAP and directed payments), to redistribute available
455 supplemental funds among hospital providers, provided that when
456 compared to a hospital's prior year supplemental payments,
457 supplemental payments made pursuant to any such transitional
458 program shall not result in a decrease of more than five percent
459 (5%) and shall not increase by more than the amount needed to
460 maximize the distribution of the available funds.
461 (v) 1. To preserve and improve access to
462 ambulance transportation provider services, the division shall
463 seek CMS approval to make ambulance service access payments as set
464 forth in this subsection (A)(18)(b) for all covered emergency
465 ambulance services rendered on or after July 1, 2022, and shall
466 make such ambulance service access payments for all covered
467 services rendered on or after the effective date of CMS approval.
468 2. The division shall calculate the
469 ambulance service access payment amount as the balance of the

470 portion of the Medical Care Fund related to ambulance
471 transportation service provider assessments plus any federal
472 matching funds earned on the balance, up to, but not to exceed,
473 the upper payment limit gap for all emergency ambulance service
474 providers.

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

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

489 c. As used in this paragraph
490 (18)(b)(v), the term "upper payment limit gap" means the
491 difference between the total amount that the ambulance
492 transportation service provider received from Medicaid and the
493 average amount that the ambulance transportation service provider

494 would have received from commercial insurers for those services
495 reimbursed by Medicaid.
496 4. An ambulance service access payment
497 shall not be used to offset any other payment by the division for
498 emergency or nonemergency services to Medicaid beneficiaries.
499 (c) (i) Not later than December 1, 2015, the
500 division shall, subject to approval by the Centers for Medicare
501 and Medicaid Services (CMS), establish, implement and operate a
502 Mississippi Hospital Access Program (MHAP) for the purpose of
503 protecting patient access to hospital care through hospital
504 inpatient reimbursement programs provided in this section designed
505 to maintain total hospital reimbursement for inpatient services
506 rendered by in-state hospitals and the out-of-state hospital that
507 is authorized by federal law to submit intergovernmental transfers
508 (IGTs) to the State of Mississippi and is classified as Level I
509 trauma center located in a county contiguous to the state line at
510 the maximum levels permissible under applicable federal statutes
511 and regulations, at which time the current inpatient Medicare
512 Upper Payment Limits (UPL) Program for hospital inpatient services
513 shall transition to the MHAP.
514 (ii) Subject to approval by the Centers for
515 Medicare and Medicaid Services (CMS), the MHAP shall provide
516 increased inpatient capitation (PMPM) payments to managed care
517 entities contracting with the division pursuant to subsection (H)
518 of this section to support availability of hospital services or

519 such other payments permissible under federal law necessary to
520 accomplish the intent of this subsection.
521 (iii) The intent of this subparagraph (c) is
522 that effective for all inpatient hospital Medicaid services during
523 state fiscal year 2016, and so long as this provision shall remain
524 in effect hereafter, the division shall to the fullest extent
525 feasible replace the additional reimbursement for hospital
526 inpatient services under the inpatient Medicare Upper Payment
527 Limits (UPL) Program with additional reimbursement under the MHAP
528 and other payment programs for inpatient and/or outpatient
529 payments which may be developed under the authority of this
530 paragraph.
531 (iv) The division shall assess each hospital
532 as provided in Section 43-13-145(4)(a) for the purpose of
533 financing the state portion of the MHAP, supplemental payments and
534 such other purposes as specified in Section 43-13-145. The
535 assessment will remain in effect as long as the MHAP and
536 supplemental payments are in effect.
537 (19) (a) Perinatal risk management services. The
538 division shall promulgate regulations to be effective from and
539 after October 1, 1988, to establish a comprehensive perinatal
540 system for risk assessment of all pregnant and infant Medicaid
541 recipients and for management, education and follow-up for those
542 who are determined to be at risk. Services to be performed
543 include case management, nutrition assessment/counseling,

544 psychosocial assessment/counseling and health education. The
545 division shall contract with the State Department of Health to
546 provide services within this paragraph (Perinatal High Risk
547 Management/Infant Services System (PHRM/ISS)). The State
548 Department of Health shall be reimbursed on a full reasonable cost
549 basis for services provided under this subparagraph (a).

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

565 (20) Home- and community-based services for physically
566 disabled approved services as allowed by a waiver from the United
567 States Department of Health and Human Services for home- and
568 community-based services for physically disabled people using

569 state funds that are provided from the appropriation to the State
570 Department of Rehabilitation Services and used to match federal
571 funds under a cooperative agreement between the division and the
572 department, provided that funds for these services are
573 specifically appropriated to the Department of Rehabilitation
574 Services.

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

591 (22) Ambulatory services delivered in federally
592 qualified health centers, rural health centers and clinics of the
593 local health departments of the State Department of Health for

594 individuals eligible for Medicaid under this article based on
595 reasonable costs as determined by the division. Federally
596 qualified health centers shall be reimbursed by the Medicaid
597 prospective payment system as approved by the Centers for Medicare
598 and Medicaid Services. The division shall recognize federally
599 qualified health centers (FQHCs), rural health clinics (RHCs) and
600 community mental health centers (CMHCs) as both an originating and
601 distant site provider for the purposes of telehealth
602 reimbursement. The division is further authorized and directed to
603 reimburse FQHCs, RHCs and CMHCs for both distant site and
604 originating site services when such services are appropriately
605 provided by the same organization.
606 (23) Inpatient psychiatric services.
607 (a) Inpatient psychiatric services to be
608 determined by the division for recipients under age twenty-one
609 (21) that are provided under the direction of a physician in an
610 inpatient program in a licensed acute care psychiatric facility or
611 in a licensed psychiatric residential treatment facility, before
612 the recipient reaches age twenty-one (21) or, if the recipient was
613 receiving the services immediately before he or she reached age
614 twenty-one (21), before the earlier of the date he or she no
615 longer requires the services or the date he or she reaches age
616 twenty-two (22), as provided by federal regulations. From and
617 after January 1, 2015, the division shall update the fair rental
618 reimbursement system for psychiatric residential treatment

619 facilities. Precertification of inpatient days and residential
620 treatment days must be obtained as required by the division. From
621 and after July 1, 2009, all state-owned and state-operated
622 facilities that provide inpatient psychiatric services to persons
623 under age twenty-one (21) who are eligible for Medicaid
624 reimbursement shall be reimbursed for those services on a full
625 reasonable cost basis.
626 (b) The division may reimburse for services
627 provided by a licensed freestanding psychiatric hospital to
628 Medicaid recipients over the age of twenty-one (21) in a method
629 and manner consistent with the provisions of Section 43-13-117.5.
630 (24) [Deleted]
631 (25) [Deleted]
632 (26) Hospice care. As used in this paragraph, the term
633 "hospice care" means a coordinated program of active professional
634 medical attention within the home and outpatient and inpatient
635 care that treats the terminally ill patient and family as a unit,
636 employing a medically directed interdisciplinary team. The
637 program provides relief of severe pain or other physical symptoms
638 and supportive care to meet the special needs arising out of
639 physical, psychological, spiritual, social and economic stresses
640 that are experienced during the final stages of illness and during
641 dying and bereavement and meets the Medicare requirements for
642 participation as a hospice as provided in federal regulations.

643 (27) Group health plan premiums and cost-sharing if it
644 is cost-effective as defined by the United States Secretary of
645 Health and Human Services.
646 (28) Other health insurance premiums that are
647 cost-effective as defined by the United States Secretary of Health
648 and Human Services. Medicare eligible must have Medicare Part B
649 before other insurance premiums can be paid.
650 (29) The Division of Medicaid may apply for a waiver
651 from the United States Department of Health and Human Services for
652 home- and community-based services for developmentally disabled
653 people using state funds that are provided from the appropriation
654 to the State Department of Mental Health and/or funds transferred
655 to the department by a political subdivision or instrumentality of
656 the state and used to match federal funds under a cooperative
657 agreement between the division and the department, provided that
658 funds for these services are specifically appropriated to the
659 Department of Mental Health and/or transferred to the department
660 by a political subdivision or instrumentality of the state.
661 (30) Pediatric skilled nursing services as determined
662 by the division and in a manner consistent with regulations
663 promulgated by the Mississippi State Department of Health.
664 (31) Targeted case management services for children
665 with special needs, under waivers from the United States
666 Department of Health and Human Services, using state funds that
667 are provided from the appropriation to the Mississippi Department

668 of Human Services and used to match federal funds under a
669 cooperative agreement between the division and the department.
670 (32) Care and services provided in Christian Science
671 Sanatoria listed and certified by the Commission for Accreditation
672 of Christian Science Nursing Organizations/Facilities, Inc.,
673 rendered in connection with treatment by prayer or spiritual means
674 to the extent that those services are subject to reimbursement
675 under Section 1903 of the federal Social Security Act.
676 (33) Podiatrist services.
677 (34) Assisted living services as provided through
678 home- and community-based services under Title XIX of the federal
679 Social Security Act, as amended, subject to the availability of
680 funds specifically appropriated for that purpose by the
681 Legislature.
682 (35) Services and activities authorized in Sections
683 43-27-101 and 43-27-103, using state funds that are provided from
684 the appropriation to the Mississippi Department of Human Services
685 and used to match federal funds under a cooperative agreement
686 between the division and the department.
687 (36) Nonemergency transportation services for
688 Medicaid-eligible persons as determined by the division. The PEER
689 Committee shall conduct a performance evaluation of the
690 nonemergency transportation program to evaluate the administration
691 of the program and the providers of transportation services to
692 determine the most cost-effective ways of providing nonemergency

693 transportation services to the patients served under the program.
694 The performance evaluation shall be completed and provided to the
695 members of the Senate Medicaid Committee and the House Medicaid
696 Committee not later than January 1, 2019, and every two (2) years
697 thereafter.

698 (37) [Deleted]

699 (38) Chiropractic services. A chiropractor's manual
700 manipulation of the spine to correct a subluxation, if x-ray
701 demonstrates that a subluxation exists and if the subluxation has
702 resulted in a neuromusculoskeletal condition for which
703 manipulation is appropriate treatment, and related spinal x-rays
704 performed to document these conditions. Reimbursement for
705 chiropractic services shall not exceed Seven Hundred Dollars
706 ($700.00) per year per beneficiary.

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

715 (40) [Deleted]

716 (41) Services provided by the State Department of
717 Rehabilitation Services for the care and rehabilitation of persons

718 with spinal cord injuries or traumatic brain injuries, as allowed
719 under waivers from the United States Department of Health and
720 Human Services, using up to seventy-five percent (75%) of the
721 funds that are appropriated to the Department of Rehabilitation
722 Services from the Spinal Cord and Head Injury Trust Fund
723 established under Section 37-33-261 and used to match federal
724 funds under a cooperative agreement between the division and the
725 department.

726 (42) [Deleted]

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

732 (44) Nursing facility services for the severely
733 disabled.

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

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

740 (45) Physician assistant services. Services furnished
741 by a physician assistant who is licensed by the State Board of
742 Medical Licensure and is practicing with physician supervision

743 under regulations adopted by the board, under regulations adopted
744 by the division. Reimbursement for those services shall not
745 exceed ninety percent (90%) of the reimbursement rate for
746 comparable services rendered by a physician. The division may
747 provide for a reimbursement rate for physician assistant services
748 of up to one hundred percent (100%) or the reimbursement rate for
749 comparable services rendered by a physician for physician
750 assistant services that are provided after the normal working
751 hours of the physician assistant, as determined in accordance with
752 regulations of the division.

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

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

768 (b) Participation in any disease management
769 program implemented under this paragraph (47) is optional with the
770 individual. An individual must affirmatively elect to participate
771 in the disease management program in order to participate, and may
772 elect to discontinue participation in the program at any time.
773 (48) Pediatric long-term acute care hospital services.
774 (a) Pediatric long-term acute care hospital
775 services means services provided to eligible persons under
776 twenty-one (21) years of age by a freestanding Medicare-certified
777 hospital that has an average length of inpatient stay greater than
778 twenty-five (25) days and that is primarily engaged in providing
779 chronic or long-term medical care to persons under twenty-one (21)
780 years of age.
781 (b) The services under this paragraph (48) shall
782 be reimbursed as a separate category of hospital services.
783 (49) The division may establish copayments and/or
784 coinsurance for any Medicaid services for which copayments and/or
785 coinsurance are allowable under federal law or regulation.
786 (50) Services provided by the State Department of
787 Rehabilitation Services for the care and rehabilitation of persons
788 who are deaf and blind, as allowed under waivers from the United
789 States Department of Health and Human Services to provide home-
790 and community-based services using state funds that are provided
791 from the appropriation to the State Department of Rehabilitation
792 Services or if funds are voluntarily provided by another agency.

793 (51) Upon determination of Medicaid eligibility and in
794 association with annual redetermination of Medicaid eligibility,
795 beneficiaries shall be encouraged to undertake a physical
796 examination that will establish a base-line level of health and
797 identification of a usual and customary source of care (a medical
798 home) to aid utilization of disease management tools. This
799 physical examination and utilization of these disease management
800 tools shall be consistent with current United States Preventive
801 Services Task Force or other recognized authority recommendations.
802 For persons who are determined ineligible for Medicaid, the
803 division will provide information and direction for accessing
804 medical care and services in the area of their residence.
805 (52) Notwithstanding any provisions of this article,
806 the division may pay enhanced reimbursement fees related to trauma
807 care, as determined by the division in conjunction with the State
808 Department of Health, using funds appropriated to the State
809 Department of Health for trauma care and services and used to
810 match federal funds under a cooperative agreement between the
811 division and the State Department of Health. The division, in
812 conjunction with the State Department of Health, may use grants,
813 waivers, demonstrations, enhanced reimbursements, Upper Payment
814 Limits Programs, supplemental payments, or other projects as
815 necessary in the development and implementation of this
816 reimbursement program.

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

820 (54) [Deleted]

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

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

838 (57) No Medicaid benefit shall restrict coverage for
839 medically appropriate treatment prescribed by a physician and
840 agreed to by a fully informed individual, or if the individual
841 lacks legal capacity to consent by a person who has legal

842 authority to consent on his or her behalf, based on an
843 individual's diagnosis with a terminal condition. As used in this
844 paragraph (57), "terminal condition" means any aggressive
845 malignancy, chronic end-stage cardiovascular or cerebral vascular
846 disease, or any other disease, illness or condition which a
847 physician diagnoses as terminal.

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

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

861 (60) Border city university-affiliated pediatric
862 teaching hospital.

863 (a) Payments may only be made to a border city
864 university-affiliated pediatric teaching hospital if the Centers
865 for Medicare and Medicaid Services (CMS) approve an increase in
866 the annual request for the provider payment initiative authorized

867 under 42 CFR Section 438.6(c) in an amount equal to or greater
868 than the estimated annual payment to be made to the border city
869 university-affiliated pediatric teaching hospital. The estimate
870 shall be based on the hospital's prior year Mississippi managed
871 care utilization.

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

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

890 (d) It is the intent of the Legislature that
891 payments shall not result in any in-state hospital receiving

892 payments lower than they would otherwise receive if not for the
893 payments made to any border city university-affiliated pediatric
894 teaching hospital.

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

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

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

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

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

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

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

940 (4) (a) The chairman of either committee or both
941 chairmen jointly may hold a committee meeting to review a proposed
942 rate change. If either chairman or both chairmen decide to hold a
943 meeting, they shall notify the division of their intention in
944 writing within seven (7) calendar days after receipt of the notice
945 from the division, and shall set the date and time for the meeting
946 in their notice to the division, which shall not be later than
947 fourteen (14) calendar days after receipt of the notice from the
948 division.
949 (b) After the committee meeting, the committee or
950 committees may object to the proposed rate change or any part
951 thereof. The committee or committees shall notify the division
952 and the reasons for their objection in writing not later than
953 seven (7) calendar days after the meeting. The committee or
954 committees may make written recommendations to the division for
955 changes to be made to a proposed rate change.
956 (5) If both chairmen notify the division in writing
957 within seven (7) calendar days after receipt of the notice from
958 the division that they do not object to the proposed rate change
959 and will not be holding a meeting to review the proposed rate
960 change, the proposed rate change will take effect on the original
961 date as scheduled by the division or on such other date as
962 specified by the division.
963 (6) (a) If there are any objections to a proposed rate
964 change or any part thereof from either or both of the chairmen or

965 the committees, the division may withdraw the proposed rate
966 change, make any of the recommended changes to the proposed rate
967 change, or not make any changes to the proposed rate change.

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

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

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

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

990 (F) The executive director shall keep the Governor advised
991 on a timely basis of the funds available for expenditure and the
992 projected expenditures. Notwithstanding any other provisions of
993 this article, if current or projected expenditures of the division
994 are reasonably anticipated to exceed the amount of funds
995 appropriated to the division for any fiscal year, the Governor,
996 after consultation with the executive director, shall take all
997 appropriate measures to reduce costs, which may include, but are
998 not limited to:

999 (1) Reducing or discontinuing any or all services that
1000 are deemed to be optional under Title XIX of the Social Security
1001 Act;

1002 (2) Reducing reimbursement rates for any or all service
1003 types;

1004 (3) Imposing additional assessments on health care
1005 providers; or

1006 (4) Any additional cost-containment measures deemed
1007 appropriate by the Governor.

1008 To the extent allowed under federal law, any reduction to
1009 services or reimbursement rates under this subsection (F) shall be
1010 accompanied by a reduction, to the fullest allowable amount, to
1011 the profit margin and administrative fee portions of capitated
1012 payments to organizations described in paragraph (1) of subsection
1013 (H).

1014 Beginning in fiscal year 2010 and in fiscal years thereafter,
1015 when Medicaid expenditures are projected to exceed funds available
1016 for the fiscal year, the division shall submit the expected
1017 shortfall information to the PEER Committee not later than
1018 December 1 of the year in which the shortfall is projected to
1019 occur. PEER shall review the computations of the division and
1020 report its findings to the Legislative Budget Office not later
1021 than January 7 in any year.

1022 (G) Notwithstanding any other provision of this article, it
1023 shall be the duty of each provider participating in the Medicaid
1024 program to keep and maintain books, documents and other records as
1025 prescribed by the Division of Medicaid in accordance with federal
1026 laws and regulations.

1027 (H) (1) Notwithstanding any other provision of this
1028 article, the division is authorized to implement (a) a managed
1029 care program, (b) a coordinated care program, (c) a coordinated
1030 care organization program, (d) a health maintenance organization
1031 program, (e) a patient-centered medical home program, (f) an
1032 accountable care organization program, (g) provider-sponsored
1033 health plan, or (h) any combination of the above programs. As a
1034 condition for the approval of any program under this subsection
1035 (H)(1), the division shall require that no managed care program,
1036 coordinated care program, coordinated care organization program,
1037 health maintenance organization program, or provider-sponsored
1038 health plan may:

1039 (a) Pay providers at a rate that is less than the
1040 Medicaid All Patient Refined Diagnosis Related Groups (APR-DRG)
1041 reimbursement rate;
1042 (b) Override the medical decisions of hospital
1043 physicians or staff regarding patients admitted to a hospital for
1044 an emergency medical condition as defined by 42 US Code Section
1045 1395dd. This restriction (b) does not prohibit the retrospective
1046 review of the appropriateness of the determination that an
1047 emergency medical condition exists by chart review or coding
1048 algorithm, nor does it prohibit prior authorization for
1049 nonemergency hospital admissions;
1050 (c) Pay providers at a rate that is less than the
1051 normal Medicaid reimbursement rate. It is the intent of the
1052 Legislature that all managed care entities described in this
1053 subsection (H), in collaboration with the division, develop and
1054 implement innovative payment models that incentivize improvements
1055 in health care quality, outcomes, or value, as determined by the
1056 division. Participation in the provider network of any managed
1057 care, coordinated care, provider-sponsored health plan, or similar
1058 contractor shall not be conditioned on the provider's agreement to
1059 accept such alternative payment models;
1060 (d) Implement a prior authorization and
1061 utilization review program for medical services, transportation
1062 services and prescription drugs that is more stringent than the
1063 prior authorization processes used by the division in its

1064 administration of the Medicaid program. Not later than December
1065 2, 2021, the contractors that are receiving capitated payments
1066 under a managed care delivery system established under this
1067 subsection (H) shall submit a report to the Chairmen of the House
1068 and Senate Medicaid Committees on the status of the prior
1069 authorization and utilization review program for medical services,
1070 transportation services and prescription drugs that is required to
1071 be implemented under this subparagraph (d);
1072 (e) [Deleted]
1073 (f) Implement a preferred drug list that is more
1074 stringent than the mandatory preferred drug list established by
1075 the division under subsection (A)(9) of this section;
1076 (g) Implement a policy which denies beneficiaries
1077 with hemophilia access to the federally funded hemophilia
1078 treatment centers as part of the Medicaid Managed Care network of
1079 providers.
1080 Each health maintenance organization, coordinated care
1081 organization, provider-sponsored health plan, or other
1082 organization paid for services on a capitated basis by the
1083 division under any managed care program or coordinated care
1084 program implemented by the division under this section shall use a
1085 clear set of level of care guidelines in the determination of
1086 medical necessity and in all utilization management practices,
1087 including the prior authorization process, concurrent reviews,
1088 retrospective reviews and payments, that are consistent with

1089 widely accepted professional standards of care. Organizations
1090 participating in a managed care program or coordinated care
1091 program implemented by the division may not use any additional
1092 criteria that would result in denial of care that would be
1093 determined appropriate and, therefore, medically necessary under
1094 those levels of care guidelines.
1095 (2) Notwithstanding any provision of this section, the
1096 recipients eligible for enrollment into a Medicaid Managed Care
1097 Program authorized under this subsection (H) may include only
1098 those categories of recipients eligible for participation in the
1099 Medicaid Managed Care Program as of January 1, 2021, the
1100 Children's Health Insurance Program (CHIP), and the CMS-approved
1101 Section 1115 demonstration waivers in operation as of January 1,
1102 2021. No expansion of Medicaid Managed Care Program contracts may
1103 be implemented by the division without enabling legislation from
1104 the Mississippi Legislature.
1105 (3) (a) Any contractors receiving capitated payments
1106 under a managed care delivery system established in this section
1107 shall provide to the Legislature and the division statistical data
1108 to be shared with provider groups in order to improve patient
1109 access, appropriate utilization, cost savings and health outcomes
1110 not later than October 1 of each year. Additionally, each
1111 contractor shall disclose to the Chairmen of the Senate and House
1112 Medicaid Committees the administrative expenses costs for the
1113 prior calendar year, and the number of full-equivalent employees

1114 located in the State of Mississippi dedicated to the Medicaid and
1115 CHIP lines of business as of June 30 of the current year.

1116 (b) The division and the contractors participating
1117 in the managed care program, a coordinated care program or a
1118 provider-sponsored health plan shall be subject to annual program
1119 reviews or audits performed by the Office of the State Auditor,
1120 the PEER Committee, the Department of Insurance and/or independent
1121 third parties.

1122 (c) Those reviews shall include, but not be
1123 limited to, at least two (2) of the following items:

1124 (i) The financial benefit to the State of
1125 Mississippi of the managed care program,

1126 (ii) The difference between the premiums paid
1127 to the managed care contractors and the payments made by those
1128 contractors to health care providers,

1129 (iii) Compliance with performance measures
1130 required under the contracts,

1131 (iv) Administrative expense allocation
1132 methodologies,

1133 (v) Whether nonprovider payments assigned as
1134 medical expenses are appropriate,

1135 (vi) Capitated arrangements with related
1136 party subcontractors,

1137 (vii) Reasonableness of corporate
1138 allocations,

1139 (viii) Value-added benefits and the extent to
1140 which they are used,
1141 (ix) The effectiveness of subcontractor
1142 oversight, including subcontractor review,
1143 (x) Whether health care outcomes have been
1144 improved, and
1145 (xi) The most common claim denial codes to
1146 determine the reasons for the denials.
1147 The audit reports shall be considered public documents and
1148 shall be posted in their entirety on the division's website.
1149 (4) All health maintenance organizations, coordinated
1150 care organizations, provider-sponsored health plans, or other
1151 organizations paid for services on a capitated basis by the
1152 division under any managed care program or coordinated care
1153 program implemented by the division under this section shall
1154 reimburse all providers in those organizations at rates no lower
1155 than those provided under this section for beneficiaries who are
1156 not participating in those programs.
1157 (5) No health maintenance organization, coordinated
1158 care organization, provider-sponsored health plan, or other
1159 organization paid for services on a capitated basis by the
1160 division under any managed care program or coordinated care
1161 program implemented by the division under this section shall
1162 require its providers or beneficiaries to use any pharmacy that

1163 ships, mails or delivers prescription drugs or legend drugs or
1164 devices.

1165 (6) (a) Not later than December 1, 2021, the
1166 contractors who are receiving capitated payments under a managed
1167 care delivery system established under this subsection (H) shall
1168 develop and implement a uniform credentialing process for
1169 providers. Under that uniform credentialing process, a provider
1170 who meets the criteria for credentialing will be credentialed with
1171 all of those contractors and no such provider will have to be
1172 separately credentialed by any individual contractor in order to
1173 receive reimbursement from the contractor. Not later than
1174 December 2, 2021, those contractors shall submit a report to the
1175 Chairmen of the House and Senate Medicaid Committees on the status
1176 of the uniform credentialing process for providers that is
1177 required under this subparagraph (a).

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

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

1212 The contractor or division shall render a final decision regarding
1213 credentialing/enrollment of the provider within sixty (60) days
1214 from the date that the temporary provider credential/enrollment is
1215 issued to the applicant.

1216 (d) If the contractor or division does not render
1217 a final decision regarding credentialing/enrollment of the
1218 provider within the time required in subparagraph (c), the
1219 provider shall be deemed to be credentialed by and enrolled with
1220 all of the contractors and eligible to receive reimbursement from
1221 the contractors.

1222 (7) (a) Each contractor that is receiving capitated
1223 payments under a managed care delivery system established under
1224 this subsection (H) shall provide to each provider for whom the
1225 contractor has denied the coverage of a procedure that was ordered
1226 or requested by the provider for or on behalf of a patient, a
1227 letter that provides a detailed explanation of the reasons for the
1228 denial of coverage of the procedure and the name and the
1229 credentials of the person who denied the coverage. The letter
1230 shall be sent to the provider in electronic format.

1231 (b) After a contractor that is receiving capitated
1232 payments under a managed care delivery system established under
1233 this subsection (H) has denied coverage for a claim submitted by a
1234 provider, the contractor shall issue to the provider within sixty
1235 (60) days a final ruling of denial of the claim that allows the
1236 provider to have a state fair hearing and/or agency appeal with

1237 the division. If a contractor does not issue a final ruling of
1238 denial within sixty (60) days as required by this subparagraph
1239 (b), the provider's claim shall be deemed to be automatically
1240 approved and the contractor shall pay the amount of the claim to
1241 the provider.

1242 (c) After a contractor has issued a final ruling
1243 of denial of a claim submitted by a provider, the division shall
1244 conduct a state fair hearing and/or agency appeal on the matter of
1245 the disputed claim between the contractor and the provider within
1246 sixty (60) days, and shall render a decision on the matter within
1247 thirty (30) days after the date of the hearing and/or appeal.

1248 (8) It is the intention of the Legislature that the
1249 division evaluate the feasibility of using a single vendor to
1250 administer pharmacy benefits provided under a managed care
1251 delivery system established under this subsection (H). Providers
1252 of pharmacy benefits shall cooperate with the division in any
1253 transition to a carve-out of pharmacy benefits under managed care.

1254 (9) The division shall evaluate the feasibility of
1255 using a single vendor to administer dental benefits provided under
1256 a managed care delivery system established in this subsection (H).
1257 Providers of dental benefits shall cooperate with the division in
1258 any transition to a carve-out of dental benefits under managed
1259 care.

1260 (10) It is the intent of the Legislature that any
1261 contractor receiving capitated payments under a managed care

1262 delivery system established in this section shall implement
1263 innovative programs to improve the health and well-being of
1264 members diagnosed with prediabetes and diabetes.
1265 (11) It is the intent of the Legislature that any
1266 contractors receiving capitated payments under a managed care
1267 delivery system established under this subsection (H) shall work
1268 with providers of Medicaid services to improve the utilization of
1269 long-acting reversible contraceptives (LARCs). Not later than
1270 December 1, 2021, any contractors receiving capitated payments
1271 under a managed care delivery system established under this
1272 subsection (H) shall provide to the Chairmen of the House and
1273 Senate Medicaid Committees and House and Senate Public Health
1274 Committees a report of LARC utilization for State Fiscal Years
1275 2018 through 2020 as well as any programs, initiatives, or efforts
1276 made by the contractors and providers to increase LARC
1277 utilization. This report shall be updated annually to include
1278 information for subsequent state fiscal years.
1279 (12) The division is authorized to make not more than
1280 one (1) emergency extension of the contracts that are in effect on
1281 July 1, 2021, with contractors who are receiving capitated
1282 payments under a managed care delivery system established under
1283 this subsection (H), as provided in this paragraph (12). The
1284 maximum period of any such extension shall be one (1) year, and
1285 under any such extensions, the contractors shall be subject to all
1286 of the provisions of this subsection (H). The extended contracts

1287 shall be revised to incorporate any provisions of this subsection
1288 (H).

1289 (I) [Deleted]

1290 (J) There shall be no cuts in inpatient and outpatient
1291 hospital payments, or allowable days or volumes, as long as the
1292 hospital assessment provided in Section 43-13-145 is in effect.
1293 This subsection (J) shall not apply to decreases in payments that
1294 are a result of: reduced hospital admissions, audits or payments
1295 under the APR-DRG or APC models, or a managed care program or
1296 similar model described in subsection (H) of this section.

1297 (K) In the negotiation and execution of such contracts
1298 involving services performed by actuarial firms, the Executive
1299 Director of the Division of Medicaid may negotiate a limitation on
1300 liability to the state of prospective contractors.

1301 (L) The Division of Medicaid shall reimburse for services
1302 provided to eligible Medicaid beneficiaries by a licensed birthing
1303 center in a method and manner to be determined by the division in
1304 accordance with federal laws and federal regulations. The
1305 division shall seek any necessary waivers, make any required
1306 amendments to its State Plan or revise any contracts authorized
1307 under subsection (H) of this section as necessary to provide the
1308 services authorized under this subsection. As used in this
1309 subsection, the term "birthing centers" shall have the meaning as
1310 defined in Section 41-77-1(a), which is a publicly or privately
1311 owned facility, place or institution constructed, renovated,

1312 leased or otherwise established where nonemergency births are
1313 planned to occur away from the mother's usual residence following
1314 a documented period of prenatal care for a normal uncomplicated
1315 pregnancy which has been determined to be low risk through a
1316 formal risk-scoring examination.

1317 (M) This section shall stand repealed on July 1, *** * *** 2027.

1318 **SECTION 2.** Section 43-13-145, Mississippi Code of 1972, is
1319 amended as follows:

1320 43-13-145. (1) (a) Upon each nursing facility licensed by
1321 the State of Mississippi, there is levied an assessment in an
1322 amount set by the division, equal to the maximum rate allowed by
1323 federal law or regulation, for each licensed and occupied bed of
1324 the facility.

1325 (b) A nursing facility is exempt from the assessment
1326 levied under this subsection if the facility is operated under the
1327 direction and control of:

1328 (i) The United States Veterans Administration or
1329 other agency or department of the United States government; or

1330 (ii) The State Veterans Affairs Board.

1331 (2) (a) Upon each intermediate care facility for
1332 individuals with intellectual disabilities licensed by the State
1333 of Mississippi, there is levied an assessment in an amount set by
1334 the division, equal to the maximum rate allowed by federal law or
1335 regulation, for each licensed and occupied bed of the facility.

1336 (b) An intermediate care facility for individuals with
1337 intellectual disabilities is exempt from the assessment levied
1338 under this subsection if the facility is operated under the
1339 direction and control of:
1340 (i) The United States Veterans Administration or
1341 other agency or department of the United States government;
1342 (ii) The State Veterans Affairs Board; or
1343 (iii) The University of Mississippi Medical
1344 Center.
1345 (3) (a) Upon each psychiatric residential treatment
1346 facility licensed by the State of Mississippi, there is levied an
1347 assessment in an amount set by the division, equal to the maximum
1348 rate allowed by federal law or regulation, for each licensed and
1349 occupied bed of the facility.
1350 (b) A psychiatric residential treatment facility is
1351 exempt from the assessment levied under this subsection if the
1352 facility is operated under the direction and control of:
1353 (i) The United States Veterans Administration or
1354 other agency or department of the United States government;
1355 (ii) The University of Mississippi Medical Center;
1356 or
1357 (iii) A state agency or a state facility that
1358 either provides its own state match through intergovernmental
1359 transfer or certification of funds to the division.
1360 (4) Hospital assessment.

1361 (a) (i) Subject to and upon fulfillment of the
1362 requirements and conditions of paragraph (f) below, and
1363 notwithstanding any other provisions of this section, an annual
1364 assessment on each hospital licensed in the state is imposed on
1365 each non-Medicare hospital inpatient day as defined below at a
1366 rate that is determined by dividing the sum prescribed in this
1367 subparagraph (i), plus the nonfederal share necessary to maximize
1368 the Disproportionate Share Hospital (DSH) and Medicare Upper
1369 Payment Limits (UPL) Program payments and hospital access payments
1370 and such other supplemental payments as may be developed pursuant
1371 to Section 43-13-117(A)(18), by the total number of non-Medicare
1372 hospital inpatient days as defined below for all licensed
1373 Mississippi hospitals, except as provided in paragraph (d) below.
1374 If the state-matching funds percentage for the Mississippi
1375 Medicaid program is sixteen percent (16%) or less, the sum used in
1376 the formula under this subparagraph (i) shall be Seventy-four
1377 Million Dollars ($74,000,000.00). If the state-matching funds
1378 percentage for the Mississippi Medicaid program is twenty-four
1379 percent (24%) or higher, the sum used in the formula under this
1380 subparagraph (i) shall be One Hundred Four Million Dollars
1381 ($104,000,000.00). If the state-matching funds percentage for the
1382 Mississippi Medicaid program is between sixteen percent (16%) and
1383 twenty-four percent (24%), the sum used in the formula under this
1384 subparagraph (i) shall be a pro rata amount determined as follows:
1385 the current state-matching funds percentage rate minus sixteen

1386 percent (16%) divided by eight percent (8%) multiplied by Thirty
1387 Million Dollars ($30,000,000.00) and add that amount to
1388 Seventy-four Million Dollars ($74,000,000.00). However, no
1389 assessment in a quarter under this subparagraph (i) may exceed the
1390 assessment in the previous quarter by more than Three Million
1391 Seven Hundred Fifty Thousand Dollars ($3,750,000.00) (which would
1392 be Fifteen Million Dollars ($15,000,000.00) on an annualized
1393 basis). The division shall publish the state-matching funds
1394 percentage rate applicable to the Mississippi Medicaid program on
1395 the tenth day of the first month of each quarter and the
1396 assessment determined under the formula prescribed above shall be
1397 applicable in the quarter following any adjustment in that
1398 state-matching funds percentage rate. The division shall notify
1399 each hospital licensed in the state as to any projected increases
1400 or decreases in the assessment determined under this subparagraph
1401 (i). However, if the Centers for Medicare and Medicaid Services
1402 (CMS) does not approve the provision in Section 43-13-117(39)
1403 requiring the division to reimburse crossover claims for inpatient
1404 hospital services and crossover claims covered under Medicare Part
1405 B for dually eligible beneficiaries in the same manner that was in
1406 effect on January 1, 2008, the sum that otherwise would have been
1407 used in the formula under this subparagraph (i) shall be reduced
1408 by Seven Million Dollars ($7,000,000.00).
1409 (ii) In addition to the assessment provided under
1410 subparagraph (i), an additional annual assessment on each hospital

1411 licensed in the state is imposed on each non-Medicare hospital
1412 inpatient day as defined below at a rate that is determined by
1413 dividing twenty-five percent (25%) of any provider reductions in
1414 the Medicaid program as authorized in Section 43-13-117(F) for
1415 that fiscal year up to the following maximum amount, plus the
1416 nonfederal share necessary to maximize the Disproportionate Share
1417 Hospital (DSH) and inpatient Medicare Upper Payment Limits (UPL)
1418 Program payments and inpatient hospital access payments, by the
1419 total number of non-Medicare hospital inpatient days as defined
1420 below for all licensed Mississippi hospitals: in fiscal year
1421 2010, the maximum amount shall be Twenty-four Million Dollars
1422 ($24,000,000.00); in fiscal year 2011, the maximum amount shall be
1423 Thirty-two Million Dollars ($32,000,000.00); and in fiscal year
1424 2012 and thereafter, the maximum amount shall be Forty Million
1425 Dollars ($40,000,000.00). Any such deficit in the Medicaid
1426 program shall be reviewed by the PEER Committee as provided in
1427 Section 43-13-117(F).
1428 (iii) In addition to the assessments provided in
1429 subparagraphs (i) and (ii), an additional annual assessment on
1430 each hospital licensed in the state is imposed pursuant to the
1431 provisions of Section 43-13-117(F) if the cost-containment
1432 measures described therein have been implemented and there are
1433 insufficient funds in the Health Care Trust Fund to reconcile any
1434 remaining deficit in any fiscal year. If the Governor institutes
1435 any other additional cost-containment measures on any program or

1436 programs authorized under the Medicaid program pursuant to Section
1437 43-13-117(F), hospitals shall be responsible for twenty-five
1438 percent (25%) of any such additional imposed provider cuts, which
1439 shall be in the form of an additional assessment not to exceed the
1440 twenty-five percent (25%) of provider expenditure reductions.
1441 Such additional assessment shall be imposed on each non-Medicare
1442 hospital inpatient day in the same manner as assessments are
1443 imposed under subparagraphs (i) and (ii).

1444 (b) Definitions.

1445 (i) [Deleted]

1446 (ii) For purposes of this subsection (4):

1447 1. "Non-Medicare hospital inpatient day"
1448 means total hospital inpatient days including subcomponent days
1449 less Medicare inpatient days including subcomponent days from the
1450 hospital's most recent Medicare cost report for the second
1451 calendar year preceding the beginning of the state fiscal year, on
1452 file with CMS per the CMS HCRIS database, or cost report submitted
1453 to the Division if the HCRIS database is not available to the
1454 division, as of June 1 of each year.

1455 a. Total hospital inpatient days shall
1456 be the sum of Worksheet S-3, Part 1, column 8 row 14, column 8 row
1457 16, and column 8 row 17, excluding column 8 rows 5 and 6.

1458 b. Hospital Medicare inpatient days
1459 shall be the sum of Worksheet S-3, Part 1, column 6 row 14, column
1460 6 row 16.00, and column 6 row 17, excluding column 6 rows 5 and 6.

1461 c. Inpatient days shall not include
1462 residential treatment or long-term care days.
1463 2. "Subcomponent inpatient day" means the
1464 number of days of care charged to a beneficiary for inpatient
1465 hospital rehabilitation and psychiatric care services in units of
1466 full days. A day begins at midnight and ends twenty-four (24)
1467 hours later. A part of a day, including the day of admission and
1468 day on which a patient returns from leave of absence, counts as a
1469 full day. However, the day of discharge, death, or a day on which
1470 a patient begins a leave of absence is not counted as a day unless
1471 discharge or death occur on the day of admission. If admission
1472 and discharge or death occur on the same day, the day is
1473 considered a day of admission and counts as one (1) subcomponent
1474 inpatient day.
1475 (c) The assessment provided in this subsection is
1476 intended to satisfy and not be in addition to the assessment and
1477 intergovernmental transfers provided in Section 43-13-117(A)(18).
1478 Nothing in this section shall be construed to authorize any state
1479 agency, division or department, or county, municipality or other
1480 local governmental unit to license for revenue, levy or impose any
1481 other tax, fee or assessment upon hospitals in this state not
1482 authorized by a specific statute.
1483 (d) Hospitals operated by the United States Department
1484 of Veterans Affairs and state-operated facilities that provide

1485 only inpatient and outpatient psychiatric services shall not be
1486 subject to the hospital assessment provided in this subsection.
1487 (e) Multihospital systems, closure, merger, change of
1488 ownership and new hospitals.
1489 (i) If a hospital conducts, operates or maintains
1490 more than one (1) hospital licensed by the State Department of
1491 Health, the provider shall pay the hospital assessment for each
1492 hospital separately.
1493 (ii) Notwithstanding any other provision in this
1494 section, if a hospital subject to this assessment operates or
1495 conducts business only for a portion of a fiscal year, the
1496 assessment for the state fiscal year shall be adjusted by
1497 multiplying the assessment by a fraction, the numerator of which
1498 is the number of days in the year during which the hospital
1499 operates, and the denominator of which is three hundred sixty-five
1500 (365). Immediately upon ceasing to operate, the hospital shall
1501 pay the assessment for the year as so adjusted (to the extent not
1502 previously paid).
1503 (iii) The division shall determine the tax for new
1504 hospitals and hospitals that undergo a change of ownership in
1505 accordance with this section, using the best available
1506 information, as determined by the division.
1507 (f) Applicability.
1508 The hospital assessment imposed by this subsection shall not
1509 take effect and/or shall cease to be imposed if:

1510 (i) The assessment is determined to be an
1511 impermissible tax under Title XIX of the Social Security Act; or
1512 (ii) CMS revokes its approval of the division's
1513 2009 Medicaid State Plan Amendment for the methodology for DSH
1514 payments to hospitals under Section 43-13-117(A)(18).
1515 (5) Each health care facility that is subject to the
1516 provisions of this section shall keep and preserve such suitable
1517 books and records as may be necessary to determine the amount of
1518 assessment for which it is liable under this section. The books
1519 and records shall be kept and preserved for a period of not less
1520 than five (5) years, during which time those books and records
1521 shall be open for examination during business hours by the
1522 division, the Department of Revenue, the Office of the Attorney
1523 General and the State Department of Health.
1524 (6) [Deleted]
1525 (7) All assessments collected under this section shall be
1526 deposited in the Medical Care Fund created by Section 43-13-143.
1527 (8) The assessment levied under this section shall be in
1528 addition to any other assessments, taxes or fees levied by law,
1529 and the assessment shall constitute a debt due the State of
1530 Mississippi from the time the assessment is due until it is paid.
1531 (9) (a) If a health care facility that is liable for
1532 payment of an assessment levied by the division does not pay the
1533 assessment when it is due, the division shall give written notice
1534 to the health care facility demanding payment of the assessment

1535 within ten (10) days from the date of delivery of the notice. If
1536 the health care facility fails or refuses to pay the assessment
1537 after receiving the notice and demand from the division, the
1538 division shall withhold from any Medicaid reimbursement payments
1539 that are due to the health care facility the amount of the unpaid
1540 assessment and a penalty of ten percent (10%) of the amount of the
1541 assessment, plus the legal rate of interest until the assessment
1542 is paid in full. If the health care facility does not participate
1543 in the Medicaid program, the division shall turn over to the
1544 Office of the Attorney General the collection of the unpaid
1545 assessment by civil action. In any such civil action, the Office
1546 of the Attorney General shall collect the amount of the unpaid
1547 assessment and a penalty of ten percent (10%) of the amount of the
1548 assessment, plus the legal rate of interest until the assessment
1549 is paid in full.

1550 (b) As an additional or alternative method for
1551 collecting unpaid assessments levied by the division, if a health
1552 care facility fails or refuses to pay the assessment after
1553 receiving notice and demand from the division, the division may
1554 file a notice of a tax lien with the chancery clerk of the county
1555 in which the health care facility is located, for the amount of
1556 the unpaid assessment and a penalty of ten percent (10%) of the
1557 amount of the assessment, plus the legal rate of interest until
1558 the assessment is paid in full. Immediately upon receipt of
1559 notice of the tax lien for the assessment, the chancery clerk

1560 shall forward the notice to the circuit clerk who shall enter the
1561 notice of the tax lien as a judgment upon the judgment roll and
1562 show in the appropriate columns the name of the health care
1563 facility as judgment debtor, the name of the division as judgment
1564 creditor, the amount of the unpaid assessment, and the date and
1565 time of enrollment. The judgment shall be valid as against
1566 mortgagees, pledgees, entrusters, purchasers, judgment creditors
1567 and other persons from the time of filing with the clerk. The
1568 amount of the judgment shall be a debt due the State of
1569 Mississippi and remain a lien upon the tangible property of the
1570 health care facility until the judgment is satisfied. The
1571 judgment shall be the equivalent of any enrolled judgment of a
1572 court of record and shall serve as authority for the issuance of
1573 writs of execution, writs of attachment or other remedial writs.
1574 (10) (a) To further the provisions of Section
1575 43-13-117(A)(18), the Division of Medicaid shall submit to the
1576 Centers for Medicare and Medicaid Services (CMS) any documents
1577 regarding the hospital assessment established under subsection (4)
1578 of this section. In addition to defining the assessment
1579 established in subsection (4) of this section if necessary, the
1580 documents shall describe any supplement payment programs and/or
1581 payment methodologies as authorized in Section 43-13-117(A)(18) if
1582 necessary.
1583 (b) All hospitals satisfying the minimum federal DSH
1584 eligibility requirements (Section 1923(d) of the Social Security

1585 Act) may, subject to OBRA 1993 payment limitations, receive a DSH
1586 payment. This DSH payment shall expend the balance of the federal
1587 DSH allotment and associated state share not utilized in DSH
1588 payments to state-owned institutions for treatment of mental
1589 diseases. The payment to each hospital shall be calculated by
1590 applying a uniform percentage to the uninsured costs of each
1591 eligible hospital, excluding state-owned institutions for
1592 treatment of mental diseases; however, that percentage for a
1593 state-owned teaching hospital located in Hinds County shall be
1594 multiplied by a factor of two (2).
1595 (11) The division shall implement DSH and supplemental
1596 payment calculation methodologies that result in the maximization
1597 of available federal funds.
1598 (12) The DSH payments shall be paid on or before December
1599 31, March 31, and June 30 of each fiscal year, in increments of
1600 one-third (1/3) of the total calculated DSH amounts. Supplemental
1601 payments developed pursuant to Section 43-13-117(A)(18) shall be
1602 paid monthly.
1603 (13) Payment.
1604 (a) The hospital assessment as described in subsection
1605 (4) for the nonfederal share necessary to maximize the Medicare
1606 Upper Payments Limits (UPL) Program payments and hospital access
1607 payments and such other supplemental payments as may be developed
1608 pursuant to Section 43-3-117(A)(18) shall be assessed and

1609 collected monthly no later than the fifteenth calendar day of each
1610 month.

1611 (b) The hospital assessment as described in subsection
1612 (4) for the nonfederal share necessary to maximize the
1613 Disproportionate Share Hospital (DSH) payments shall be assessed
1614 and collected on December 15, March 15 and June 15.

1615 (c) The annual hospital assessment and any additional
1616 hospital assessment as described in subsection (4) shall be
1617 assessed and collected on September 15 and on the 15th of each
1618 month from December through June.

1619 (14) If for any reason any part of the plan for annual DSH
1620 and supplemental payment programs to hospitals provided under
1621 subsection (10) of this section and/or developed pursuant to
1622 Section 43-13-117(A)(18) is not approved by CMS, the remainder of
1623 the plan shall remain in full force and effect.

1624 (15) Nothing in this section shall prevent the Division of
1625 Medicaid from facilitating participation in Medicaid supplemental
1626 hospital payment programs by a hospital located in a county
1627 contiguous to the State of Mississippi that is also authorized by
1628 federal law to submit intergovernmental transfers (IGTs) to the
1629 State of Mississippi to fund the state share of the hospital's
1630 supplemental and/or MHAP payments.

1631 (16) This section shall stand repealed on July 1, *** * * ***
1632 <u>2027</u>.

1633 **SECTION 3.** This act shall take effect and be in force from

1634 and after July 1, 2024.