

Amendment No. 1 to HB1872

Sexton C  
Signature of Sponsor

**AMEND Senate Bill No. 1836**

**House Bill No. 1872\***

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Title 71, Chapter 5, Part 5, is amended by adding the following as a new section:

**71-5-161.**

(a) This section continues the hospital payment rate corridors applicable to payments by managed care organizations to hospitals for services provided to TennCare enrollees established by § 71-5-703(b)(3), as enacted by Chapter 276 of the Public Acts of 2015.

(b) Hospital payment rate variation corridors shall be established by the state's actuary and approved by the bureau of TennCare for payments by managed care organizations to hospitals for services provided to TennCare enrollees as follows:

(1) As required by § 71-5-703(b)(3), as enacted by Chapter 276 of the Public Acts of 2015, the bureau shall implement provisions in its contractor risk agreements (CRAs) with all managed care organizations requiring payment rates for each hospital in the aggregate from all managed care organizations with which the hospital has network contracts to be no less than the minimum levels or more than the maximum levels set forth in subsections (c) and (d); and

(2) Compliance with these standards shall be determined on the basis of the totality of all rates for the hospital by all managed care organizations in the aggregate with which it has a network contract, rather than on the basis of rates for a hospital under a network contract with an individual managed care

Amendment No. 1 to HB1872

Sexton C  
Signature of Sponsor

**AMEND Senate Bill No. 1836**

**House Bill No. 1872\***

organization. Managed care organizations shall not enter into or maintain a single case agreement or contract with any hospital that authorizes or requires rates for the hospital that do not conform to the hospital payment variability standards set forth in this section.

(c) The minimum and maximum levels for aggregate rates to hospitals for services to TennCare enrollees shall be based on the percentages of each hospital's federal fiscal year (FFY) 2011 medicare reimbursement set forth in subsection (d). Compliance with these minimum and maximum payment rates shall be determined on the basis of the totality of payments to a hospital for services to TennCare enrollees from all managed care organizations with which the hospital has a network contract. The variation corridors established by this subsection (c) are for the purpose of limiting the amount of variation in the rates paid by TennCare managed care organizations to hospitals, and this subsection (c) shall not create a right by a hospital to receive any actual amount of reimbursement in the aggregate from all TennCare managed care organizations.

(d)

(1) For routine, nonspecialized inpatient services, the minimum level is fifty-three and eight-tenths percent (53.8%), and the maximum level is eighty percent (80%);

(2) For outpatient services, the minimum level is ninety-three and two-tenths percent (93.2%), and the maximum level is one hundred and four percent (104%);

(3) For cardiac surgery services, the minimum level is thirty-two percent (32%), and the maximum level is eighty-three percent (83%);

(4) For specialized neonatal services, the minimum level is four percent (4%), and the maximum level is one hundred seventy-four percent (174%); and

(5) For other specialized services, the minimum level is forty-nine percent (49%), and the maximum level is one hundred sixty-four percent (164%).

(e) The bureau shall publish the list of MS-DRGs included in each service category on its web site, and the bureau shall update the list annually to reflect any changes as necessary.

(f) The bureau shall maintain rules implementing the requirements of this section. All rules promulgated by the commissioner of finance and administration or the bureau prior to and in effect on July 1, 2016, concerning the annual coverage assessment under this part or Chapter 276 of the Public Acts of 2015, shall remain in force and effect and shall be administered and enforced by the bureau until these rules are modified.

SECTION 2. Tennessee Code Annotated, Title 71, Chapter 5, is amended by adding the following as a new part:

**71-5-1101.** This part shall be known and may be cited as the "Annual Coverage Assessment Act of 2016".

**71-5-1102.** As used in this part, unless the context otherwise requires:

(1) "Annual coverage assessment" means the annual assessment imposed on covered hospitals as set forth in this part;

(2) "Annual coverage assessment base" is a covered hospital's net patient revenue as shown in its medicare cost report for its fiscal year that ended during calendar year 2008, on file with CMS as of September 30, 2009, subject to the following qualifications:

(A) If a covered hospital does not have a full twelve-month medicare cost report for 2008 on file with CMS but has a full twelve-month cost report for a subsequent year, the first full twelve-month medicare cost report for a year following 2008 on file with CMS shall be the annual coverage assessment base;

(B) If a covered hospital was first licensed in 2014 or later and did not replace an existing hospital, and if the hospital has a medicare cost report on file with CMS, the hospital's initial cost report on file with CMS shall be the base for the hospital assessment. If the hospital does not have an initial cost report on file with CMS but does have a complete twelve-month joint annual report filed with the department of health, the net patient revenue from the twelve-month joint annual report shall be the annual coverage assessment base. If the hospital does not have a medicare cost report or a full twelve-month joint annual report filed with the department of health, the annual coverage assessment base is the covered hospital's projected net patient revenue for its first full year of operation as shown in its certificate of need application filed with the health services and development agency;

(C) If a covered hospital was first licensed in 2014 or later and replaced an existing hospital, the annual coverage assessment base shall be the hospital's initial medicare cost report on file with CMS. If the hospital does not have a medicare cost report on file with CMS, such hospital's annual coverage assessment base shall be either the predecessor hospital's net patient revenue as shown in its medicare cost report for its fiscal year that ended during calendar year 2008, or, if the predecessor hospital does not have a 2008 medicare cost report, the cost report for the first fiscal year following 2008 on file with CMS;

(D) If a covered hospital is not required to file an annual medicare cost report with CMS, then the hospital's annual coverage assessment base shall be

its net patient revenue for the fiscal year ending during calendar year 2008 or the first fiscal year that the hospital was in operation after 2008 as shown in the covered hospital's joint annual report filed with the department of health; and

(E) If a covered hospital's fiscal year 2008 medicare cost report is not contained in any of the CMS healthcare cost report information system files and if the hospital does not meet any of the other qualifications listed in subdivisions (2)(A)-(E), then the hospital shall submit a copy of the hospital's 2008 medicare cost report to the bureau in order to allow for the determination of the hospital's net patient revenue for the state fiscal year 2016-2017 annual coverage assessment;

(3) "Bureau" means the bureau of TennCare;

(4) "CMS" means the federal centers for medicare and medicaid services;

(5) "Controlling person" means a person who, by ownership, contract, or otherwise, has the authority to control the business operations of a covered hospital. Indirect or direct ownership of ten percent (10%) or more of a covered hospital shall constitute control;

(6) "Covered hospital" means a hospital licensed under title 33 or title 68, as of July 1, 2016, except an excluded hospital;

(7) "Excluded hospital" means:

(A) A hospital that has been designated by CMS as a critical access hospital;

(B) A mental health hospital owned by this state;

(C) A hospital providing primarily rehabilitative or long-term acute care services;

(D) A children's research hospital that does not charge patients for services beyond that reimbursed by third-party payers; and

(E) A hospital that is determined by the bureau as eligible to certify public expenditures for the purpose of securing federal medical assistance percentage payments;

(8) "Medicare cost report" means CMS-2552-96, the cost report for electronic filing of hospitals, for the period applicable as set forth in this section; and

(9) "Net patient revenue" means the amount calculated in accordance with generally accepted accounting principles for hospitals that is reported on Worksheet G-3, Column 1, Line 3, of the medicare cost report, excluding long-term care inpatient ancillary revenues.

**71-5-1103.**

(a) There is imposed on each covered hospital licensed as of July 1, 2016, an annual coverage assessment for fiscal year (FY) 2016-2017 as set forth in this part.

(b) The annual coverage assessment imposed by this part shall not be effective and validly imposed until the bureau has provided the Tennessee Hospital Association with written notice that includes:

(1) A determination from CMS that the annual coverage assessment is a permissible source of revenue that shall not adversely affect the amount of federal financial participation in the TennCare program;

(2) Either:

(A) Approval from CMS for the distribution of the full amount of additional payments to hospitals to offset unreimbursed TennCare costs as set forth in § 71-5-1105(d)(2); or

(B) The rules proposed by the bureau pursuant to § 71-5-1104(i)(2); and

(3) Confirmation that all contracts between hospitals and managed care organizations comply with the hospital rate variation corridors set forth in § 71-5-703(b)(3), as enacted by Chapter 276 of the Public Acts of 2015, and § 71-5-161.

(c) The general assembly intends that the proceeds of the annual coverage assessment not be used as a justification to reduce or eliminate state funding to the TennCare program. The annual coverage assessment shall not be effective and validly imposed if the coverage or the amount of revenue available for expenditure by the TennCare program in FY 2016-2017 is less than:

(1) The governor's FY 2016-2017 recommended budget level; plus

(2) Additional appropriations made by the general assembly to the TennCare program for FY 2016-2017, except to the extent new federal funding is available to replace funds that are appropriated as described in subdivision (c)(1) and that are above the amount that the state receives from CMS under the regular federal matching assistance percentage.

(d)

(1)

(A) The general assembly intends that the proceeds of the annual coverage assessment not be used as justification for any TennCare managed care organization to implement across-the-board rate reductions to negotiated rates with covered or excluded hospitals or physicians in existence on July 1, 2016. For those rates in effect on July 1, 2016, the bureau shall include provisions in the managed care organizations' contractor risk agreements that prohibit the managed care organizations from implementing across-the-board rate reductions to covered or excluded network hospitals or physicians either by category or by type of provider. The requirements of the preceding sentence shall

also apply to services or settings of care that are ancillary to the primary license of a covered or excluded hospital or physician, but shall not apply to reductions in benefits or reimbursement for such ancillary services if the reductions:

(i) Are different from those items being restored in § 71-5-1105(d); and

(ii) Have been communicated in advance of implementation to the general assembly and the Tennessee Hospital Association.

(B)

(i) For purposes of this subsection (d), services or settings of care that are ancillary to the primary license of a covered or excluded hospital or physician shall include all services where the physician or covered or excluded hospital, including a wholly owned subsidiary or controlled affiliate of a covered or excluded hospital or hospital system, holds more than a fifty percent (50%) controlling interest in such ancillary services or settings of care, but shall not include any other ancillary services or settings of care. For across-the-board rate reductions to ancillary services or settings of care, the bureau shall include appropriate requirements for notice to providers in the managed care organizations' contractor risk agreements.

(ii) For purposes of this subsection (d), services or settings of care that are "ancillary" shall mean, but not be limited to, ambulatory surgical facilities, outpatient treatment clinics or imaging centers, dialysis centers, home health and related

services, home infusion therapy services, outpatient rehabilitation, or skilled nursing services.

(iii) For purposes of this subsection (d), "physician" includes a physician licensed under title 63, chapter 6 or chapter 9, and a group practice of physicians that hold a contract with a managed care organization.

(2) This subsection (d) does not preclude good faith negotiations between managed care organizations and covered or excluded hospitals, hospital systems, and physicians on an individualized, case-by-case basis, nor is this subsection (d) intended by the general assembly to serve as justification for managed care organizations in this state, covered or excluded hospitals, hospital systems, or physicians to unreasonably deny any party the ability to enter into such individualized, case-by-case good faith negotiations. Such good faith negotiation necessarily implies mutual cooperation between the negotiating parties and may include, but is not limited to, the right to terminate contractual agreements, the ability to modify negotiated rates, pricing, or units of service, the ability to alter payment methodologies, and the ability to enforce existing managed care techniques or to implement new managed care techniques.

(3) This subsection (d) shall not preclude the full implementation of the requirements set forth in § 71-5-161 and § 71-5-703(b)(3), as enacted by Chapter 276 of the Public Acts of 2015.

(4) Notwithstanding this subsection (d), if CMS mandates a TennCare program change or a change is required by state or federal law that impacts rates, and that change is required to be implemented by the managed care organizations in accordance with their contracts, or if the annual coverage assessment becomes invalid, then nothing in this part shall prohibit the managed

care organizations from implementing any rate changes as may be mandated by the bureau or by state or federal law.

**71-5-1104.**

(a) The annual coverage assessment established for this part shall be four and fifty-two hundredths percent (4.52%) of a covered hospital's annual coverage assessment base.

(b) The annual coverage assessment shall be paid in equal quarterly installments, with the first quarterly payment due on the fifteenth day of the first month of the first quarter of the state fiscal year after the bureau has satisfied the requirements of § 71-5-1103(b). Subsequent installments shall be due on the fifteenth day of the first month of the three (3) successive calendar quarters following the calendar quarter in which the first installment is due.

(c) To facilitate collection of the annual coverage assessment, the bureau shall send each covered hospital, at least thirty (30) days in advance of each quarterly payment due date, a notice of payment along with a return form developed by the bureau. Failure of a covered hospital to receive a notice and return form, however, shall not relieve a covered hospital from the obligation of timely payment. The bureau shall also post the return form on its web site.

(d) Failure of a covered hospital to pay a quarterly installment of the annual coverage assessment, when due, shall result in an imposition of a penalty of five hundred dollars (\$500) per day until such installment is paid in full.

(e) If a covered hospital ceases to operate after July 1, 2016, and before July 1, 2017, the hospital's total annual coverage assessment shall be equal to its annual coverage assessment base multiplied by a fraction, the denominator of which is the number of calendar days from July 1, 2016, until July 1, 2017, and the numerator of

which is the number of days from July 1, 2016, until the date the board for licensing healthcare facilities has recorded as the date that the hospital ceased operation.

(f) If a covered hospital ceases operation prior to payment of its full annual coverage assessment, then the person or persons controlling the hospital as of the date the hospital ceased operation shall be jointly and severally responsible for any remaining annual coverage assessment installments and unpaid penalties associated with previous late payments.

(g) If a covered hospital fails to pay a quarterly installment of the annual coverage assessment within thirty (30) days of its due date, the bureau shall suspend the payments to the hospital as required by § 71-5-1105(d)(2) until the quarterly installment is paid and report such failure to the department that licenses the covered hospital. Notwithstanding any other law, failure of a covered hospital to pay a quarterly installment of the annual coverage assessment or any refund required by this part shall be considered a license deficiency and grounds for disciplinary action as set forth in the statutes and rules under which the covered hospital is licensed.

(h) In addition to the action required by subsection (g), the bureau is authorized to file a civil action against a covered hospital and its controlling person or persons to collect delinquent annual coverage assessment installments, late penalties, and refund obligations established by this part. Exclusive jurisdiction and venue for a civil action authorized by this subsection (h) shall be in the chancery court for Davidson County.

(i)

(1) If any federal agency with jurisdiction over this annual coverage assessment determines that the annual coverage assessment is not a valid source of revenue or if there is a reduction of the coverage and funding of the TennCare program contrary to § 71-5-1103(c), or if the requirements of §§ 71-5-

161 and 71-5-1103(b) are not fully satisfied, or if one (1) or more managed care organizations impose rate reductions contrary to § 71-5-1103(d), then:

(A) No subsequent installments of the annual coverage assessment shall be due and payable; and

(B) No further payments shall be paid to hospitals pursuant to § 71-5-1105(d)(2) after the date of such event.

(2)

(A) Notwithstanding this part, if CMS discontinues approval of or otherwise fails to approve the full amount of payments to hospitals to offset losses incurred from providing services to TennCare enrollees as authorized under § 71-5-1105(d)(2), then the bureau shall suspend any payments from or to covered hospitals otherwise required by this part and shall promulgate rules that:

(i) Establish the methodology for determining the amounts, categories, and times of payments to hospitals, if any, instead of the payments that otherwise would have been paid under § 71-5-1105(d)(2) if approved by CMS;

(ii) Identify the benefits and services for which funds will be available in order to mitigate reductions or eliminations that otherwise would be imposed in the absence of the coverage assessment;

(iii) Determine the amount and timing of payments for benefits and services identified under subdivision (i)(2)(A)(ii) as appropriate;

(iv) Reinstigate payments from or to covered hospitals as appropriate; and

(v) Otherwise achieve the goals of this subdivision.

(B) The rules adopted under this subdivision (i)(2) shall, to the extent possible, achieve the goals of:

(i) Maximizing the amount of federal matching funds available for the TennCare program; and

(ii) Minimizing the variation between payments hospitals will receive under the rules as compared to payments hospitals would have received if CMS had approved the total payments described in § 71-5-1105(d).

(C) Notwithstanding any other law, the bureau is authorized to exercise emergency rulemaking authority to the extent necessary to meet the objectives of this subdivision (i)(2).

(3) Upon occurrence of any of the events set forth in subdivisions (i)(1) or (i)(2), the bureau shall then have authority to make necessary changes to the TennCare budget to account for the loss of annual coverage assessment revenue.

(j) A covered hospital or an association representing covered hospitals, the membership of which includes thirty (30) or more covered hospitals, shall have the right to file a petition for declaratory order pursuant to § 4-5-223 to determine if there has been a failure to satisfy one (1) of the conditions precedent to the valid imposition of the annual coverage assessment.

(k) A covered hospital may not increase charges or add a surcharge based on, or as a result of, the annual coverage assessment.

(l) Notwithstanding this part, if the bureau receives notification from CMS of the determination and approval set forth in § 71-5-1103(b), and if the determination and approval have retroactive effective dates, then:

(1) Quarterly annual coverage assessment payments that become due by application of the retroactive determination date from CMS shall be paid to the bureau within thirty (30) days of the bureau notifying the Tennessee Hospital Association that CMS has issued the determination; and

(2) Quarterly payments to covered hospitals required by § 71-5-1105(d)(2) that become due by application of the retroactive approval date from CMS shall be paid within fifteen (15) days of the bureau notifying the Tennessee Hospital Association that CMS has issued such approval.

**71-5-1105.**

(a) The funds generated as a result of this part shall be deposited in the maintenance of coverage trust fund created by § 71-5-160, the existence of which is continued as provided in subsection (b). The fund shall not be used to replace any monies otherwise appropriated to the TennCare program by the general assembly or to replace any monies appropriated outside of the TennCare program.

(b) The maintenance of coverage trust fund shall continue without interruption and shall be operated in accordance with § 71-5-160 and this section.

(c) The maintenance of coverage trust fund shall consist of:

(1) All annual coverage assessments received by the bureau; and

(2) Investment earnings credited to the assets of the maintenance of coverage trust fund.

(d) Monies credited or deposited to the maintenance of coverage trust fund, together with all federal matching funds, shall be available to and used by the bureau only for expenditures in the TennCare program and shall include the following purposes:

(1) Expenditure for benefits and services under the TennCare program that would have been subject to reduction or elimination from TennCare funding

for FY 2016-2017, except for the availability of one-time funding for that year only, as follows:

(A) Replacement of across-the-board reductions in covered and excluded hospital and professional reimbursement rates described in the governor's recommended budgets since FY 2011;

(B) Maintenance of essential access hospital payments to the maximum allowed by CMS under the TennCare waiver of at least one hundred million dollars (\$100,000,000);

(C) Maintenance of payments to critical access hospitals to achieve reimbursement of full cost of benefits provided to TennCare enrollees up to ten million dollars (\$10,000,000);

(D) Maintenance of reimbursement to offset critical access charity costs up to six million dollars (\$6,000,000);

(E) Maintenance of payments for graduate medical education of at least fifty million dollars (\$50,000,000);

(F) Maintenance of reimbursement for medicare part A crossover claims at the lesser of one hundred percent (100%) of medicare allowable or the billed amount;

(G) Avoidance of any coverage limitations relative to the number of hospital inpatient days per year or annual cost of inpatient services for a TennCare enrollee;

(H) Avoidance of any coverage limitations relative to the number of nonemergency outpatient visits per year for a TennCare enrollee;

(I) Avoidance of any coverage limitations relative to the number of physician office visits per year for a TennCare enrollee;

(J) Avoidance of coverage limitations relative to the number of laboratory and diagnostic imaging encounters per year for a TennCare enrollee;

(K) Maintenance of coverage for occupational therapy, physical therapy, and speech therapy services; and

(L) Making medicaid-disproportionate-share hospital payments at the maximum amount authorized by the federal Social Security Act for FY 2016-2017 or expanded essential access hospital (EAH) payments if approved by CMS;

(2)

(A) Solely from the annual coverage assessment payments received by the bureau, payments to covered hospitals to offset losses incurred in providing services to TennCare enrollees as set forth in this subdivision (d)(2);

(B) Each covered hospital shall be entitled to payments for FY 2016-2017 of a portion of its unreimbursed cost of providing services to TennCare enrollees. Unreimbursed TennCare costs are defined as the excess of TennCare cost over TennCare net revenue as reported on Schedule E, items (A)(1)(c) and (A)(1)(d) from the hospital's 2014 joint annual report filed with the department of health. TennCare costs are defined as the product of a facility's cost-to-charge ratio times TennCare charges. The amount of the payment to covered hospitals shall be no less than forty-three and twenty-four hundredths percent (43.24%) of unreimbursed TennCare cost for all hospitals licensed by the state that reported unreimbursed TennCare cost on the 2014 joint annual report (JAR), excluding state-owned hospitals;

(C) The payments required by this subdivision (d)(2) shall be made in four (4) equal installments. Each installment payment shall be made by the third business day of four (4) successive calendar quarters, with the first calendar quarter to be the calendar quarter in which the annual coverage assessment is first levied in accordance with § 71-5-1104. The bureau shall provide to the Tennessee Hospital Association a schedule showing the quarterly payments to each hospital at least seven (7) days in advance of the payments; and

(D) The payments required by this subdivision (d)(2) may be made by the bureau directly to the hospitals, or the bureau may transfer the funds to one (1) or more managed care organizations with the direction to make payments to hospitals as required by this subsection (d). The payments to a hospital pursuant to this subdivision (d)(2) shall not be considered part of the reimbursement to which a hospital is entitled under its contract with a TennCare managed care organization;

(3) Refunds to covered hospitals based on the payment of annual coverage assessments or penalties to the bureau through error, mistake, or a determination that the annual coverage assessment was invalidly imposed;

(4)

(A) Solely from funds remaining in the trust fund as of June 30, 2016, payments, and expenditures in the TennCare program as follows:

(i) In the total amount of five hundred eighty-seven thousand nine hundred dollars (\$587,900) to maintain reimbursement at the emergency care rate for nonemergent care to children aged twelve (12) to twenty-four (24) months to avoid

the reduction described in the governor's FY 2016-2017 recommended budget;

(ii) In the total amount of two million one hundred one thousand dollars (\$2,101,000) to the bureau to offset the elimination of the provision in the TennCare managed care contractor risk agreements for hospitals as follows:

"CRA 2.12.9.60-Specify in applicable provider agreements that all providers who participate in the federal 340B program give TennCare MCOs the benefit of 340B pricing.";

(iii) In the total amount of three million dollars (\$3,000,000) for reimbursement to offset a portion of the remaining critical access hospital charity costs; and

(iv) In the total amount of three million dollars (\$3,000,000) to fund critical access hospital charity costs for FY 2015-2016; and

(B) Expenditures authorized under this subdivision (d)(4) shall be in addition to expenditures otherwise authorized under subdivisions (d)(1)-(3); and

(5) Payments authorized under rules promulgated by the bureau pursuant to § 71-5-1104(i)(2).

(e) If a hospital closes or changes status from a covered hospital to an excluded hospital and consequently reduces the amount of the annual coverage assessment to the extent that the amount is no longer sufficient to cover the total cost of the items included in subsection (d), the payments for these items may be adjusted by an amount equal to the shortfall, including the federal financial participation. The items to be

adjusted and the amounts of the adjustments shall be determined by the bureau in consultation with hospitals.

(f) The bureau shall modify the contracts with TennCare managed care organizations and otherwise take action necessary to assure the use and application of the assets of the maintenance of coverage trust fund, as described in subsection (d).

(g) The bureau shall submit requests to CMS to modify the medicaid state plan, the contractor risk agreements, or the TennCare II Section 1115 demonstration project, as necessary, to implement the requirements of this part.

(h) At quarterly intervals beginning September 1, 2016, the bureau shall submit a report to the finance, ways and means committees of the senate and the house of representatives, to the health and welfare committee of the senate, and to the health committee of the house of representatives, which report shall include:

(1) The status, if applicable, of the determination and approval by CMS set forth in § 71-5-1103(b) of the annual coverage assessment;

(2) The balance of funds in the maintenance of coverage trust fund; and

(3) The extent to which the maintenance of coverage trust fund has been used to carry out this part.

(i) No part of the maintenance of coverage trust fund shall be diverted to the general fund or used for any purpose other than as set forth in this part.

**71-5-1106.** This part shall expire on June 30, 2017; provided, however, that the following rights and obligations shall survive such expiration:

(1) The authority of the bureau to impose late payment penalties and to collect unpaid annual coverage assessments and required refunds;

(2) The rights of a covered hospital or an association of covered hospitals to file a petition for declaratory order to determine whether the annual coverage assessment has been validly imposed;

(3) The existence of the maintenance of coverage trust fund and the obligation of the bureau to use and apply the assets of the maintenance of coverage trust fund;  
and

(4) The obligation of the bureau to implement and maintain the requirements of § 71-5-161 and § 71-5-703(b)(3), as enacted by Chapter 276 of the Public Acts of 2015.

SECTION 3. This act shall take effect July 1, 2016, the public welfare requiring it.